ZAMBIA

National Disability Survey

2015

Zambia National Disability Survey 2015

&HQWUDO 6WDWLVWLFDO 2I¿FH
Lusaka, Zambia

Ministry of Community Development and Social Services
Lusaka, Zambia

DECEMBER 2018

ZAMBIA

NATIONAL DISABILITY SURVEY

LIST OF ABBREVIATIONS

AIDS	$FTXLUHG ,PPXQH 'H¿FLHQF\ 6\QGURPH
AT	Advanced Technology
CRPD	(United Nations) Convention on the Rights of Persons with Disabilities
CSAs	Census Supervisory Areas
CSO	&HQWUDO 6WDWLVWLFDO 2I¿FH
DPOs	disabled people’s organizations
DVD	Digital Versatile Disc
EAs	Enumeration Areas
Eds.	Editors
GDP	Gross Domestic Product
GHQ	General Health Questionnaire
GRZ	Government of the Republic of Zambia
HIV	+XPDQ ,PPXQRGH¿FLHQF\ 9LUXV
ICF	,QWHUQDWLRQDO &ODVVL¿FDWLRQ RI)XQFWLRQLQJ 'LVDELO
INESOR	Institute of Economic and Social Research
LCMS	Living Conditions Monitoring Surveys
MCDSS	Ministry of Community Development and Social Services
MoF	0LQLVWU\ RI)LQDQFH
MoH	Ministry of Health
N	Number
n.s.	1RW VSHFL¿HG
N/A	Not applicable
NDS	National Disability Survey
NGOs	Non-governmental organizations
NPC	National Planning Commission
NRC	National Registration Card
OECD	Organisation for Economic Cooperation and Development
PPES	probability proportional to estimated size
PSUs	primary sampling units
SES	socio-economic status
Std.	Standard
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TV	Television
UN	United Nations
UNDP	United Nations Development Plan
UNICEF	8QLWHG 1DWLRQV &KLOGUHQ¶V)XQG
UNSC	United Nations Statistical Commission
UNZA	University of Zambia
WG	Washington Group (on Disability Statistics)
WHO	World Health Organisation

TABLE OF CONTENTS

LIST OF ABBREVIATIONS IV

1. ACKNOWLEDGEMENTS 5

2. EXECUTIVE SUMMARY 6

3. PREFACE 9

4. INTRODUCTION 10

Background to the study 10
=DPELD FRXQWU\ SUR¿OH EDFNJURXQG RI =DPELD &62 12
%DFNJURXQG GLVDELOLW\ SROLF\ LQ WKH FRQWH[W RI =DPELD ± DQ RYHU
recent developments and ongoing policy processes 14

5. CONCEPTUAL UNDERSTANDING 15

Disability 15
$SSOLFDWLRQ RI ,&) LQ WKH FXUUHQW VWXG\ 16
Living conditions 17
Disability and living conditions 17
&RPELQLQJ WZR WUDGLWLRQV DQG WKH ,&) 18

6. METHODOLOGY 19

Survey objectives 19
Study design and methodology 19
Survey organization 21
Survey questionnaires 21

7. RESULTS 23

Household section 23
,QGLYLGXDO VHFWLRQ ,QGLYLGXDO TXHVWLRQQDLUH \HDUV 41
,QGLYLGXDO VHFWLRQ &KLOG 0RGXOH ,QGLYLGXDO TXHVWLRQQDLUH ± 80

8. DISCUSSION 110

Household section 110
Individual section (18 years and older) 111
&KLOG VHFWLRQ ± \HDUV 113
Conclusion 115

REFERENCES 116

APPENDICES 118

$SSHQGL[$FWLYLW\ OLPLWDWLRQV DPRQJ SHUVRQV DJHG \HDUV DQG DERYH 118
$SSHQGL[6RFLR HFRQRPLF VWDWXV VFDOH E\ DFWLYLW\ OLPLWDWLRQ 119
$SSHQGL[3HUVRQV ZLWK GLVDELOLW\ DJHG \HDUV DQG DERYH ZKR DSSOLHG
for a grant, by disability severity, sex and rural/urban 122
$SSHQGL[3HUVRQV ZLWK GLVDELOLW\ DJHG \HDUV DQG DERYH FXUUHQWO\ UHFHLYLQJ
social security, grant or any other form of pension, by disability severity, sex
and rural/urban 123
$SSHQGL[$FWLYLW\ OLPLWDWLRQ DPRQJ SHUVRQV ZLWK GLVDELOLW\ DJHG \HDUV
and over by highest level of school attended 124
$SSHQGL[+RXVHKROG TXHVWLRQQDLUH 125
$SSHQGL[,QGLYLGXDO ZLWK GLVDELOLW\ TXHVWLRQQDLUH 145
$SSHQGL[,QGLYLGXDO ZLWKRXW GLVDELOLW\ TXHVWLRQQDLUH 174
$SSHQGL[0RGXOH RQ &KLOG)XQFWLRQLQJ DQG 'LVDELOLW\ TXHVWLRQQDLUH 196

TABLES

Table 6.1 Calculation of sample of households with persons with disabilities 20
Table 7.1 Results of the household and individual interviews 24
Table 7.2 Number of enumeration areas, households and population, by province 24
Table 7.3 Sample distribution, by household disability status, sex, age group and rural/urban (N=9,190) 25
Table 7.4 Percentage distribution of households with and without disabled members, by rural/urban and province 25
Table 7.5 Average household size, by household type and rural/urban 27
Table 7.6 Dependency ratios, by household type, rural/urban and province 28
Table 7.7 Housing ownership, by household type 29
Table 7.8 Source of energy for cooking (N=9,190) 29
Table 7.9 Source of energy for lighting (N=9,190) 29
Table 7.10 Source of drinking water (N=9,190) 30
Table 7.11 Toilet facilities (N=9,190) 30
Table 7.12 Ownership of agricultural land and livestock (N=9,190) 31
Table 7.13 Primary source of income, by households with and without persons with disabilities (N=9,190) 37
Table 7.14 Main causes of death, by household type (percentage of all deaths) 38
Table 7.15 Demographic information, by disability status, percentage and mean age 41
7DEOH 'LVWULEXWLRQ RI VHYHUH GLVDELOLW\ DFFRUGLQJ WR GLVDELOLW\ FRUH GRPDL 47
7DEOH &DXVHV RI GLVDELOLW\ \HDUV 49
7DEOH 2QVHW RI GLVDELOLW\ \HDUV 50
Table 7.19 Distribution of personal experience among persons with disabilities of being abused or discriminated against, by age, sex and province 51
7DEOH 3HUVRQV ZLWK GLVDELOLWLHV ZKR QHHGHG ZHUH DZDUH RI DQG UHFHLYHG VHUY 54
7DEOH *DS SURSRUWLRQ RI SHRSOH ZKR QHHGHG EXW GLG QRW UHFHLYH WKH VHUYLFHV 54
7DEOH 6RFLDO LQYROYHPHQW DQG SDUWLFLSDWLRQ 1 63
7DEOH 5HDVRQV IRU QRW YRWLQJ E\ GLVDELOLW\ VWDWXV \HDUV 1 66
7DEOH 0RVW LPSRUWDQW VRXUFHV RI LQIRUPDWLRQ DERXW GLVHDVHV 69 \HDUV
7DEOH ([SHULHQFHG SUREOHPV XQGHUVWDQGLQJ KHDOWK LQIRUPDWLRQ 69 E\ GLVDELOLW\
7DEOH (YHU KDG WKH GLVHDVH E\ GLVDELOLW\ VWDWXV \HDUV 70
7DEOH 6NLOOV WUDLQLQJ E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 75
7DEOH 0DLQ DFWLYLW\ GXULQJ ODVW VHYHQ GD\V E\ GLVDELOLW\ VWDWXV 77 DQG VH[
7DEOH 7KH VDPSOH RI FKLOGUHQ LQ WKH VWXG\ ± \HDUV 80
7DEOH 'LVWULEXWLRQ RI FKLOGUHQ ZLWK GLVDELOLWLHV LQ WKH VDPSOH 80 DQG PHDQ DJH
7DEOH 0HDQ DJH E\ GLVDELOLW\ VWDWXV DQG VH[± \HDUV 1 81
Table 7.32 Age distribution of children, by disability status and sex (N=3,862) 81
7DEOH &DXVH RI GLVDELOLW\ E\ VH[± \HDUV 1 94
7DEOH 6HUYLFH JDS E\ GLVDELOLW\ VWDWXV ± \HDUV 1 96
7DEOH 3URSRUWLRQ RI FKLOGUHQ E\ DFFHVVLELOLW\ WR IDFLOLWLHV DW 99 KRPH DQG GLV
7DEOH 3HUFHQWDJH RI FKLOGUHQ E\ DFFHVVLELOLW\ WR IDFLOLWLHV RXW 99 VLGH KRPH E\
7DEOH 0DLQ DFWLYLW\ GXULQJ WKH VHYHQ GD\V SUHFHGLQJ WKH VXUYH\ 104 ± \HDUV 1
7DEOH 3HUFHQWDJH RI FKLOGUHQ E\ NQRZOHGJH RI IRXU FRPPRQ GLVHDVHV 108 GLVDELOLW
7DEOH 3HUFHQWDJH RI FKLOGUHQ E\ NQRZOHGJH RI IRXU FRPPRQ GLVHDVHV 108 GLVDELOLW
7DEOH 3HUFHQWDJH RI FKLOGUHQ E\ VRXUFH RI LQIRUPDWLRQ IRU IRXU FRPPRQ GLVHDV 108
7DEOH 3URSRUWLRQ RI FKLOGUHQ ZLWK D SUREOHP LQ REWDLQLQJ RU XQGHUVWDQGLQJ LQIR 109
7DEOH 'LVHDVH H[SHULHQFH E\ GLVDELOLW\ VWDWXV ± \HDUV 1 109

FIGURES

)LJXUH 7KH ,&) PRGHO 16
)LJXUH 0HDQ QXPEHU RI SHUVRQV ZLWK GLVDELOLWLHV LQ KRXVHKROGV ZLWK GLVDEOHG 26
)LJXUH 3HUFHQWDJH RI KRXVHKROGV KDYLQJ DW OHDVW RQH GLVDEOHG PHPEHU KHDGHG 26
)LJXUH $JH GLVWULEXWLRQ E\ KRXVHKROG W\SH 27
)LJXUH 'LVWULEXWLRQ RI KRXVHKROG DVVHWV E\ KRXVHKROG W\SH 1 31
)LJXUH 'LVWULEXWLRQ RI KRXVHKROG DVVHWV E\ KRXVHKROG W\SH UXUDO 32 1
)LJXUH 'LVWULEXWLRQ RI KRXVHKROG DVVHWV E\ KRXVHKROG W\SH XUEDQ 32 1
)LJXUH 0HDQ VFDOH YDOXH RI 6(6 E\ KRXVHKROG W\SH DQG UXUDO XUEDQ 33 1
)LJXUH 6RFLR HFRQRPLF VWDWXV E\ KRXVHKROG W\SH DQG SURYLQFH 1 34
)LJXUH 0HDQ GLHWDU\ GLYHUVLW\ VFDOH E\ KRXVHKROG W\SH DQG UXUDO 35 XUEDQ 1

)LJXUH 0HDQ GLHWDU\ GLYHUVLW\ VFDOH E\ KRXVHKROG W\SH DQG SURYLQFH 1 35
)LJXUH $YDLODELOLW\ RI LQIRUPDWLRQ E\ KRXVHKROG W\SH DQG UXUDO XUEDQ 1 35
)LJXUH $YDLODELOLW\ RI LQIRUPDWLRQ E\ KRXVHKROG W\SH DQG SURYLQFH 36
)LJXUH 3HUFHQWDJH UHSRUWLQJ D GHDWK E\ KRXVHKROG W\SH 37
)LJXUH 'LVDELOLW\ SUHYDOHQFH DPRQJ DOO UHVSRQGHQWV DJHG DQG DERYH E\ VH[DQ 39
)LJXUH 'LVDELOLW\ SUHYDOHQFH DPRQJ GXOWV DJHG E\ VH[DQG UXUDO XUEDQ 39
)LJXUH 3UHYDOHQFH RI GLVDELOLW\ E\ SURYLQFH \HDUV 39
)LJXUH 3UHYDOHQFH RI GLVDELOLW\ DPRQJ FKLOGUHQ DJHG ± E\ VH[DQG UXUDO XUEDQ 40
)LJXUH 3UHYDOHQFH RI GLVDELOLW\ DPRQJ FKLOGUHQ DJHG ± E\ SURYLQFH 40
)LJXUH 3HUFHQWDJH RI SHUVRQV ZKR ZHUH PDUULHG E\ GLVDELOLW\ VWDWXV VH[DQG UXU 42
)LJXUH 3URSRUWLRQ RI VSRXVHV RI SHUVRQV ZLWK DQG ZLWKRXW GLVDELOLWLHV OLYLQJ ZLWK 43
)LJXUH 3URSRUWLRQ KDYLQJ FKLOGUHQ E\ GLVDELOLW\ VWDWXV VH[DQG UXUDO XUEDQ 43
)LJXUH 0HDQ QXPEHU RI FKLOGUHQ E\ GLVDELOLW\ VWDWXV VH[DQG UXUDO XUEDQ \HD 44
)LJXUH 0DLQ FDUHU E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 1 44
)LJXUH $FWLYLW\ OLPLWDWLRQV DPRQJ SHUVRQV ZLWK GLVDELOLWLHV \HDUV 1 45
)LJXUH 1XPEHU RI DFWLYLW\ OLPLWDWLRQV DW OHDVW VRPH GLI¿FXOW\ E\ VH[\HDUV 46
)LJXUH /HYHO RI GLI¿FXOW\ :* VFDOH VFRUH E\ VH[DQG UXUDO XUEDQ \HDUV 1 46
)LJXUH /HYHO RI GLI¿FXOW\ :* VFDOH E\ SURYLQFH \HDUV 1 47
)LJXUH 'LVDELOLW\ VHYHULW\ E\ VH[DQG UXUDO XUEDQ \HDUV 1 48
)LJXUH 6HYHULW\ RI GLVDELOLW\ E\ SURYLQFH \HDUV 1 48
)LJXUH 0HDQ DJH RI GLVDELOLW\ RQVHW E\ GLVDELOLW\ VHYHULW\ DQG VH[\HDUV 1 50
)LJXUH $EXVH DQG GLVFULPLQDWLRQ E\ GLVDELOLW\ VHYHULW\ \HDUV 1 DQG 1 52
)LJXUH 3URSRUWLRQ RI UHVSRQGHQWV ZLWK DQG ZLWKRXW GLVDELOLWLHV ZKR FODLP WR
EHIRUH DJH E\ VH[DQG UXUDO XUEDQ \HDUV 1 52
)LJXUH 3URSRUWLRQ RI UHVSRQGHQWV VH[XDOO\ DEXVHG DV FKLOGUHQ \HDUV 1 53
)LJXUH 6DWLVIDFWLRQ ZLWK VHUYLFHV \HDUV 55
)LJXUH 8VH RI DVVLVWLYH GHYLFH DPRQJ SHUVRQV ZLWK GLVDELOLWLHV E\ VH[DQG UXUDO 55
)LJXUH 8VH RI DVVLVWLYH GHYLFHV E\ VH[DQG SURYLQFH \HDUV 1 56
)LJXUH 8VH RI DVVLVWLYH GHYLFHV E\ GLVDELOLW\ VHYHULW\ DQG VH[\HDUV 1 56
)LJXUH 7\SHV RI GHYLFHV LQ XVH \HDUV 1 ± 57
)LJXUH 7\SH RI GHYLFHV LQ JRRG ZRUNLQJ RUGHU \HDUV 1 ± 57
)LJXUH 6RXUFHV RI DVVLVWLYH GHYLFHV 1 ± 58
)LJXUH 0DLQWHQDQFH RI DVVLVWLYH GHYLFHV \HDUV 1 ± 58
)LJXUH ,QIRUPDWLRQ DQG WUDLQLQJ JLYHQ LQ XVH RI DVVLVWLYH GHYLFHV \HDUV 1 ± 59
)LJXUH 6DWLVIDFWLRQ ZLWK DVVLVWLYH GHYLFH E\ VH[DQG UXUDO XUEDQ \HDUV 1 59
)LJXUH 6DWLVIDFWLRQ ZLWK VHUYLFHV E\ VHYHULW\ RI GLVDELOLW\ \HDUV 1 60
)LJXUH $FFHVVLELOLW\ WR IDFLOLWLHV DW KRPH IRU SHUVRQV ZLWK GLVDELOLWLHV \HD 60
)LJXUH $FFHVVLELOLW\ WR VHUYLFHV IDFLOLWLHV LQ WKH ORFDO FRPPXQLW\ \HDUV 1 61
)LJXUH +HOS IURP IDPLO\ PHPEHUV LQ GDLO\ OLIH DFWLYLWLHV \HDUV 1 ± 61
)LJXUH 6RFLDO SDUWLFLSDWLRQ µ\HV¶ E\ GLVDELOLW\ VWDWXV \HDUV 1 ± 62
)LJXUH $ZDUHQHVV RI '32V DPRQJ SHUVRQV ZLWK GLVDELOLWLHV E\ VH[DQG UXUDO XUEDQ 63
)LJXUH 3URSRUWLRQ RI SHUVRQV ZLWK GLVDELOLWLHV ZKR DUH DZDUH RI DQG DUH PHPEHU
UXUDO XUEDQ \HDUV 1 S 64
)LJXUH 3HUVRQV ZLWK D 1DWLRQDO 5HJLVWUDWLRQ &DUG E\ GLVDELOLW\ VWDWXV VH[DQ 64
)LJXUH 5HJLVWHUHG YRWHUV E\ GLVDELOLW\ VWDWXV VH[DQG UXUDO XUEDQ \HDUV 1 65
)LJXUH 3HUVRQV ZKR YRWHG LQ WKH JHQHUDO HOHFWLRQ E\ GLVDELOLW\ VWDWXV VH[65
)LJXUH 3HUVRQV ZKR YRWHG LQ WKH JHQHUDO HOHFWLRQ E\ GLVDELOLW\ VHYHULW\ DQ 66
)LJXUH 3V\FKRVRFLDO ZHOOEHLQJ *+4 E\ GLVDELOLW\ VWDWXV VH[DQG UXUDO XUEDQ 67
)LJXUH 3V\FKRVRFLDO ZHOOEHLQJ *+4 E\ GLVDELOLW\ VHYHULW\ DQG VH[\HDUV 1 67
)LJXUH *HQHUDO SK\VLFDO KHDOWK E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 1 68
)LJXUH *HQHUDO PHQWDO KHDOWK E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 1 68
)LJXUH .QRZOHGJH RI IRXU FRPPRQ GLVHDVHV E\ GLVDELOLW\ VWDWXV \HDUV 1 ± 68
)LJXUH (YHU DWWHQGHG VFKRRO E\ GLVDELOLW\ VWDWXV VH[DQG UXUDO XUEDQ \HDU 70
)LJXUH (YHU DWWHQGHG IRUPDO SULPDU\ HGXFDWLRQ E\ GLVDELOLW\ VWDWXV VH[DQG UX 71
)LJXUH 0HDQ QXPEHU RI \HDUV DW VFKRRO DPRQJ WKRVH ZKR HYHU DWWHQGHG VFKRRO E\
\HDUV 1 71
)LJXUH 1XPEHU RI \HDUV DW VFKRRO E\ GLVDELOLW\ VHYHULW\ VH[DQG UXUDO XUEDQ 72
)LJXUH /HYHO RI HGXFDWLRQ KDV KHOSHG VHFXUH D MRE E\ GLVDELOLW\ VWDWXV VH[DQG 72
)LJXUH +LJKHVW OHYHO RI HGXFDWLRQ DWWHQGHG E\ GLVDELOLW\ VWDWXV DQG VH[\H 73
)LJXUH +LJKHVW OHYHO RI HGXFDWLRQ DWWHQGHG E\ GLVDELOLW\ VWDWXV DQG UXUDO XU 73
)LJXUH (YHU EHHQ UHIXVHG HQWU\ WR VFKRRO E\ VH[\HDUV 1 74

)LJXUH 6WXGLHG DV IDU DV SODQQHG E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 1 74
)LJXUH $ELOLW\ WR UHDG E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 1 75
)LJXUH $ELOLW\ WR UHDG E\ GLVDELOLW\ VWDWXV DQG UXUDO XUEDQ \HDUV 1 75
)LJXUH 3HUFHQWDJH RI SHRSOH ZLWK D VNLOO E\ GLVDELOLW\ VWDWXV VH[DQG UXUDO 76
)LJXUH 3HUFHQWDJH RI SHRSOH ZLWK D VNLOO E\ GLVDELOLW\ VHYHULW\ VH[DQG UXUDO 76
)LJXUH +RZ WKH VNLOO ZDV DFTXLUHG E\ GLVDELOLW\ VWDWXV DQG VH[\HDUV 1 77
)LJXUH 3HUFHQWDJH ZKR KDG SDLG ZRUN IRU DW OHDVW RQH KRXU LQ WKH SUHYLRXV VH
\HDUV 1 78
)LJXUH 3HUFHQWDJH ZKR KDG DSSOLHG IRU D JUDQW E\ VH[DQG UXUDO XUEDQ SHUVRQ 78
)LJXUH 3HUFHQWDJH LQ UHFHLSW RI DQ\ JUDQW E\ VH[DQG UXUDO XUEDQ GLVDEOHG RQ 79
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)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZLWK GLVDELOLWLHV ZKR KDG GLI¿FXOW\ VHHLQJ DQG 82
)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZLWK GLVDELOLWLHV ZKR KDG GLI¿FXOW\ OHDUQLQJ Q 83
)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZLWK GLVDELOLWLHV ZKR KDG GLI¿FXOW\ OHDUQLQJ W
± \HDUV 1 83
)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZKR KDG GLI¿FXOW\ ZDONLQJ E\ VH[\HDUV 1 84
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)LJXUH 3URSRUWLRQ RI SDUHQWV FDUHJLYHUV ZLWK D FKLOG ZLWK GLVDELOLWLHV ZKR K
ZDQWHG ± \HDUV 1 85
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)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZLWK GLVDELOLWLHV ZKR KDG GLI¿FXOW\ SOD\LQJ E\ 86
)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZLWK GLI¿FXOW\ SOD\LQJ ZLWK WR\V RU KRXVHKROG R 86
)LJXUH 3URSRUWLRQ RI GLVDEOHG FKLOGUHQ ZLWK GLI¿FXOW\ ZDONLQJ RU PHWUHV 86
)LJXUH 3URSRUWLRQ RI FKLOGUHQ ZLWK GLI¿FXOW\ ZLWK VHOI FDUH E\ VH[± \HDUV 87
)LJXUH 3URSRUWLRQ RI GLVDEOHG FKLOGUHQ ZLWK GLI¿FXOW\ XQGHUVWDQGLQJ RWKHUV 87
)LJXUH 3URSRUWLRQ RI GLVDEOHG FKLOGUHQ ZLWK GLI¿FXOW\ EHLQJ XQGHUVWRRG ± 87
)LJXUH 3URSRUWLRQ RI GLVDEOHG FKLOGUHQ ZLWK GLI¿FXOW\ OHDUQLQJ WR GR QHZ WKL 88
)LJXUH 3URSRUWLRQ RI GLVDEOHG FKLOGUHQ ZLWK GLI¿FXOW\ UHPHPEHULQJ WKLQJV WK 88
)LJXUH 3URSRUWLRQ RI GLVDEOHG FKLOGUHQ ZLWK GLI¿FXOW\ FRQWUROOLQJ WKHLU EHK 89
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)LJXUH $FWLYLW\ OLPLWDWLRQ VFDOH YDOXHV E\ GLVDELOLW\ VWDWXV \HDUV 1 93
)LJXUH $FWLYLW\ OLPLWDWLRQ VFDOH YDOXHV E\ GLVDELOLW\ VWDWXV DQG ORFDWLRQ 93
)LJXUH $FWLYLW\ OLPLWDWLRQ PHDQ VFDOH YDOXHV E\ GLVDELOLW\ VWDWXV DQG SURYL 94
)LJXUH 3URSRUWLRQ RI FKLOGUHQ E\ KRZ RIWHQ WUDQVSRUWDWLRQ KDG EHHQ D SUREO 95
)LJXUH 3URSRUWLRQ RI FKLOGUHQ E\ KRZ RIWHQ SHRSOH¶V DWWLWXGHV DW VFKRRO RU
± \HDUV 1 95
)LJXUH 3URSRUWLRQ RI FKLOGUHQ E\ KRZ RIWHQ WKH\ H[SHULHQFHG SUHMXGLFH RU GLVFUL 95
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)LJXUH 3URSRUWLRQ RI FKLOGUHQ E\ VDWLVIDFWLRQ ZLWK KHDOWK VHUYLFHV DQG GLVD 98
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)LJXUH 3HUFHQWDJH RI FKLOGUHQ UHIXVHG HQWU\ WR SUH VFKRRO E\ GLVDELOLW\ VWDW 101
)LJXUH 3HUFHQWDJH RI FKLOGUHQ UHIXVHG HQWU\ WR SULPDU\ VFKRRO E\ GLVDELOLW\ V 102
)LJXUH 3HUFHQWDJH RI FKLOGUHQ UHIXVHG HQWU\ WR VHFRQGDU\ VFKRRO E\ GLVDELOLW 102
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)LJXUH 3HUFHQWDJH RI FKLOGUHQ ZKR KDYH VWXGLHG DV IDU DV SODQQHG E\ GLVDELOL 103
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)LJXUH 7\SH RI PHGLFLQH XVHG E\ FKLOGUHQ ZLWK GLVDELOLWLHV ZKR XVHG PHGLFLQH 105
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)LJXUH 3HUFHQWDJH RI FKLOGUHQ E\ ZHOOEHLQJ DQG GLVDELOLW\ VWDWXV DQG VH[± 106
)LJXUH 3HUFHQWDJH RI FKLOGUHQ E\ SK\VLFDO KHDOWK GLVDELOLW\ VWDWXV DQG VH[107
)LJXUH 3HUFHQWDJH RI FKLOGUHQ E\ PHQWDO KHDOWK GLVDELOLW\ VWDWXV DQG V 107

1. ACKNOWLEDGEMENTS

Zambia conducted the National Disability Survey (NDS 2015) from June to July 2015. The disability survey was planned against the background of limited existing research-based knowledge about disability in Zambia. It includes both prevalence estimates and a broad mapping and analysis of socio-economic and demographic characteristics of persons with disabilities, including children, and an assessment of their quality of life in terms of activities, participation and use of services. It is therefore anticipated that the information generated by the study will inform the mainstreaming of the response to disability in Zambia.

7KH VXUYH\ EHQH¿WHG JUHDWO\ IURP WKH XQZDYHULQJ ¿QDQFLDO DVV
81,&() DQG WKH *RYHUQPHQW RI)LQODQG , WKHUHIRUH ZLVK WR WKDQN
generosity in making available the funds for this survey and for facilitating the provision of technical assistance. I also
ZLVK WR WKDQN WKH *RYHUQPHQW RI WKH 5HSXEOLF RI =DPELD ± DQG LQ
DQG 6RFLDO 6HUYLFHV 0&'66 ± IRU VXSSOHPHQWLQJ WKH FRRSHUDWLQJ
0\ RI¿FH LV LQGHEWHG WR 6,17() IRU WKH WHFKQLFDO VXSSRUW SURYLGH
GLOLJHQFH DQG SDWLHQFH HQVXUHG WKDW WKH RI¿FHUV LQYROYHG LQ
WUDLQLQJ GDWD SURFHVVLQJ DQG DQDO\VLV ± KDG WKH QHFHVVDU\ WHF
for making available standard instruments to guide the survey methodology and its implementation. I would also like to extend my gratitude to MCDSS personnel at the national, provincial and district levels for their support in allowing staff to participate. My sincere gratitude goes to the various institutions that deal with issues affecting people with
GLVDELOLWLHV IRU WKHLU UHYLHZV DQG IHHGEDFN RQ WKH ¿HOG LQVWU
respondents for their cooperation and for providing data on such a sensitive issue as disability.

)LQDOO\ , WKDQN DOO &HQWUDO 6WDWLVWLFDO 2I¿FH VWDII LQYROYHG
the different stages of the survey, including data collection, data processing, analysis and writing of this report.

Goodson Sinyenga
Acting Director of Census and Statistics
December 2018

2. EXECUTIVE SUMMARY

The Zambia National Disability Survey 2015 was initiated by the Ministry of Community Development and Social Services (MCDSS), and implemented by WKH &HQWUDO 6WDWLVWLFDO 2¿FH &62 WKH 8QLYHUVLW\ RI =DPELD 81=$ LQ FROODERUDWLRQ ZLWK 6,17() 7HFKQRORJ\ DQG 6RFLHW\ 1RUZD\ DQG 81,&() =DPELD Its main objective was to estimate the national prevalence of disability among adults and children, disaggregated by sex, severity of disability, province and the rural/urban division. It is based on the understanding of disability VHW RXW LQ WKH ,QWHUQDWLRQDO &ODVVL¿FDWLRQ RI)XQFWLRQLQJ 'LVDELOLW\ DQG +HDOWK ,&)

The Washington Group 6 screening questions and the :DVKLQJWRQ *URXS 81,&() &KLOG 0RGXOH ZHUH XVHG both to identify individuals with disability and to conduct further analysis of associations between disability and indicators of standards of living. A number of indicators were included and are analysed at the household level DPRQJ ERWK DGXOWV \HDUV DQG FKLOGUHQ ± \HDUV

Prevalence of disability was estimated to be 10.9 percent DPRQJ DGXOWV \HDUV ,W in rural areas, and higher among females than among PDOHV $PRQJ FKLOGUHQ ± \HDUV WKH SUHYDOHQFH ZDV estimated to be 4.4 percent. Prevalence varied between the provinces, with the highest estimates in Luapula and Copperbelt Provinces among both adults and children.

A detailed questionnaire was administered that VSHFL¿FDOO\ DGGUHVVHG WKH LQGLYLGXDO LGHQWL¿HG as having disability. The person with disability was the respondent (individual-level data); if the individual with disability was unable to respond to the questionnaire, then a proxy was used. The report also includes some comparisons on living conditions between persons with and without disability (controls).

Individuals with disability included in the study were clearly older than the matched control individuals. This study also indicates an age gradient in disability that follows from the natural ageing process.

The most common functional problem reported was with sight; this was followed by problems with walking, remembering, hearing, self-care and communication. A large majority (57.9 percent) reported mild disability; moderate and severe disability were highest for sight and walking problems. Of individuals with disability, around one in three had more than one functional problem. Severity of disability varied with sex, location and province to some extent.

Nearly one person in three gave disease/illness as the main cause of disability, while one in eight reported that the disability had been present at birth (congenital). While disability onset in the population could occur at DQ\ VWDJH RI OLIH DERXW D WKLUG LQ WKH SRSXODWLRQ EHWZHHQ ELUWK DQG \HDUV RI DJH (21.1 percent) acquired their disability after the age of 60.

Around 10 percent said they had been beaten or scolded, and around 8 percent reported experience of having been discriminated against by public services. Abuse and discrimination increased with severity of disability. About 8 percent had experienced physical abuse as a child, while 2 percent had suffered sexual abuse. There are variations between the provinces in all these indicators; also more females than males had experienced sexual abuse, whereas somewhat more males had experienced beating/scolding and physical abuse.

*DSV LQ DFFHVV WR VHUYLFHV ZHUH LG as a proportion of those who needed a service but did not access it. Empowerment programmes (94.3 percent), welfare services (93.4 percent) and legal aid (84.7 percent) had the largest gaps, while the lowest were in health services (8.1 percent) and health information (9.9 percent). About 20 percent of individuals with disability used an assistive device. There were more individuals with assistive devices in urban areas and among individuals with severe disability. A narrow range RI DVVLVWLYH GHYLFHV SUHGRPLQDWH information and mobility devices. The source of assistive devices was most commonly private, and the device users mostly maintained their devices themselves. Around one in four was not content with the assistive device, and those with more serious disability tended to be less content than those with mild or moderate disability.

Persons with disabilities are less involved/included in social and community life than those without disabilities.

Those with disabilities are thus consulted less often on household decisions, are included less often in family events and are involved less frequently in family matters DQG IDPLO\ FRQYHUVDWLRQV)XUWKHUPRUH LQGLYLGXDOV ZLWK disability take part less often in traditional practices or ceremonies; few of them make important decisions about their own lives; they often feel that their voices are not being heard; and few report taking part in local community meetings. Lower levels of social participation were found across age categories and types of functional problem, and more severe disabilities were associated with less social participation.

Relatively few persons with disabilities are aware of disabled people's organizations (DPOs) and only 5.3 percent said they belonged to one. The large majority did, however, vote in general elections, and the differences between persons with and without disability were small.

About 1 in 10 persons with disabilities experienced problems with accessibility. This problem was more pronounced outside the home, and for many of them hotels, recreational facilities, sports facilities and banks ZHUH QRW DFFHVVLEOH)HZHU DFFHVVLELOLW\ SUREOHPV ZHUH reported for primary health clinics, places of worship, shops and hospitals. In rural areas, the main problem is that many of the services and facilities are simply not available to persons with disabilities.

Persons with disabilities have more health problems than WKRVH ZLWKRXW GLVDELOLWLHV ± IRU ERWK SK\VLFDO DQG PHQWDO health. Increased severity of disability was associated ZLWK LQFUHDVHG KHDOWK SUREOHPV 7KH VWXG\ DOVR FRQ¿UPV that persons with disabilities have a lower sense of wellbeing (which measures anxiety and depression) than those without disabilities. Awareness of four common diseases/illnesses (HIV/AIDS, sexually transmitted infections (STIs), diabetes and tuberculosis (TB)) is generally high in the population. However, persons with disabilities generally have less information about these diseases/illnesses and tend to rely more on informal sources of information than those without disabilities.

A large majority of respondents reported having accessed formal primary education, though fewer persons with disabilities (80.8 percent) than without (89.9 percent) reported having attended school at some point. Generally, persons with disabilities, rural dwellers and females reported fewer years at school.

Among persons with disabilities, 41.4 percent of males said that their level of education had helped them to get a job, compared to 20.3 percent of females. About 33 percent of persons with disabilities were illiterate, compared to 23.1 percent of those without a disability. In both categories, more females than males were illiterate.

More persons with disabilities than without reported KDYLQJ D VNLOO PDOHV SHUFHQW
IHPDOHV SHUFHQW YV SHUFHQW
economic activity, the study shows that individuals with disabilities, rural respondents and females are less frequently engaged in formal employment.

7KH VWXG\ SURYLGHV D SUR¿OH RI FKLOG
This shows that disability covers more than visible or serious impairments, and includes a range of functional problems present in the child population. The sample of FKLOGUHQ DJHG ± \HDUV FRPSULVHG RI ZKRP ZHUH LGHQWL¿HG DV KDYLQJ data indicate that among children with disability, 40 percent of their disabilities are congenital and 31 percent are the result of disease/illness.

There are considerable gaps in service provision (i.e. the proportion of those who need a service vs. the proportion who actually access it) among children with disability DJHG ± \HDUV IRU DVVLVWLYH GHYLFH SHUFHQW IRU FRXQVHOOLQJ ± SHUF WUDLQLQJ ± SHUFHQW DQG IRU HGXF SHUFHQW 2QO\ LQ WKH ¿HOGV RI KHD health services was a comparison made between children with and without disabilities, but here the gaps in services were found to be considerably larger for children with WKDQ ZLWKRXW GLVDELOLWLHV KHDOWK YV SHUFHQW KHDOWK LQIRUPDWLRQ SHUFHQW (YHQ WKRXJK WKH PDMRULW\ WKH VHUYLFHV WKH\ UHFHLYHG VWLOO D FKLOGUHQ ZLWK GLVDELOLW\ ZHUH QRW V

There were generally small differences between children ± \HDUV ZLWK DQG ZLWKRXW GLVDELO

DW KRPH $URXQG ± SHUFHQW UHSRUWHG WKDW WKH YDULRXV URRPV ZHUH DFFHVVLEOH)DFLOLWLHV DQG VHUYLFHV LQ WKH local community were less accessible, however, and more children with disability than without reported accessibility problems. Place of work was the least accessible place for both categories of children (20.3 percent vs. 24.1 percent). The most accessible facilities ZHUH WKH KHDOWK FOLQLF VKRSV DQG SODFHV RI ZRUVKLS ± ZLWK accessibility of over 80 percent. The largest accessibility gaps between children with and without disability were sports facilities (with a 14.8 percentage point difference in favour of children without disabilities), shops (12.8 percentage points) and schools (12.6 percentage points).

*HQHUDOO\ PRVW FKLOGUHQ ± \HDUV UHFHLYHG SULPDU\ education, although there are disparities between children with disability and those without (86.8 percent vs. 95.0 percent, respectively). One third of children with disability were illiterate, compared to 18 percent of non-disabled children. Literacy was higher among children without disabilities (81.7 percent) than with disabilities (67.0 percent). More children without disability were at school and more children with disability did housework in their own home or did not participate in any particular activity.

A total of 25.5 percent of boys and 23.4 percent of girls ± \HDUV ZLWK GLVDELOLWLHV WDN traditional medicine for their disability. In all, 5.8 percent of children with disability use an assistive device; more urban than rural respondents report using such a device, and more boys than girls in urban areas.

Overall, the National Disability Survey undertaken in Zambia in 2015 provides a unique source of data upon which to assess the situation among individuals with disabilities and their households. The study is a broad one, covering many different areas, and it is representative of children and adults with and without disabilities in Zambia. More in-depth or topically narrower studies may be necessary to generate further knowledge in particular areas of priority. There are relatively small differences in indicators of living conditions at the household level, but at the individual level the differences are pronounced and to the detriment of individuals with disabilities.

3. PREFACE

The Zambia National Disability Survey 2015 began in June 2015. Complete enumeration of chosen households in the selected enumeration areas (EAs) was achieved by 30 July 2015. The National Disability Survey was the second FRPSUHKHQVLYH VXUYH\ RQ GLVDELOLW\ DQG ZDV FRQGXFWHG E\ WKH ¿ Ministry of Community Development and Social Services, after a pilot study conducted by the University of Zambia Institute of Economic and Social Research (INESOR) in 2004.

'LVDELOLW\ VWDWLVWLFV FDQ SURYLGH D ZHDOWK RI LQIRUPDWLRQ RQ UDQJLQJ IURP WKH LPSDLUPHQWV WKH\ VXIIHU WKH GLI¿FXOWLHV WKH\ and the barriers that confront them in their lives; therefore, information from the survey can be extrapolated from individuals to the whole population, in order to determine the prevalence of domains of disability.

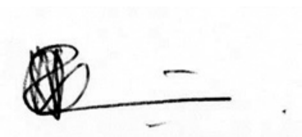
The preliminary results of the disability survey were released on 8 December 2015. These were based on early WDEXODWLRQV RI WKH GDWD ZKLFK ZHUH FROOHFWHG LQ WKH ¿HOG XV the time taken for data processing by cutting out the data-entry aspect. The data processing for the survey started in July 2015.

8QOLNH WKH SUHOLPLQDU\ UHVXOWV WKLV UHSRUW FRQWDLQV ¿QDO SR household characteristics, as well as the characteristics of the adults and children captured in the survey. The household-level data are disaggregated by households with and without disabled members. At the individual level, the information is disaggregated by disability status.

This report also presents information on quality of life, in terms of activities, participation and use of services by persons with disability. This information is further broken down by province, the rural/urban distinction, age and sex.

Good planning, using evidence-based decision making, is vital in making provision for all the different categories of Zambian people. Indicators provided in this report offer a good basis for decision making by the government and other stakeholders that contributes to improving the welfare of persons with disabilities. As stipulated by the UN's sustainable development goals, no one must be left behind; thus adequate provision for persons with disabilities as a special group in society is key to the development of any country.

At this stage, I would like to thank all of our cooperating partners who supported the 2015 National Disability Survey. 6SHFLDO WKDQNV JR WR WKH 8QLWHG 1DWLRQV &KLOGUHQ¶V)XQG 81,&() IRU WKH PDWHULDO ¿QDQFLDO DQG WHFKQLFDO VXSSRUW WKH\ SURYLGH &HQWUDO 6WDWLVWLFDO 2I¿FH GXULQJ WKLV PDPPRWK QDWLRQDO H[HU people and to all the residents of Zambia for their support and cooperation during the National Disability Survey. I hope the information contained in this report will be used effectively by all to plan and deliver development to the =DPELDQ SHRSOH ± DQG LQ SDUWLFXODU WR SHUVRQV ZLWK GLVDELOLW



Olipa Phiri Mwansa, MP

4. INTRODUCTION

This report is the product of a long-term initiative by the Ministry of Community Development and Social Services 0&'66 ZLWK ¿QDQFLDO DQG WHFKQLFDO VXSSRUW IURP 81,&() =DPELD Zambia in 2004, and it was felt that the time was right now to update the existing knowledge on the situation of people ZLWK GLVDELOLWLHV LQ WKH FRXQWU\ 7KH &HQWUDO 6WDWLVWLFDO 2 WKH OHDG UROHV LQ LPSOHPHQWLQJ WKH QDWLRQDO VXUYH\ DQG WKH 6RFLHW\ ZDV FKRVHQ E\ 81,&() =DPELD DV WKH WHFKQLFDO FRQVXOWD throughout the exercise. This study in Zambia draws on the experience of a series of similar studies undertaken in VRXWKHUQ $IULFD DV ZHOO DV RQ LQWHUQDWLRQDO GHYHORSPHQWV L of a growing body of evidence about the living conditions of persons with disabilities in low- and middle-income contexts.

=DPELD UDWL¿HG WKH 8QLWHG 1DWLRQV &RQYHQWLRQ RQ WKH 5LJKWV current study responds to the requirement in that document that all ratifying countries should collect data that can be used to map the situation of disabled persons. Such data are crucial for policy development, the development of services, priority setting, poverty reduction, etc.

BACKGROUND TO THE STUDY

7KRXJK WKH\ FRQWLQXH WR HYROYH VWDWLVWLFV RQ GLVDELOLW\ KDY is partly thanks to the long, ongoing process of establishing a new conceptual framework for disability measurement; but it is also due to increased interest internationally in the situation facing people with disabilities. Over a number of years, it has come to be realized that when policies are developed and implemented to reduce poverty and create inclusive societies, research and statistics are needed to ensure that particular account is taken of poor people with disabilities living in the low-income context of developing countries. The CRPD is very clear both that high-quality statistics are required and that it is the responsibility of national governments to ensure that this previously neglected ¿HOG LV JLYHQ SULRULW\

.QRZOHGJH RI WKH H[WHQW DQG QDWXUH RI GLVDELOLW\ LV LPSRUWD Estimates of disability prevalence are, however, highly dependent on the research instrument (screening instrument) used for the purpose. The main problem with current prevalence estimates globally is that different types of screening questions are used, which makes comparison between studies problematic. Also, the concept of disability has evolved over the past few decades, which has resulted in various different interpretations, and thus differences in the scope of research. An international seminar was hosted in 2001 by the United Nations Statistical Commission (UNSC) to address the disparate means of disability data collection. Recognizing the need for statistical and methodological work at the international level to facilitate the cross-national comparison of data on disability, the UNSC authorized the formation of the Washington Group on Disability Statistics (WG) in 2001.

7KH GHYHORSPHQW DQG DGRSWLRQ RI WKH ,QWHUQDWLRQDO &ODVVL¿F World Health Organization (WHO, 2001) provided an opportunity for the development of a joint terminology and understanding of disability across the disciplines.

2YHU WKH ODVW GHFDGH DQG PRUH WKH ,&) KDV JDLQHG LQ SURPLQH 7KH ,&) LV LQFUHDVLQJO\ DOVR EHLQJ DFFHSWHG DV WKH IRXQGDWLRQ WKH :* KDV EDVHG WKH GHYHORSPHQW RI LWV TXHVWLRQV IRU FHQVX WKH ,&) DQG WKH ZRUN RI WKH :*

1 http://www.cdc.gov/nchs/washington_group.htm

The previous large scale national study on disability in Zambi
apply the six questions developed by the WG (WG6) for censuses and surveys. The main problem with the questions, however, is that they are not well adapted to disability among children. Thus, the WG recently developed a Module on Child Functioning and Disability in collaboration with UNIC
of the six WG questions for adults and the WG UNICEF Child Modu
promise of better capturing the experience of disability in a s
the recently developed Child Module.

While determining prevalence is important surveys offer more
provide an opportunity to compare the situation of people with and without disabilities. Some studies in low-income countries have already collected a broad range of socio-economic and demographic characteristics of persons with disabilities Of particular relevance for the Zambia Nationa
partners on the living conditions of people with disabilities in Namibia (Eide, van Rooy and Loeb, 2003), Zimbabwe (Eide et al., 2003), Malawi (Loeb and Eide, 2004), Zambia (Eide and Loeb, 2006), South Africa (Loeb et al., 2008),
Mozambique (Eide and Kamaleri Lesotho Kamaleri and Eide
Botswana (Eide and Mmatli, 2016). The content and design of these studies were developed in close collaboration
with research partners government ministries central stat
countries. Together, they constitute a unique regional disability database that can serve as a reference for the Zambia National Disability Survey. In particular, the previous study in Zambia can provide reference data and adds to the value of the new data by enabling comparison over time.

Socio-economic and socio-demographic characteristics, quality of life in terms of activities, participation and use
of services – all these are elements to be found in the above
with disabilities. Most of the questions and scales in those studies are tried and tested research instruments. The earlier designs (content) were thus incorporated into the design-development process for this study, although the
current priorities in Zambia have strongly influenced its desi
availability of new research instruments. This new study will enable comparison between groups (impairment types, sex, urban/rural dwellers, region, age groups, etc.), which is often a very powerful tool in demonstrating particular needs for intervention.

While surveys are very useful for establishing estimates for a population and formulating a broad description of
the situation across a range of relevant indicators they ha
suited to producing in-depth knowledge of a phenomenon (i.e. they often yield relatively limited information on the
topics included Secondly they lack flexibility once data col
scope for acquiring subjective experiences and understanding
the complexity and heterogeneity of disability in terms of how individuals function and what they experience, any
survey tools including the recently developed WG UNICEF Child
obtain a fuller picture and to enrich the interpretation of
is recommended – for instance combining a survey with an in d
happen, the current set-up and funding of the study in Zambia represents just such an opportunity. Although the two sub-studies (survey and qualitative) will not be presented and analysed together in this report, it is expected that this will be done at a later stage.

ZAMBIA COUNTRY PROFILE: BACKGROUND OF ZAMBIA (CSO)

Zambia is a landlocked country in southern Africa. It is located between latitudes 8° and 18° south and longitudes 22° and 34° east and covers a total area of 752,612 square kilometres. The country is bordered by the Democratic Republic of Congo to the north, Tanzania to the north-east, Malawi to the east, Mozambique, Zimbabwe, Botswana and Namibia to the south, and Angola to the west.

ADMINISTRATION

=DPELD LV DGPLQLVWUDWLYHO\ GLYLGHG LQWR SURYLQFHV QDPHO Muchinga, Northern, North-Western, Southern and Western. At the time of the 2015 National Disability Survey, the country had 74 districts, 150 constituencies and 1,430 wards. Lusaka is the capital city and the seat of government. Administration generally comprises central and local government.

LANGUAGES

(QJOLVK LV WKH RI¿FLDO ODQJXDJH RI FRPPXQLFDWLRQ DQG LQVWUXF .DRQGH /R]L /XQGD /XYDOH 1\DQMD DQG 7RQJD 2WKHU WKDQ (QJOLV and are used on national television and radio, as well as in national documents. However, Zambia has a total of 73 spoken dialects.

ECONOMY

Zambia's economy is driven primarily by the mining, agriculture and construction sectors. The GDP growth rate at constant prices was 2.9 percent in 2015, down from 4.7 percent in 2014 (CSO, 2016).

The copper-mining industry has been the mainstay of the Zambian economy since the early post-colonial years, accounting for about 95 percent of annual export earnings and contributing about 45 percent of government revenues LQ WKH GHFDGH IROORZLQJ LQGHSHQGHQFH ±

In the mid-1970s, with global copper prices plummeting, the Zambian economy deteriorated sharply. Efforts were made to minimize the dependency on copper and to diversify the economy through the creation of import substitution parastatals. These efforts did not achieve the desired results, and so a series of vigorous structural adjustment programmes was launched. In spite of these, the poverty levels for the majority of Zambian people remained very KLJK ,Q DQ HIIRUW WR PLWLJDWH WKH KLJK SRYHUW\ OHYHOV =DPEL National Development Plan instituted a strategy that focused on broad-based wealth and job creation through citizen SDUWLFLSDWLRQ DQG WHFKQRORJLFDO DGYDQFHV 'XULQJ WKH SHUL ± ZDV LPSOHPHQWHG ZLWK WKH DLP RI DFKLHYLQJ VXVWDLQHG LQIUDVWUXFWXUH DQG KXPDQ GHYHORSPHQW 0R) 7KLV SODQ ZD SULPDU\ JURZWK DUHDV LGHQWL¿HG E\ WKH SODQ LQFOXGHG VNLOOV G ZLWK WKH IRFXV RQ HQKDQFLQJ ZDWHU DQG VDQLWDWLRQ HGXFDWLRQ

POVERTY

The majority of Zambians continue to live in poverty. Results from the 2006 and 2010 Living Conditions Monitoring 6XUYH\V /&06 VKRZ WKDW SRYHUW\ OHYHOV UHPDLQ KLJK LQ VSLWH R of the population below the poverty line fell from 62.8 percent to 60.5 percent. The 2015 LCMS indicates a further GHFOLQH LQ WKH SRYHUW\ OHYHO WR SHUFHQW 7KH SHUFHQWDJH R in 2006 to 40.8 percent in 2015.

Poverty in Zambia continues to be more of a rural than an urban phenomenon. Rural poverty is three times the level in XUEDQ DUHDV LQ UXUDO SRYHUW\ ZDV HVWLPDWHG DW SHUFH

HEALTH

Health plays a critical role in the development of the country. No meaningful progress can be made without a proper policy and legal framework. Since the 1991 health reforms, the focus has been on building a health system that is responsive to the needs of the people, regardless of colour, gender and socio-economic status. The basic principle of those reforms was to achieve better-quality health services by strengthening leadership, accountability, partnership and sustainability at all levels of service delivery. Thanks to these reforms, a number of successes have been scored, mainly in terms of strengthening the health system, with an emphasis on delivering services closer to the people. There has been a move from a highly centralized health system (in which the central structures provided support and national guidance to the peripheral structures) to a more decentralized system. In 2010, Zambia's health system had a total of KHDOWK IDFLOLWLHV ± DQ LQFUHDVH RI VLQFH

The National Health System is arranged in a manner that is aimed at providing health services as close to the family as possible with a primary health care approach. In order to achieve this, the health system is designed with the following VWUXFWXUH

- Community
- Health posts
- Health centres
-)LUVW OHYHO KRVSLWDO ± GLVWULFW
- 6HFRQG OHYHO KRVSLWDO ± JHQHUDO
- 7KLUG OHYHO KRVSLWDO ± FHQWUDO

(MoH, 2012)

With the emergence of global socio-economic trends and with changes in the technological and epidemiological SUR¿OH RI WKH FRXQWU\ WKH KHDOWK VHFWRU IDFHV D QXPEHU RI FKDO and non-communicable diseases, resulting in high morbidity and mortality. According to the 2013/2014 Zambia Demographic and Health Survey, one adult in eight (13 percent) was HIV positive. The infant mortality rate was 45 deaths per 1,000 live births, while the maternal mortality ratio was 398 deaths per 100,000 live births.

EDUCATION

Education is a powerful tool for the economic development of an individual and a nation. The revised Sixth National 'HYHORSPHQW 3ODQ LGHQWL¿HV HGXFDWLRQ WUDLQLQJ VFLHQFH DQG W

=DPELD KDV D WKUHH WLHU HGXFDWLRQ V\VWHP FRQVLVWLQJ RI VHYHQ secondary education and post-secondary schooling. In the past decade, the government has embarked on a number of initiatives to ensure universal access to education. In 2010, an increase was recorded in the number of basic schools *UDGHV ± $Q LQFUHDVH ZDV DOVR UHFRUGHG LQ WKH QXPEHU RI KL attributed to the upgrading of some basic schools into high schools and the construction of new high schools.

GENDER ISSUES

Gender issues are concerned with promoting equality between the sexes and improving the status of both women and men in society. It is well understood that social and economic development can only be attained if there is equal participation of men and women in the development process.

Zambia's vision for gender, as stated in its Vision 2030, is to achieve gender equity and equality in the socio-economic development process by 2030 (GRZ, 2006). In this regard, the government has put in place a National Gender Policy, which ensures the advancement of gender-mainstreaming policies and legislation.

BACKGROUND: DISABILITY POLICY IN THE CONTEXT OF ZAMBIA – AN OVERVIEW OF RECENT DEVELOPMENTS AND ONGOING POLICY PROCESSES

The 2011 World Report on Disability estimates indicate that 15.6 percent of the world's population aged 15 years DQG ROGHU OLYHV ZLWK PRGHUDWH RU VHYHUH GLVDELOLW\ ZKLOH PRGHUDWH RU VHYHUH GLVDELOLW\ :+2 +RZHYHU JLYHQ WKH PD prevalence rates vary greatly. Information on disability prevalence in Zambia is very limited, and there are disparities in prevalence between provinces, between rural and urban areas, and between population groups.

The government of the Republic of Zambia recognizes that disability is a human rights and developmental issue, and WKHUHIRUH LQ LW UDWL¿HG WKH 8QLWHG 1DWLRQV &RQYHQWLRQ R to improve the welfare of people with disability. In addition, the country has put in place a number of laws and policies on people with disabilities, including the Persons with Disabilities Act No. 6 of 2012 and the National Policy on Disability. In line with the CRPD, the Zambian Vision 2030 also recognizes the need to streamline service delivery for people with disabilities, in order to achieve the goals and objectives of the Vision.

Despite huge strides in policy and legislation, the country has not responded adequately to the needs of people with disabilities, who still face challenges in realizing their social, economic, cultural and political rights. This is largely due to the lack of equal opportunities and means to participate fully in all aspects of life. According to the World Health Organization (WHO, 2011), many people with disabilities do not have equal access to health care, education, social protection and employment opportunities. This situation applies also to Zambia.

)RU SODQQLQJ SXUSRVHV =DPELD KDV EHHQ XVLQJ WKH :+2 HVWLPDWH to approximately 10 percent of the population). According to the 2010 Census of Population and Housing, 2.0 percent RI WKH =DPELDQ SRSXODWLRQ KDYH D GLVDELOLW\ corresponding to LQFOXGLQJ SH 274,944 persons. Among the provinces, Western Province has the highest proportion of people with disabilities (2.9 percent) and Lusaka the lowest (1.3 percent) (CSO, 2012). It should be noted, however, that the census measured GLVDELOLW\ XVLQJ D ODUJHO\ PHGLFDO GH¿QLWLRQ ZLWK D IRFXV RQ and children.

Apart from prevalence estimates, little information is available on the socio-demographic characteristics of people with disabilities and on quality of life, particularly in terms of participation in activities and use of services. This is due to a paucity of data on the characteristics of those with disabilities and limited comprehensive knowledge and understanding of the issues faced by people with disabilities in terms of their participation in day-to-day activities DQG WKHLU DFFHVV WR EDVLF VRFLDO VHUYLFHV 7KHVH LVVXHV LQF accessibility, and access to public services.

The weaknesses in the evidence base outlined above largely explain the limited scope and depth of the current policy response to disability, even though recent national development plans have sought to address the issue. The tendency to generalize around disability has hampered any nuanced approach towards the inclusion of children and adults with disabilities. This has been compounded by the absence of reliable data on the number of people with disabilities and RQ WKH QXPEHU RI SHRSOH DIIHFWHG E\ D VSHFL¿F GLVDELOLW\

In view of the above, the Government of Zambia, through the Ministry of Community Development and Social 6HUYLFHV WRRN WKH LQLWLDWLYH WR XQGHUWDNH D 1DWLRQDO 'LVDE to the national evidence base on disability by generating strategic information on the prevalence, type and severity of disabilities among adults and children, as well as on the main issues that persons with disabilities face in terms of SDUWLFLSDWLRQ DQG XVH RI EDVLF VRFLDO VHUYLFHV ,Q DGGLWLRQ disability into relevant policies and programmes that will be crucial in helping all stakeholders improve the wellbeing of people with disabilities.

5. CONCEPTUAL UNDERSTANDING

Disability and living conditions are core concepts in the study presented in this report. Both concepts are open to
LQWHUSUHWDWLRQ DQG FDQ EH SHUFHLYHG LQ GLIIHUHQW ZD\V :KLOH
as the main model for disability, it is important to recognize that the understanding of disability can vary from one
VRFLR FXOWXUDO FRQWH[W WR DQRWKHU :K\WH DQG ,QJVWDG 6F
inherent in the current study is necessary to aid in the interpretation and utilization of its results.

DISABILITY

During the 1970s, there was a strong reaction against the terminology in use at that time by the representatives of
RUJDQL]DWLRQV IRU SHRSOH ZLWK GLVDELOLWLHV DQG E\ SURIHVVLRQD
of disability focused more on the interaction between individuals and their environment, and on the close connection between the limitations experienced by people with disabilities, the design and structure of their environments and the attitudes and practices of the general population. Recent developments have seen a shift in terminology and an increasing tendency to view the disability complex as a process (the disablement process), involving a number of different elements at the individual, societal and contextual levels. The traditionally dominant medical model of
GLVDELOLW\ ZDV FKDOOHQJHG E\ WKH VRFLDO PRGHO)LQNHOVWHLQ D
development of an interactional model for disability (WHO, 2001).

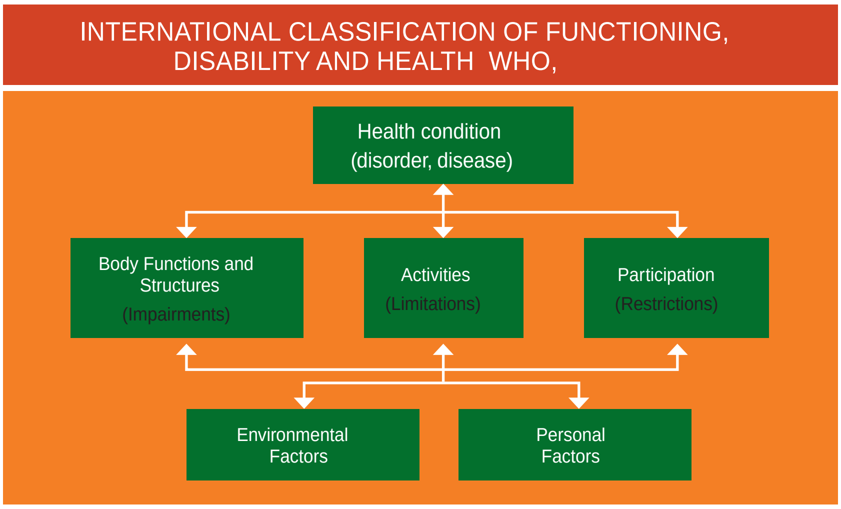
$UWLFOH RI WKH 81 &RQYHQWLRQ RQ WKH 5LJKWV RI 3HUVRQV ZLWK 'LV

> *'Persons with disabilities 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' (UN, 2006).*

INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH

7KH DGRSWLRQ RI WKH :RUOG +HDOWK 2UJDQL]DWLRQ¶V ,&) :+2 Z
GLVDELOLW\ FRQFHSW)URP DQG WKH ¿UVW FODVVL¿FDWLRQ ,QWH
and Handicaps (WHO, 1980)), a process lasting two decades resulted in a shift in the WHO conceptual framework from a medical model (impairment based) to a new scheme that focuses on limitations in activities and social participation. Although it does not represent a shift from a strictly medical to a strictly social model, the development
WKDW FXOPLQDWHG LQ ,&) PD\ EH XQGHUVWRRG DV D PHUJLQJ RI WKH V
model that implies a much wider understanding of disability and the disablement process.

Figure 5.1 The ICF model



APPLICATION OF ICF IN THE CURRENT STUDY

7KH GHYHORSPHQWV OHDGLQJ WR WKH ,&) DUH LPSRUWDQW DV WKH\ K
IRU WKH FROOHFWLRQ RI VWDWLVWLFDO GDWD RQ GLVDELOLW\ 1HZ FR
LQ ZKLFK GLVDELOLW\ LV PHDVXUHG :KLOH WKH FXUUHQW VWXG\ GRHV
EHHQ WKH LQWHQWLRQ WR WHVW WKH QHZ FODVVL¿FDWLRQ DV VXFK \
in particular to treat disability as limitations on activity and restrictions on social participation. This is clear to see in the screening procedure, in the inclusion of measures on activity limitations and participation restrictions, and in the measurement of environmental barriers. The current study provides a unique opportunity to apply some core concepts
IURP WKH ,&) DQG WR WHVW VRPH DVSHFWV RI WKH PRGHO VWDWLVWLF

$Q XQGHUVWDQGLQJ RI GLVDELOLW\ DV GH¿QHG E\ DFWLYLW\ OLPLWDW
framework shown in Figure 5.1 XQGHUOLHV WKLV VWXG\ :LWK WKLV LQ PLQG WKH \
refers to (or is associated with) an individualistic and impairment-based understanding. As a term, it is nevertheless
DSSOLHG WKURXJKRXW WKLV WH[W VLQFH LW LV D FRPPRQO\ DFFHSWH
WHUPLQRORJ\ ± LWV XVH LV SUDFWLFDO

(QYLURQPHQWDO IDFWRUV DUH LPSRUWDQW HOHPHQWV LQ WKH ,&) PR
of disability that limitations on activity and restrictions on participation are formulated in the exchange between individuals and their environment. In the current study, environmental factors are included in a separate section, utilizing an established research instrument. It is, however, acknowledged that studies like this one traditionally focus on the individual, and that this is also the case here.

THE SIX WASHINGTON GROUP QUESTIONS AND THE CHILD MODULE

%XLOGLQJ RQ WKH ,&) WKH :DVKLQJWRQ *URXS RQ 'LVDELOLW\ 6WDWLVW
ZLWK GLVDELOLWLHV LQ FHQVXVHV DQG VXUYH\V 7KHVH DUH XVHG LQ W
distinguish between persons with and without disability. Likewise, acknowledging that the six WG questions were not
DEOH WR FDSWXUH FKLOG GLVDELOLW\ LQ DQ RSWLPDO ZD\ WKH :DVKLQJ
RQ &KLOG)XQFWLRQL Both instruments are incorporated into the current study, which makes it
RQH RI WKH ¿UVW ODUJH VFDOH[3] VWXGLHV WR DSSO\ WKH &KLOG 0RGXOH

LIVING CONDITIONS

7KH FRQFHSWV RI µVWDQGDUG RI OLYLQJ¶ RU µOLYLQJ FRQGLWLRQV¶ KDY
GH¿QLWLRQ LQWR D FXUUHQW FRQFHUQ ZLWK KXPDQ FDSDELOLWLHV DQ
(Heiberg and Øvensen, 1993). Although economic and material indicators do play an important role in the tradition
RI VWDQGDUG RI OLYLQJ VXUYH\V LQ WKH LQGXVWULDOL]HG FRXQWULHV
so much by his or her economic possessions, but by the ability to exercise choice and to affect the course of his or her own life. Standard of living studies have been concerned more and more with such questions, and they currently attempt to examine the degree to which people can participate in social, political and economic decision making and can work creatively and productively to shape their own future (UNDP, 1997).

$ QXPEHU RI FRUH LWHPV FDQ EH UHJDUGHG DV YLWDO WR DQ\ VWDQGD
KRXVLQJ ZRUN DQG LQFRPH 2WKHU LQGLFDWRUV PD\ LQYROYH XVH RI
ZHOOEHLQJ SHUFHSWLRQV RI VRFLDO FRQÀLFW DFFHVV WR SROLWLFDO
DQG SURWHFWLRQ HWF 7KH FKRLFH RI ZKLFK LQGLFDWRUV WR LQFOXGH
study and the circumstances under which the studies are undertaken.

DISABILITY AND LIVING CONDITIONS

5HVHDUFK LQWR OLYLQJ FRQGLWLRQV LV ± E\ LWV YHU\ QDWXUH ± FRP
monitoring development over time within groups and populations is often the very reason for carrying out such studies. The purpose is thus often to identify population groups with certain characteristics and to study whether there are
V\VWHPDWLF GLIIHUHQFHV LQ OLYLQJ FRQGLWLRQV EHWZHHQ WKRVH JUR
groups over time and compare development over time between groups. Population sub-groups of interest in such
VWXGLHV DUH RIWHQ GH¿QHG E\ JHRJUDSK\ VH[DJH RU ± WKH IRFXV RI
countries has demonstrated that people with disabilities are worse off across the whole spectrum of indicators that are concerned with living conditions; this gap has persisted, even as there has been a steady improvement in conditions for all (Hem and Eide, 1998). This research-based information has been very useful for advocacy purposes, for education and for changing attitudes within the population, as well as for planning and resource-allocation purposes. The same patterns of systematic differences are also to be found in low-income countries, as has been documented in our studies in other countries of the region (see section 4.1). When the stated purpose of the research is to study the living
FRQGLWLRQV RI SHRSOH ZLWK GLVDELOLWLHV LW LV HVVHQWLDO WR VH\
WR LGHQWLI\ ZKR LV GLVDEOHG DQG ZKR LV QRW 7KLV LV D PRUH FRPSO
DQG D µVRFLDO PRGHO¶ +RZ WKLV LV XQGHUVWRRG DQG FDUULHG RXW
consequently on the application of results (see section 5.1 on the disability concept).

2 http://www.cdc.gov/nchs/data/washington_group/meeting13/wg13_unicef_child_disability_background.pdf

3 An earlier version of the Child Module was applied in this study. The nal version was adopted after this data collection was carried out.

7KH ,&) PD\ WR VRPH H[WHQW EH YLHZHG DV DQ DWWHPSW WR FRPELQH
SKHQRPHQRQ¶ 7KH DXWKRUV EHKLQG WKLV UHVHDUFK UHSRUW VXSSRU
manifested in the exchange between individuals and their environment. Disability is thus present if an individual is (severely) restricted in his or her daily life activities due to a mismatch between functional abilities and the demands of society. The role of the physical and social environment in disabling individuals has been very much in focus over the
SDVW ± \HDUV ZLWK WKH DGRSWLRQ RI WKH 6WDQGDUG 5XOHV 81
WKH ,&) :+2 DQG WKHQ WKH &53' 81 ,W LV ORJLFDO IRU WK
into the mechanisms that produce disability at the interface between the individual and his/her environment. It is true that studies into the living conditions of people with disabilities in high-income countries have been criticized for not
SURJUHVVLQJ IURP DQ LQGLYLGXDOLVWLF SHUVSHFWLYH GDWD DUH FF
IRFXV RI DWWHQWLRQ ,W LV D GLOHPPD WKDW WKLV UHVHDUFK WUDGL
YLHZ RQ GLVDELOLW\ WKDW PRVW UHVHDUFKHUV LQ WKH ¿HOG ZRXOG
ZH QHYHUWKHOHVV DUJXH WKDW D µWUDGLWLRQDO¶ VWXG\ LV QHHGHG
situation and to draw comparisons between groups and over time. In high-income countries, such studies have proved to be powerful tools in the continuous struggle for the improvement in the living conditions of people with disabilities.

COMBINING TWO TRADITIONS AND THE ICF

7KH GHVLJQ WKDW KDV EHHQ GHYHORSHG DQG WHVWHG KHUH VHHNV
conditions and disability studies. Pre-existing and validated questionnaires that were used in Namibia (on general
OLYLQJ FRQGLWLRQV ± 13& DQG LQ 6RXWK $IULFD RQ GLVDELOL
adapted for use in the survey. A third element, on activities and participation, was included so as to incorporate the
FRQFHSWXDO GHYHORSPHQWV WKDW KDYH WDNHQ SODFH LQ FRQQHFW
traditions, we end up with a set of variables that describes the situation of people with disabilities and that is broader than traditional disability statistics. The possibility emerges for a broad comparison of the conditions facing people with disabilities (and households containing people with disabilities) and without disabilities (and households without any disabled members). This comparative aspect is quite rare in disability statistics. In the current study, a comparison
LV PDGH SRVVLEOH EHWZHHQ SHRSOH DQG KRXVHKROGV ZLWK DQG ZLW
of a long-term research activity, with similar studies being carried out in southern Africa, creating a unique database for comparison in the region.

6. METHODOLOGY

SURVEY OBJECTIVES

The main purpose of the National Disability Survey is to determine the prevalence of disability among adults and children in Zambia, to analyse the socio-economic and demographic characteristics of people with disabilities, including children, and to assess the main issues that affect their quality of life in terms of participation and use of basic social services. This allows a sound evidence base to be established for policy formulation and programming to promote the inclusion of people with disabilities, including children.

7KH VSHFL¿F REMHFWLYHV RI WKH VWXG\ DUH

i. to estimate the national prevalence of disability among adults and children[4] disaggregated by sex, severity of disability, province and the rural/urban distinction;
ii. to analyse the demographic and socio-economic characteristics of persons with disabilities, including children (including wealth, employment status, education level, formal and informal support mechanisms, participation, access to services);
iii. to identify critical issues and barriers faced by persons with disabilities, including children, in terms of restricting their participation in activities and access to services;To develop a strategy for the collection of comprehensive, reliable and culturally adapted statistical data on living conditions among persons with disabilities; and
iv. to identify various forms of limitations on activity that people with disabilities face.

STUDY DESIGN AND METHODOLOGY

This section highlights the sampling strategy, sampling frame, sample size and allocation.

SAMPLING STRATEGY

The National Disability Survey (NDS) is a national, representative household survey that was carried out by the Central 6WDWLVWLFDO 2I¿FH DQG WKH 0LQLVWU\ RI &RPPXQLW\ 'HYHORSPHQW D
The cross-sectional survey targeted all households in Zambia at the time of the survey, excluding institutionalized SRSXODWLRQ JURXSV DQG GLSORPDWV DFFUHGLWHG WR =DPELD 7KH V
Central, Copperbelt, Eastern, Luapula, Lusaka, Muchinga, Northern, North-Western, Southern and Western.

SAMPLING FRAME

The sampling frame consisted of a list of enumeration areas (EAs), also referred to as primary sampling units (PSUs). The frame was based on the 2010 population census frame. Zambia's political structure includes 10 provinces, GLYLGHG LQWR GLVWULFWV FRQVWLWXHQFLHV DQG ZDUGV)
census supervisory areas (CSAs), which are further divided into EAs. The EAs have information on the number of households and population. The average size of an EA is 110 households.

4 Disability prevalence among adults was measured based on the response to the Washington Group 6 questions. Disability prevalence among children was measured by means of 14 questions in the UNICEF/WG Child Module. Both measures concern activity limitations due to a health condition.

SAMPLE SIZE AND ALLOCATION

The sample size for the survey was adequate to give reliable estimates at the national and provincial levels. Analysis was at both the individual and the household level, with comparisons done between persons with and without disability and between households with and without at least one person with disability. To determine the sample size needed, WKH IROORZLQJ DVVXPSWLRQV ZHUH PDGH

- 'HVLUHG OHYHO RI FRQ¿GHQFH RI WKH VXUYH\ UHVXOWV SHUFHQ
- Acceptable margin of error of the survey results (1.5 percent);
- Estimated baseline indicator (10.9 percent).

,Q DGGLWLRQ WKH VDPSOH VL]H ZDV DGMXVWHG IRU

- Anticipated non-response (5 percent); and
- Design effect.

7DNLQJ WKH DERYH SDUDPHWHUV LQWR FRQVLGHUDWLRQ WKH IRUPXOD

$$n=Z^2 [P(1-P)/e^2]$$

:KHUH] OHYHO RI FRQ¿GHQFH] VFRUH RI SHUFHQW LQ D QRUPD

p=baseline level of indicators

e=margin of error.

Table 6.1 Calculation of sample of households with persons with disabilities

Z	Z^2	O	1 - p	e	e^2	N	(*)Design effect	(/)Response rate	=Final N
1.96	3.8416	0.109	0.891	0.015	0.000225	1,659	2	0.90	3,685

The total number of households obtained in the sample was 3,685. This translated into 368 EAs countrywide, and the EAs were allotted to the 10 provinces using proportional allocation, based on the total number of households in the EAs.

7KH VXUYH\ XVHG D WZR VWDJH VWUDWL¿HG FOXVWHU VDPSOH GHVLJQ WKH ¿UVW VWDJH DQG WKH KRXVHKROGV VHOHFWHG GXULQJ WKH VHFR 2010 population and housing census frame using the probability proportional to estimated size (PPES) procedure. In each selected EA, all households were listed during the exercise carried out prior to enumeration, in order to provide a comprehensive sampling frame for the selection of households. The exercise simply involved the complete listing RI KRXVHKROGV RU WKH FRPSOHWH FRXQW RI KRXVHKROGV LQ WKH ($ done at an individual level after the households were randomly selected. An average of 25 households were selected in each EA. All individuals in the selected households were interviewed to determine whether the household would be FODVVL¿HG DV ZLWK RU ZLWKRXW D GLVDEOHG PHPEHU

7KH VXUYH\ FRPSULVHG

- Random sampling of EAs;
- ,Q HDFK VHOHFWHG ($ OLVWLQJ RI KRXVHKROGV LQ WKH ($ DVVLJ
- ,Q HDFK VHOHFWHG ($ UDQGRP VDPSOLQJ RI D ¿[HG QXPEHU RI KR
- ,Q HDFK VHOHFWHG KRXVHKROG VFUHHQLQJ E\ PHDQV RI :* DQG V &KLOG 0RGXOH ± \HDUV ± \HDUV DQG ± \HD **All individuals** FRYHULQJ DO **responded for themselves** (the main carer for children aged below 12 years, as well as for those aged 12 and

above if the child was unable to respond (or together with the main carer if that was deemed to be the correct way to proceed));

- ,Q KRXVHKROGV ZLWK GLVDEOHG PHPEHUV DGPLQLVWHULQJ RI WKH DQG WKH LQGLYLGXDO TXHVWLRQQDLUH WR DOO LQGLYLGXDOV ZKR by proxy, as above);
- ,Q VDPSOHG KRXVHKROGV ZLWKRXW GLVDEOHG LQGLYLGXDOV DGPL household head and the individual questionnaire to one non-disabled person randomly selected from the KRXVHKROG XVLQJ WKH .LVK *ULG

SURVEY ORGANIZATION

The NDS is a comprehensive survey involving several agencies and many individuals. It was implemented under the aegis of the Ministry of Community Development and Social Services, which provided overall coordination and guidance to the survey. Moreover, the Ministry of Community Development and Social Services, as the major user of the survey results, had a major role to play in guiding the design of the questionnaires and survey content. The CSO was responsible for general administrative management of the survey, including overseeing day-to-day operations, WUDLQLQJ ¿HOG VWDII DQG VXSHUYLVLQJ ¿HOG DQG RI¿FH RSHUDWLRQ processing and data analysis, and had primary responsibility for dissemination of the survey results.

6,17() SURYLGHG WHFKQLFDO JXLGDQFH WR WKH LPSOHPHQWLQJ LQVWLW through periodic short-term visits6,17() ZDV UHVSRQVLEOH IRU WKH FRQWHQW RI WKH T the study design, in collaboration with the CSO and stakeholders=DPELD 81,&() SURYLGHG ¿QDQFLDO D support to the survey. Survey ethical clearance was done by the University of Zambia's Ethical Committee.

7KH VXUYH\ ZDV FRQGXFWHG E\ WHDPV HDFK WHDP FRQVLVWLQJ RI D V After the questionnaire was developed, a pre-test workshop was held from 31 March to 7 April 2015 to test the instruments. After the pre-test, a training workshop was held for the trainers from 13 to 24 April 2015; its main objective was to WUDLQ WKH RI¿FHUV ZKR ZRXOG LQ WXUQ WUDLQ WKH HQXPHUDWRUV DQG supervisors) was held from 17 to 31 May 2015. There were 150 participants divided into four classes. The training comprised hands-on tablet practice, assessments, class mock interviews, lectures, local language interpretations and D ¿HOG SUDFWLFDO

SURVEY QUESTIONNAIRES

)RXU TXHVWLRQQDLUHV ZHUH XVHG IRU WKH 1'6 a household questionnaire, an individual questionnaire for persons with GLVDELOLWLHV D TXHVWLRQQDLUH IRU SHUVRQV ZLWKRXW GLVDELOLWL and Disability questionnaire).

All households in the NDS sample were visited and enumerated using a household questionnaire. The household questionnaire collected information on the usual members of that household and socio-demographic data on each person (such as name, sex, age, disability status and education). The household questionnaire also collected information on housing characteristics, such as source of income, expenditure, source of drinking water, sanitation facilities and ownership of durable goods. Deaths in the household were also recorded on the household questionnaire.

7KH TXHVWLRQQDLUH DOVR LQFOXGHG TXHVWLRQV WKDW ZHUH XVHG WR using the individual questionnaire, once the household questionnaire had been administered.

IDENTIFICATION OF INDIVIDUALS WITH DISABILITY

$ ZLGH GH¿QLWLRQ RI GLVDELOLW\ ZDV DSSOLHG LQ RUGHU WR FDSWXU

$PRQJ DGXOWV \HDUV WKH VL[:DVKLQJWRQ *URXS TXHVWLRQV ZHU
to one of the questions was included as a person with disability.

$PRQJ FKLOGUHQ ± \HDUV TXHVWLRQV ± 5(attached) were used to
LGHQWLI\ FKLOGUHQ ZLWK GLVDELOLWLHV $Q\ FKLOG UHVSRQGLQJ µVR
child with disability.

HOUSEHOLDS WITH AT LEAST ONE PERSON WITH DISABILITY

(YHU\RQH ZLWK GLVDELOLW\ ZDV HOLJLEOH IRU DQ LQGLYLGXDO LQWHU
XVLQJ WKH 0RGXOH RQ &KLOG)XQFWLRQLQJ DQG 'LVDELOLW\ TXHVWLR
\HDUV ZLWK D GLI¿FXOW\ LGHQWL¿HG DV KDYLQJ above), the carer or parent of DFFRUG
WKH FKLOG ZDV DVNHG WR UHVSRQG WR WKH TXHVWLRQV LQ WKH &KLOG
if they were able to respond on their own (if they were unable, they either had a carer with them or the carer responded on their behalf).

$OO DGXOWV \HDUV ZHUH DVNHG WKH VL[:DVKLQJWRQ *URXS TXHV
KRXVHKROG LQWHUYLHZ)RU WKRVH ZKR ZHUH QRW DYDLODEOH DQ DV
interview. If for some reason an appointment could not be made, the household head, main respondent or carer who knew the household members well would respond. Only if the person was incapacitated and could not respond on their own was a carer asked to respond to the questionnaire.

Those aged 18 years and older were interviewed using the questionnaire for individuals with disability (Appendix 7).
7KH LQGLYLGXDO ZLWK GLVDELOLW\ TXHVWLRQQDLUH FROOHFWHG LQIR

i. Activity limitation;
ii. Participation restriction;
iii. Inventory of environmental factors;
iv. Discrimination and abuse, services and accessibility;
v. Education;
vi. Economic activity;
vii. Assistive devices;
viii. Involvement in family, social life and society;
ix. Health and general wellbeing;
x. HIV/AIDS, STIs, diabetes and TB;
xi. Reproductive health of family members.

HOUSEHOLDS WITHOUT A PERSON WITH DISABILITY

Households without a person with a disability were interviewed using the questionnaire for individuals without disability (Appendix 8). The questionnaire for individuals without disability asked for similar information to that collected by the questionnaire for individuals with disability, except that it did not ask about assistive devices, discrimination and abuse, accessibility, etc.

5 At the time of the study, the Child Module had not been nalized, and so an earlier version of the module was used.

7. RESULTS

7KH UHVXOWV DUH SUHVHQWHG LQ WKUHH VXE VHFWLRQV

- Household section:Results from a comparative analysis of households with at least one member with disability and households without any disabled member (household data). The head of the household or another knowledgeable adult household member was the main informer. Data on every member of the household were also collected. Estimated disability prevalence is also presented in this section.
- Individual section 1: $GXOWV DJHG 7KH UHVXOWV DUH EDVHG RQ D GHWDL WKH VLWXDWLRQ RI SHRSOH LGHQWL¿HG DV KDYLQJ GLVDELOLW\ 7K data). This section also includes some comparisons on living conditions between persons with and without disability.
- Individual section 2: &KLOG 0RGXOH FKLOG Children in the sampled households were interviewed (see section 6.4) using a separate questionnaire comprising the Child Module and selected indicators from the adult individual section that were assessed to be most relevant for children.

7KURXJKRXW WKLV VHFWLRQ WKH WHUP µGLVDEOHG¶ DQG µQRQ GLVDEOH ZLWK ZLWKRXW GLVDELOLWLHV¶ +HUH WKH WHUP µGLVDELOLW\¶ UHIHU disabled/individuals without disabilities refers to individuals without functional limitations. Details on how individuals ZLWK GLVDELOLW\ ZHUH LGHQWL¿HG DUH IRXQG LQ VHFWLRQ

Sampling weight was implemented in the analysis to account for differences in the population and households in the different provinces. The purpose of weighting in this study is to adjust the effect of imbalanced representation of estimation domains due to over- and under-sampling. Particular care was also taken during the analysis to control IRU VH[XUEDQ UXUDO DQG UHJLRQDO GLVWULFWV GLIIHUHQFHV ,I WKH comment is made in the text.

HOUSEHOLD SECTION

This section looks at the general characteristics of household members and household-level indicators. In general, a household is a group of people (or a single person) who live in a permanent structure and make common provision IRU IRRG 7KH\ PD\ RU PD\ QRW EH UHODWHG EXW RQH SHUVRQ LV UHJD to people whdive and eat together $ SHUVRQ ZKR OLYHV DORQH DQG FDWHUV IRU KHU\ KRXVHKROG 7KH PDLQ XQLW RI WKH VXUYH\ LV WKH KRXVHKROG DV MX LQIRUPDWLRQ DERXW WKH SHUPDQHQW PHPEHUV Excluded, as were any members who were absent for more than six months. Those at boarding school or away for seasonal work were considered PHPEHUV RI WKH KRXVHKROG EXW WKRVH LQ ORQJ WHUP LQVWLWXWLR living or working abroad were not considered to be permanent household members. Information on households and household members was collected before it was determined whether a particular household did or did not have a disabled member.

A total of 9,190 households were included in the Zambia National Disability Survey. No pre-screening was carried out, and the sample of households with disabled members and without thus represents the real proportions found in the population. The head of the household (or a knowledgeable adult household member) was the key informer for the household section of the questionnaire. The total number of households with a disabled member was 2,912, giving an overall disability prevalence of 31.7 percent of households. The total population enumerated was 46,533.

7KH VHFWLRQ DOVR FRPSULVHV D QXPEHU RI KRXVHKROG OHYHO LQGLF demographics, housing standards, ownership of land, household assets, dietary diversity, access to information, income, household deaths and prevalence of disability.

DESCRIPTION OF THE POPULATION AND SAMPLE

The household and individual response rates are shown in Table 7.1 A total of 9,197 households were occupied; of these, 9,190 were successfully interviewed, yielding a household response rate of 99.9 percent. The response rate IRU IHPDOHV DJHG \HDUV DQG DERYH ZDV KLJKHU WKDQ IRU PDOHV ± FKLOGUHQ DJHG ± \HDUV DOO LQWHUYLHZV ZHUH VXFFHVVIXOO\ FRQ

Table 7.1 Results of the household and individual interviews

	TOTAL	RURAL	URBAN
Total households	9,197	5,950	3,249
Households interviewed	9,190	5,945	3,245
Household response rate (%)	99.9	99.9	99.9
Total individuals 18+ years	5,760	3,466	2,210
Total males	2,751	1,697	1,054
Male interviews	2,702	1,663	1,039
Male response rate (%)	98.2	98.0	98.6
Total females	3,009	1,822	1,187
Female interviews	2,974	1,803	1,171
Female response rate (%)	98.8	99.0	98.7
Total children 2–17 years	3,862	2,655	1,207
Male children	1,924	1,364	560
Male interviews	1,924	1,364	560
Male response rate (%)	100	100	100
Female children	1,938	1,291	647
Female interviews	1,938	1,291	647
Female response rate (%)	100	100	100

Table 7.2shows the total number of enumeration areas, the total number of households and the population by province. In all, 368 EAs were visited, representing a total population of 15,177,968. Lusaka Province had the largest population (2,540,227) while Muchinga had the smallest (825,004).

Table 7.2 Number of enumeration areas, households and population, by province

PROVINCE	TOTAL NUMBER OF ENUMERATION AREAS	TOTAL NUMBER OF HOUSEHOLDS	POPULATION
Central	34	318,340	1,515,298
Copperbelt	46	443,837	2,286,453
Eastern	40	357,954	1,846,328
Luapula	32	222,109	1,149,914
Lusaka	50	556,281	2,540,227
Muchinga	30	160,299	825,004
Northern	34	233,983	1,281,951
North-Western	30	148,919	842,842
Southern	40	377,310	1,843,158
Western	32	211,634	1,046,793
Total	368	3,030,667	15,177,968

Table 7.3shows the sample distribution by household type, sex, age group and the rural/urban distinction. The table shows that there were more females in urban areas for households both with and without disabled members. In all age groups, the table shows more people in rural than urban areas for both household types.

Table 7.3 Sample distribution, by household disability status, sex, age group and rural/urban (N=9,190)

	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS		TOTAL	
	Rural	Urban	Rural	Urban	Rural	Urban
Males	1,041	565	2,014	1,042	3,055	1,607
Females	1,017	708	2,080	1,117	3,097	1,825
Children 2–4 years	120	38	545	243	665	281
Children 5–17 years	531	265	1,459	662	1,990	927
Persons aged 18 years and older	1,407	970	2,090	1,254	3,497	2,224

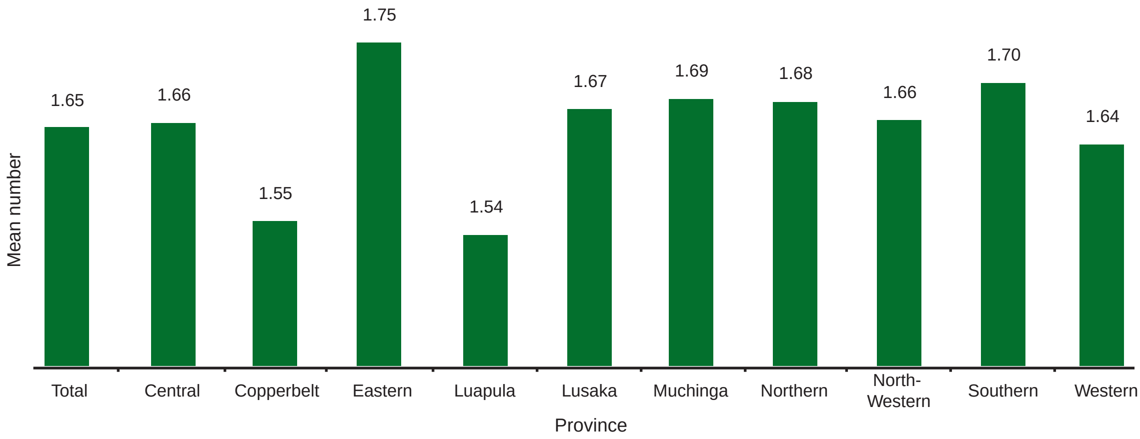
Table 7.4shows the percentage distribution of households with and without disabled members by rural/urban location and province. In both household types, the percentage of households was higher in rural than in urban areas. Copperbelt Province had the highest proportion of households with a disabled person (18.8 percent) and Muchinga Province had the lowest (4.7 percent).

Table 7.4 Percentage distribution of households with and without disabled members, by rural/urban and province

PROVINCE	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS		TOTAL HOUSEHOLDS	
	%	Number	%	Number	%	Number
Total	100.0	954,006	100.0	2,076,661	100.0	3,030,667
Rural	58.1	554,105	61.0	1,266,617	60.1	1,820,722
Urban	41.9	399,901	39.0	810,044	39.9	1,209,945
Central	10.2	97,109	10.7	221,231	10.5	318,340
Copperbelt	18.8	179,706	12.7	264,131	14.6	443,837
Eastern	9.0	86,013	13.1	271,941	11.8	357,954
Luapula	10.6	100,828	5.8	121,281	7.3	222,109
Lusaka	16.8	160,249	19.1	396,033	18.4	556,281
Muchinga	4.7	44,670	5.6	115,629	5.3	160,299
Northern	7.4	70,745	7.9	163,237	7.7	233,983
North-Western	5.0	47,348	4.9	101,571	4.9	148,919
Southern	10.2	96,969	13.5	280,341	12.4	377,310
Western	7.4	70,368	6.8	141,265	7.0	211,634

Figure 7.1 shows the mean number of persons with disabilities in households with disabled members. Eastern Province had the highest mean (1.75 persons), while Luapula had the lowest (1.54 persons).

Figure 7.1 Mean number of persons with disabilities in households with disabled members by province



DEMOGRAPHICS

Demographic information covers the proportion of households headed by an individual with a disability, household size and age distribution. About 47.7 percent of all households with at least one disabled member were headed by a person with a disability. There is no urban/rural difference on this indicator, but the proportion of household heads ZLWK D GLVDELOLW\ YDULHV VXEVWDQWLDOO\ IURP SURYLQFH WR SURY percent) and Central Province the highest (57.5 percent). See Figure 7.2

Figure 7.2 Percentage of households having at least one disabled member headed by a person with a disability

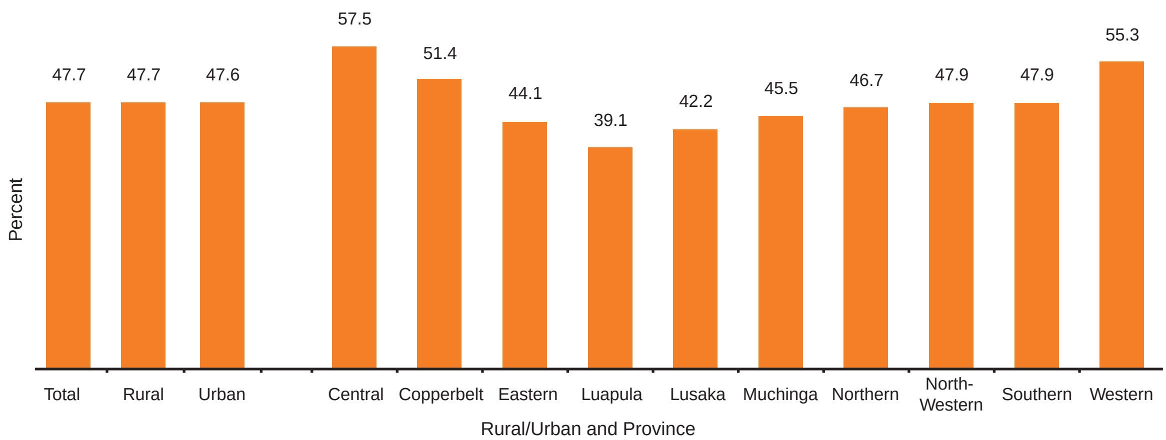


Table 7.5shows the average household size by household type and rural/urban. The average household size was 5.0; WKH DYHUDJH IRU KRXVHKROGV ZLWK D GLVDEOHG PHPEHU ZDV DQG was 5.0. In both rural and urban areas, and in almost all the provinces, households with a disabled person had more PHPEHUV ELJJHU KRXVHKROG VL]H WKDQ KRXVHKROGV ZLWKRXW DQ\R exceptions to this were Muchinga and Luapula Provinces, where the average household without a disabled member was bigger than the average household with a disabled individual (a difference of 0.1 and 0.4, respectively).

Table 7.5 Average household size, by household type and rural/urban

REGION	HOUSEHOLDS WITH DISABLED INDIVIDUALS	HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	TOTAL HOUSEHOLDS
Total	5.1	5.0	5.0
Rural	5.3	5.1	5.1
Urban	4.9	4.8	4.8
Central	4.8	4.7	4.8
Copperbelt	5.3	5.1	5.2
Eastern	5.4	5.1	5.2
Luapula	5.0	5.4	5.2
Lusaka	4.6	4.5	4.6
Muchinga	5.1	5.2	5.1
Northern	5.7	5.4	5.5
North-Western	5.7	5.6	5.7
Southern	5.3	4.8	4.9
Western	5.1	4.9	4.9

The age distribution in the two household types is shown Figure 7.3. 7KH PRGDO DJH FDWHJRU\ LV ± (overall 25.5 percent). Households with disabled members had a higher proportion of members in the age bracket ± \HDUV DQG LQ WKH WKUHH ROGHVW FDWHJRULHV ± ± DQG

+RXVHKROGV ZLWKRXW D GLVDEOHG PHPEHU KDG VOLJKWO\ PRUH PHPEH \HDUV DQG PRUH PHPEHUV LQ WKH DJH JURXSV ± DQG ± \HDUV

Figure 7.3 Age distribution, by household type

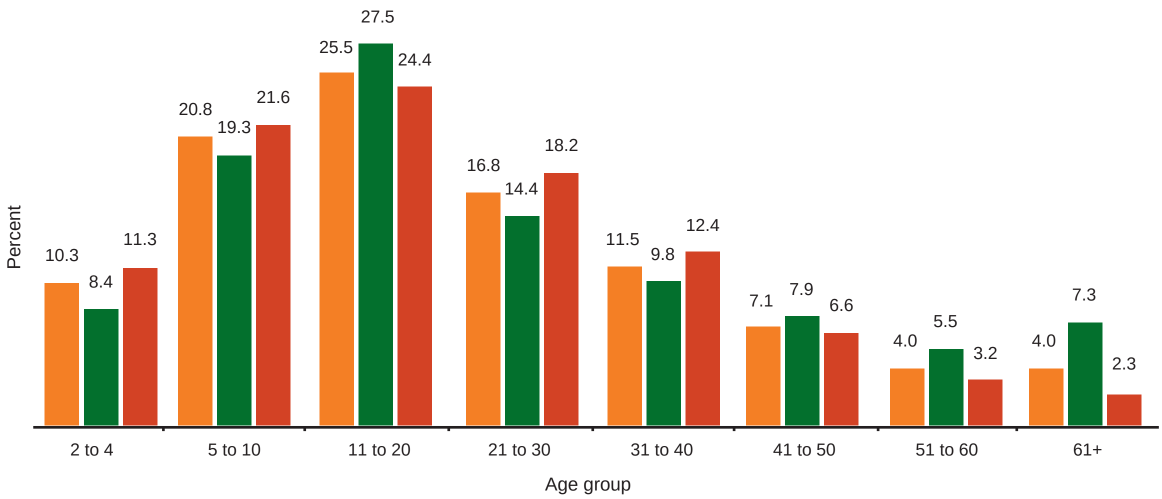


Table 7.6 shows the overall, child and old-age dependency ratios by household type, rural/urban and province. 'HSHQGHQF\ UDWLRV UHYHDO WKH EXUGHQ RI GHSHQGHQF\ SODFHG E\ WK UDWLR DQG WKH HOGHUO\ SRSXODWLRQ DJHG WKH ROG DJH GHSHQGH

2YHUDOO GHSHQGHQF\ LV WKH UDWLR RI WKH SRSXODWLRQ DJHG ± DQ GHSHQGHQF\ LV WKH UDWLR RI WKH FKLOG SRSXODWLRQ ± SHU SHU UDWLR RI WKH SRSXODWLRQ DJHG SHU SHUVRQV RI ZRUNLQJ DJH

Table 7.6 also shows that the overall dependency ratio was higher for households without a disabled member (94.5 IRU HYHU\ SHUVRQV DJHG ± FRPSDUHG WR SHU LQ KRXV dependency ratio was higher for households with disabled members in both rural and urban areas and in all provinces. Only in Muchinga Province was the child dependency ratio higher in households with a disabled person than in those ZLWKRXW SHU SHUVRQV DJHG ± DV DJDLQVW SHU

Table 7.6 Dependency ratios, by household type, rural/urban and province

TOTAL/REGION/ PROVINCE	OVERALL DEPENDENCY RATIO		CHILD DEPENDENCY RATIO		OLD-AGE DEPENDENCY RATIO	
	Households with disabled individuals	Households without disabled individuals	Households with disabled individuals	Households without disabled individuals	Households with disabled individuals	Households without disabled individuals
Total	89.6	94.5	79.2	91.4	10.4	3.1
Rural	107.7	108.8	95	104.8	12.7	3.9
Urban	69.4	74	61.6	72.2	7.8	1.8
Central	84.3	90.5	72.4	86.4	11.9	4.1
Copperbelt	70.6	79.2	61.1	76.8	9.5	2.3
Eastern	111.2	104.3	96.5	100.2	14.6	4.1
Luapula	103.4	111.4	95.1	108.3	8.3	3.1
Lusaka	66.6	71	58.8	64.4	7.8	1.6
Muchinga	116.9	110.1	107.2	106.7	9.7	3.4
Northern	111.8	111.2	101.3	108	10.5	3.3
North-Western	106.2	122.6	95.3	117.7	10.9	4.9
Southern	100.4	97.2	91.8	94.5	8.7	2.8
Western	107.2	109.9	88.6	105.7	18.6	4.2

HOUSING

Information on housing helps in understanding the characteristics of the households sampled and in assessing the socio-economic status of the population. This part covers housing ownership, source of energy for cooking and lighting, source of drinking water, and sanitation facilities.

Respondents in the survey were asked whether or not they owned the house they were occupying. Most respondents (household level) from rural households (both with and without a disabled member) reported owning the house they lived in (88.3 percent of households with a disabled member and 83.0 percent of those without). Among urban households with a disabled member, it was common to own the house, but 38.7 percent reported that they rented their house. Conversely, among urban households without a disabled member, most reported renting the house they were living in (57.1 percent), while 36.7 percent owned (Table 7.7).

Table 7.7 Housing ownership, by household type

	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	
Accommodation/Tenure status	Rural	Urban	Rural	Urban
Rented	4.4	38.7	6.1	57.1
Owned by member	88.3	56.1	83.0	36.7
Rent free (not owned)	3.2	2.9	3.7	4.0
Provided by employer (government)	2.8	2.1	3.7	1.5
Provided by employer (private)	1.2	0.3	3.5	0.7
Other	0.1	0.0	0.0	0.0

)RU ERWK KRXVHKROG W\SHV LQ XUEDQ DUHDV WKH PRVW FRPPRQ VRXUF
areas the most common energy source was wood (Table 7.8).

Table 7.8 Source of energy for cooking (N=9,190)

	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	
Source of energy for cooking	Rural	Urban	Rural	Urban
Electricity	2.7	26.0	3.9	30.4
Paraffin	0.0	0.0	0.0	0.1
Gas	0.0	0.0	0.0	0.1
Wood	78.1	9.9	80.8	6.5
Coal	0.4	0.5	0.4	0.5
Charcoal	18.6	63.7	14.6	62.4
Solar	0.1	0.0	0.1	0.0
Other*	0.0	0.0	0.1	0.0

* Cow dung and none were placed in Other because there were only very few cases.

The most common source of energy for lighting in urban areas for both household types was electricity. In rural households (both types), the most common source was a torch/lamp (Table 7.9).

Table 7.9 Source of energy for lighting (N=9,190)

	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	
Source of energy for lighting	Rural	Urban	Rural	Urban
Electricity	5.9	64.6	7.4	66.4
Paraffin	1.5	1.2	0.8	0.9
Gas	0.0	0.0	0.0	0.0
Wood	2.7	0.5	2.5	0.2
Coal/charcoal	0.4	0.9	0.3	1.3
Solar	4.8	0.4	5.6	0.8
Candles	6.9	19.1	5.5	15.8
Torch/lamp (battery powered)	73.6	12.8	74.6	14.3
None	2.3	0.6	1.5	0.2
Grass	1.7	0.1	1.4	0.0
Other	0.2	0.0	0.2	0.0

In urban areas, more households with a disabled member than without used water piped into the dwelling (21.0 percent, compared to 18.0 percent) and piped into the yard/plot (25.4 percent, compared to 24.7 percent). In rural areas, more households without a disabled member used unprotected wells (25.5 percent) than did households with a disabled member (25.1 percent). See Table 7.10

Table 7.10 Source of drinking water (N=9,190)

	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	
Source of drinking water	Rural	Urban	Rural	Urban
Piped into dwelling (piped water)	1.2	21.0	1.1	18.0
Piped to yard/plot (piped water)	1.7	25.4	2.1	24.7
Public tap/standpipe (piped water)	4.4	20.8	7.0	27.4
Tube well or borehole	34.4	8.6	33.5	5.9
Protected well (dug well)	12.3	10.9	9.0	9.3
Unprotected well (dug well)	25.1	8.5	25.5	9.6
Protected spring (water from spring)	0.9	0.5	0.6	0.2
Unprotected spring (water from spring)	3.9	0.5	4.2	0.7
Tanker truck	0.1	0.0	0.0	0.0
Surface water (river/dam/lake/pond/stream/canal)	15.9	2.0	16.7	1.9
Bottled water	0.0	1.1	0.0	1.6
Other	0.2	0.7	0.1	0.6

In terms of toilet facilities (Table 7.11 D KLJKHU SHUFHQWDJH RI XUEDQ KRXVHKROGV ZL WR SLSHG VHZHU V\VWHP ÀXVK RU SRXU WRLOHW WKDQ GLG KRXVHK percent, respectively). Pit latrines both with slabs and without (open pit) were the most commonly used toilet facilities (both household types). In rural areas, pit latrines without slabs were the most frequent for households both with and without a disabled member (67.0 percent and 65.0 percent, respectively).

Table 7.11 Toilet facilities (N=9,190)

	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	
Type of toilet facility	Rural	Urban	Rural	Urban
Flush to piped sewer system (flush or pour toilet)	0.6	29.1	0.4	23.4
Flush to septic tank (flush or pour toilet)	1.4	5.6	1.5	7.4
Flush to pit latrine (flush or pour toilet)	0.1	3.1	0.3	2.9
Flush to somewhere else (flush or pour toilet)	0.0	0.6	0.1	0.3
Flush, don't know where (flush or pour toilet)	0.1	0.3	0.0	0.2
Ventilated improved pit latrine (pit latrine)	1.5	1.4	1.5	1.6
Pit latrine with slab (pit latrine)	12.5	29.0	15.5	34.4
Pit latrine without slab/open pit (pit latrine)	67.0	28.7	65.0	28.4
Composting toilet	0.1	0.0	0.0	0.0
Hanging toilet/hanging latrine	0.2	0.0	0.0	0.0
No facility/bush/field	16.1	2.2	15.5	1.2
Other	0.4	0.1	0.2	0.2

OWNERSHIP OF AGRICULTURAL LAND AND LIVESTOCK

Households with disabled members reported owning more agricultural land and livestock in both urban and rural areas. In rural areas, 84.8 percent of respondents in such households reported owning agricultural land, as against 79.2 percent of households without disabled individuals. In urban areas, more households with disabled members reported RZQLQJ OLYHVWRFN ± SHUFHQW FRPSDUHG WR Table 7.12) SHUFHQW RI KRXV

Table 7.12 Ownership of agricultural land and livestock (N=9,190)

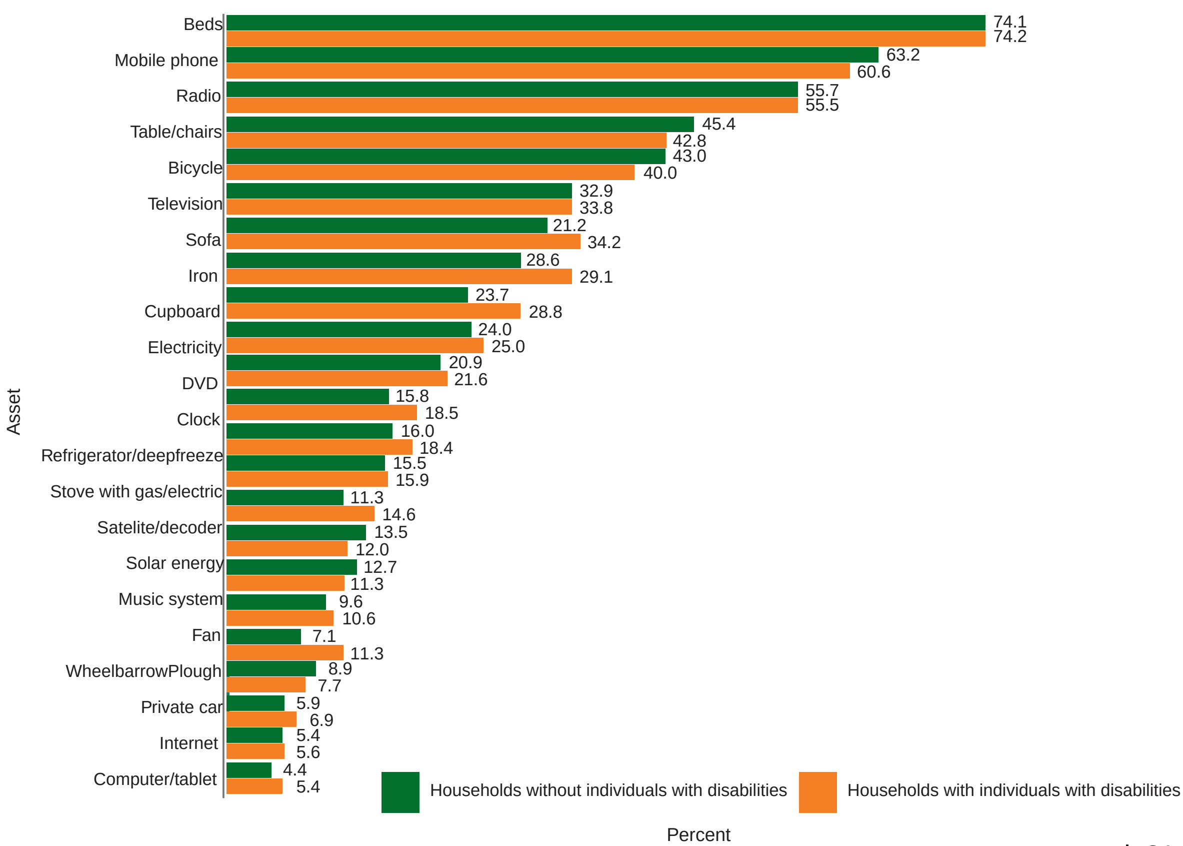
	HOUSEHOLDS WITH DISABLED INDIVIDUALS		HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS	
Ownership of agricultural land	Rural	Urban	Rural	Urban
Yes	84.8	28.1	79.2	18.7
No	15.2	71.9	20.8	81.3
Ownership of livestock				
Yes	60.2	15.6	59.3	10.9
No	39.8	84.4	40.7	89.1

HOUSEHOLD ASSETS

Respondents were asked about some of the items that the household possessed, such as radio and television set, a refrigerator and a wheelbarrow. Asset ownership is a proxy indicator for the relative wealth of a household (Wittenberg and Leibrandt, 2017).

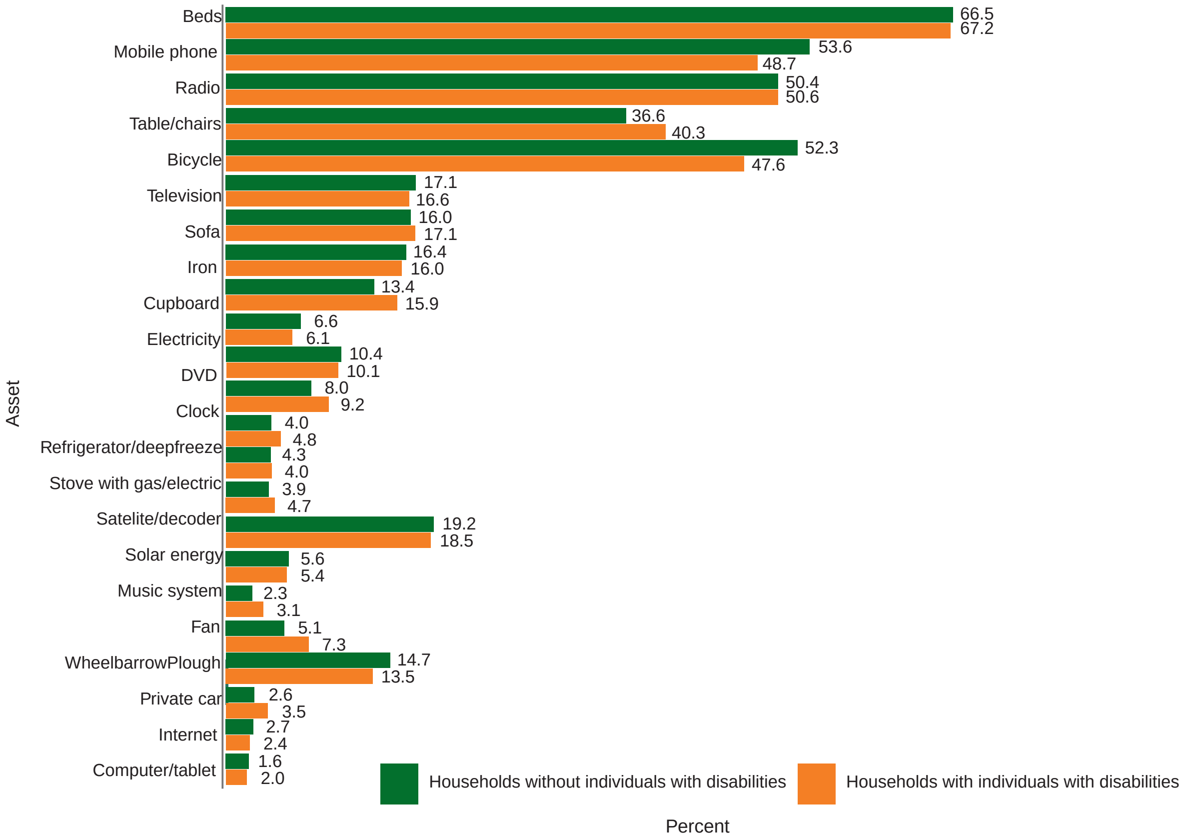
Figure 7.4 VKRZV WKH RYHUDOO GLVWULEXWLRQ RI D UDQJH RI KRXVHKROG LW of the items, more households with disabled members than without reported owning the different items.

Figure 7.4 Distribution of household assets, by household type (N=9,190)



In rural areas, more households without disabled members reported owning the various items than did households with disabled members (Figure 7.5).

Figure 7.5 Distribution of household assets, by household type, rural (N=5,945)



In urban areas, more households without disabled members reported owning the various items than households with disabled members (Figure 7.6).

Figure 7.6 Distribution of household assets, by household type, urban (N=3,245)

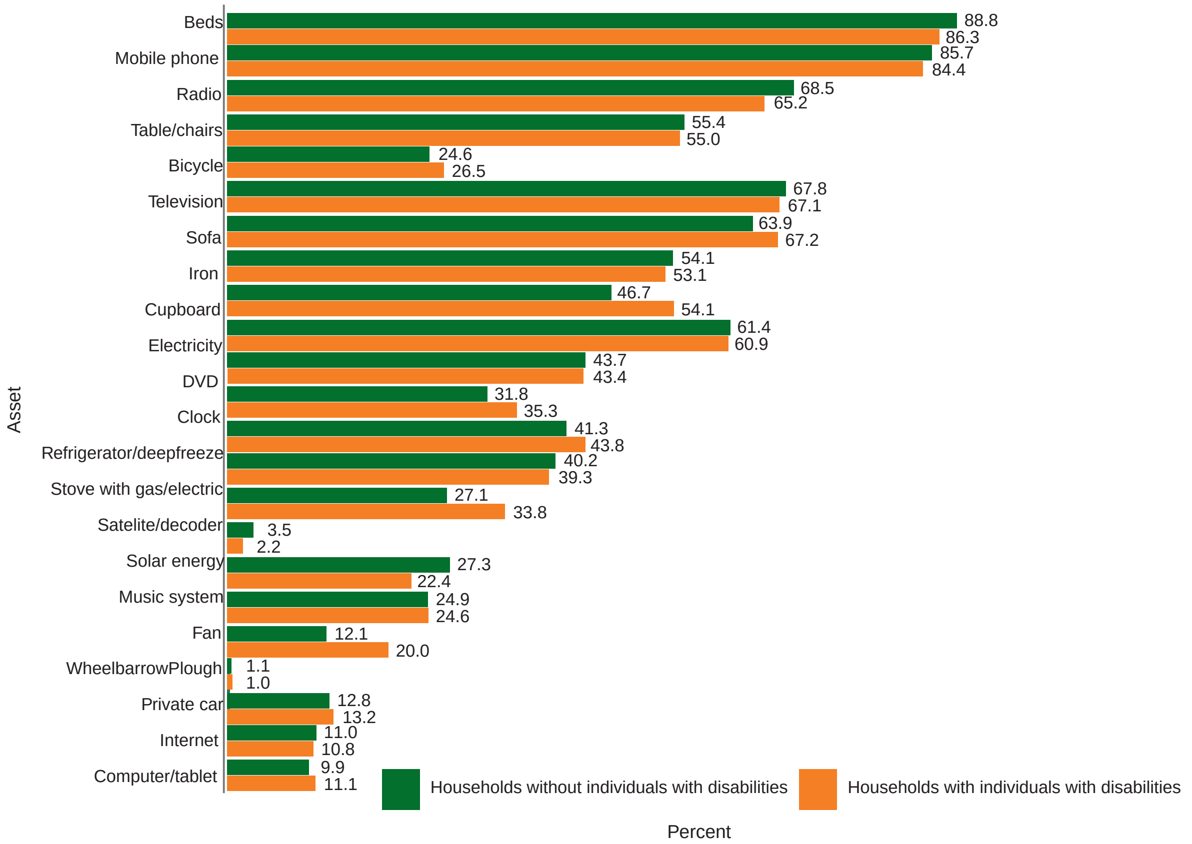
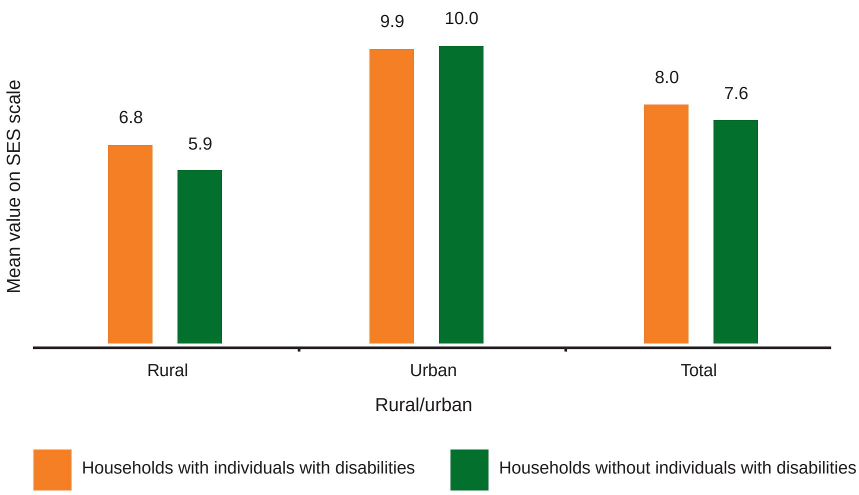


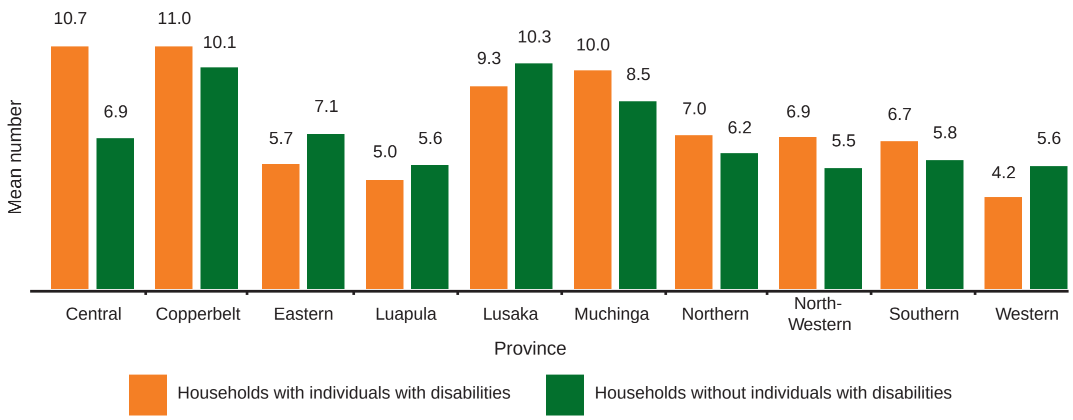
Figure 7.7shows the mean scale value of socio-economic status (SES) by household type and rural/urban location. The SES index is a linear combination of household assets and ownership of livestock and agricultural land. Overall, WKH ¿JXUH VKRZV WKDW KRXVHKROGV ZLFK KDYH SHUVRQV ZLWK GLVD without disabled members (8.0 and 7.6, respectively). This pattern holds true for rural areas (6.8 vs. 5.9). In urban areas, however, households having persons with disabilities scored 9.9, while households without persons with disabilities scored 10.0 on the SES scale.

Figure 7.7 Mean scale value of SES, by household type and rural/urban (N=9,190)



As Figure 7.8 shows, with the exception of four provinces (Eastern, Luapula, Lusaka and Western), households having persons with disabilities scored higher on the SES scale than households without.

Figure 7.8 Socio-economic status, by household type and province (N=9,190)



DIETARY DIVERSITY

$ GLHWDU\ VFDOH ZDV FRQVWUXFWHG XVLQJ WKH IROORZLQJ LWHPV

1. Cereals;
2. Roots and tubers (vegetables);
3. Leaf vegetables;
4.)UXLWV
5. Meat, poultry, offal;
6. Eggs;
7.)LVK DQG VHDIRRG
8. Pulses/legumes/nuts;
9. Milk and milk products;
10. Oil/fats;
11. Sugar/honey;
12. Condiments and any other foods. (Swindale and Bilinsky, 2006)

Respondents were asked which of these 12 food groups had been consumed in the household in the previous two weeks during the day and at night. The responses were added together to form a dietary diversity scale. Figure 7.9 shows the mean dietary diversity scale by household type and rural/urban. In both rural and urban areas, it is clear from WKH ¿JXUH WKDW KRXVHKROGV ZKHUH QRERG\ KDG D GLVDELOLW\ VFRU which had persons with disabilities. That is, households without a disabled member reported having consumed more of the different food groups.

Northern Province was the only province to record higher scores on the dietary diversity scale for households with a disabled member. In the other provinces, households having persons with disabilities scored either the same or less than households without a disabled member (Figure 7.10).

Figure 7.9 Mean dietary diversity scale, by household type and rural/urban (N=9,190)

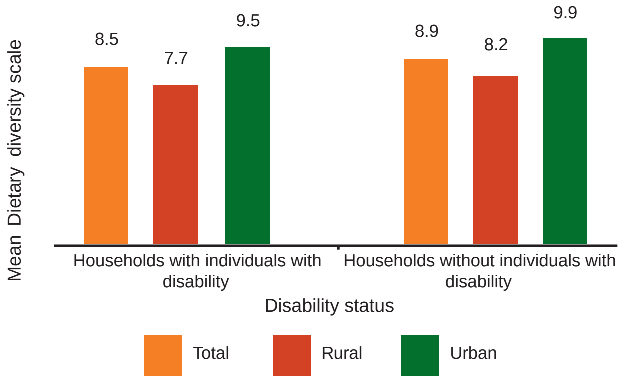
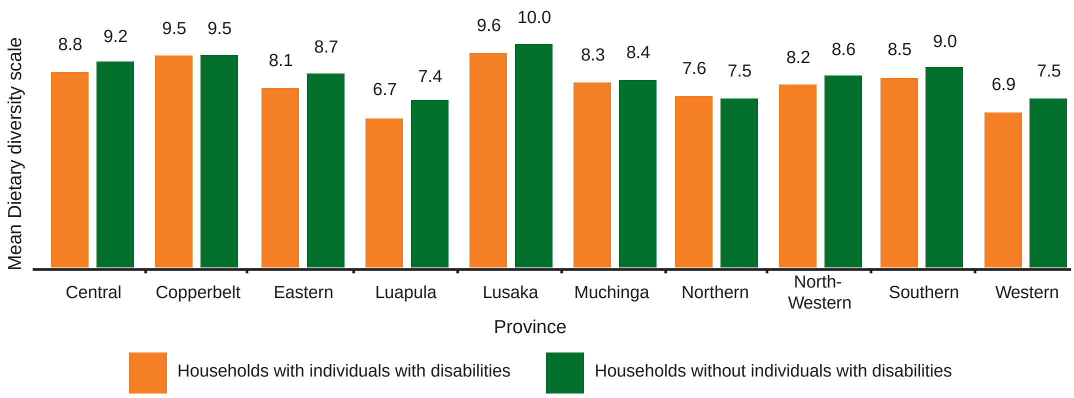


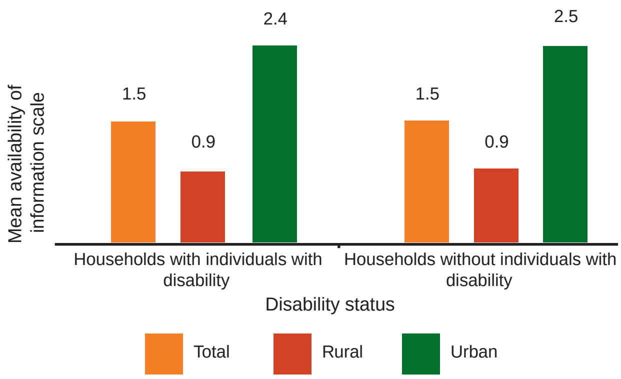
Figure 7.10 Mean dietary diversity scale, by household type and province (N=9,190)



AVAILABILITY OF INFORMATION

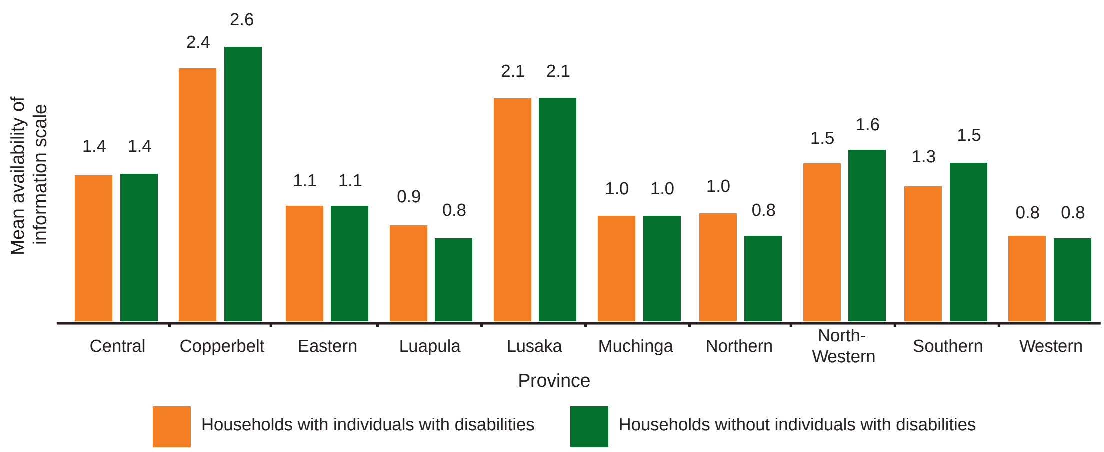
Access to information was measured using questions on the availability of TV, the internet, newspapers and library VHUYLFHV 7KH IRXU LWHPV ZKHUH DGGHG WRJHWKHU Figure 7.11 shows the DQ µDYDLO availability of information scale by household type and rural/urban. Urban households had greater availability of information than rural households. The difference between the two household types is marginal.

Figure 7.11 Availability of information, by household type and rural/urban (N=9,107)



There are some small variations between household types across the provinces, with Luapula, Northern, Eastern and Muchinga scoring lowest on the scale. Copperbelt province reported the highest availability of information (2.4 and 2.6 for households with and without disabled members, respectively), followed by Lusaka Province at 2.1 for both household types (Figure 7.12).

Figure 7.12 Availability of information, by household type and province



INCOME

Household income has an important role in the wellbeing of households. A household's day-to-day expenditure on food, shelter, education, health, etc. depends largely on what households earn. Thus, in addition to household assets, household income can be used to measure the wealth of a household. Households were asked to state their primary sources of income (if any).

Table 7.13 shows the primary source of income for households with and without disabled members. It is clear that generally subsistence farming was the most important primary source of income for both household W\SHV)RU KRXVHKROGV ZLWK GLVDEOHG members, grants were the second most important source of income, while for households without members persons it was wage/salary.

In rural areas, subsistence farming was the main primary source of income, followed by wage/salary for both household types. In urban areas, wage/salary was the main primary source of income, followed by non-registered informal business for both household types.

Table 7.13 Primary source of income, by households with and without persons with disabilities (N=9,190)

	HOUSEHOLDS WITH DISABLED INDIVIDUALS			HOUSEHOLDS WITHOUT DISABLED INDIVIDUALS		
	Total	Rural	Urban	Total	Rural	Urban
Grant	29.4	0.3	0.3	0.3	0.5	0.1
Wage/salary work (gross salary)	25.2	10.2	46.0	32.1	17.4	55.1
Remittances received	5.1	3.9	6.7	1.8	1.2	2.8
Cash cropping	1.4	1.9	0.7	2.5	3.9	0.3
Livestock/poultry	0.3	0.4	0.1	0.1	0.1	0.2
Subsistence farming	43.7	68.7	9.1	41.0	63.5	5.8
Subsistence fishing	2.2	3.5	0.4	2.2	3.4	0.2
Formal business (registered)	2.1	0.4	4.4	1.7	0.5	3.7
Informal business (non-registered)	14.3	7.7	23.3	16.2	8.5	28.2
Private insurance/pension	0.6	0.2	1.2	0.2	0.0	0.4
Workman's compensation	0.1	0.0	0.1	0.0	0.0	0.0
Rent	2.4	0.5	5.1	1.1	0.1	2.8
No income from any source	1.8	1.6	2.1	0.5	0.6	0.4
Begging	0.6	0.7	0.5	0.1	0.1	0.1
Other	0.0	0.0	0.0	0.0	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

HOUSEHOLD DEATHS

The 2015 NDS also collected information on deaths in the households. Household members were asked if any member of the household had died in the 12 months before the survey. Age at death and the main cause of death were also ascertained.

Figure 7.13 shows the percentage of reported deaths by household type in the 12 months prior to the survey. Of all reported household deaths, 53.8 percent were reported in households without disabled individuals, while 46.2 percent were reported in households with disabled members.

Figure 7.13 Percentage reporting a death, by household type

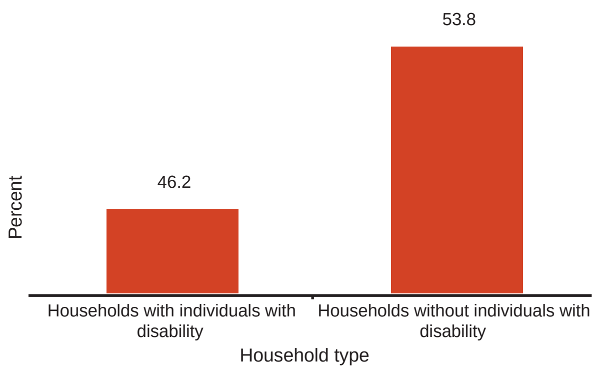


Table 7.14shows the main cause of death by household type. The results make it clear that malaria was the leading UHSRUWHG FDXVH RI GHDWK LQ ERWK KRXVHKROG W\SHV KRXVHKROG percent of deaths) than households without any disability (17.3 percent). The second leading cause of death in households with disabled members was HIV/AIDS-related causes (6.8 percent); in households without anyone who ZDV GLVDEOHG GLDUUKRHD DQG ZLWFKFUDIW ZHUH WKH MRLQW VHFRQ

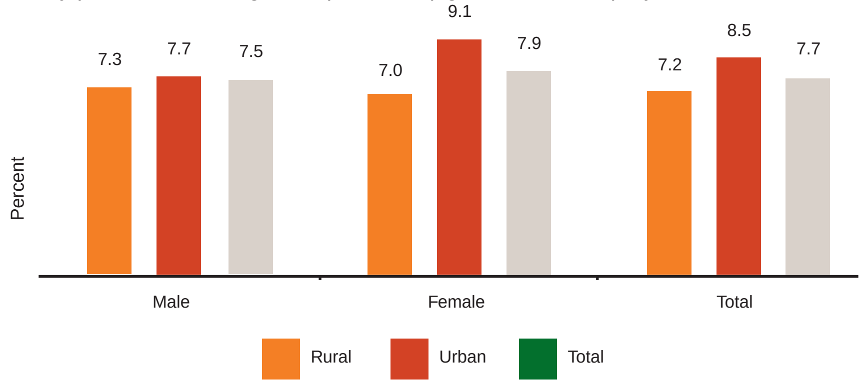
Table 7.14 Main causes of death, by household type (percentage of all deaths)

CAUSE OF DEATH	HOUSEHOLDS WITH INDIVIDUALS WITH DISBILITIES	HOUSEHOLDS WITHOUT INDIVIDUALS WITH DISABILITIES
Accident	3.2	5.1
Violence/Murder	2.3	1.6
Cancer	2.7	2.0
TB	5.9	5.9
Malaria	21.0	17.3
Diarrhoea	4.1	6.3
Malnutrition	1.4	2.0
Measles	0.9	2.0
Pneumonia	5.0	2.7
Heart disease	3.7	3.1
High blood presure	3.2	3.1
Diabetes	0.9	0.8
HIV/AIDS (related)	6.8	2.7
Other disease	4.1	3.1
Old age	4.6	5.5
Witchcraft	5.5	6.3
Suicide	0.5	0.8
Other	15.1	17.3
Don't know	9.1	12.5

PREVALENCE

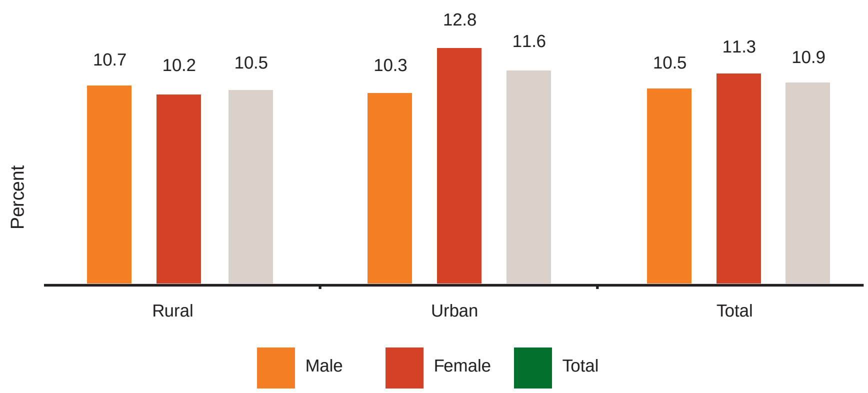
7KH SUHYDOHQFH RI GLVDELOLW\ LQ =DPELD ZDV SHUFHQW SHUFH 'LVDELOLW\ ZDV PRUH SUHYDOHQW LQ XUEDQ DUHDV IRU ERWK PDOHV DQ (Figure 7.14).

Figure 7.14 Disability prevalence among all respondents (aged 2 and above), by sex and urban/rural



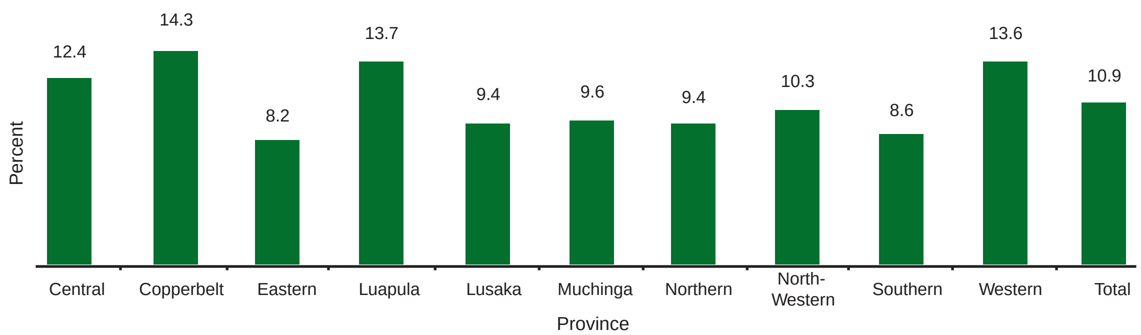
$PRQJ DGXOWV Figure 7.15 shows, the total prevalence is 10.9 percent and is higher in urban than in rural areas (11.6 percent and 10.5 percent). It is higher among females than males in urban areas, but the other way around in rural areas.

Figure 7.15 Disability prevalence among adults aged 18+, by sex and rural/urban



The prevalence of disability by province is shown Figure 7.16. Copperbelt had the highest percentage of people with disabilities (14.3 percent), followed by Luapula Province (13.7 percent). Eastern Province had the lowest SHUFHQWDJH ± SHUFHQW

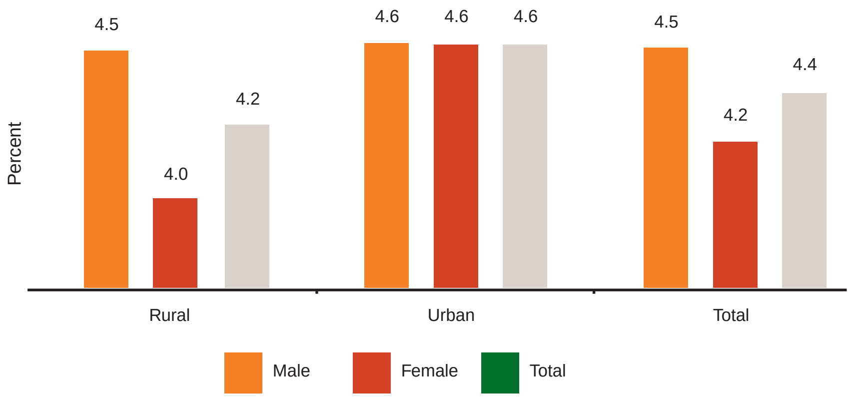
Figure 7.16 Prevalence of disability, by province (18+ years)



PREVALENCE OF DISABILITY AMONG CHILDREN

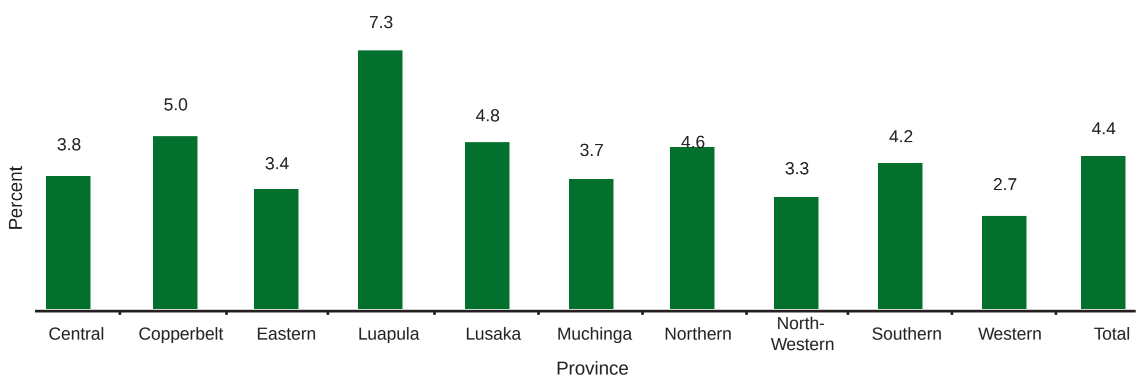
Figure 7.17 VKRZV WKH SUHYDOHQFH RI GLVDELOLW\ DPRQJ FKLOGUHQ DJHG disability was 4.4 percent, with 4.2 percent in rural and 4.6 percent in urban areas. The prevalence of disability was slightly higher among males than females (4.5 percent and 4.2 percent, respectively).

Figure 7.17 Prevalence of disability among children aged 2–17, by sex and rural/urban



7KH SUHYDOHQFH RI GLVDELOLW\ DPRQJ FKLOGUHQ Figure 7.18 Luapula Province E\ SURY had the highest prevalence (7.3 percent), followed by Copperbelt (5.0 percent). Western Province had the lowest prevalence, at 2.7 percent.

Figure 7.18 Prevalence of disability among children aged 2–17, by province



INDIVIDUAL SECTION 1: INDIVIDUAL QUESTIONNAIRE 18+ YEARS

This section starts with some demographic information and continues with descriptions of disability/activity limitations in the sample of persons with disabilities, as well as types of limitations, severity and causes. There then follow experiences of abuse and discrimination, access and quality of basic services, including assistive devices, family and social involvement/participation, including awareness and membership of disabled people's organizations (DPOs) and participation in elections. Then there is information on accessibility in the home and LQ WKH FRPPXQLW\ WKLV LV IROORZHG E\ KHDOWK DQG KHDOWK LQIRU activity.

DEMOGRAPHICS

This sub-section includes data on age and sex distribution, geographical (urban/rural and province) distribution of persons with and without disabilities, and marital status.

In all, 82.4 percent (1,921) of those persons with disabilities responded themselves; proxy reporters answered in 12.5 percent (291) of the interviews; the remaining 5.1 percent (119) was when the proxy responded together with the disabled person Table 7.15 below presents demographic information on persons with and without disabilities. The information includes the proportion of disabled and non-disabled persons according to age group, VH[DQG GLVWULFW 7KH WDEOH UHYHDOV WKDW GLVDELOLW\ FXWV DFU GLVDELOLWLHV LV LQ WKH DJH JURXS ± DQG WKH ORZHVW LV LQ WKH KLJKHVW SURSRUWLRQ LV LQ WKH DJH JURXS ± SHUFHQW ZLWK D 7KH PHDQ DJH RI SHUVRQV ZLWK GLVDELOLWLHV ZDV \HDUV DQ There were more females among persons with disabilities. There was a notable mean age difference, with persons with disabilities substantially older than non-disabled in both urban and rural areas. Mean age differed across the provinces from 46.1 years to 54.8 years among persons with disabilities, and from 31.7 years to 36.5 years among persons without.

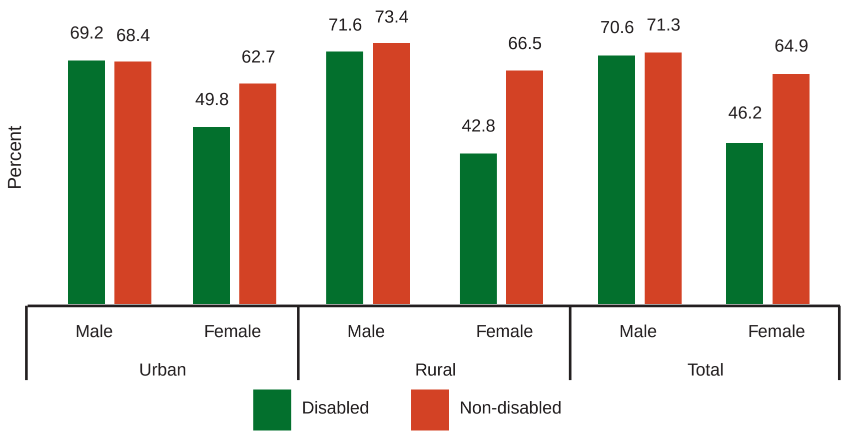
Table 7.15 Demographic information, by disability status, percentage and mean age

		DISABLED	NON-DISABLED
Age	18–20	5.8	13.0
	21–30	15.4	40.5
	31–40	13.7	23.1
	41–50	17.7	11.1
	51–60	16.1	6.5
	61–70	14.5	3.4
	71+	16.8	2.5
	N (base)	2,377	3,344

		DISABLED	NON-DISABLED
		Mean age	Mean age
Total		49.7	33.7
Sex	Male	49.0	33.9
	Female	50.2	33.1
	N (base)	2,377	3,344
		Mean age	Mean age
Location	Urban	46.9	32.2
	Rural	51.9	34.4
N (base)		2,377	3,344
		Mean age	Mean age
Province	Central	50.7	35.0
	Copperbelt	50.1	33.6
	Eastern	53.1	33.2
	Luapula	46.7	35.4
	Lusaka	46.1	31.7
	Muchinga	48.0	33.8
	Northern	48.9	33.4
	North-Western	49.2	36.5
	Southern	50.1	32.5
	Western	54.8	33.5
	Total	49.7	33.7

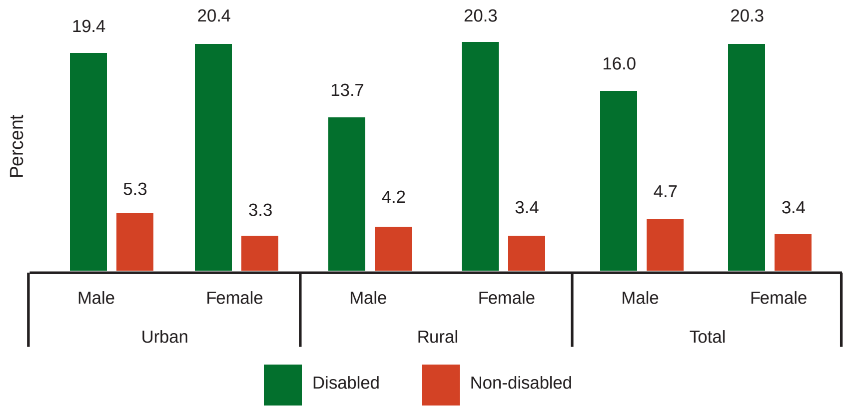
Figure 7.19 shows the percentage of people who were married by disability status, sex and rural/urban. More IHPDOHV ZLWKRXW GLVDELOLWLHV ZHUH PDUULHG[2] WKDQ $WKRVH ZLWK The corresponding GLIIHUHQFH IRU PDOHV ZDV VPDOO $PRQJ ERWK XUEDQ DQ non-disabled women were married than disabled women, whereas the differences between men with and without disabilities were small (n.s.).

Figure 7.19 Percentage of persons who were married, by disability status, sex and rural/urban (18+ years, N = 5,643)



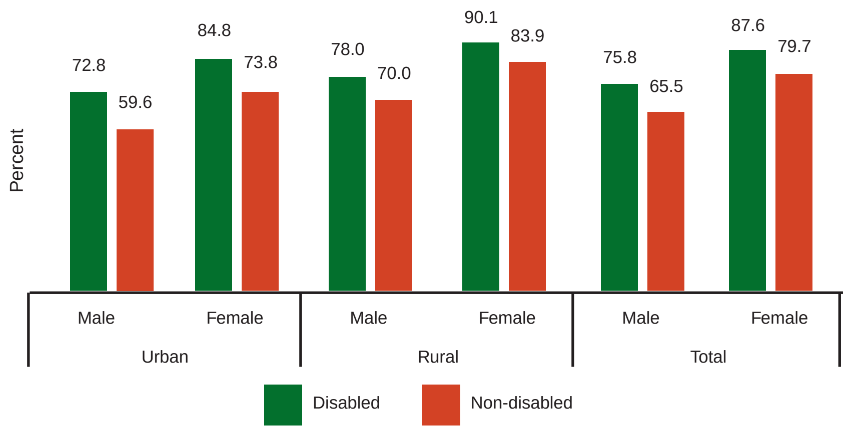
0RUH IHPDOHV KDYH GLVDEOHG VSRXVHV ² SHUFHQW ZLWK WKH difference found among rural dwellers. Moreover, more urban respondents with disabilities and urban males without disabilities reported having a disabled spouse than did their rural counterparts, with the difference being most pronounced among males (Figure 7.20).

Figure 7.20 Proportion of spouses of persons with and without disabilities living with a disability, by sex and rural/urban (18+ years, N=3,569)



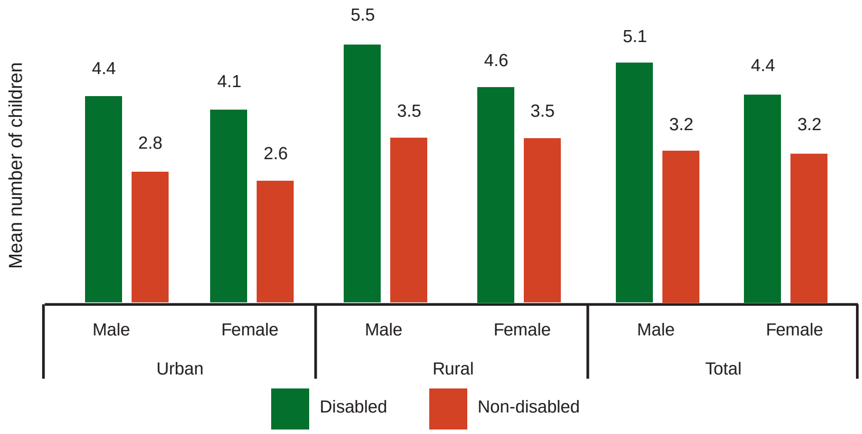
More persons with disabilities report having children. Figure 7.21 reveals that this is a consistent pattern across sex and location. More females than males have children, and this is true of both persons with and without disabilities.)LQDOO\ KDYLQJ FKLOGUHQ LV PRUH FRPPRQ LQ UXUDO DUHDV DPRQJ ER

Figure 7.21 Proportion having children, by disability status, sex and rural/urban (18+ years, N=5,643)



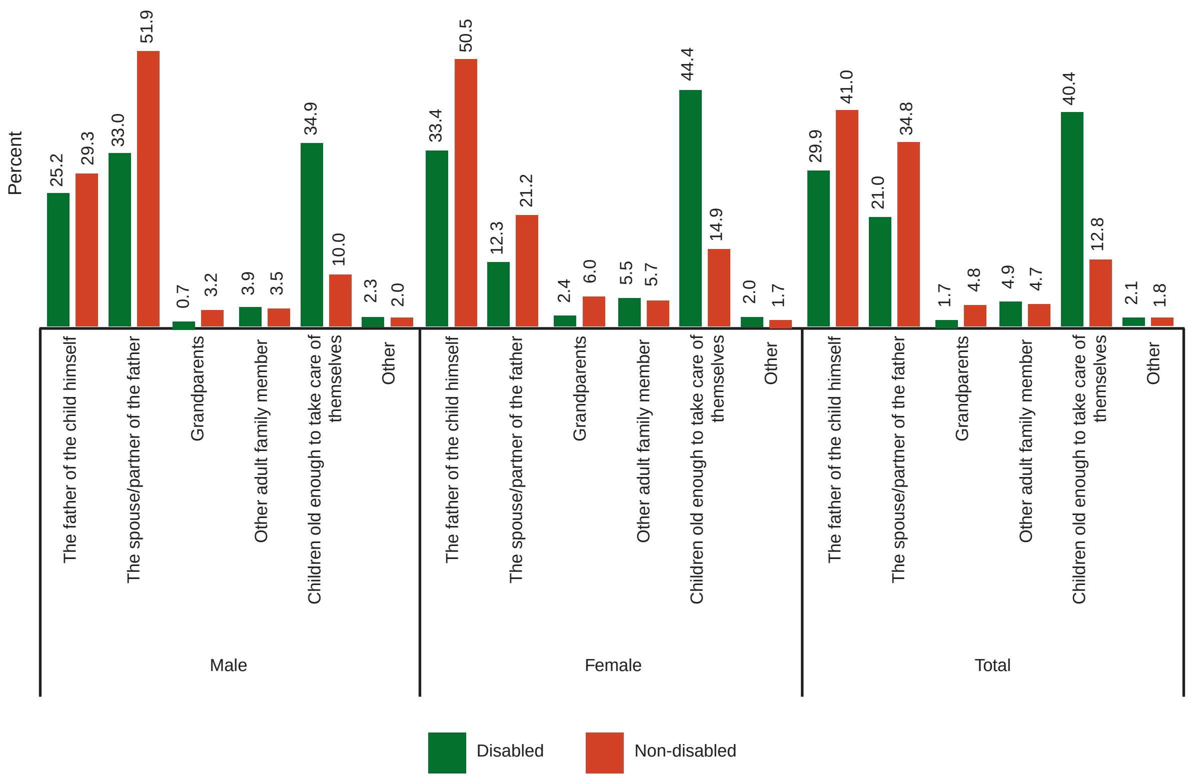
The mean number of children varies from 5.5 among rural males with disability to 2.6 among urban females without GLVDELOLW\ 7KH ¿JXUH IRU ZRPHQ ZLWK GLVDELOLW\ LV DQG IRU WK Individuals with disabilities have a higher (mean) number of children across sex and location, and rural respondents have more children than urban respondents (males and females alike) (See Figure 7.22

Figure 7.22 Mean number of children, by disability status, sex and rural/urban (18+ years, N=4,363)



Individuals with children were asked who it was who mainly took care of them (or helped take care of them). Figure 7.23 VKRZV WKDW JHQHUDOO\ VSHDNLQJ UHVSRQGHQWV WRRN FDUH with disability and 50.5 percent of females without disabilit$ S $PRQJ PDOHV WKHLU VS WRRN FDUH RI WKH FKLOGUHQ ± WKLV ZDV WKH FDVH IRU SHUFHQW without.

Figure 7.23 Main carer, by disability status and sex (18+ years, N=4,363)



ACTIVITY LIMITATIONS

In this sub-section, the application of the six Washington Group screening questions is explained. There then follows an analysis of the distribution of severity of disability, controlling for sex and location (urban/rural and province). This sub-section also covers the distribution of causes of disability and disability onset.

,Q WKLV VWXG\ ZH DSSOLHG WKH VL[,&) EDVHG GRPDLQV GHYHORSHG E
LQWHQGHG IRU XVH DV VFUHHQLQJ TXHVWLRQV LQ FHQVXVHV DQG VXUYH

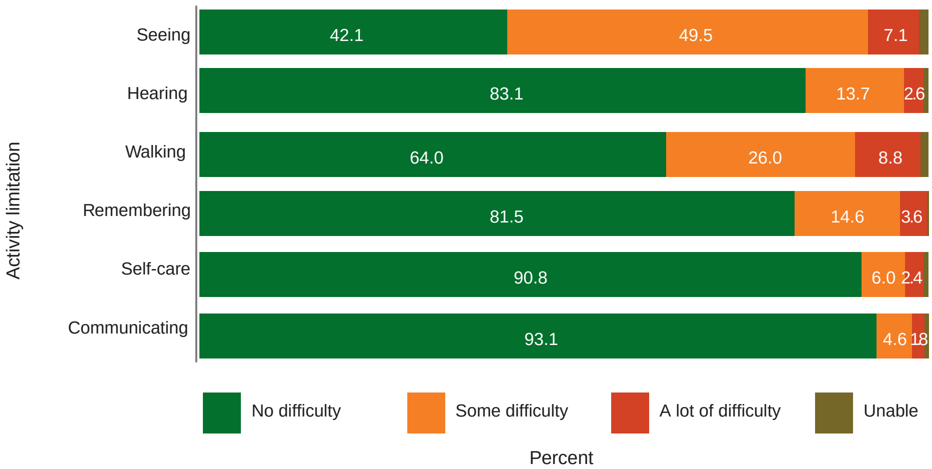
%HFDXVH RI D KHDOWK SUREOHP GR \RX KDYH GLI¿FXOW\

i. Seeing, even if using glasses?
ii. Hearing, even if using hearing aids?
iii. Walking or climbing steps?
iv. Remembering or concentrating?
v. With self-care, such as washing all over or dressing?
vi. 8VLQJ \RXU XVXDO FXVWRPDU\ ODQJXDJH GR \RX KDYH GLI¿FXOW\ or being understood by others)?

)RU DOO VL[TXHVWLRQV WKH DQVZHU FDWHJRULHV DUH L 1R GLI¿FXO
Unable to do.

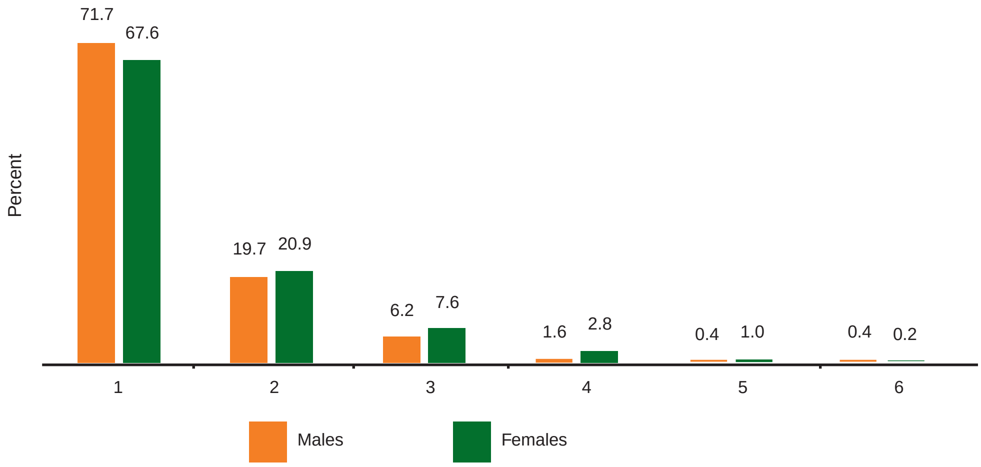
)URP WKH Figure 7.24, seeing emerges as the activity domain where most respondents with disability (49.5
SHUFHQW UHSRUWHG KDYLQJ µVRPH GLI¿FXOW\¶ 7KLV LV IROORZHG E\ Z
hearing (13.7 percent), self-care (6.0 percent) and communication (4.6 percent). The most serious activity limitation
L H µD ORW RI GLI¿FXOW\¶ µXQDEOH WR GR¶ LV UHSRUWHG IRU ZDON
UHPHPEHULQJ SHUFHQW VHOI FDUH DQG KHDULQJ SHUFHQW DQ
GLIIHUHQFHV LQ WHUPV RI VH[ZHUH IRXQG IRU DOO GRPDLQV PRUH PD
FRPPXQLFDWLQJ ZKLOH PRUH IHPDOHV UHSRUWHG GLI¿FXOWLHV ZLWK VH

Figure 7.24 Activity limitations among persons with disabilities (18+ years) (N=2,377)



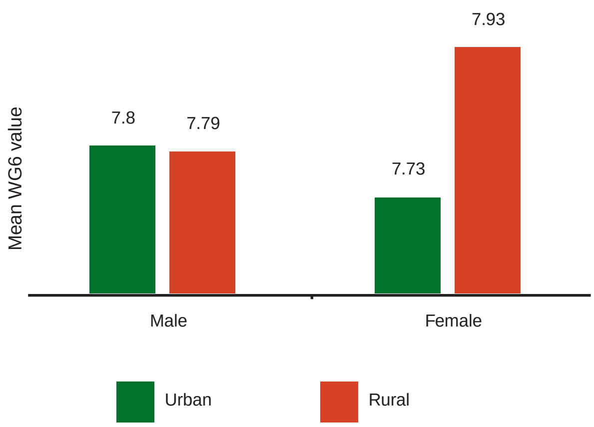
More male respondents with disability (71.7 percent) than female respondents (67.6 percent) reported having at least VRPH GLI¿FXOW\ ZLWKLQ MXVW RQH GRPDLQ DQG DOVR ZLWKLQ DOO V GLI¿FXOW\ ZLWKLQ WZR WKUHH Figure 7.25 IRXU DQG ¿YH GRPDLQV

Figure 7.25 Number of activity limitations (at least some di culty), by sex (18+ years) (N=2,377)



The six activity limitation domains were added together to form a WG6/Activity limitation scale. This new variable DFWLYLW\ OLPLWDWLRQV KDV DV LWV ORZHVW SRVVLEOH YDOXH DQ The mean value (all persons with disabilities) on the scale was 7.81 and standard deviation was 1.43. While the GLIIHUHQFHV LQ WKH PHDQ VFDOH YDOXH DUH UHODWLYHO\ VPDOO ZRP FRXQWHUSDUWV DQG DOVR PRUH GLI¿FXOWLHV WKDQ PHQ 8UEDQ ZRP urban/rural difference among females is not found among males (Figure 7.26).

Figure 7.26 Level of di culty/WG6 scale score, by sex and rural/urban (18+ years, N=2,377)



7KHUH LV VRPH YDULDWLRQ LQ UHSRUWHG GLI¿FXOWLHV :* VFDOH DFUR
Western and Luapula Provinces scoring highest and North-Western lowest. While the differences appear relatively
VPDOO WKH YDULDWLRQ LQ PHDQ :* VFDOH YDOXH DFURVV WKH SURY
(Figure 7.27).

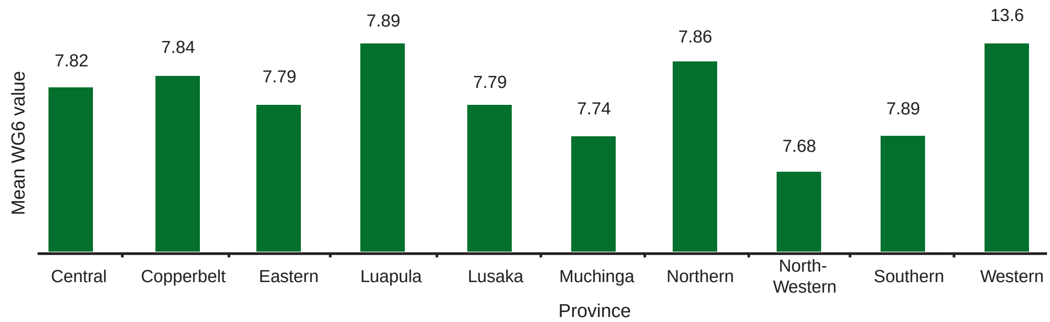


Figure 7.27 Level of di culty/WG6 scale, by province (18+ years, N=2,377)

'H¿QLQJ VHYHUH GLVDELOLW\ DV HLWKHU µD ORW RI GLI¿FXOW\¶ RU µXQD
in Table 7.16 :KHQ LW FRPHV WR VHHLQJ DQG ZDONLQJ WKHUH LV D FOHDU DJ
LQFUHDVHV ZLWK DJH WKHQ WHQGV WR UHGXFH LQ WKH PLGGOH \HDUV D
WKH KLJKHVW SURSRUWLRQ LV REVHUYHG LQ WKH DJH JURXS ± DQG W
distinct age pattern for hearing, remembering and self-care.

Table 7.16 Distribution of severe disability [1] according to disability core domain and age group (18+ years, N=2,377)

DISABILITY CORE DOMAIN	AGE GROUP							
	18–20	21–30	31–40	41–50	51–60	61–70	71+	Total
	%	%	%	%	%	%	%	
Seeing	4.9	4.4	7.0	6.6	6.9	8.3	17.7	8.3
Hearing	3.3	7.9	2.0	2.4	1.4	1.9	3.4	3.2
Walking	6.0	5.6	6.2	8.4	10.1	12.9	17.9	9.9
Remembering	7.4	3.6	5.3	3.9	1.0	1.6	6.2	3.7
Self-care	4.5	3.0	1.9	1.9	2.2	2.8	6.6	3.1
Communicating	5.7	6.4	2.2	1.7	0.2	0.9	1.7	2.4

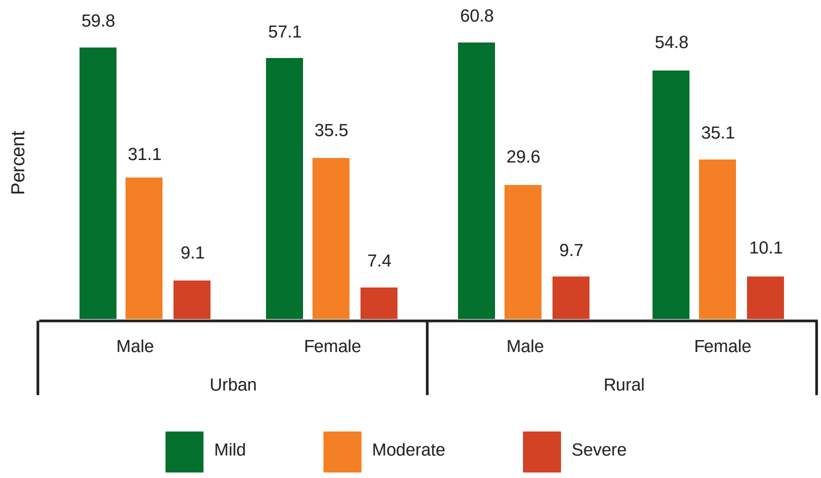
[1] 6HYHUH GLVDELOLW\ LV GH¿QHG DV HLWKHU µ$ ORW RI GLI¿FXOW\¶ RU µ

Alternative disability severity measure

7KH :* VFDOH ZDV VSOLW LQWR WKUHH FDWHJRULHV UHÀHFWLQJ GLIIH
ZHUH UHFRGHG DV µPLOG GLVDELOLW\¶ DQG DV µPRGHUDWH GLVDELO
a pragmatic categorization, designed to produce reasonably equal groups. Nevertheless, mild disability constituted 57.9 percent of respondents, moderate disability 32.9 percent and severe disability 9.2 percent.

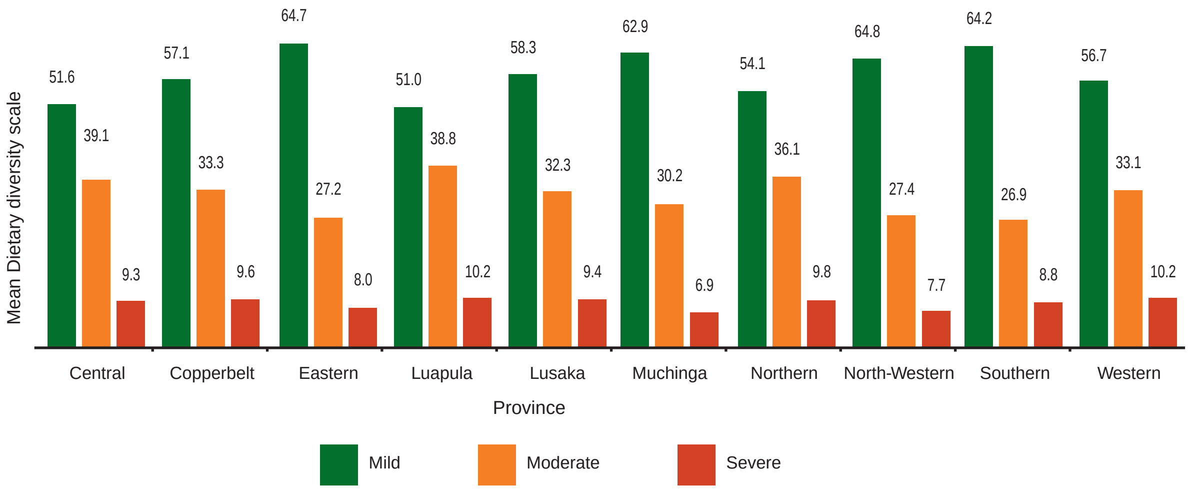
Figure 7.28shows the distribution along this measure of severity among the sample of disabled persons included in WKLV VWXG\ 7KH UHVXOWV ¿UVW RI DOO UHYHDO D UHODWLYHO\ HTXDO ERWK PDOHV DQG IHPDOHV 6PDOO GLIIHUHQFHV ZHUH IRXQG PRUH PD pattern was reversed for moderate disability.

Figure 7.28 Disability severity, by sex and rural/urban (18+ years, N=2,377)



As Figure 7.29shows, the pattern (mostly mild disability, followed by moderate and lastly severe disability) is found in all provinces, although there is some variation in the ratio of the three severity categories across the provinces. The proportion of severe disability varies across the provinces, from 6.9 percent (Muchinga) to 10.2 percent (Luapula and Western).

Figure 7.29 Severity of disability, by province (18+ years, N=2,377)



Causes of disability

People's personal perceptions about the causes of their disability were recorded. This is not necessarily the same as
PRUH REMHFWLYH DVVHVVPHQWV 1R DWWHPSW ZDV PDGH WR DFTXLUH I
different causes are listed in Table 7.17. Disability due to disease was reported as the most frequent cause (32.7
SHUFHQW)DOOV DQG DFFLGHQWV ZHUH JLYHQ DV FDXVHV E\ SHUFHQ
FDXVHV DFFRXQWHG IRU SHUFHQW DQG WKH FRPELQDWLRQ RI DFFL
SHRSOH UHVSRQGHG µGR QRW NQRZ¶ ± UDWKHU LQGLFDWLYH RI OLPLWH
$OVR SHUFHQW FKRVH WR UHVSRQG µRWKHU¶ 7KXV WKH FRPELQDWL
PDNLQJ LW GLI¿FXOW WR SURGXFH D JRRG SUR¿OH RI FDXVHV RI GLVDEL

Table 7.17 Causes of disability (18+ years)

CAUSES OF DISABILITY	N	%
From birth/congenital	285	12.3
Accident	146	6.3
Fall	34	1.4
Burns	11	0.4
Disease/illness	802	32.7
Beaten by member of the family	8	0.4
Violence outside the house	10	0.4
War related	2	0.1
Animal related	4	2.0
Stress related	59	2.7
Witchcraft	79	3.1
Other (side effects from the use of medicine; experienced this problem after giving birth; got injured while playing)	357	16.1
Do not know/refuse	534	24.0
Total	2,331	100.0

Disability onset

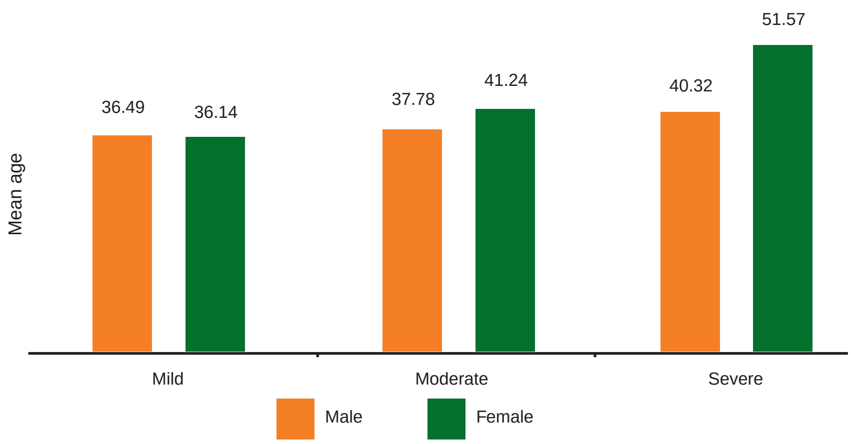
5HVSRQGHQWV ZHUH DOVR DVNHG ZKHQ WKHLU GLVDELOLW\ EHJDQ &OHD
because they may not know exactly or else do not remember. This must be considered when interpreting the results.
Table 7.18 shows that the distribution is relatively even across the age categories. Some 14.8 percent of disabilities
EHJDQ LQ WKH DJH EUDFNHW ± \HDUV DQG DQ DGGLWLRQDO SHUFHQ

Table 7.18 Onset of disability (18+ years)

	N	%
From birth/first living year	234	9.8
1–5 years	117	5.0
6–10 years	100	4.2
11–20 years	291	12.4
21–30 years	272	11.7
31–40 years	280	12.1
41–50 years	332	14.4
51–60 years	213	9.3
61–70 years	226	9.6
71+ years	266	11.5
Total	2,377	100.0

The mean age of disability onset rose with increasing disability severity. The male/female difference changed from 0.4 years (males higher) among those with mild disability, to 4.4 years for moderate disability (females higher) and 11.3 years for severe disability (females higher), indicating an association between severity and age, with an age gradient WKDW LV PRUH SURQRXQFHG DPRQJ ZRPHQ 7KLV UHÀHFWV ERWK DQ H[the mean age of women is higher than that of men (Figure 7.30).

Figure 7.30 Mean age of disability onset, by disability severity and sex (18+ years, N=2,331)



ABUSE AND DISCRIMINATION

This sub-section looks at the data on abuse and neglect, discrimination and sexual abuse, broken down by the common demographic variables (sex, location, age) and disability severity.

An attempt was made to recode the personal experience of disabled respondents of abuse and discrimination in the family and in society. Three questions were asked to assess the experience of being discriminated against, with answer FDWHJRULHV µ\HV¶ µQR¶ DQG µGRQ¶W NQRZ¶ 7KHVH TXHVWLRQV FRQF

- Experience of being beaten or scolded by family members or relatives;
- Experience of being beaten or scolded by others;
- Experience of being discriminated against in any public services (e.g. hospital, clinic, police station, bank, etc.).

The analysis presented in Table 7.19 GRHV QRW LQFOXGH WKH µGRQ¶W NQRZ¶ DQVZHU FD

Some 9.7 percent reported having been beaten or scolded. Variation between the age groups indicates a somewhat reduced incidence with increasing age. Except for in the two oldest age groups, well over 50 percent of those who reported having been beaten or scolded said the beating/scolding had been done by a family member. Discrimination by public services (total 8.3 percent) also appeared to reduce somewhat with age. Differences in terms of sex were UHODWLYHO\ VPDOO EXW PDOHV WHQGHG WR UHSRUW EHDWLQJ VFROGL more often. Reported beating/scolding varied across the provinces, with the highest incidence recorded for Northern 3URYLQFH SHUFHQW DQG WKH ORZHVW IRU /XDSXOD 3URYLQFH S of beating/scolding within the family varied substantially, with Lusaka respondents reporting that more than one third SHUFHQW RI WKH EHDWLQJ VFROGLQJ KDG EHHQ GRQH E\ D IDPLO\ P 3URYLQFH ZDV SHUFHQW $ S 'LVFULPLQDWLRQ E\ SXEOLF IRXQG IRU /XVDND 3URYLQFH SHUFHQW DQG WKH ORZHVW IRU 6RXWK

Table 7.19 Distribution of personal experience among persons with disabilities of being abused or discriminated against, by age, sex and province

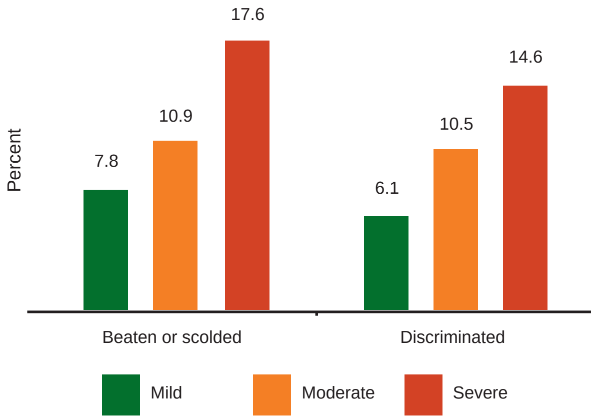
	BEATEN/SCOLDED	PROPORTION BEATEN/SCOLDED BY FAMILY MEMBER[1]	DISCRIMINATED AGAINST BY PUBLIC SERVICE
	N=2,294	N=222 [2]	N=2,299
Total	9.7	59.1	8.3
18–20	16.3	56.6	7.6
21–30	16.8	61.9	13.0
31–40	9.6	64.7	10.8
41–50	13.2	61.6	10.2
51–60	6.8	58.1	6.5
61–70	4.2	48.0	4.9
71 and above	5.1	46.6	5.1
Male	10.3	58.0	10.2
Female	9.3	60.0	6.8
Central	6.6	68.7	8.2
Copperbelt	8.7	54.1	8.3
Eastern	12.4	43.5	9.1
Luapula	5.7	57.1	7.0
Lusaka	8.5	35.1	11.2
Muchinga	8.7	76.9	7.4
Northern	20.3	66.7	9.4
North-Western	10.1	66.5	6.8
Southern	13.7	80.0	4.4
Western	8.6	70.0	8.2

[1] Proportion who reported that the beating/scolding had been done by a family member.

[2] Total number who reported that they had been beaten or scolded.

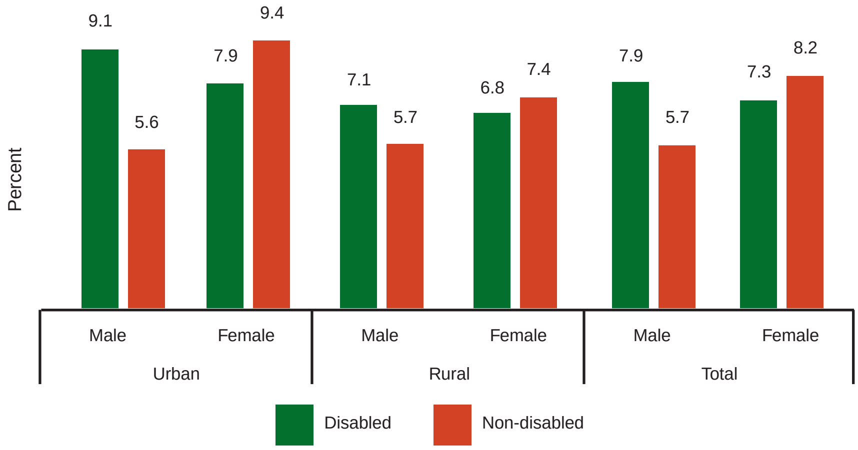
Figure 7.31 demonstrates that abuse and discrimination (as measured here) increases with increased severity of disability, with the most severely disabled being those most exposed. Among persons with mild disability, 7.8 percent KDG EHHQ EHDWHQ RU VFROGHG DQG SHUFHQW KDG H[SHULHQFHG G GLVDELOLW\ ZHUH SHUFHQW DQG SHUFHQW DQG IRU WKRVH ZLW $ S [2]DQG $S

Figure 7.31 Abuse and discrimination, by disability severity (18+ years, N=2,294 and N=2,299)



Among males, more persons with than without disability reported having suffered physical abuse as a child (7.9 SHUFHQW YV[2] SHSUFHQW0RSUH IHPDOHV ZLWKRXW SHUFHQW WKDQ Z that they had been physically abused as a child. Slightly fewer females with than without disabilities reported physical DEXVH LQ XUEDQ DUHDV [2]=5.52, p=0.06), while the even smaller difference in rural areas is QRW VLJQL¿FDQW SHUFHQW DQG SHUFHQW Q V 0RUH XUEDQ SK\VLFDO DEXVH DV D FKLOG[2] SHUFHQW ZKLOH WKH GLIIHUHQFH DPRQ QRW VLJQL¿FDQW SHUFHQW DQG SHUFHQW Q V 7KH KLJKHVW U disabilities (9.1 percent) and the lowest among urban males without disability (5.6 percent) (Figure 7.32).

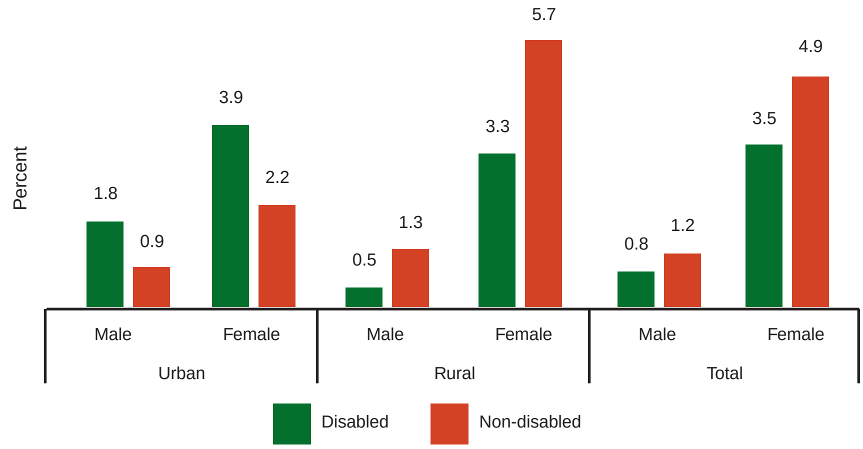
Figure 7.32 Proportion of respondents (with and without disabilities) who claim to have been physically abused as a child (before age 18), by sex and rural/urban (18+ years) (N=5,429)



Among males, 0.8 percent of disabled and 1.2 percent of non-disabled individuals said they had been sexually abused DV D FKLOG QRW VWDWLVWLFDOO\ VLJQL¿FDQW $PRQJ IHPDOHV ZLWK ZKLOH WKH FRUUHVSRQGLQJ ¿JXUH IRU IHPDOHV ZLWKRXW GLVDELOLW IHPDOHV LQ XUEDQ DQG UXUDO DUHDV WKH GLIIHUHQFHV EHWZHHQ G highest reported proportion of sexual abuse was among females without disability in rural areas (5.7 percent) (Figure 7.33).

)RU ERWK SK\VLFDO DQG VH[XDO DEXVH WKHVH DUH VHQVLWLYH TXHV reporting may thus be expected.

Figure 7.33 Proportion of respondents sexually abused as children (18+ years, N=5,483)



WELFARE AND HEALTH SERVICES

7KLV VXE VHFWLRQ ¿UVW DQDO\VHV DZDUHQHVV RI VHUYLFHV DQG JDSV VHUYLFHV UHFHLYHG DQG WKH VHUYLFHV QHHGHG 7KHUH WKHQ IROORZ V D VHULHV RI ¿JXUHV RQ DVVLVWLYH GHYLFHV LV SUHVHQWHG KRZ PDQ\ X training/information, maintenance and satisfaction with devices. Several of the indicators are broken down by the common demographic variables.

Those who need, are aware of and receive selected basic services

An attempt was made to record the need of disabled people for several welfare and health services, and at the same time to determine whether they are aware of and have received the services.[6] Table 7.20 lists the different welfare and health services and the proportion of persons with disabilities who were in need of, were aware of and received the services. Some 79 percent reported having received health services and 67.4 percent reported having accessed health information. Access to other services ranged from 1.5 percent (legal advice) to 28.3 percent (traditional/faith healer).

6 'Aware of' is understood as knowing whether the speci c services are available to them (awareness about availability), 'needed' as 'ever needed', and 'received' as 'ever received'. As for all other questions in the study, the responses are based on the perceptions of the respondent.

Table 7.20 Persons with disabilities who needed, were aware of and received services (18+ years, N=2,332)

TYPE OF SERVICES	NEEDED	AWARE OF	RECEIVED
	%	%	%
Medical rehabilitation	47.6	42.5	17.2
Assistive devices	58.8	75.1	16.5
Educational[1]	31.1	42.4	14.8
Vocational	35.2	44.8	8.2
Counselling for disabled person	32.0	35.1	7.2
Counselling for parent/family	25.9	26.3	8.9
Empowerment programmes	60.2	57.1	3.8
Welfare	60.1	56.8	4.9
Health services	89.6	89.5	79.0
Health information	79.9	80.4	67.4
Traditional/faith healer	33.5	90.7	28.3
Legal	11.0	32.0	1.5

[1] Specialized educational services for disabled people.

Generally, awareness of the different services exceeded need. This means that the respondents were aware of the existing services that they may need. A series of questions probed whether the respondents had needed and accessed a range of different services. If a service was needed but not accessed, this was registered as a gap in services; the responses added together served as measures of need, access and gaps in services. The largest gaps were found for empowerment programmes, welfare services and legal advice; the smallest were for traditional healer, health services and health information (Table 7.21).[7]

Table 7.21 Gap: proportion of people who needed but did not receive the services (%) (N=2,332)

TYPE OF SERVICES	GAP[1]	RECEIVED	GAP IN PERCENTAGE POINTS
Empowerment programmes	94.3	3.0	49.8
Welfare	93.4	3.2	45.2
Legal	84.7	22.6	8.3
Counselling for disabled person	78.0	7.2	25.6
Vocational	77.5	7.7	26.6
Assistive devices	73.2	15.7	43.0
Counselling for parent/family	64.7	9.5	17.4
Medical rehabilitation	63.3	17.7	30.5
Educational	53.1	14.4	16.3
Traditional/faith healer	19.3	70.1	5.4
Health services	8.1	3.2	7.0
Health information	9.9	78.9	7.7

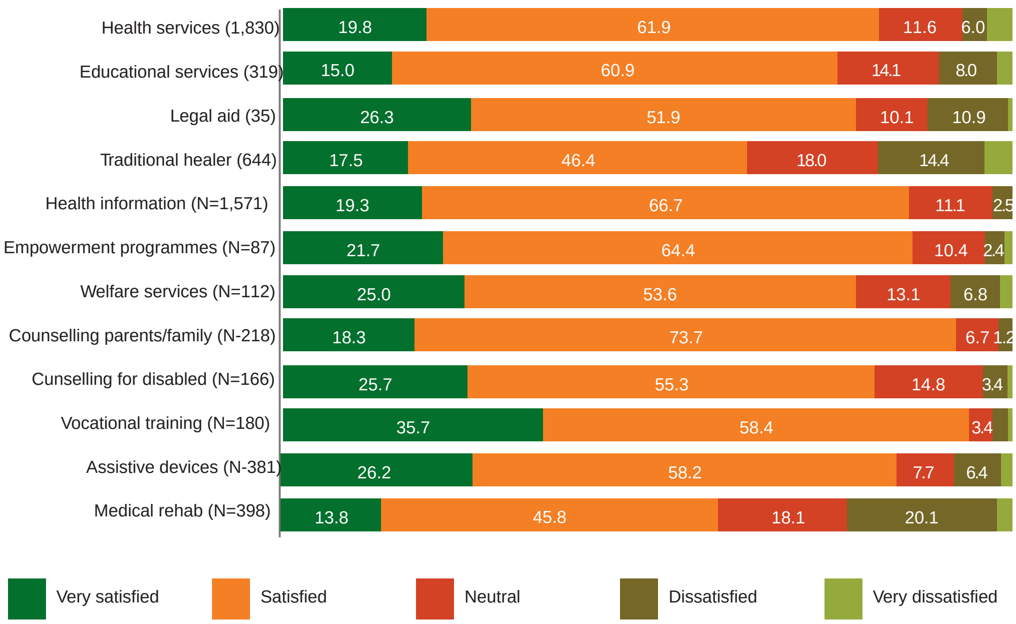
[1] Persons with disabilities who received the service as a proportion of those who needed the service (1-(received /needed)*100).

7 When assessing the gap, it is important to bear in mind the di erence between relative and nominal gap. Relative gap is measured as a relationship between needed and received, while the nominal gap indicates the size/quantity of the gap. For example, while there is a large relative gap concerning legal advice, the nominal gap is small, because both needed and received are low.

Satisfaction with services

7KH UHVSRQGHQWV ZKR KDG DFFHVVHV WR WKH UHVSHFWLYH VHUYLFHV
VHUYLFHV DQG RU GHYLFHV 0RVW UHVSRQGHQWV ZHUH HLWKHU VDWLV
percent), counselling for families of persons with disabilities (92 percent), empowerment programmes (86.1 percent),
DQG KHDOWK LQIRUPDWLRQ SHUFHQW 7KH ORZHVW ¿JXUHV IRU VDW
UHKDELOLWDWLRQ SHUFHQW DQG WUDGLWLRQDO KHDOHU SHUF
HLWKHU VDWLV¿HG RU YHU\ VDWLV¿HG ZHUH DV IROORZV DVVLVWLYH G
FRXQVHOOLQJ IRU GLVDEOHG SHRSOH ± SHUFHQW ZHOIDUH VHUYLFHV
services 75.9 percent. Note that the number of responses varied substantially between the different services, as it only included those who had accessed the different services and who reported on their satisfaction (Figure 7.34).

Figure 7.34 Satisfaction with services (18+ years)(%)



Assistive devices

Of those respondents with a disability, 20.2 percent of males and 19.7 percent of females reported that they use an assistive device (Figure 7.35).

Figure 7.35 Use of assistive device among persons with disabilities, by sex and rural/urban (18+ years, N=2,294)

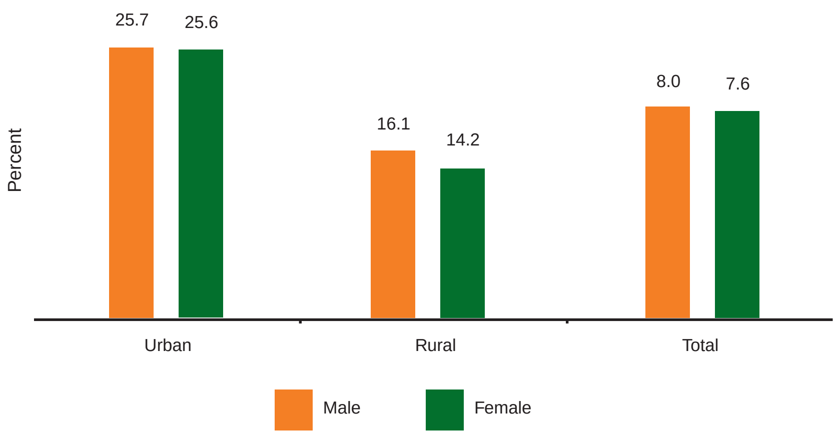
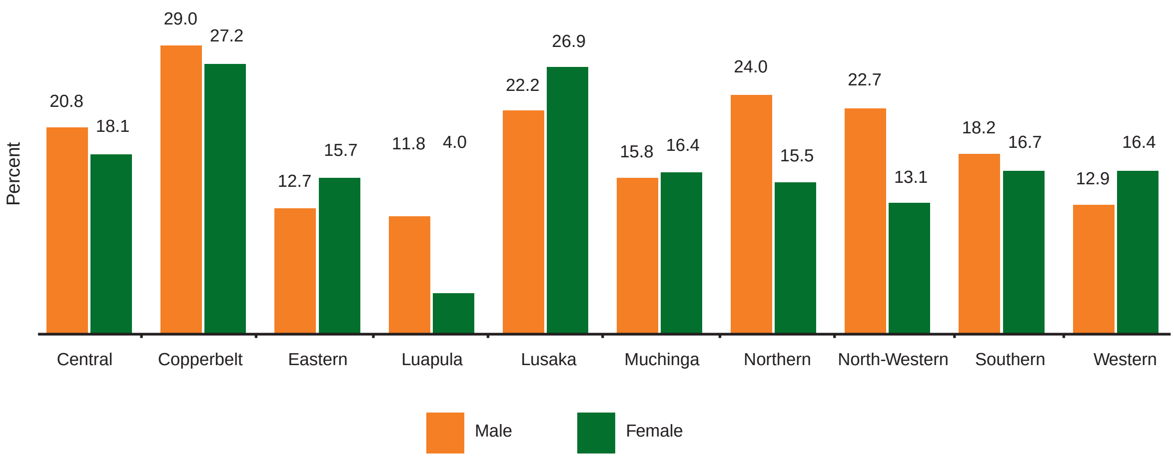


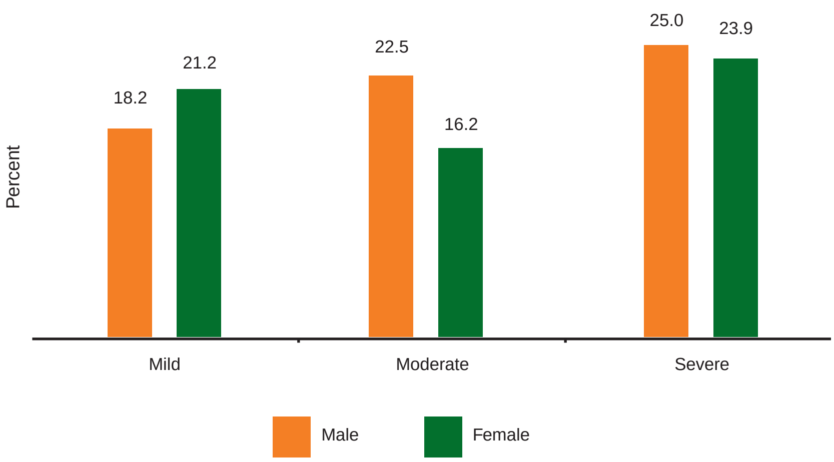
Figure 7.36 illustrates the differences in the use of assistive devices by sex and province. Use of assistive devices varied considerably between provinces, with Copperbelt scoring the highest (29.0 percent of males and 27.2 percent of females); Luapula (11.8 percent of males and 4.0 percent of females) and Western Provinces (12.9 percent of males and 16.4 percent of females) scored the lowest. In six provinces, males score higher than females; in the remaining four provinces the reverse is the case. Differences in terms of sex are particularly large in North-Western Province, with males scoring higher.

Figure 7.36 Use of assistive devices, by sex and province (18+ years, N=2,332)



Assistive devices were mostly used by people with severe disabilities. Among males, use of assistive devices increased with severity; women with mild disability were more likely to use devices than were women with moderate disability (Figure 7.37).

Figure 7.37 Use of assistive devices, by disability severity and sex (18+ years, N=2,332)



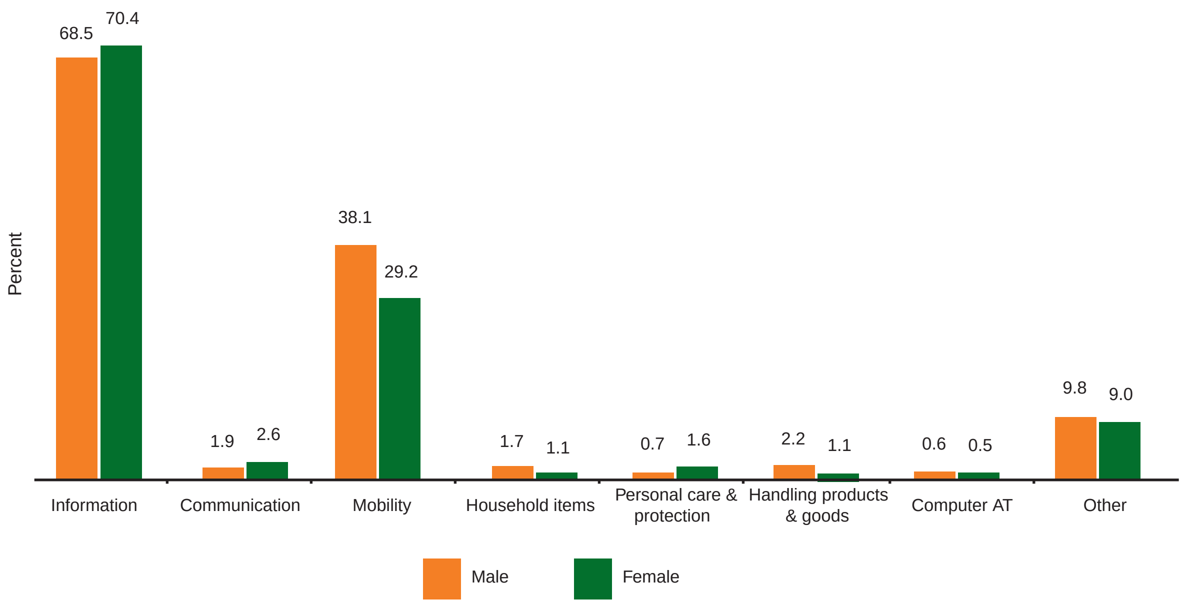
7KH W\SHV RI DVVLVWLYH GHYLFHV H[HPSOL¿HG LQ WKH TXHVWLRQQDLU

- ,QIRUPDWLRQ H J H\H JODVVHV KHDULQJ DLGV PDJQLI\LQJ JODVV
- &RPPXQLFDWLRQ VLJQ ODQJXDJH LQWHUSUHWHU ID[SRUWDEOH Z
- 3HUVRQDO PRELOLW\ ZKHHOFKDLU FUXWFKHV ZDONLQJ VWLFN ZK
- +RXVHKROG LWHPV ÀDVKLQJ OLJKW RQ GRRUEHOO DPSOL¿HG WHO

- 3HUVRQDO FDUH DQG SURWHFWLRQ VSHFLDO IDVWHQHUV EDWK DQ
  safety rails, eating aids;
-)RU KDQGOLQJ SURGXFWV DQG JRRGV JULSSLQJ WRQJV DLGV IRU RS
- &RPSXWHU DVVLVWLYH WHFKQRORJ\ NH\ERDUG IRU WKH EOLQG

Respondents were asked what type of devices they used (some had more than one device). There were two major FDWHJRULHV RI DVVLVWLYH GHYLFHV UHSRUWHG DV EHLQJ LQ XVH PRUH of females) reported using an information device; and one third of respondents (38.1 percent of males and 29.2 percent RI IHPDOHV XVHG D PRELOLW\ GHYLFH $OO RWKHU Figure 7.38 L¿F FDWHJRULH

Figure 7.38 Types of devices in use (18+ years, N=403–432)



Most of the devices were reported to be in good working order. As Figure 7.39 shows, among the most common devices, information devices were reported to be in good working order in 78.5 percent of cases and mobility devices in 71.0 percent of cases.

Figure 7.39 Type of devices in good working order (18+ years, N=1–275)

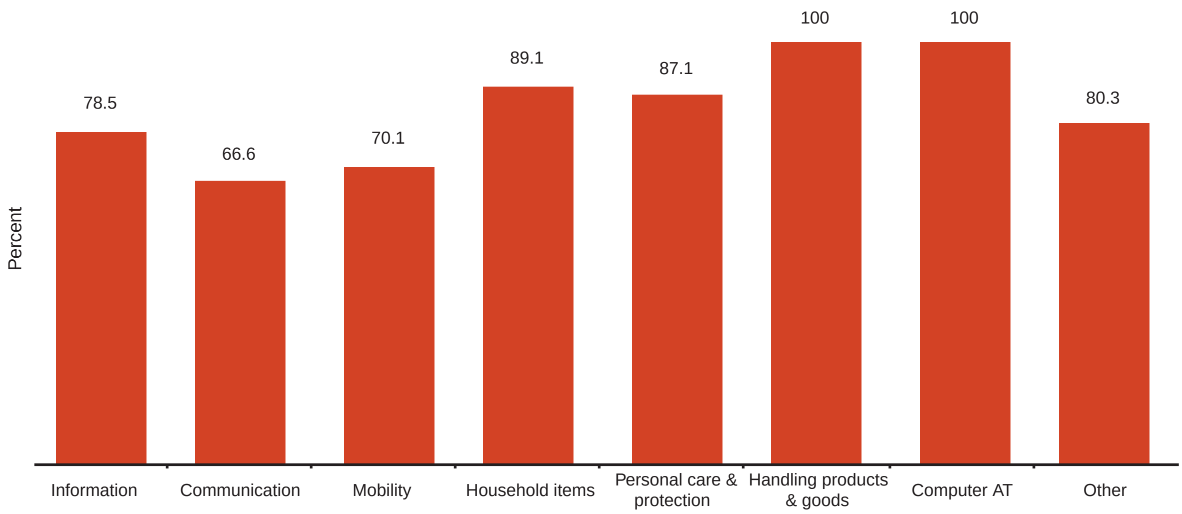
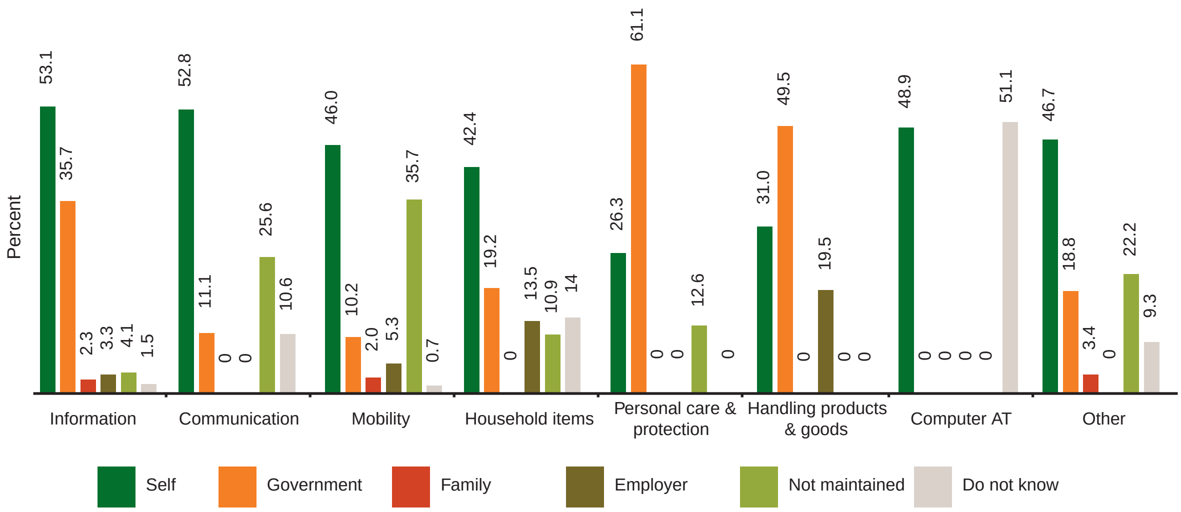


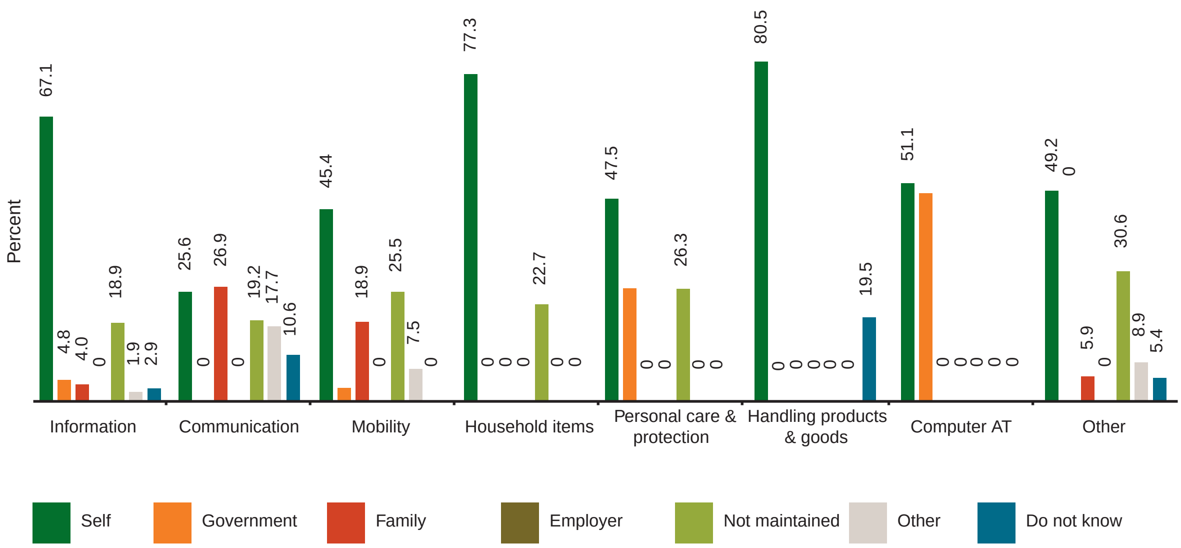
Figure 7.40 shows the sources of assistive devices. Government health services are the main source for two types of device (those for personal care and protection and for handling products and goods). Private sources dominate information, communication, mobility, household items and computer assisted technology devices. Non-governmental RUJDQL]DWLRQV 1*2V SOD\ D OHVV FHQWUDO UROH DV D VRXUFH RI G SURWHFWLRQ GHYLFHV $VNHG DERXW WKH VRXUFH RI WKHLU GHYLFHV should be taken in interpreting these results due to the low numbers for some devices.

Figure 7.40 Sources of assistive devices (18+, N=2–290)



6HOI PDLQWHQDQFH SUHGRPLQDWHV IRU VHYHQ RI Figure 7.41 shows GHYLFH 67.1 percent of information devices are maintained by the user, and 45.4 percent of mobility devices. About 18.9 SHUFHQW RI LQIRUPDWLRQ GHYLFHV DUH QRW PDLQWDLQHG DW DOO D percent. As above, care needs to be taken not to over-interpret results due to the low number of several device types.

Figure 7.41 Maintenance of assistive devices (18+ years, N=2–290)



When it comes to information and training received, yet again care should be taken with interpretation because of the low numbers involved. IFigure 7.42 WKH DQVZHUV µGR QRW NQRZ¶ DQG µGR QRW UH µQR LQIRUPDWLRQ¶ IHZ FDVHV 7KH PRVW UREXVW UHVXOWV DUH IRU L other devices (N=40). In all, 60.2 percent of those who use an information device report having received complete LQIRUPDWLRQ DQG WUDLQLQJ DQ DGGLWLRQDO SHUFHQW VDLG WKH\ WKH SLFWXUH LV GLIIHUHQW SHUFHQW GLG QRW UHFHLYH DQ\ LQIRU percent had no information on use.

Figure 7.42 Information and training given in use of assistive devices (18+ years, N=2–290)

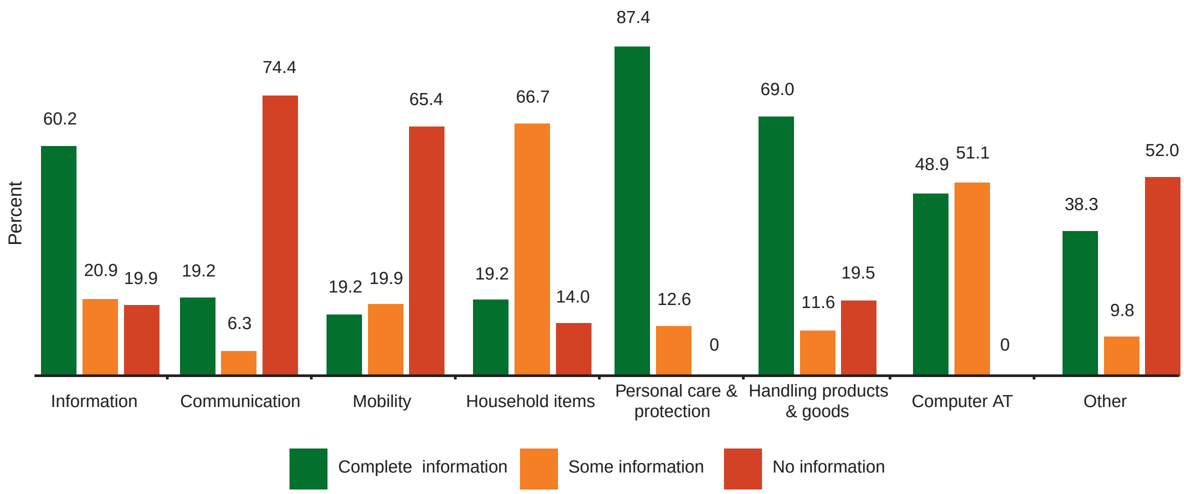
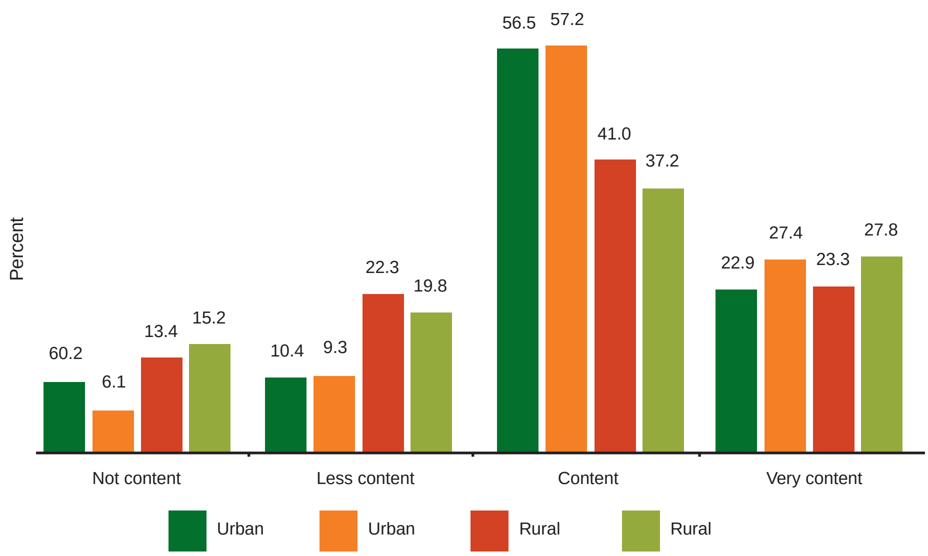


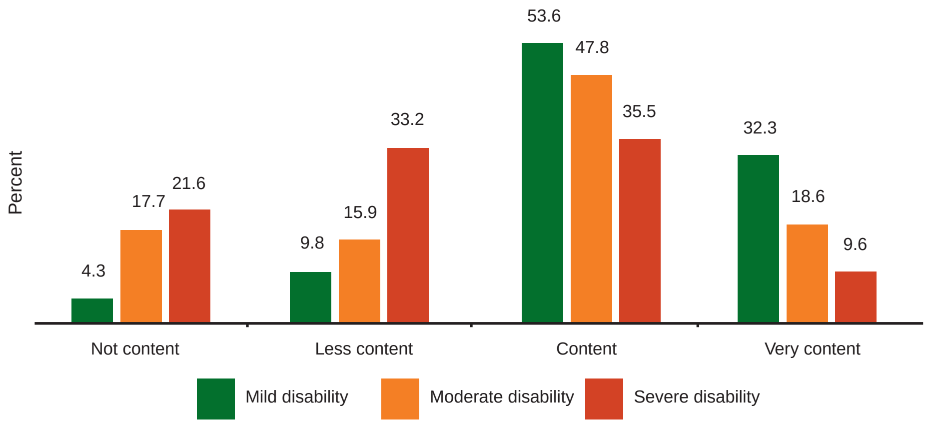
Figure 7.43 shows that more urban men and women are content with their assistive devices than are their rural counterparts. More women (both rural and urban) than men reported being very content with their assistive devices.

Figure 7.43 Satisfaction with assistive device, by sex and rural/urban (18+ years, N=426)



6DWLVIDFWLRQ ZLWK DVVLVWLYH GHYLFHV ZDV ²VLJQLÀFDQWO\ DVVRFLDW in Figure 7.44. Those with more severe disabilities were less content than people with mild and moderate disabilities.

Figure 7.44 Satisfaction with services, by severity of disability (18+ years, N=426)

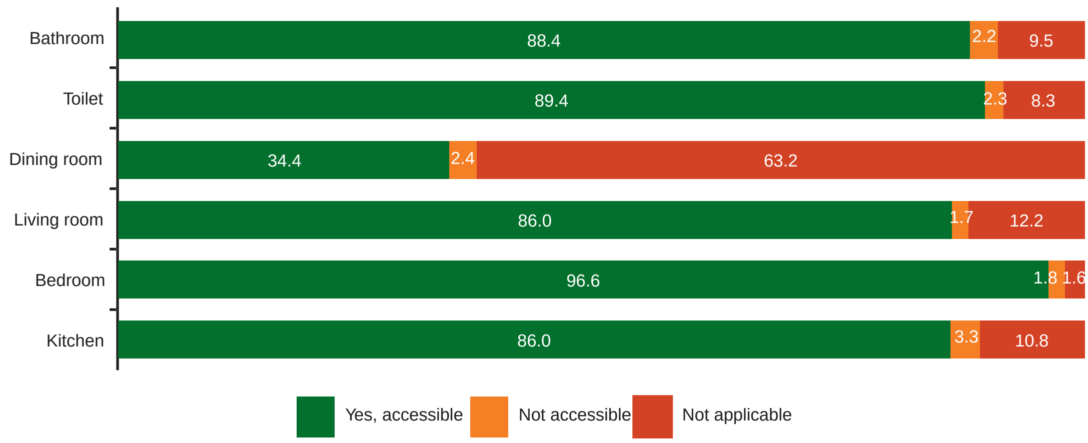


ACCESSIBILITY

This sub-section analyses accessibility at home and in the local community for persons with disabilities.

Respondents were asked to assess the accessibility of facilities at home and of services and facilities outside the home/ LQ WKH ORFDO FRPPXQLW\ 7KHUH ZHUH WKUHH DQVZHU FDWHJRULHV DSSOLFDEOH¶ ZDV XVHG E\ WKRVH ZKR GLG Figure 7.45 shows that 96.6 percent VSHFL¿F IDF of respondents had access to a bedroom, 89.4 percent to a toilet, 88.4 percent to a bathroom and 86.0 percent to the living room and kitchen. Some 34.4 percent of respondents indicated that they had access to the dining room, while 63.2 percent reported that they did not have a separate dining room.

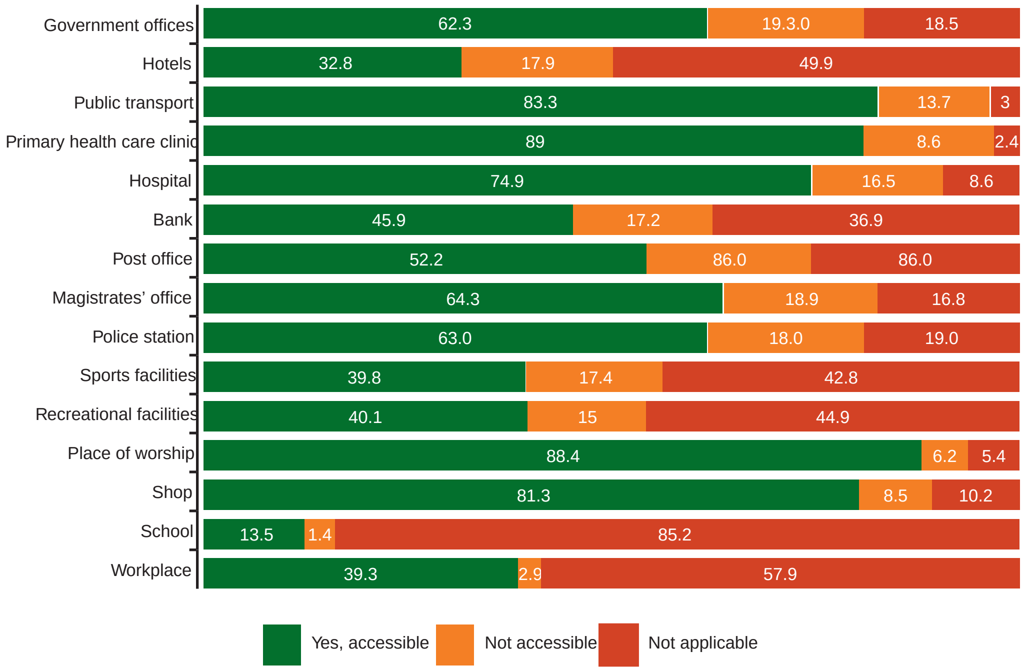
Figure 7.45 Accessibility to facilities at home for persons with disabilities (18+ years, N=2,377)



Outside the home, the most accessible place was a clinic (89.0 percent), followed by a place of worship (88.4 percent), public transport (83.3 percent), shops (81.3 percent) and a hospital (74.9 percent); the least accessible was the school (13.5 percent). The proportion who had a facility available (and relevant) but not accessible varied from 20.0 percent SRVW RI¿FH WR SHUFHQW VFKRRO

7KH SURSRUWLRQ UHVSRQGLQJ µQRW DSSOLFDEOH¶ ZDV UHODWLYHO\ K that the sample also included rural respondents. Figure 7.46 shows that for many, hotels (49.4 percent), recreational facilities (44.9 percent), sports facilities (42.8 percent) and banks (36.9 percent) are simply not available, again indicating rural residency.

Figure 7.46 Accessibility to services/facilities in the local community (18+ years, N=2,377)

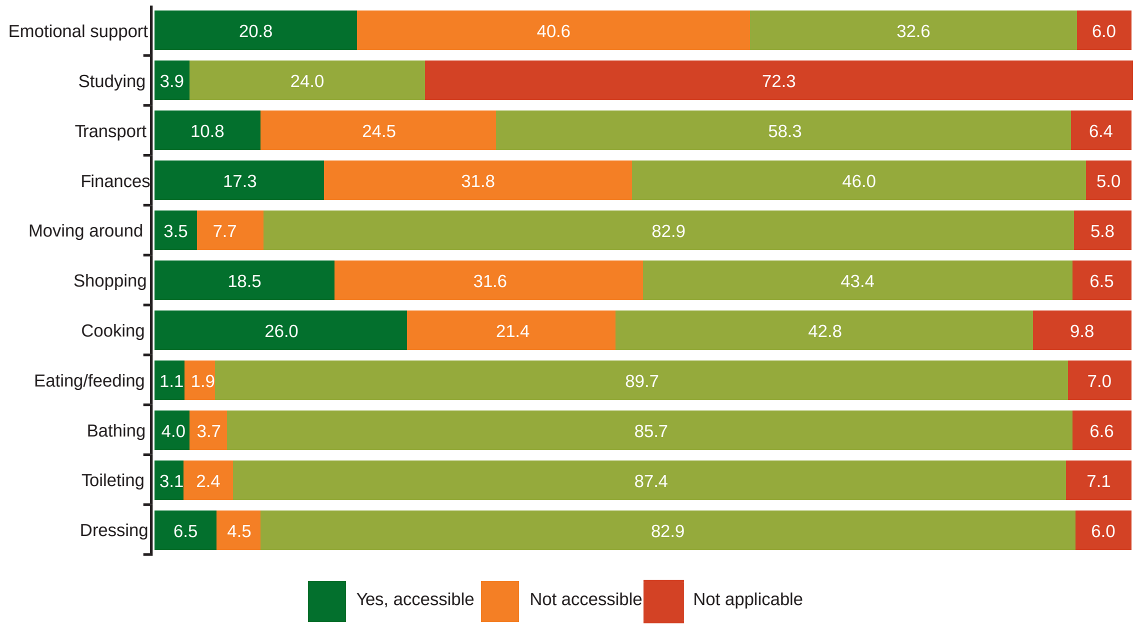


FAMILY SUPPORT AND SOCIAL INVOLVEMENT

This sub-section presents information on the type of help that people with disabilities receive from their family members, as well as a range of indicators on social involvement and participation.

Emotional support is the biggest category of help that disabled people receive within the family, with a combined VFRUH FRYHULQJ WKH UHVSRQVHV µ\HV RIWHQ¶ DQG µ\HV VRPHWLPHV¶ KHOS ZLWK HDWLQJ IHHGLQJ ± D PHUH SHUFHQWDJH (Figure 7.47). Persons JHWWLQJ with disabilities also received help with cooking, shopping, moving around and transport (between 35.3 percent and 50.1 percent).

Figure 7.47 Help from family members in daily life activities (18+ years) (N=2,330–2,331)



)DPLO\ DQG VRFLDO LQYROYHPHQW LQFOXVLRQ ZDV PHDVXUHG WKURXJ
ZLWK GLVDELOLWLHV DUH OHVV LQYROYHG LQFOXGHG WKDQ DUH SHUV
EHLQJ KHDUG¶ RWKHUZLVH DOO VLJQL¿FDQW DW S RU S 3HUVR
persons without disabilities on household decisions (89.0 percent vs. 94.0 percent); they are included less frequently in family events (76.3 percent vs. 87.2 percent); fewer persons with disabilities feel involved in the family (94.5 percent vs. 97.9 percent); and they are less often involved in family conversations (94.7 percent vs. 97.5 percent) (Figure 7.48)XUWKHUPRUH SHUVRQV ZLWK GLVDELOLWLHV WDNH SDUW OHVV R
percent vs. 52.6 percent), and fewer make important decisions about their own lives (93.4 percent vs. 98.2 percent).
)HZHU RI WKHP IHHO WKDW WKHLU YRLFH LV EHLQJ KHDUG SHUFH
local community meetings (54.2 percent vs. 61.3 percent). Greater social involvement was found among persons
ZLWKRXW GLVDELOLWLHV DFURVV WKH DJH JURXSV DQG W\SHV RI GLI¿
WKH VHYHULW\ RI WKH GLVDELOLW\ LQFOXGHG Figure 7.48, the two response categories LQ WK
µ\HV DOZD\V¶ DQG µ\HV VRPHWLPHV¶ Table 7.22, the same indicators are presented RQH \H
with all three answer categories.

Figure 7.48 Social participation ('yes'), by disability status (18+ years) (N=5,630–5,647)

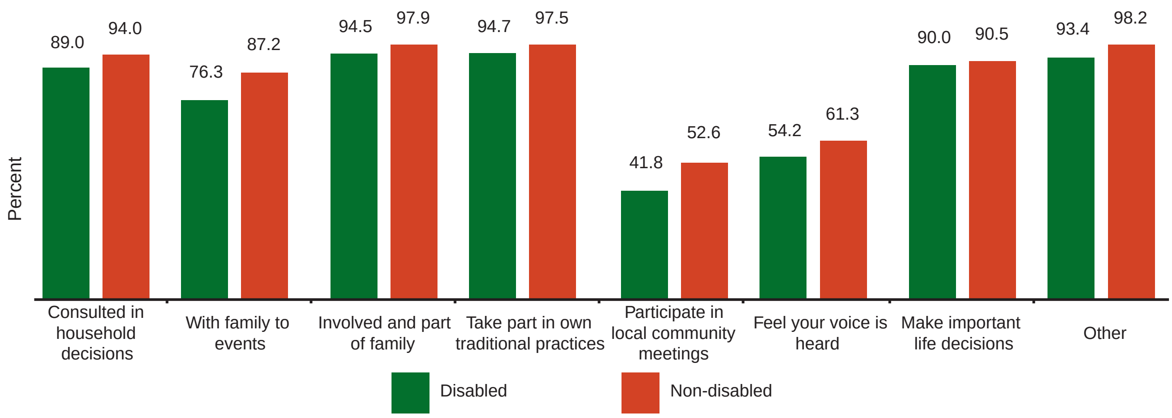


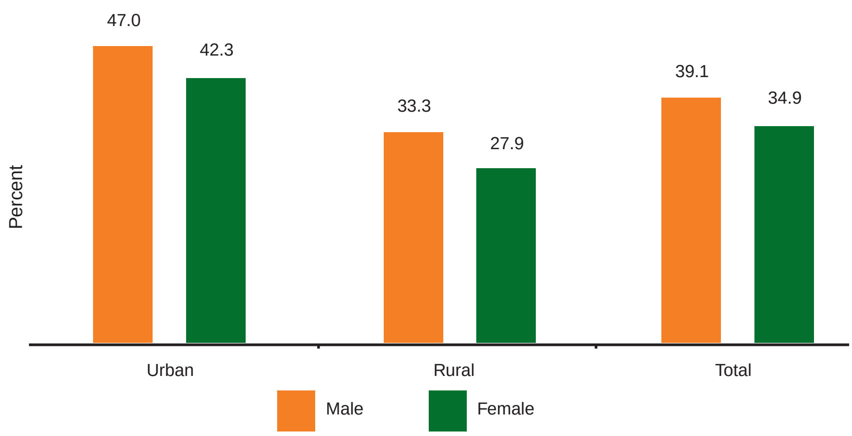
Table 7.22 Social involvement and participation (%) (N=5,643)

	DISABLED			NON-DISABLED		
	Always	Sometimes	No	Always	Sometimes	No
Are you consulted about making household decisions? (p<.001)	61.2	27.8	11.0	69.4	24.6	6.0
Do you go with the family to events such as family gatherings/social events? (p<.001)	28.9	47.4	23.7	41.2	46.0	12.8
Do you feel involved and part of the household or family? (p<.001)	74.5	20.0	5.5	78.2	19.7	2.1
Does the family involve you in conversations? (p<.001)	64.9	29.8	5.3	69.1	28.4	2.5
Do/did you take part in your own traditional practices/ceremonies? (p<.001)	12.5	29.2	58.2	19.3	33.3	47.4
Do you make important decisions about your own life? (p<.001)	74.0	19.4	6.6	81.9	16.3	1.8
Do you feel your voice is being heard? (p<.01)	30.2	59.8	10.0	35.2	55.3	9.5
Do you participate in local community meetings? (p<.001)	16.8	37.4	45.8	23.7	37.6	38.7

DISABLED PEOPLE'S ORGANIZATIONS: AWARENESS AND MEMBERSHIP

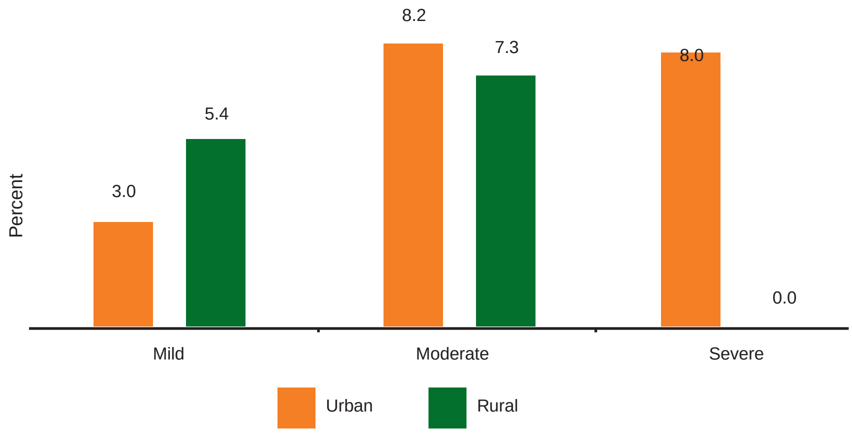
Respondents were asked about their awareness and membership of disabled people's organizations (DPOs). More men than women are aware of DPOs (39.1 percent vs. 34.9 percent). In rural areas, 33.3 percent of men and 27.9 SHUFHQW RI ZRPHQ ZHUH DZDUH RI '32V ,Q XUEDQ DUHDV WKH ¿JXUHV ZI percentage point difference was 13.7 for men and 14.4 for women (Figure 7.49).

Figure 7.49 Awareness of DPOs among persons with disabilities, by sex and rural/urban (18+ years, N=2,331)



$ VLJQL¿FDQW DVVRFLDWLRQ ZDV IRXQG EHWZHHQ GLVDELOLW\ VHYHUL
with an increase in membership from mild to moderate and severe disability. The results further indicate that people with severe disabilities in rural areas were not members of any DPOs (Figure 7.50).

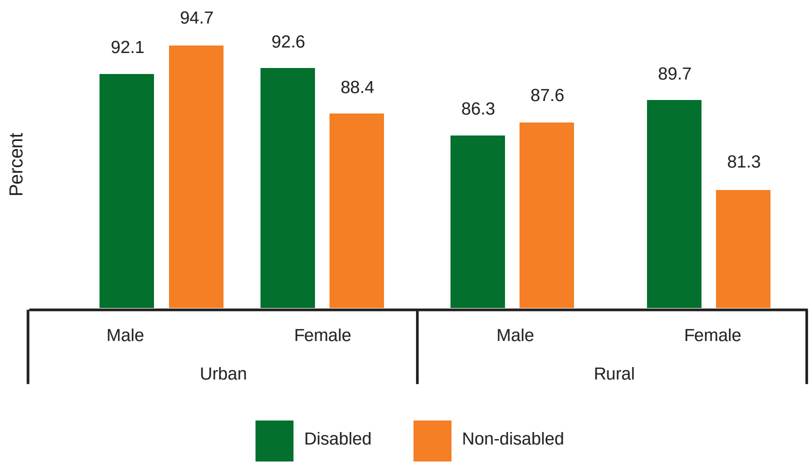
Figure 7.50 Proportion of persons with disabilities who are aware of and are members of DPOs, by disability severity and rural/urban (18+ years) (N=858) (p<.001)



Participation in voting

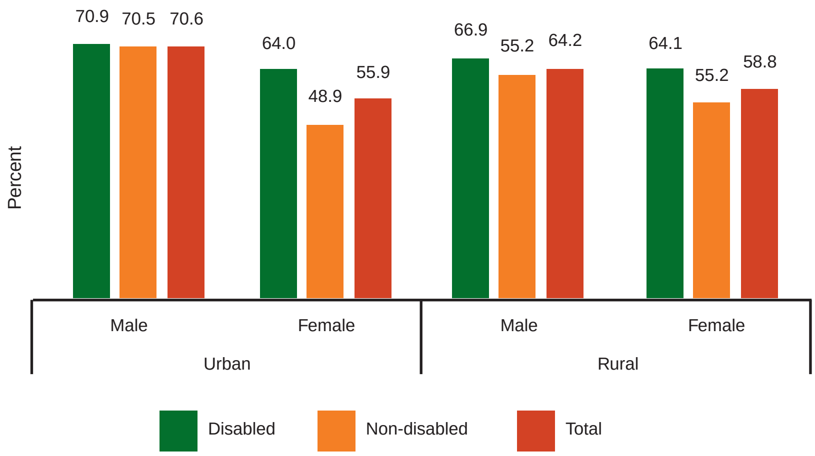
In order to be registered as a voter in Zambia, one must have a National Registration Card (NRC). As Figure 7.51 shows, it is more common to have a registration card in urban than in rural areas. More women with disability than without are registered; among men, the difference between those with and those without disability is small and is not VWDWLVWLFDOO\ VLJQL¿FDQW ,Q UXUDO DUHDV WKH GLIIHUHQFH EHW
than in urban areas.

Figure 7.51 Persons with a National Registration Card, by disability status, sex and rural/urban (18+ years, N=5,643)



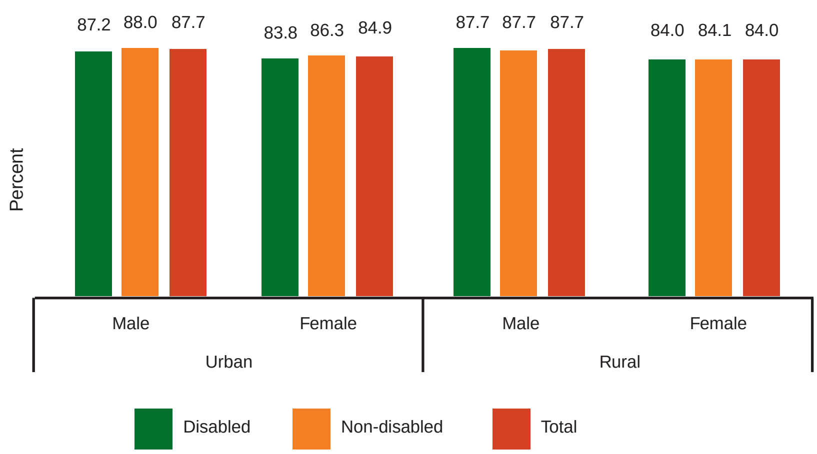
The next step before voting is to become registered as a voter. Figure 7.52 shows that considerably fewer people are registered to vote than hold an NRC. It is more common for men than for women to be registered; and more urban than rural respondents are registered.

Figure 7.52 Registered voters, by disability status, sex and rural/urban (18+ years, N=5,643)



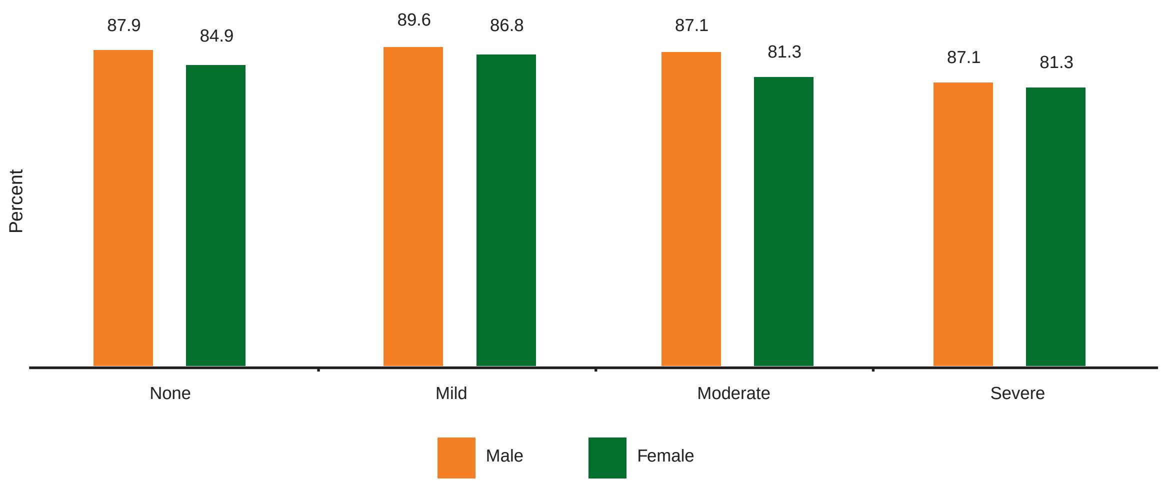
:LWK UHJDUG WR YRWLQJ WKHUH ZHUH VPDOO DQG LQVLJQL¿FDQW GLIII (Figure 7.53).

Figure 7.53 Persons who voted in the 2011 general election, by disability status, sex and rural/urban (18+ years, N=3,547)



In Figure 7.54, ZH VHH WKDW WKH WHQGHQF\ LV IRU YRWLQJ SDUWLFLSDWLRQ DPRQJ ERWK PDOHV $ DQG χ^2=5.38, p=0.05). An exception to this trend is that fewer persons without disability reported voting in the last election than persons with mild disability.

Figure 7.54 Persons who voted in the 2011 general election, by disability severity and sex (18+ years, N=3,547)



Those who did not vote were asked why. Some 46.4 percent of persons with disabilities who did not vote responded µRWKHU UHDVRQ¶ WKH FRUUHVSRQGLQJ ¿JXUH IRU SHUVRQV ZLWKRX &RQVHTXHQWO\ SHUVRQV ZLWK GLVDELOLWLHV VFRUHG S KTable HU LQ WK 7.23).

Table 7.23 Reasons for not voting, by disability status (18+ years) (N=483)

	DISABLED (%)	NON-DISABLED (%)
Vote area not accessible	27.6	32.8
Not interested in politics	24.5	28.3
Below voting age	1.4	7.5
Other reason[1]	46.4	31.3

[1] 0DLQ FDWHJRULHV LOOQHVV PRELOLW\ SUREOHPV HFRQRPLF SUREO

HEALTH

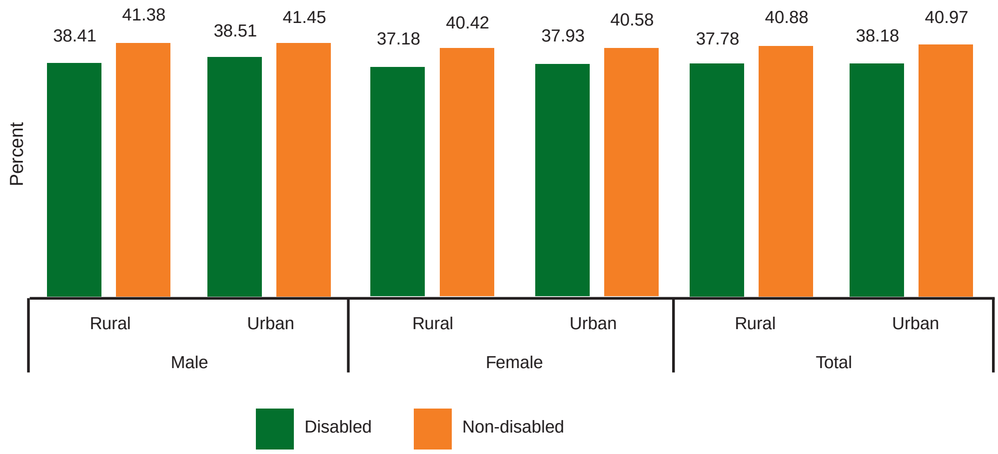
Respondents were asked about their psychosocial wellbeing, general physical and mental health.

The General Health Questionnaire (GHQ) was used in this study as a screening device for identifying minor psychiatric disorders in the general population, and is suitable for all ages from adolescence upwards. The GHQ covers two main DUHDV LQDELOLW\ WR FDUU\ RXW QRUPDO IXQFWLRQV DQG WKH DSSHD

The GHQ uses a 12-item screening scale, recoded so that score 1 is the most negative response and 4 the most positive. $GGLQJ WKH LWHPV WRJHWKHU WKXV \LHOGV D VFDOH ZLWK D UDQJ disorders or better mental health (less anxiety and depression).

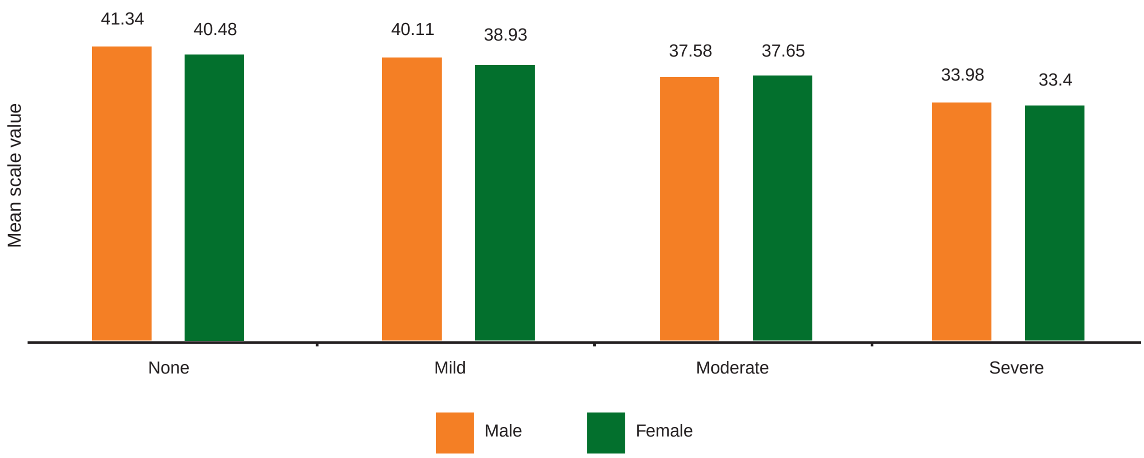
Figure 7.55shows that persons without disabilities have higher scores on the wellbeing scale by residence and sex. In urban areas, males without disability had a score of 41.45, compared to 38.51 for men with disability. Urban females without disability scored 40.58, compared to 37.93 for women with disability. In rural areas, men with disability scored 41.38 compared to 38.41 for those with disability. And for rural females, those without disabilities scored 40.42 compared to 37.18 for those with disabilities. The overall difference between persons with and without disability was VWDWLVWLFDOO\ VLJQL¿FDQW) S

Figure 7.55 Psychosocial wellbeing/GHQ 12, by disability status, sex and rural/urban (18+ years, N=5,642)



Psychosocial wellbeing is reduced as the severity of disability increases, as is shown in Figure 7.56)
S $GLIIHUHQFH LQ WHUPV RI VH[LV DOVR IRXQG ZLWK IHPDOHV VFR
IRXU VHYHULW\ FDWHJRULHV) S

Figure 7.56 Psychosocial wellbeing/GHQ 12, by disability severity and sex (18+ years, N=5,642)



5HVSRQGHQWV ZHUH DVNHG WR DVVHVV WKHLU JHQHUDO SK\VLFDO DQG pattern, in that persons with disabilities scored substantially lower than persons without disabilities on both the mental and the physical health scale. Differences in terms of sex are minimal, though there is a tendency for women to have D ORZHU VFRUH WKDQ PHQ IRU ERWK SK\VLFDO DQG PHQWDO KHDOWK Figure 7.57 and Figure 7.58).

Figure 7.57 General physical health, by disability status and sex (18+ years, N=5,631)

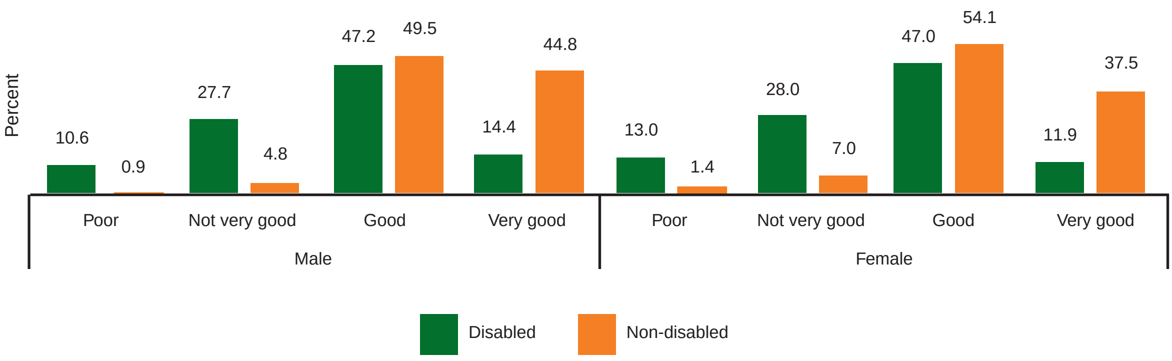
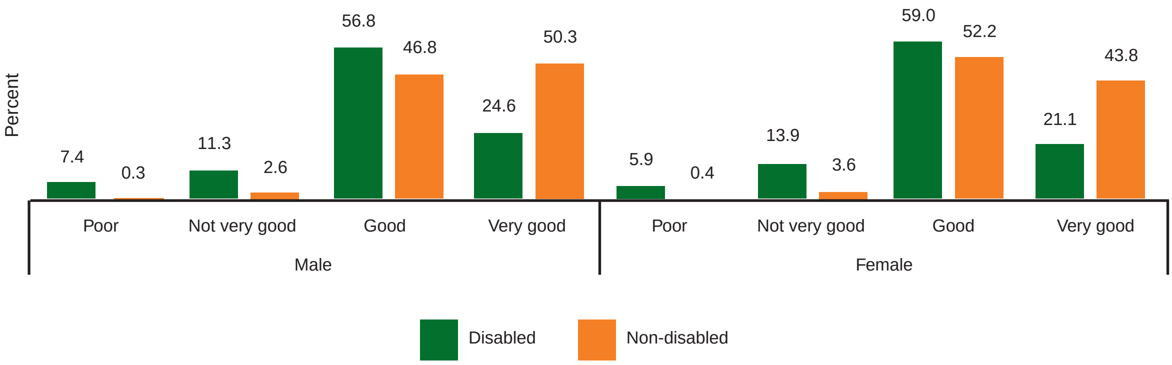


Figure 7.58 General mental health, by disability status and sex (18+ years, N=5,628)

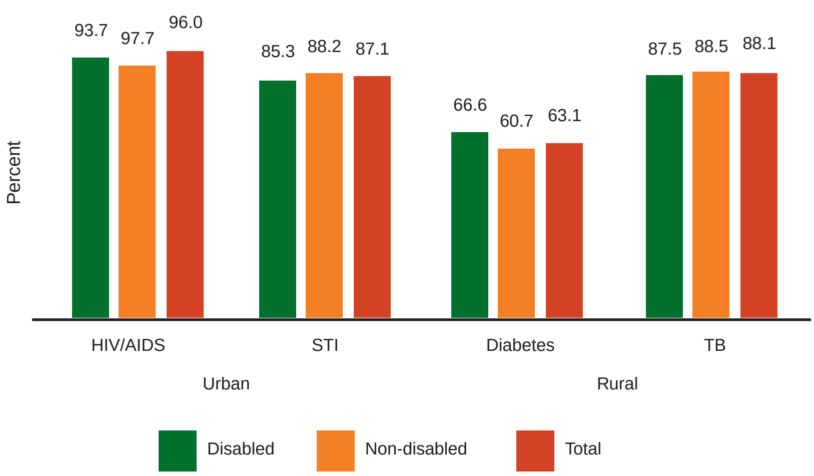


HEALTH INFORMATION

7KLV VXE VHFWLRQ ORRNV DW NQRZOHGJH RI FRPPRQ GLVHDVHV GLI diseases, and whether respondents were affected by the diseases.

The majority of respondents stated that they knew about HIV/AIDS (96.0 percent), STIs (87.1 percent), diabetes (63.1 SHUFHQW DQG 7% SHUFHQW 3HUVRQV ZLWKRXW GLVDELOLWLHV V and STIs ²$ S QR VLJQLILFDQW GLIIHUHQFH ZDV IRXQG IRU 7% ZKL DERXW G²LDEHWHV Figure 7.59).

Figure 7.59 Knowledge of four common diseases, by disability status (18+ years) (N=5,590–5,628)



Most of the respondents had obtained their information about the four diseases from health facilities. The second and third most common sources were friends and schools, followed by radio and TV. Disabled people tended to report the family as a source more often than non-disabled people; the opposite was the case for school (Table 7.24).

Table 7.24 Most important sources of information about diseases (18+ years)

	HIV/AIDS (N=5,404)		STIS (N=4,884)		DIABETES (N=3,470)		TB (N=4,933)	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Health facility	62.1	64.0	62.1	62.3	57.3	52.0	63.0	61.6
Doctor	1.1	1.0	1.3	1.0	1.8	1.3	1.0	1.2
At work	2.1	1.4	1.5	1.0	1.1	1.4	1.4	0.8
Newspaper/magazine	0.5	0.8	0.7	0.4	0.6	0.7	0.4	0.4
Friends	9.3	8.3	13.6	12.8	13.2	16.5	9.6	9.6
Family	8.1	3.1	7.5	4.6	12.7	10.1	11.7	8.8
Radio/TV	7.8	7.6	5.1	5.5	7.2	7.8	6.8	6.4
Poster/pamphlet	0.3	0.3	0.5	0.4	0.3	0.3	0.4	0.4
School	8.1	12.9	7.4	11.6	5.1	9.6	5.4	10.5
Other	0.4	0.6	0.3	0.3	0.6	0.4	0.3	0.3
Don't know	0.2	0.1	0.1	0.0	0.1	0.0	0.1	0.0

Among persons with disabilities, the proportion who said that they had problems understanding health information IRU WKH VSHFL¿F GLVHDVHV UDQJHG IURP SHUFHQW WR SHUFHQW percent to 10.8 percent. More persons with disabilities had a problem understanding the information for all four GLVHDVHV KRZHYHU WKH GLIIHUHQFH LV QRQ VLJQL¿FDQW IRU GLDEHWH 0RVW SUREOHPV DUH UHSRUWHG IRU GLDEHWH (Table 7.25) DORZHG E\ +,9 $,'6 67

Table 7.25 Experienced problems understanding health information, by disability status (18+ years)

	PERSONS WITH DISABILITIES	NON-DISABLED	P
HIV/AIDS (N=5,365)	11.6	9.8	.06
Diabetes (N=3,442)	12.2	10.8	n.s.
TB (N=4,895)	7.3	6.6	n.s.
STI (N=4,852)	8.4	8.0	n.s.

The majority of persons both with and without disabilities had been tested for HIV (though more of those without GLVDELOLWLHV KDG KDG WKLV H[SHULHQFH)RU WKH RWKHU WKUHH GL GLVHDVH ,Q DOO SHUFHQW RI SHUVRQV ZLWK GLVDELOLWLHV VD percent had had diabetes. More disabled people had had diabetes, TB and STIs than those without disabilities (Table 7.26).

Table 7.26 Ever had the disease, by disability status (18+ years)

DISEASE	PERSONS WITH DISABILITIES	PERSONS WITHOUT DISABILITIES	TOTAL	P
HIV/AIDS[1] (N=5,404)	65.0	71.1	68.6	<.001
Diabetes (N=3,425)	2.5	0.4	1.3	<.001
STI (N=4,884)	2.5	0.4	1.3	<.001
TB (N=3,470)	4.9	2.3	3.4	<.001

[1] This question is about ever being tested for HIV.

EDUCATION

This sub-section focuses on school attendance, school achievement, relevance of schooling for employment, refusal of school attendance and literacy.

Figure 7.60generally reveals a pattern where more persons without disabilities than with reported attending school at VRPH SRLQW 7KH RYHUDOO ¿JXUHV DUH SHUFHQW DQGS SHUFHQW for persons with and without disabilities, respectively. The results also reveal that fewer females than males had attended school (both urban and rural locations) and that school attendance in rural areas is lower than in urban areas. Thus, the lowest school attendance (i.e. ever attended school) was recorded among rural females with disabilities (64.4 percent); the highest was among urban males without disabilities (98.0 percent).

Figure 7.60 Ever attended school, by disability status, sex and rural/urban (18+ years, N=5,643)

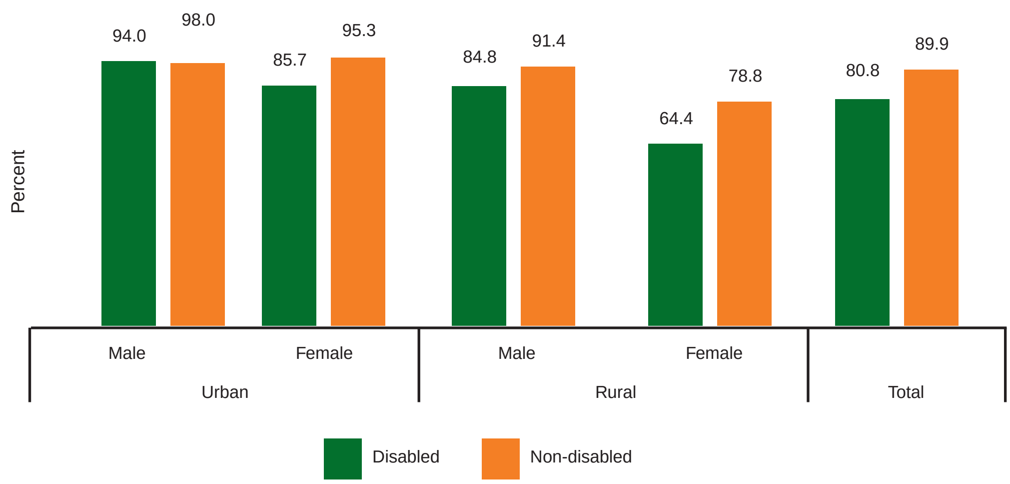
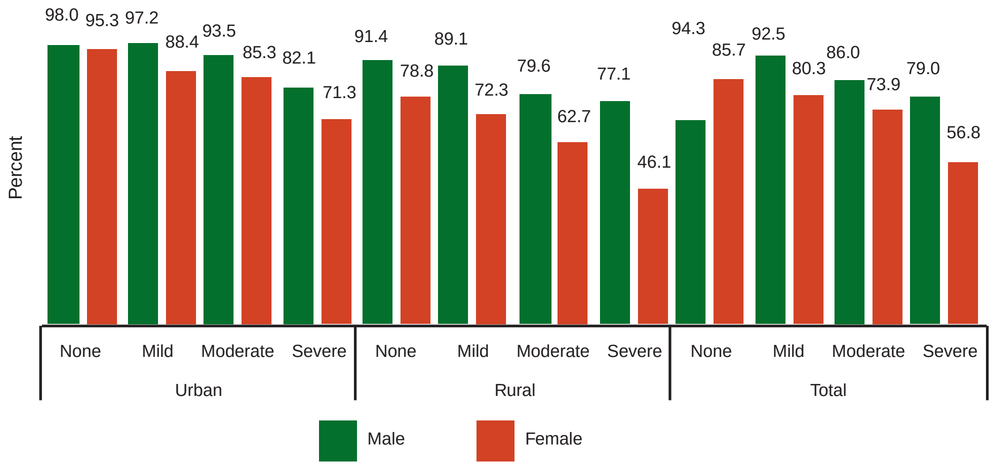


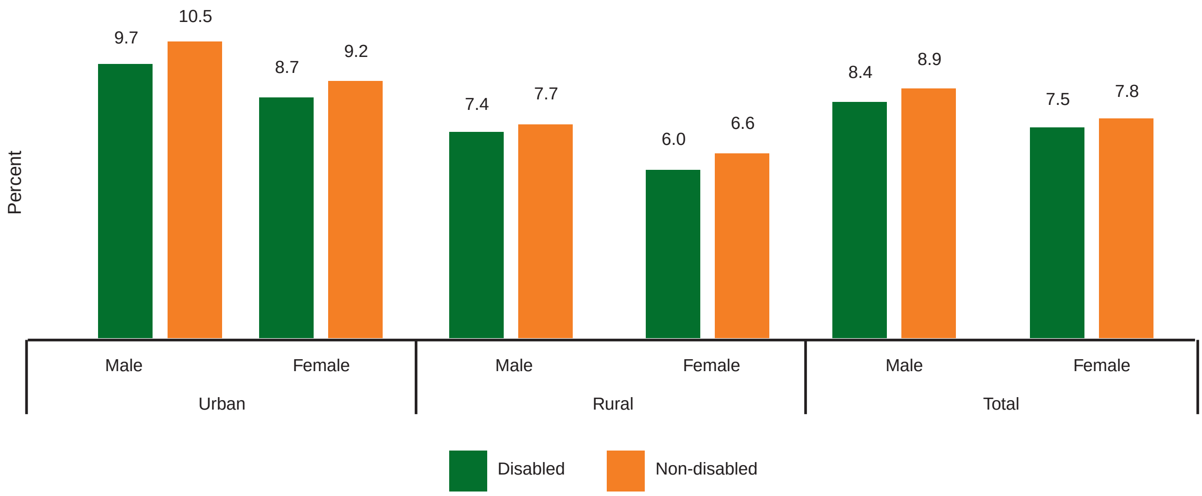
Figure 7.61 VKRZV WKDW VFKRRO DWWHQGDQFH HYHU DWWHQGHG LV UHGXF males and females, urban and rural sub-samples). Rural females with severe disabilities scored lowest (46.1 percent ever attended) and urban males with no disabilities scored highest.

Figure 7.61 Ever attended formal primary education, by disability status, sex and rural/urban (18+ years, N=5,643)



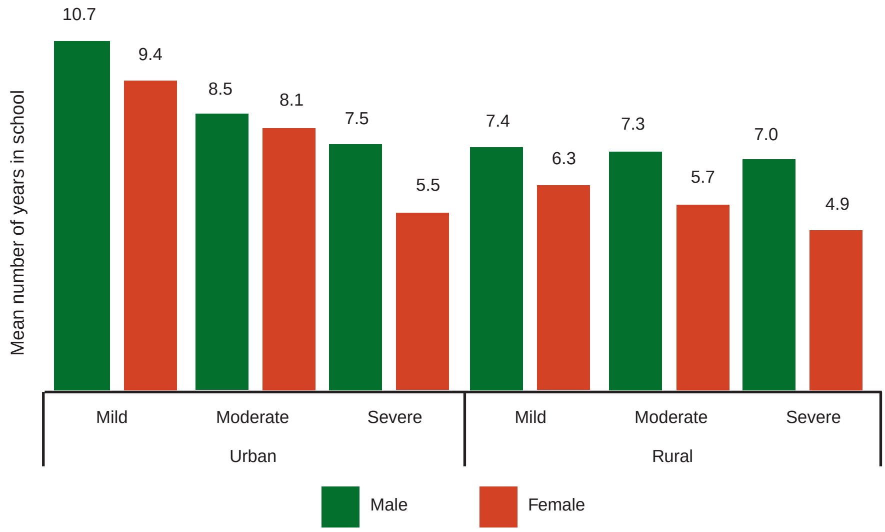
The mean number of years in school for males with disability was 8.4 and for those without it was 8.9; for females, WKH FRUUHVSRQGLQJ QXPEHUV ZHUH DQG PDOHV) S IHPD disability had a higher mean number of school years in all subgroups; females had a lower mean number of school years in both urban and rural areas; and rural respondents had fewer school years than urban respondents. The lowest mean number of school years is to be found among rural females with disabilities (6.0 years) and the highest among urban males without disabilities (10.5 years) (Figure 7.62).

Figure 7.62 Mean number of years at school among those who ever attended school, by disability status, sex and rural/urban (18+ years, N=4,894)



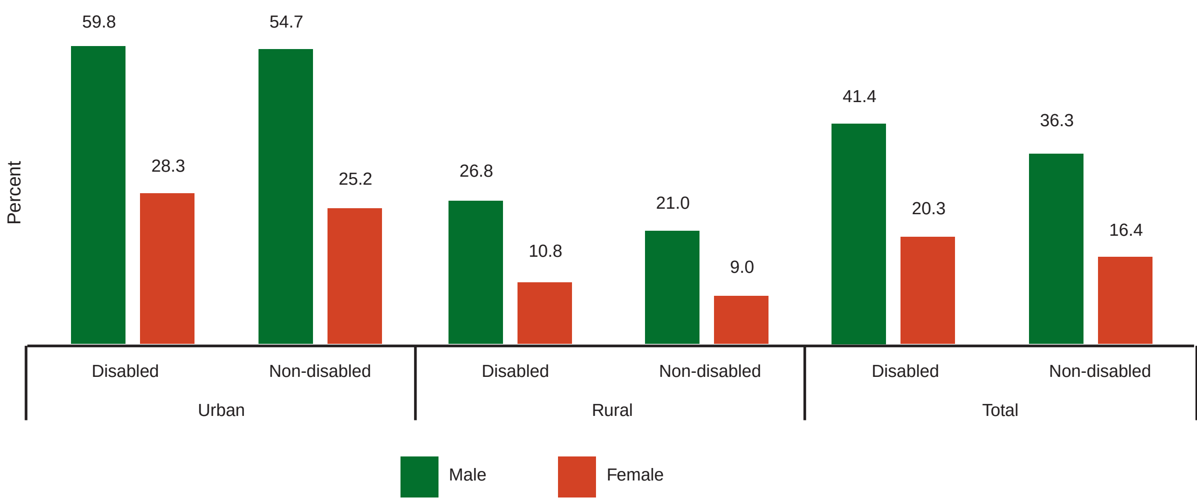
7KH QXPEHU RI \HDUV DW VFKRRO GHFOLQHV DV WKH VHYHULW\ RI GLVDEL UHSRUW PRUH \HDUV WKDQ IHPDOHV DQG XUEDQ UHVSRQGHQWV PRUH WK disabilities reported that on average they spent 4.9 years at school, while urban males with mild disability reported 10.7 years (Figure 7.63).

Figure 7.63 Number of years at school, by disability severity, sex and rural/urban (18+ years) (N=1,874)



7KHUH ZDV QRWDEOH YDULDWLRQ LQ ZKHWKHU WKH OHYHO RI HGXFDW
IHPDOHV ²RYHUDOO $ DQG EHWZHHQ UXUDO ² DQG XUEDQ 7KH DUHDV KLJKHU
VFRUH UHVSRQVH µ\HV OHYHO RI HGXFDWLRQ KDV KHOSHG¶ ZDV IRX
for those with and without disability, respectively). The lowest score was found among rural females (10.8 percent and 9.0 percent for those with and without disability, respectively) (Figure 7.64).

Figure 7.64 Level of education has helped secure a job, by disability status, sex and rural/urban (18+ years) (N=4,894)



0RUH LQGLYLGXDOV ZLWK GLVDELOLW\ WKDQ ZLWKRXW KDYH SULPDU\ V
vs. 36.7 percent for males and 55.6 percent vs. 50.5 percent for females (Figure 7.65).)RU VHFRQGDU\ VFKRRO
other way around, with 50.7 percent of males without disabilities and 39.0 percent of males with disabilities stating
WKLV DV WKH KLJKHVW OHYHO 7KH FRUUHVSRQGLQJ ¿JXUHV IRU IHPDO
KDG KLJKHU HGXFDWLRQ DV WKHLU KLJKHVW OHYHO PDOHV ZLWK GLVD
scored 10.9 percent. It was also noted that more individuals with disabilities (12.6 percent) report higher education as their highest level than individuals without disability (9.8 percent). The overall differences between individuals with
DQG ZLWKRXW GLVDELOLWLHV DUH VLJQL¿FDQW 7KH GLIIHUHQFHV DPRQJ P
DQG IHPDOHV $

Figure 7.65 Highest level of education attended, by disability status and sex (18+ years) (N=4,895)

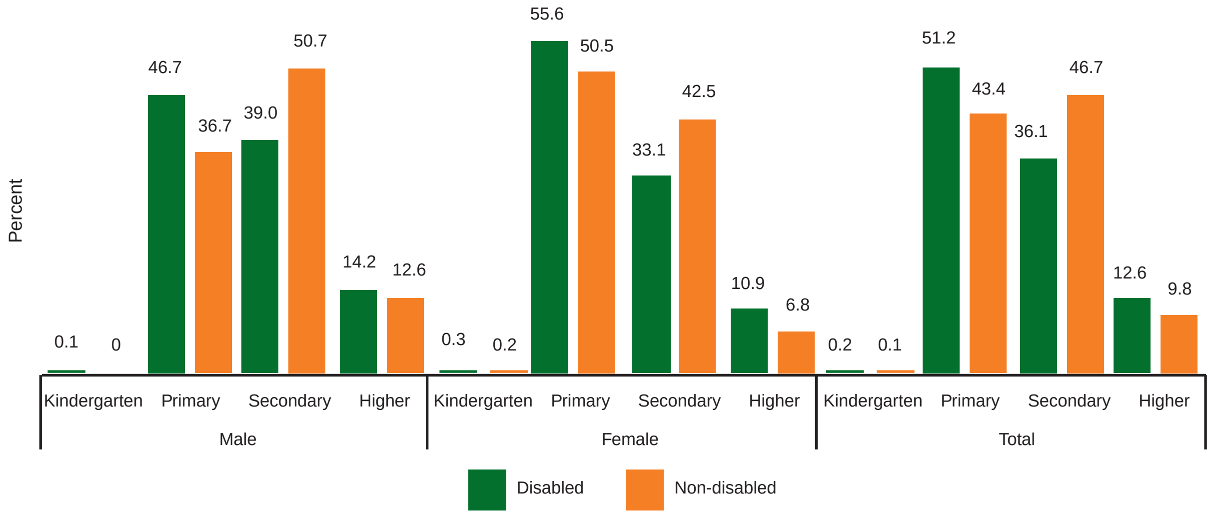
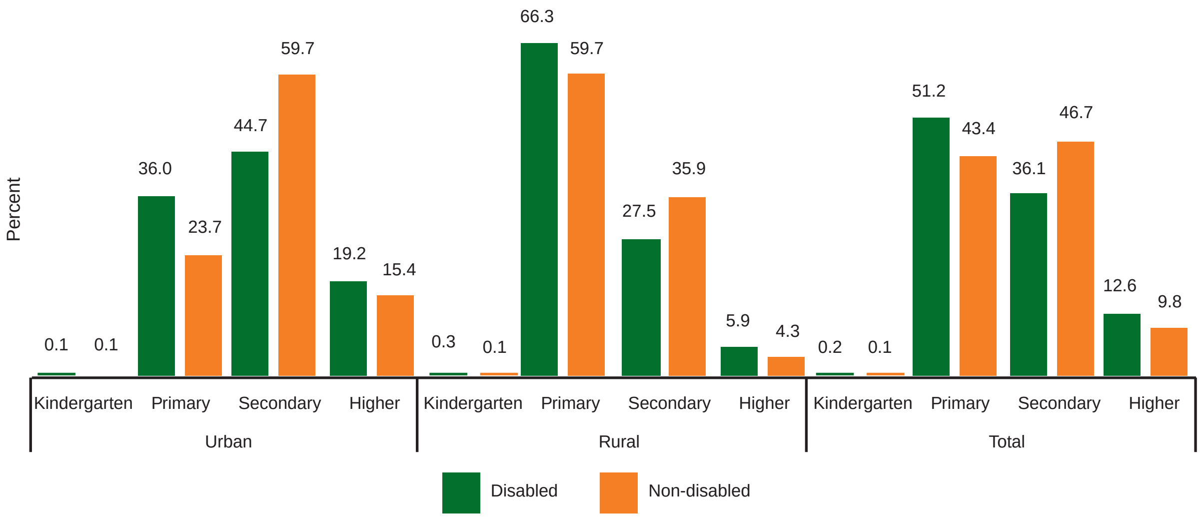


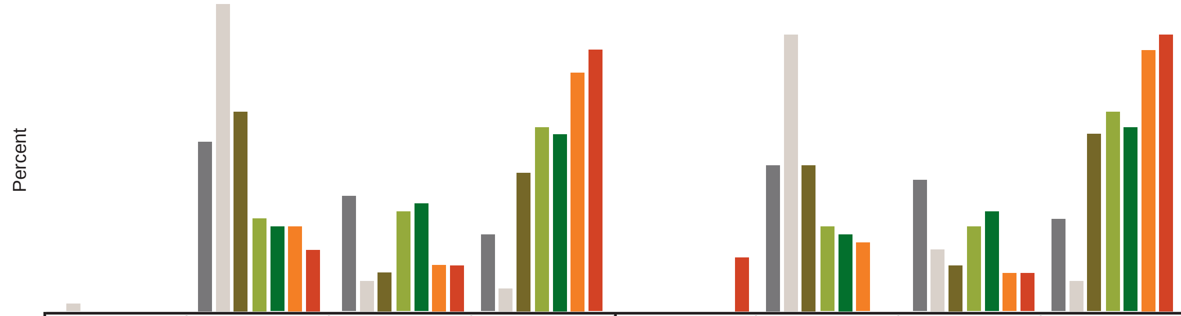
Figure 7.66 reveals that primary school was generally the highest level of education attained in rural areas (66.3 percent and 59.7 percent among persons with and without disabilities, respectively), while secondary school was the highest level attained in urban areas (44.7 percent and 59.7 percent among persons with and without disabilities, UHVSHFWLYHO\ )XUWKHUPRUH KLJKHU HGXFDWLRQ LV Figure 7.66 FRPPRQ LQ reveals the same differences between persons with and without disabilities as Figure 7.65. The overall urban/rural GLIIHUHQFHV EHWZHHQ SHRSOH ZLWK DQG ZLWKRXW GLVDELOLWLHV ZHUH $ S DQG XUEDQ UHVSRQGHQWV $

Figure 7.66 Highest level of education attended, by disability status and rural/urban (18+ years) (N=4,895)



9HU\ IHZ UHSRUWHG KDYLQJ EHHQ UHIXVHG HQWU\ WR VFKRRO DW WKH GL to university stands out as the highest (15.1 percent), otherwise the highest for males is 3.1 percent refusal of entry to primary school. However, around 10 percent (varying from 9.5 percent to 13.7 percent) did state that their family KDG QRW DSSOLHG IRU SULPDU\ VFKRRO VHFRQGDU\ VFKRRO FROOHJH R these categories could partly cover refusals or expectations of refusal (Figure 7.67).

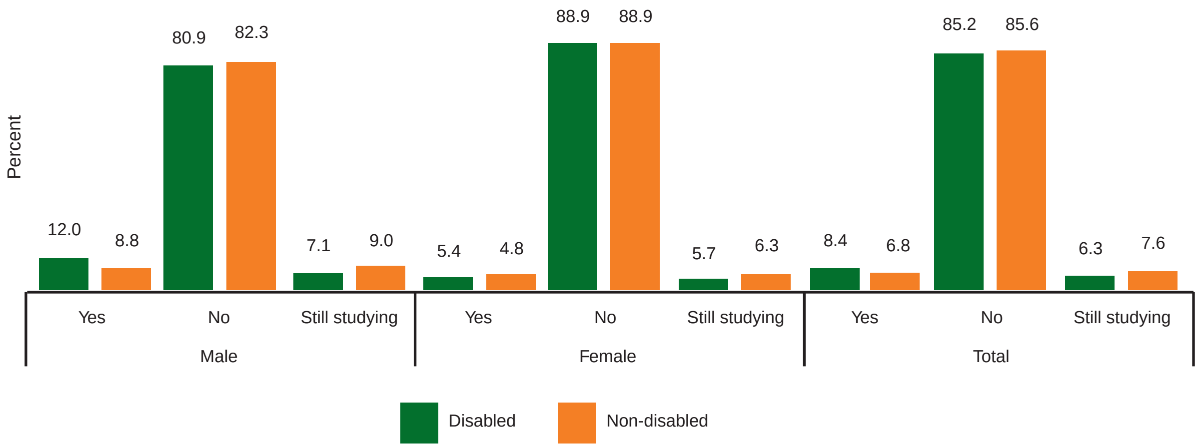
Figure 7.67 Ever been refused entry to school, by sex (18+ years) (N=2,332)



	Male: Yes	Male: No	Male: Family did not seek admission	Male: Not applicable	Female: Yes	Female: No	Female: Family did not seek admission	Female: Not applicable
Preschool	1.1	45.4	32.0	21.6	0.9	39.1	34.7	25.2
Primary	3.1	81.2	9.5	6.2	1.6	71.9	16.7	9.8
Secondary	0.9	51.5	10.5	37.1	0.4	39.4	12.7	47.5
Special school	0.6	24.9	26.6	47.9	0.3	23.6	24.0	2.2
Special class	0.4	24.1	28.0	47.5	0.5	22.2	27.4	49.9
College	0.3	22.6	13.7	63.4	0.1	18.3	11.5	70.0
University	0.4	16.9	13.6	69.1	15.1	0.0	11.9	73.0

Only 12.0 percent of males with disability and 8.8 percent without, and only 5.4 percent of females with disability and 4.8 percent without stated that they had studied as far as they had ever intended (Figure 7.68).

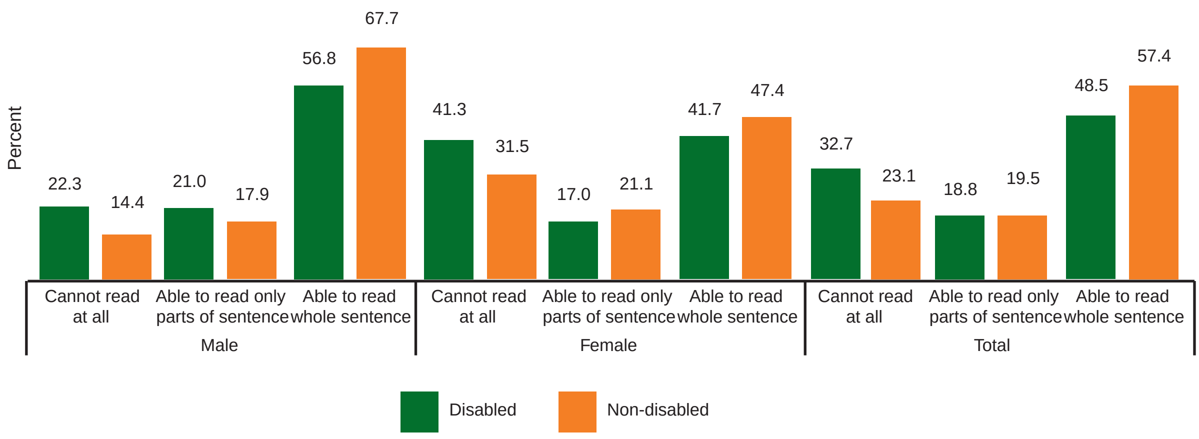
Figure 7.68 Studied as far as planned, by disability status and sex (18+ years) (N=5,540)



Literacy

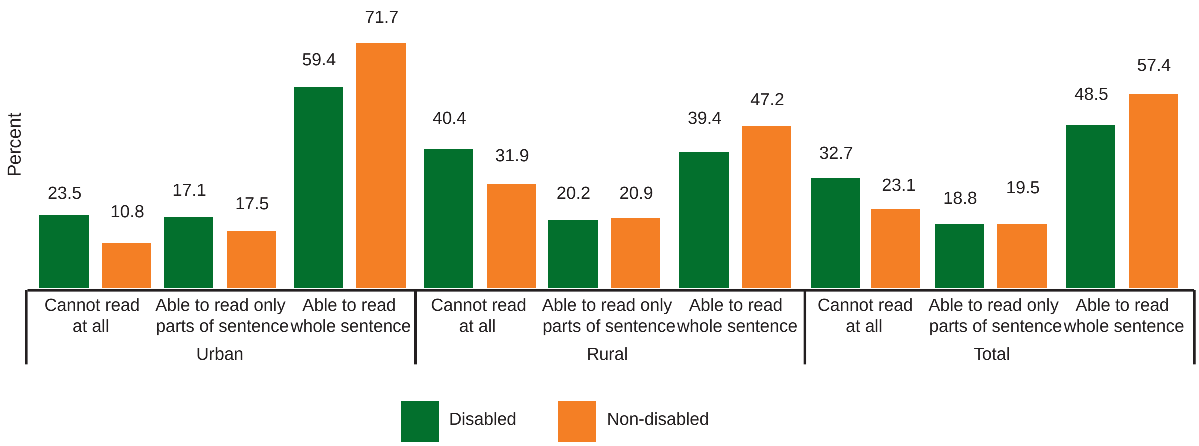
The study showed that literacy levels (measured as ability to read) were higher among persons without disabilities
$ S $PRQJ SHUVRQV ZLWK GLVDELOLWLHV DOPRVW RQH WKLU
¿JXUH IRU SHUVRQV ZLWKRXW GLVDELOLWLHV ZDV SHUFHQW ,Q W
ZLWK DQG ZLWKRXW GLVDELOLW\ DOLNH 2 PRUH IHPDOHV $PRQJ PDOHV
majority of persons with and without disabilities (56.8 percent and 67.7 percent) could read whole sentences, while
WKH FRUUHVSRQGLQJ ¿JXUHV IRU IHPDOHV Figure 7.69) ¿JXUH SHUFHQW DQG

Figure 7.69 Ability to read, by disability status and sex (18+ years) (N=5,540)



Literacy levels were also analysed with respect to the urban/rural divide. Whether disabled or not, there were more UXUDO UHVSRQGHQWV ZKR FRXOG QRW UHDG DW DOO (Figure 7.70) UHG WR WKH

Figure 7.70 Ability to read, by disability status and rural/urban (18+ years) (N=5,540)



The study also investigated whether those respondents who had learned to read and write as adults had received informal skills training at home or outside, and whether they had received formal skills training at a learning institution RU RXWVLGH $PRQJ WKRVH ZKR ZHUH OLWHUDWH IHZ KDG OHDUQHG KR results indicate that more individuals with disabilities had received informal training at home and outside home than had individuals without disabilities (Table 7.27).

Table 7.27 Skills training, by disability status and sex (18+ years) (%)

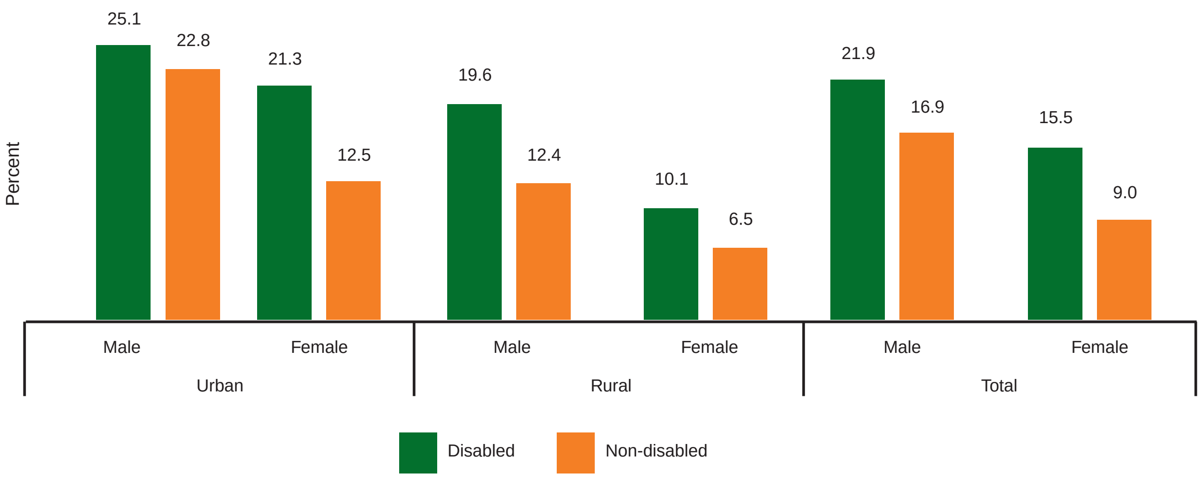
	PERSONS WITH DISABILITIES		PERSONS WITHOUT DISABILITIES	
	Male	Female	Male	Female
Did you learn to read/write as an adult (N=812)	2.4	3.4	8.2	5.3
Received informal training at home (N=5,643)	21.9	20.8	18.3	15.6
Received informal training outside home (N=5,643)	20.4	14.5	16.3	9.7
Received formal skills training at learning institution (N=5,643)	12.5	7.2	10.5	4.9
Received formal skills training outside learning institution (N=5,643)	8.0	2.5	6.8	2.9

ECONOMIC ACTIVITY

Respondents were asked about their skills and their main economic activity, and whether they were in paid employment or received any types of grant.

Figure 7.71 VKRZV WKDW PRUH SHUVRQV ZLWK D GLVDELOLW\ $OVR WKH SHUFHQWDJH of people with a skill was higher in urban areas and among males.

Figure 7.71 Percentage of people with a skill, by disability status, sex and rural/urban (N=5,643)



Having a skill was also examined in conjunction with severity of disability. Among urban and rural males and rural females, more persons with a disability had a skill, although the proportion of those with a skill gradually declines with the severity of the disability. Among urban females, the pattern is different, in that the proportion of those with a skill actually increases from mild to moderate disability (Figure 7.72).

Figure 7.72 Percentage of people with a skill, by disability severity, sex and rural/urban (N=5,643)

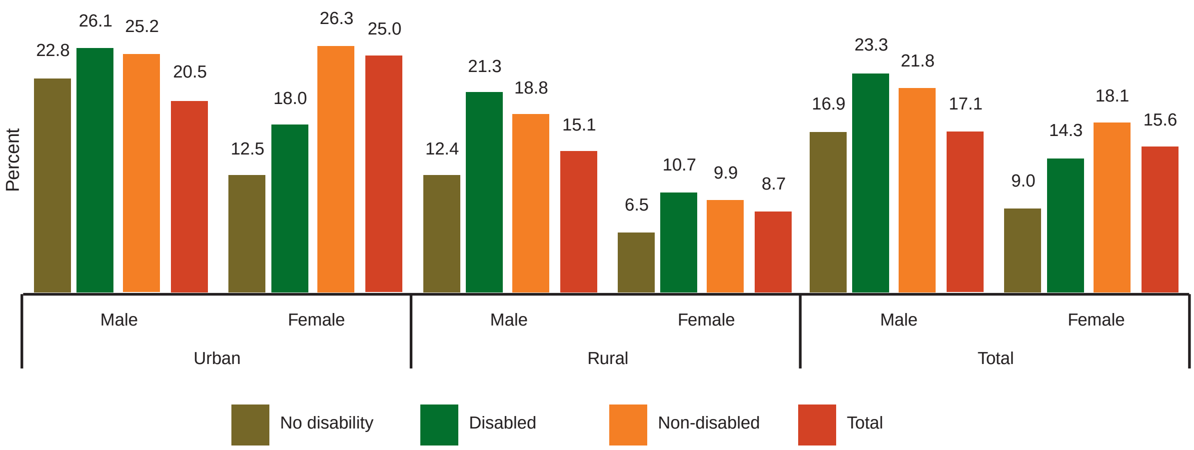
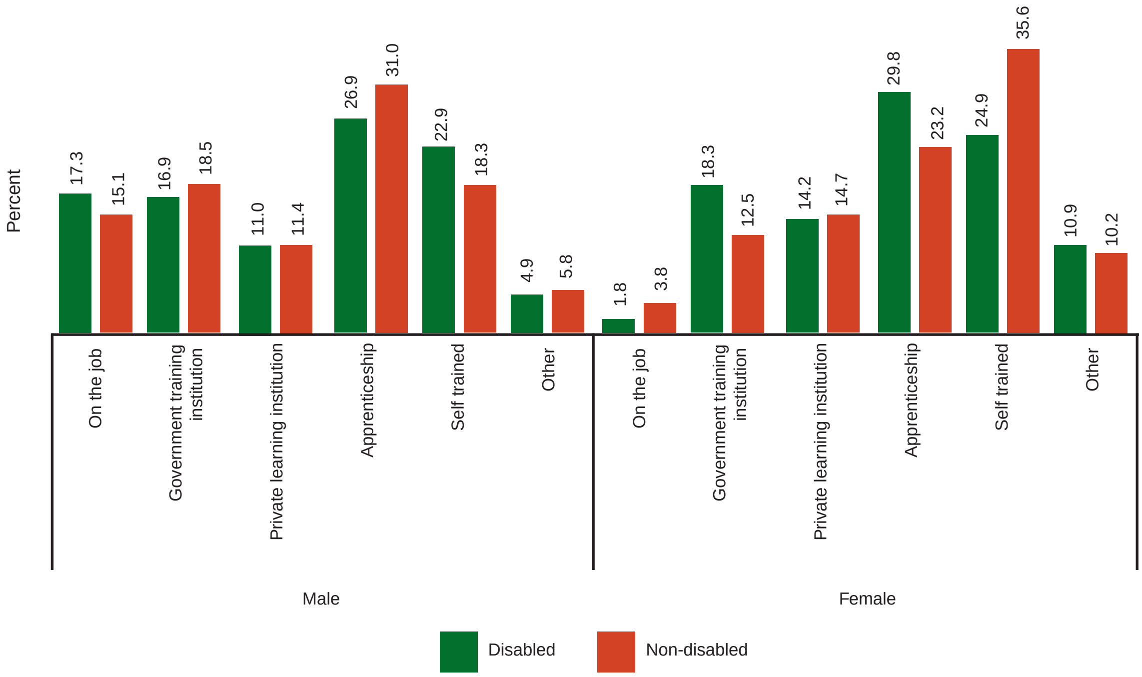


Figure 7.73 shows that people acquired their skills mostly through apprenticeship and self-training. There were generally only small differences between persons with and without disability, although among women some of those differences were larger than among men. More women with disabilities than their male counterparts had done an apprenticeship (29.8 percent vs. 26.9 percent); meanwhile more men than women had acquired their skills through on-the-job training.

Figure 7.73 How the skill was acquired, by disability status and sex (18+ years) (N=837)



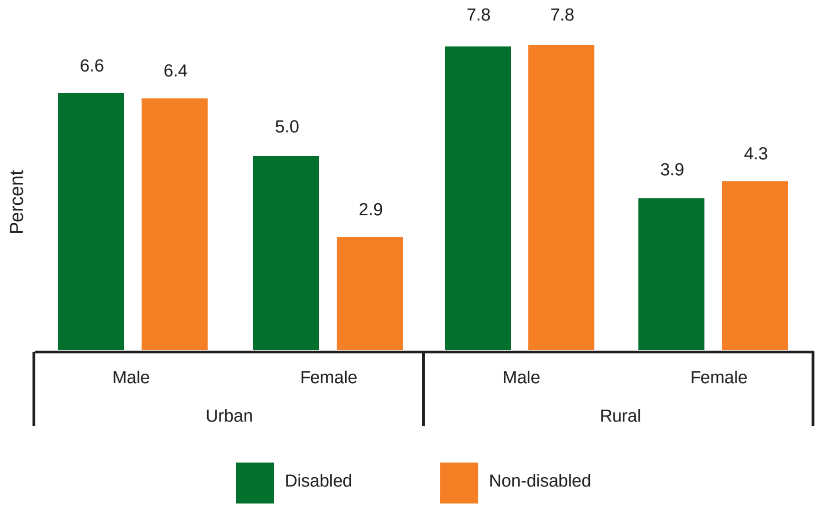
Respondents were asked to state their main activity during the previous seven days (Table 7.28). Paid employment/ business was the biggest category across both disability status and sex, accounting for 26.7 percent and 16.7 percent of males and females with disabilities, and 41.6 percent and 19.4 percent of males and females without disabilities.

Table 7.28 Main activity during last seven days, by disability status and sex (18+ years) (N=5,642)

	PERSONS WITH DISABILITIES		NON-DISABLED		TOTAL	
	Males	Females	Males	Females	Males	Females
In paid employment/business	26.7	16.7	41.6	19.4	21.2	20.4
In paid employment but temporarily not working due to illness	0.6	0.2	0.4	0.5	0.4	0.4
Volunteer work	0.7	0.7	0.5	0.5	0.7	0.5
Contributing family worker	6.3	6.8	7.1	14.2	6.6	10.7
Intern/apprentice	0.1	0.1	0.3	0.1	0.1	0.2
Own-use production worker	18.5	13.9	20.4	14.6	16.0	17.4
Not working but looking for work/business	7.5	4.1	11.3	5.6	5.7	8.3
Looking but not available for work	0.5	0.1	0.2	0.3	0.3	0.3
Available but not looking for work	2.4	2.2	3.1	1.8	2.3	2.4
Neither looking nor available for work but want to work	1.5	1.1	1.0	1.5	1.3	1.2
Housewife/homemaker	0.8	23.0	1.0	29.8	12.9	15.6
Retired	3.3	1.6	0.8	0.1	1.8	0.4
In school	5.0	3.3	6.6	4.4	4.0	5.5
Too old to work	9.9	14.9	1.0	1.1	12.6	1.1
Not working, not looking for work and not available for other reason	16.2	12.5	4.7	6.0	14.2	5.4

:KHQ µSDLG ZRUN IRU DW OHDVW RQH KRXU LQ WKH SUHYLRXV VHYHQ
WKH GLIIHUHQFHV IRXQG ZHUH JHQHUDOO\ VPDOO WKH ODUJHVW ZDV
percent) reported having had at least one hour's paid work in the previous seven days than did women without disabilities (2.9 percent) (Figure 7.74).

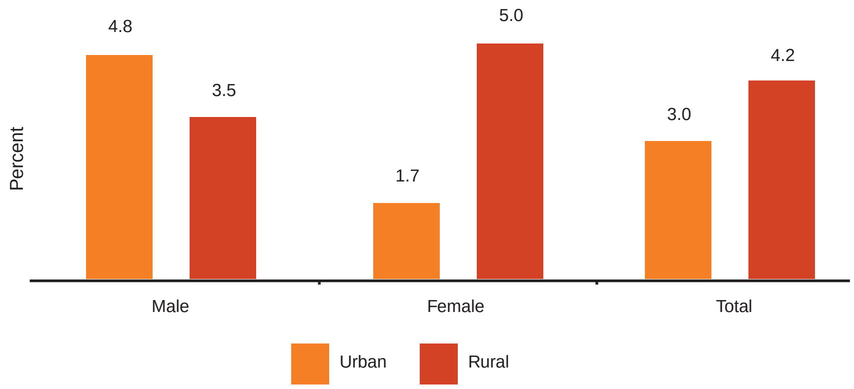
Figure 7.74 Percentage who had paid work for at least one hour in the previous seven days, by disability status, sex and rural/urban (18+ years) (N=1,711)



Grants

Overall 3.0 percent of urban and 4.2 percent of rural respondents aged 18 and above had applied for some type of grant. More males in urban areas and more females in rural areas had applied. Overall, slightly more females than males had ever applied (Figure 7.75).

Figure 7.75 Percentage who had applied for a grant, by sex and rural/urban (persons with disabilities only) (18+ years) (N=2,322)



A total of 3.4 percent of rural and 4.3 percent of urban respondents with disabilities aged 18 and above stated that they
FXUUHQWO\ UHFHLYHG D JUDQW S   7KH SURSRUWLRQ ZDV KLJKHVW
XUEDQ IHPDOHV   SHUFHQW   7KH PDOH IHPDOH GLIIHU²=7.55,H ZDV VLJ
S   7KH XUEDQ UXUDO GLIIHUHQFH Z²DV EDSUHO\ DQGQLRQFDQWJQPRFDQ
females (Figure 7.76). The great majority of those who reported receiving a grant stated that they were in a position to decide for themselves how to spend their grant or pension (Figure 7.77). Here the urban/rural difference among
IHPDOHV LV DOP²RVW VSLJQL¿RDQKWU$SLVH GLIIHUHQFHV DUH QRW VLJQL¿

Figure 7.76 Percentage in receipt of any grant, by sex and rural/urban (disabled only) (18+ years) (N=2,322)

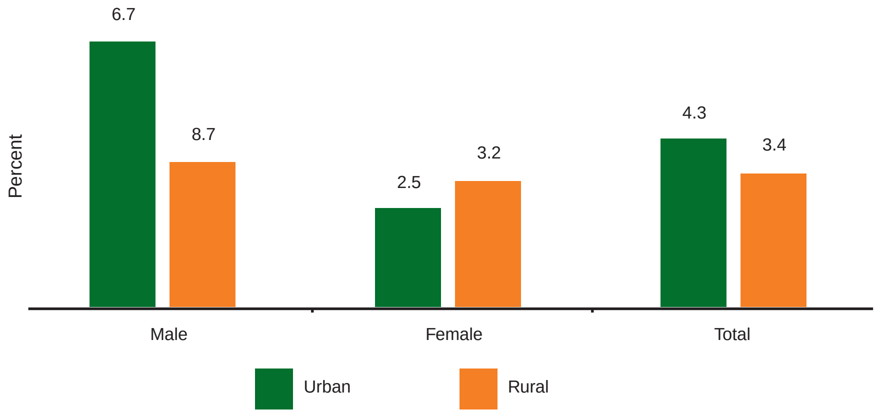
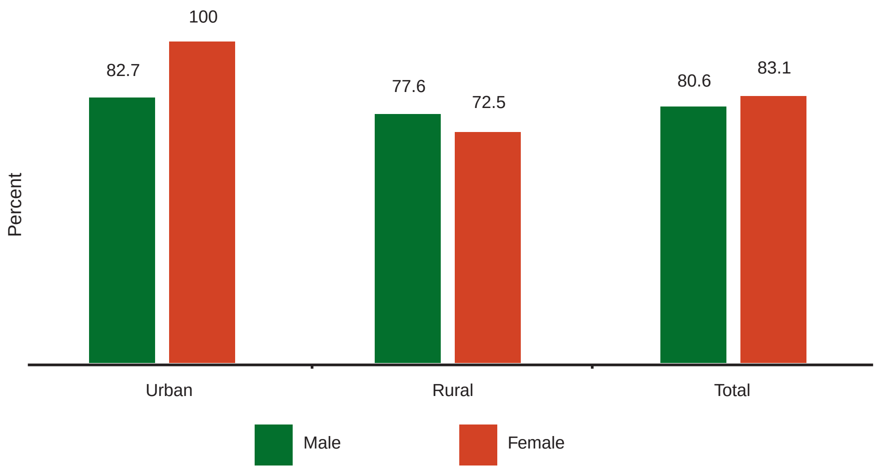


Figure 7.77 Proportion of respondents with disabilities who decide for themselves how to use the grant (18+ years, N=79)



INDIVIDUAL SECTION 2: CHILD MODULE: INDIVIDUAL QUESTIONNAIRE 2–17 YEARS

7KH &KLOG 0RGXOH GHYHORSHG E\ 81,&() DQG WKH :DVKLQJWRQ *URXS F RI FKLOGUHQ ± \HDUV 7KLV VHFWLRQ SURYLGHV D SUR¿OH RI WKH Zambia. It goes on to draw comparisons between children with and without disabilities with respect to environmental barriers, services, accessibility, education, economic activity, assistive devices, health and health information.

THE SAMPLE OF CHILDREN IN THE STUDY

7KH VDPSOH IRU WKH &KLOG 0RGXOH FRPSULVHG FKLOGUHQ DJH GLVDELOLWLHV DQG FKLOGUHQ ZLWKRXW ,Q DOO SHUFHQW RI of the children with disabilities and 48.8 percent of the non-disabled. The sample of children in the study is shown in Table 7.29

Table 7.29 The sample of children in the study (2–17 years)

	DISABLED CHILDREN		NON-DISABLED CHILDREN		TOTAL	
	N	%	N	%	N	%
Male	505	52.9	1,419	48.8	1,924	49.8
Female	449	47.1	1,489	51.2	1,938	50.2
Total	954	100.0	2,908	100.0	3,862	100.0
Urban	303	68.2	904	68.9	1,207	31.1
Rural	651	31.8	2,004	31.1	2,655	68.7
Total	954	100.0	2,908	100.0	3,862	100.0

Some 28.1 percent of the children with disabilities responded on their own, and most of those resided in urban areas and were females; 35.2 percent of responses were provided by the caregiver on behalf of the child; and 36.7 percent of responses were provided by the caregiver together with the child (Table 7.30).

Table 7.30 Distribution of children with disabilities in the sample and mean age, by sex and rural/urban (2–17 years) (N=954)

INTERVIEW	TOTAL %	MEAN AGE	URBAN		RURAL	
			Boys %	Girls %	Boys %	Girls %
Respondent	28.1	11.8 years	25.7	38.5	22.5	29.5
Caregiver	35.2	9.0 years	38.9	28.6	38.3	33.5
Both respondent and caregiver	36.7	8.1 years	35.4	32.9	39.2	36.9
Mean age of children		9.4 years	9.4 years	10.3 years	9.2 years	9.1 years

7KH PHDQ DJH RI FKLOGUHQ ZLWK GLVDELOLWLHV ZDV \HDUV ER\V GLVDEOHG FKLOGUHQ ER\V \HDUV JLUOV \HDUV 7KH GLIIHUHQF GLVDELOLWLHV ZDV VWDWLVWLFDOO\ (Table 7.31). VLJQLILFDQW) S

Table 7.31 Mean age, by disability status and sex (2–17 years) (N=3,862)

DISABILITY STATUS	MEAN AGE		
	Males	Females	Total
Disabled (N=954)	9.3	9.6	9.4
Non-disabled (N=2,908)	7.8	8.3	8.1

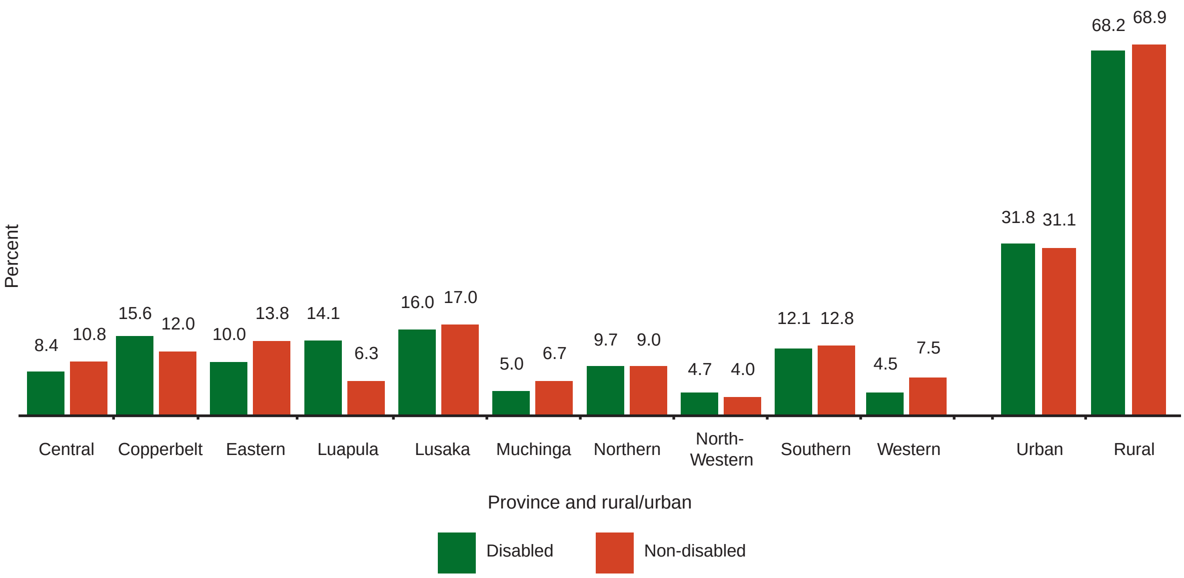
The age distribution of children by disability status and sex is shown Table 7.32 The highest percentage of disabilities for children was found at age 9 (8.6 percent) for males and age 11 (8.9 percent) for females.

Table 7.32 Age distribution of children, by disability status and sex (N=3,862)

AGE IN YEARS	DISABLED BOYS	NON-DISABLED BOYS	DISABLED GIRLS	NON-DISABLED GIRLS
2	5.5	10.3	4.3	9.3
3	5.0	10.0	5.8	7.8
4	6.6	8.1	4.7	9.0
5	6.8	8.9	7.1	9.1
6	6.8	7.9	6.9	6.8
7	7.4	7.4	8.8	5.9
8	7.5	7.1	7.4	7.4
9	8.6	5.3	5.9	6.4
10	6.7	6.5	5.9	6.1
11	6.9	7.0	8.9	6.5
12	5.8	3.9	4.5	4.3
13	4.9	3.9	5.5	4.1
14	6.4	3.7	6.0	3.8
15	5.6	3.8	5.5	4.9
16	3.7	3.8	5.2	4.3
17	6.0	2.9	5.7	4.2

Figure 7.78shows the distribution of children with and without disabilities by province and in urban/rural locations. Among the disabled children, 31.8 percent were in urban areas while 68.2 percent were in rural areas compared to 31.1 percent and 68.9 percent among the non-disabled children for rural and urban areas, respectively. There was some variation in the distribution of children with and without disabilities across the 10 provinces. Lusaka Province had the highest percentage of disabled children (16.0 percent), followed by Copperbelt Province (15.6 percent), while Western Province recorded the lowest (4.5 percent).

Figure 7.78 Distribution of children in the sample with/without disabilities, by province (2–17 years) (N=3,862)



ACTIVITY LIMITATIONS

:H QRZ SURYLGH D SUR¿OH RI DFWLYLW\ OLPLWDWLRQV ZLWKLQ WKH G EUDFNHWV LQ WKH ¿JXUHV DQG WDEOHV DUH DFFRUGLQJ WR WKH DJH descriptive analyses, only children with disabilities are included, while others offer a comparison between children with and without disabilities.

2–17 years

2I WKRVH FKLOGUHQ ZKR GLG QRW XVH VSHFWDFOHV SHUFHQW RI E (n.s.), while less than 1 percent could not see at all. Of the children who did not wear hearing aids, 21.8 percent of boys DQG SHUFHQW RI JLUOV KDG (Figure 7.79) GLI¿FXOW\ LQ KHDULQJ Q V

Figure 7.79 Proportion of children with disabilities who had di culty seeing and hearing,by sex (2–17 years)

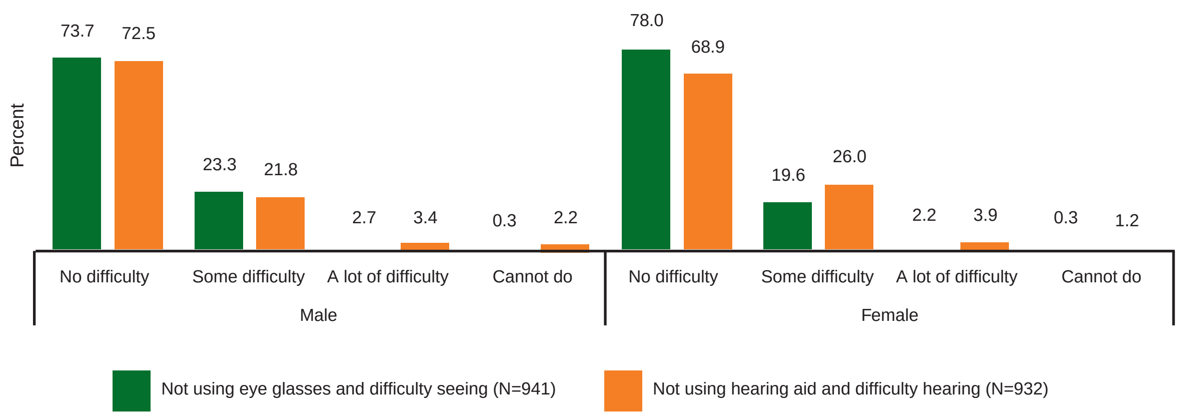
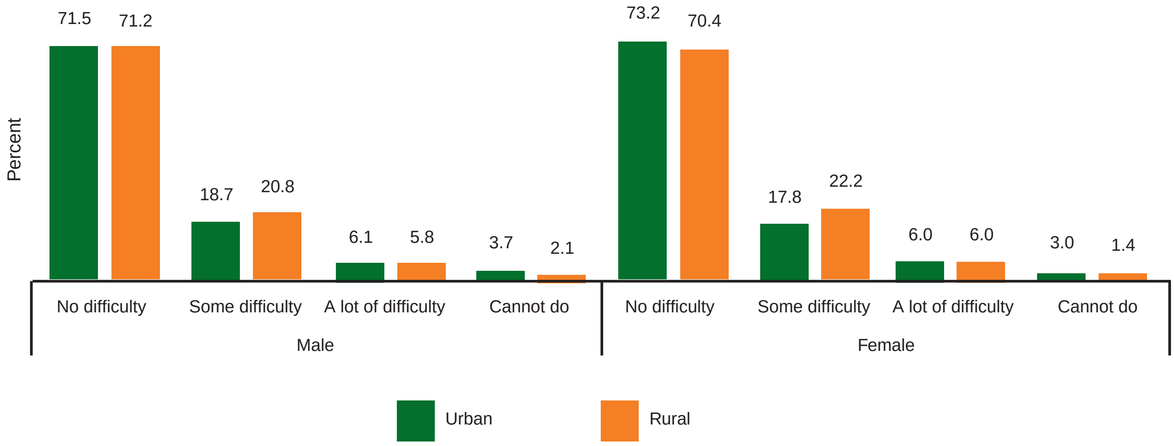


Figure 7.80 VKRZV WKDW WKH PDMRULW\ RI FKLOGUHQ ZLWK GLVDELOLWLHV things. There was hardly any difference between boys and girls or between those in urban and rural areas. Of the boys with disabilities, 3.7 percent in urban areas and 2.1 percent in rural areas could not learn new things at all; among girls, WKH ¿JXUHV ZHUH SHUFHQW DQG SHUFHQW

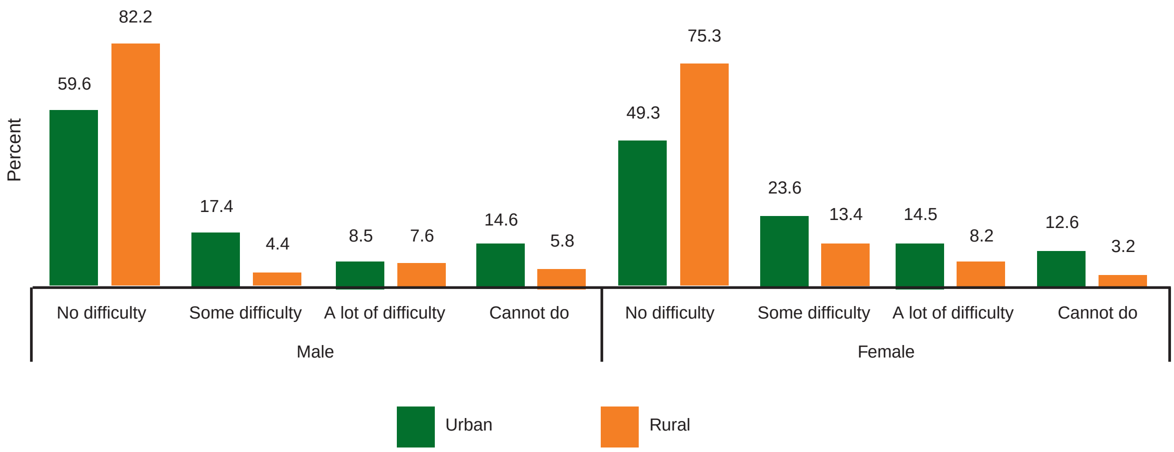
Figure 7.80 Proportion of children with disabilities who had di culty learning new things, by sex and rural/urban (2–17 years) (N=952)



2–3 years

7KH PDMRULW\ RI FKLOGUHQ ZLWK GLVDELOLWLHV DJHG ± \HDUV KDYH REMHFWV WKDQ GR RWKHU FKLOGUHQ RI WKH VDPH DJH 8UEDQ PDOHV 82.2 percent and females 75.3 percent). Neither the difference between boys and girls nor the difference between XUEDQ DQG UXUDO UHVSRQGHQWV LV VWDWLVWLFDOO\ VLJQL¿FDQW 6WL VRPH GLI¿FXOW\ DQG PRUH ER\V UHSRUW WKDW WKH\ FDQQRW OHDUQ WK EUDFNHW UHSRUW PRUH GLI¿FXOWLHV WKDQ UXUDO UHVSRQGHQWV DOW N) (Figure 7.81).

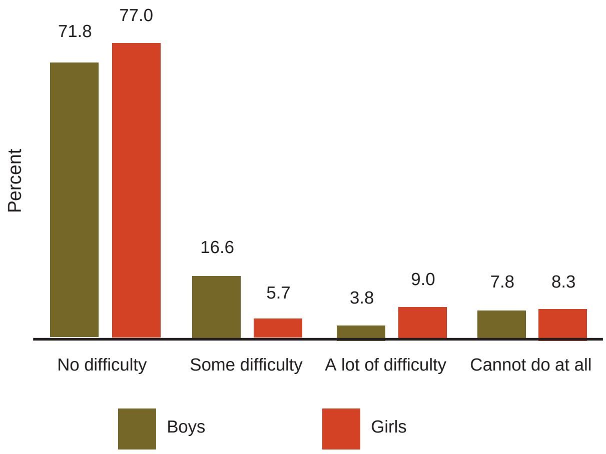
Figure 7.81 Proportion of children with disabilities who had di culty learning the names of common objects, by sex and rural/urban (2–3 years) (N=102)



2–4 years

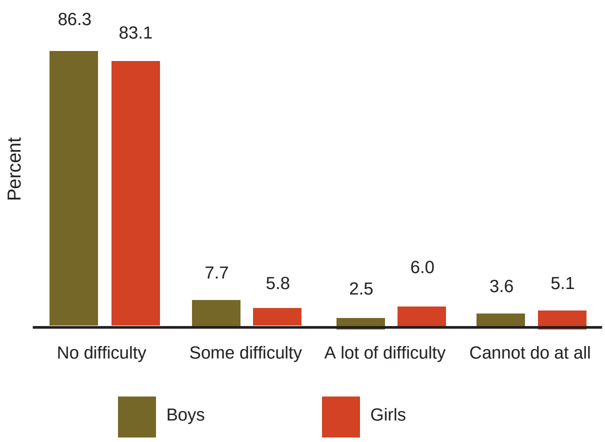
7KH JUHDW PDMRULW\ RI FKLOGUHQ DJHG ± \HDUV KDYH QR GLI¿FXOW girls respectively (n.s.) (Figure 7.82). This implies that 28.2 percent of boys and 23.0 percent of girls have at least VRPH GLI¿FXOW\ LQ ZDONLQJ D ORW RI GLI¿FXOW\ ZDONLQJ RU FRXOG

Figure 7.82 Proportion of children who had di culty walking, by sex (2–4 years) (N=153)



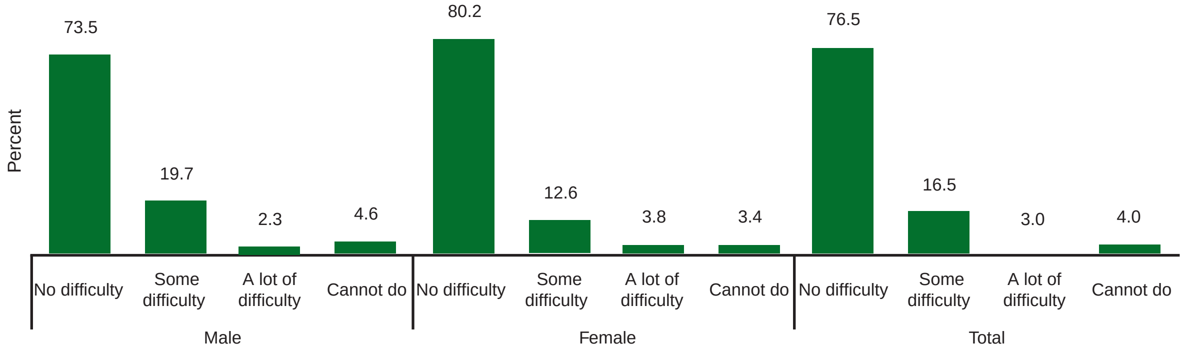
/LNHZLVH WKH PDMRULW\ RI GLVDEOHG FKLOGUHQ SHUFHQW RI E picking up small objects with their hands (Figure 7.83).

Figure 7.83 Proportion of children who had di culty picking up small objects with their hands, by sex (2–4 years) (N=158)



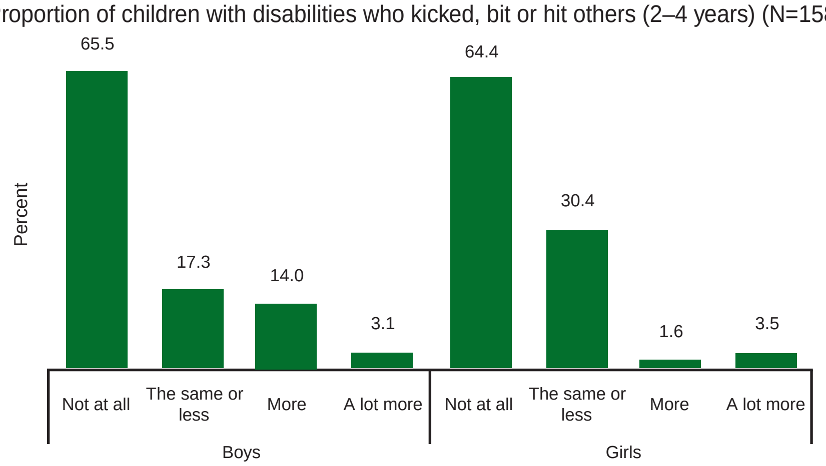
Data on communication between the caregiver and the child were also collected. Most caregivers (76.5 percent) KDG QR GLI¿FXOW\ XQGHUVWDQGLQJ ZKDW WKH FKLOG ZDQWHG ,Q PR\ LQ XQGHUVWDQGLQJ WKH QHHGV RI ER\V UDWKHU WKDQ JLUOV WKH G S Figure 7.84).

Figure 7.84 Proportion of parents/caregivers with a child with disabilities who had di culty understanding what the child wanted (2–4 years) (N=158)



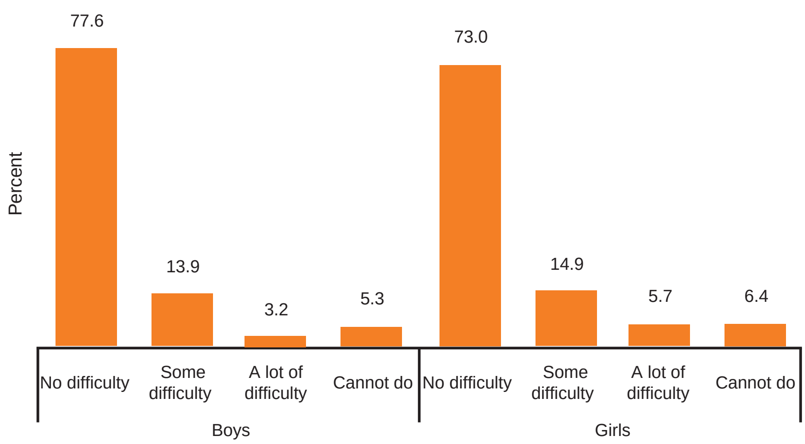
,Q DOO SHUFHQW RI JLUOV DQG SHUFHQW RI ER\V ZLWK D GLVDEL
some 3.5 percent of girls and 3.1 percent of boys did kick, bite or hit others a lot more than non-disabled children of the same age (Figure 7.85).

Figure 7.85 Proportion of children with disabilities who kicked, bit or hit others (2–4 years) (N=158)



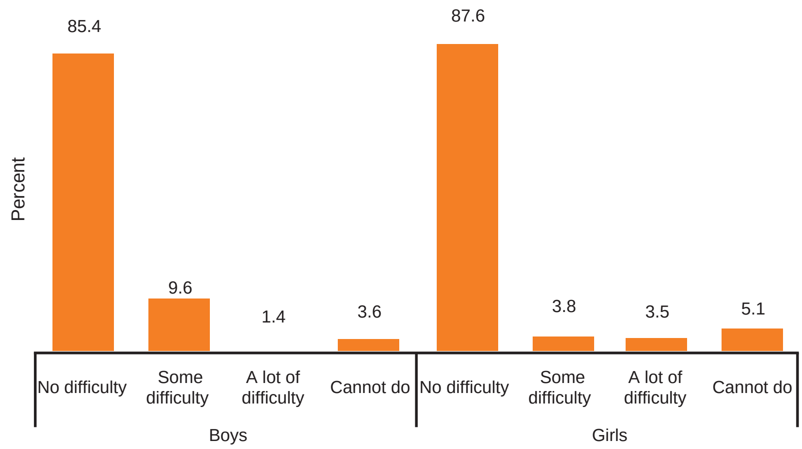
2I FKLOGUHQ ZLWK GLVDELOLWLHV DJHG ± SHUFHQW RI ER\V DQG
SHUFHQW RI ER\V DQG SHUFHQW RI JLUOV KDG VRPH GLI¿FXOW\
RI GLI¿FXOW\ DQG SHUFHQW RI ER\V DQG SHUFHQW RI JLUOV ZHUH
GLI¿FXOW\ SOD\LQJ PHDQZKLOH JLUOV VFRUHG (Figure 7.86). RQ WKH WKUHH R

Figure 7.86 Proportion of children with disabilities who had di culty playing, by sex (2–4 years) (N=158)



,Q DOO SHUFHQW RI GLVDEOHG ER\V DQG SHUFHQW RI GLVDEOH
KRXVHKROG REMHFWV SHUFHQW RI ER\V DQG SHUFHQW RI JLUOV K
JLUOV KDG D ORW RI GLI¿FXOW\ DQG SHUFHQW RI ER\V DQG SHUF
KLJKHU RQ WKH FDWHJRULHV µD Figure 7.87). The differences between boys and girls were W GR¶
QRW VWDWLVWLFDOO\ VLJQL¿FDQW

Figure 7.87 Proportion of children with di culty playing with toys or household objects (2–4 years) (N=158)

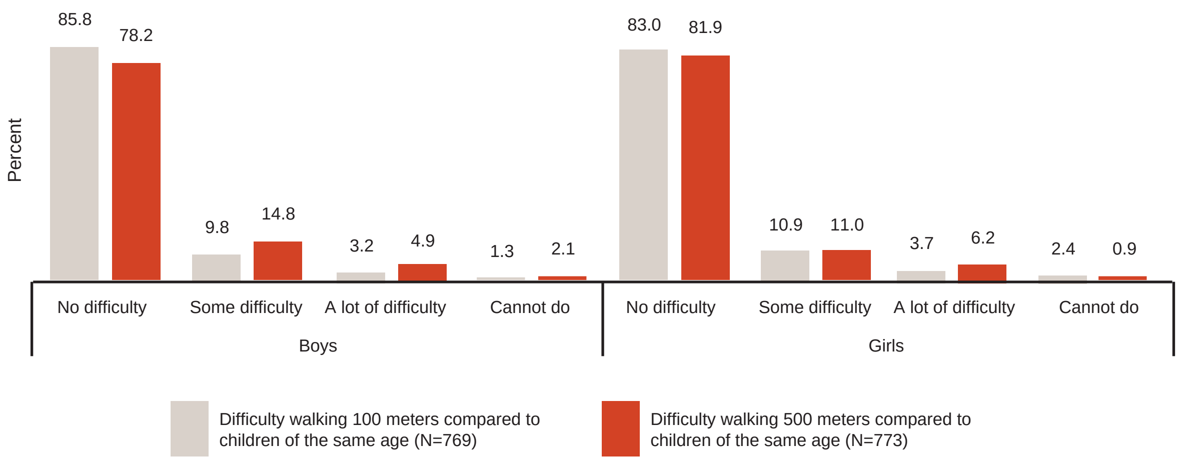


5–17 years

2I WKRVH GLVDEOHG UHVSRQGHQWV DJHG ± \HDUV WKH YDVW PDMRU
UHSRUWHG QR GLI¿FXOW\ LQ ZDONLQJ PHWUHV 7KHUH DUH VRPH VP
RI VH[VRPH GLI¿FXOW\ ZDV UHSRUWHG E\ SHUFHQW RI ER\V DQG
SHUFHQW RI JLUOV UHSRUWHG WKDW WKH\ HLWKHU KDG D ORW RI GLI¿F
SHUFHQW ZKR KDG VRPH GLI¿FXOW\ ZDON Figure 7.88). PHWUHV WKDQ JLUOV

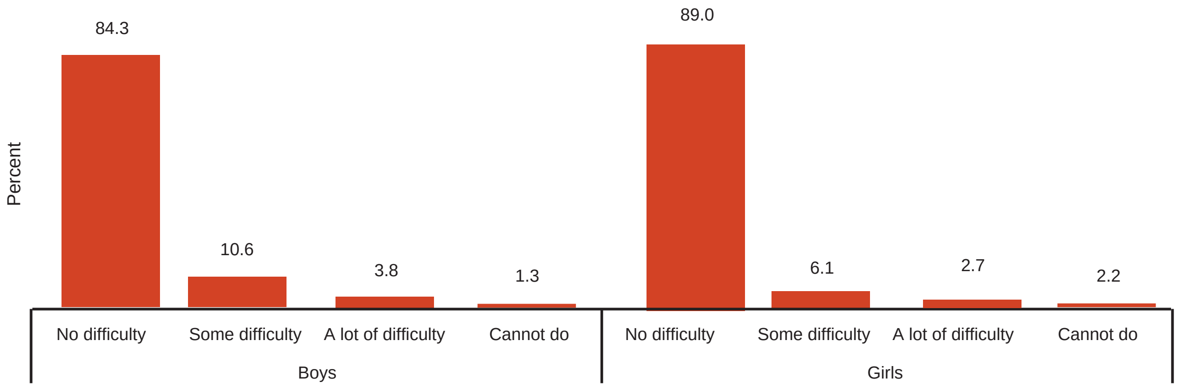
Figure 7.88 Proportion of disabled children with di culty walking 100 or 500 metres (5–17 years)

0RUH ER\V SHUFHQW WKDQ JLUOV SHUFHQW KDG VRPH GLI¿FX



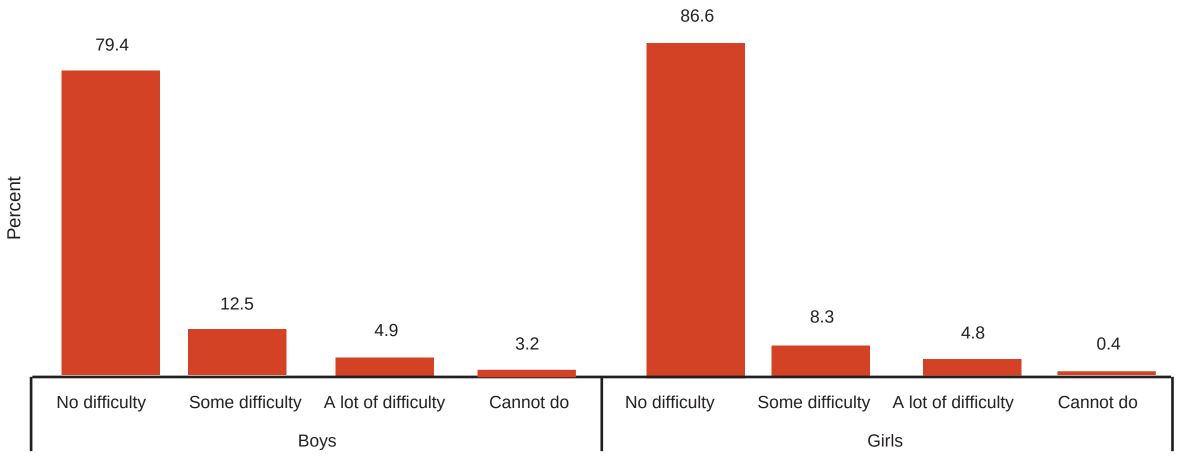
ER\V DQG JLUOV ZDV VLJQL¿FDQW² RQO\ SD Figure 7.89). UEDQ UHVSRQGHQWV $

Figure 7.89 Proportion of children with di culty with self-care, by sex (5–17 years) (N=794)



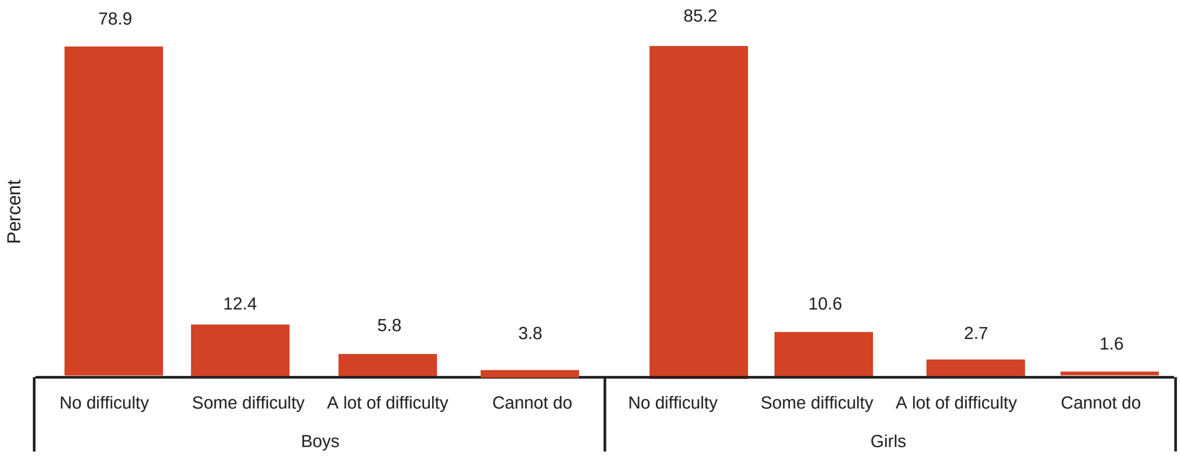
7KHUH ZDV D GLIIHUHQFH LQ WHUPV RI VH[LQ XQGHUVWDQGLQJ RWKHUV (86.6 percent vs. 79.4 percent); meanwhile 3.2 percent of boys could not understand other people at all, compared to MXVW SHUFHQW IRU Figure 7.90). $

Figure 7.90 Proportion of disabled children with di culty understanding others (5–17 years) (N=794)



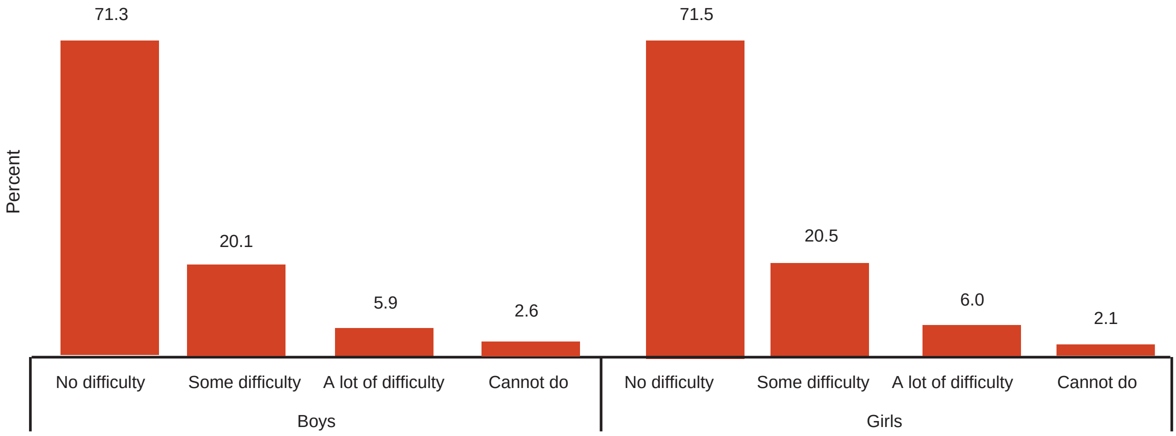
0RUH ER\V WKDQ JLUOV KDG DW OHDVW VRPH GLI¿FXOW\ EHLQJ XQGHUVWRRG SHUFHQW FRXOG QRW EH XQGHUVWRRG E\ RWKHUV DW DOO, WKH FRU S Figure 7.91).

Figure 7.91 Proportion of disabled children with di culty being understood (5–17 years) (N=794)



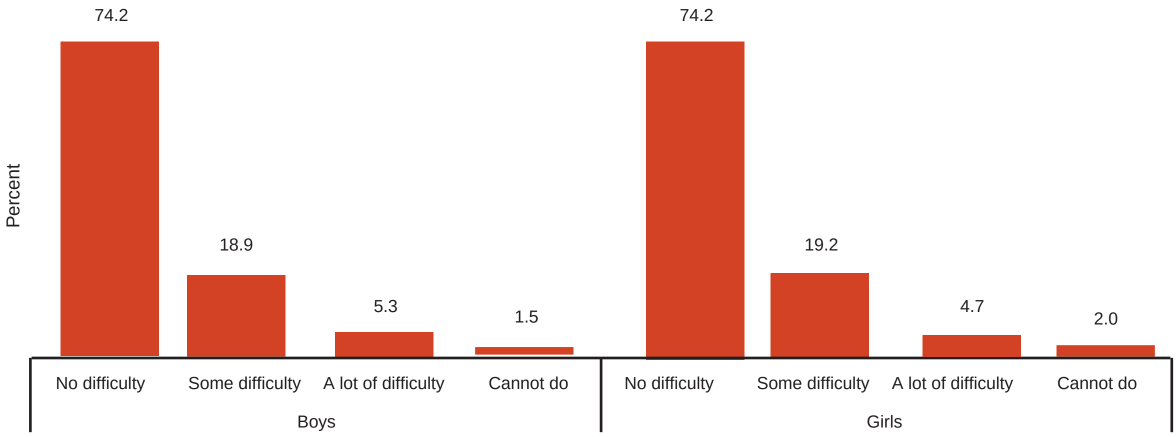
2QH LQ ¿YH SHUFHQW RI ER\V DQG SHUFHQW RI JLUOV GLG KD
GLIIHUHQFHV LQ WHUPV RI VH[ZHUH Figure 7.92). DQG QRW VWDWLVWLFDOO\

Figure 7.92 Proportion of disabled children with di culty learning to do new things (5–17 years) (N=952)



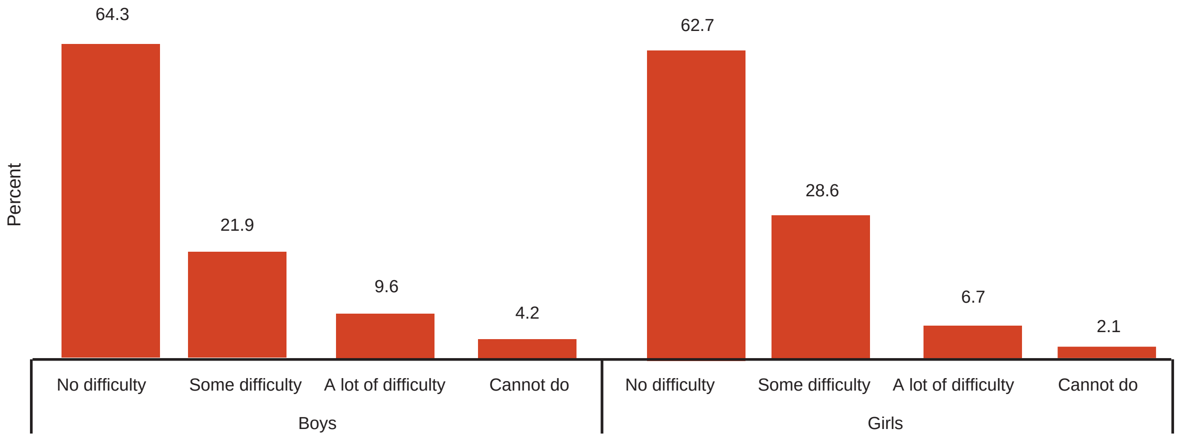
0RVW FKLOGUHQ ZLWK GLVDELOLWLHV SHUFHQW RI ERWK ER\V DQ
WKLQJV WKDW WKH\ KDG OHDUQHG WKDQ RWKHU FKLOGUHQ RI WKH VDP
KDG D ORW RI GLI¿FXOW\ DQG SHUFHQW Figure 7.93). Gender differences XQDEOH
ZHUH PDUJLQDO DQG QRW VWDWLVWLFDOO\ VLJQL¿FDQW

Figure 7.93 Proportion of disabled children with di culty remembering things they have learned (5–17 years) (N=794)



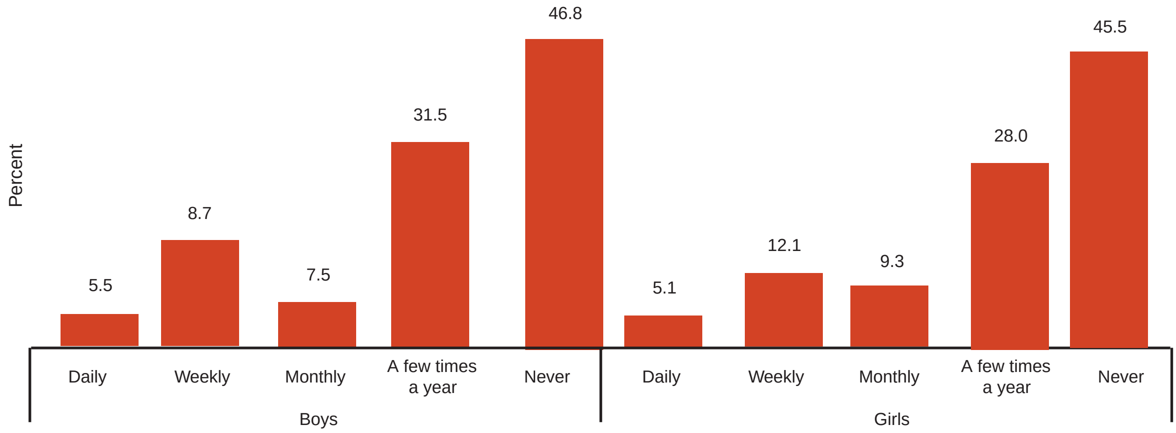
0RUH ER\V WKDQ JLUOV UHSRUWHG GLI¿FXOW\ LQ FRQWUROOLQJ WKHL
UHDFK VWDWLVWLFDO VLJQL¿FDQFH $PRQJ ER\V SHUFHQW KDG HLV
DJH ZKLOH WKH FRUUHVSRQGLQJ Figure 7.94). DPRQJ JLUOV ZDV SHUFHQW

Figure 7.94 Proportion of disabled children with di culty controlling their behaviour (5–17 years) (N=794)



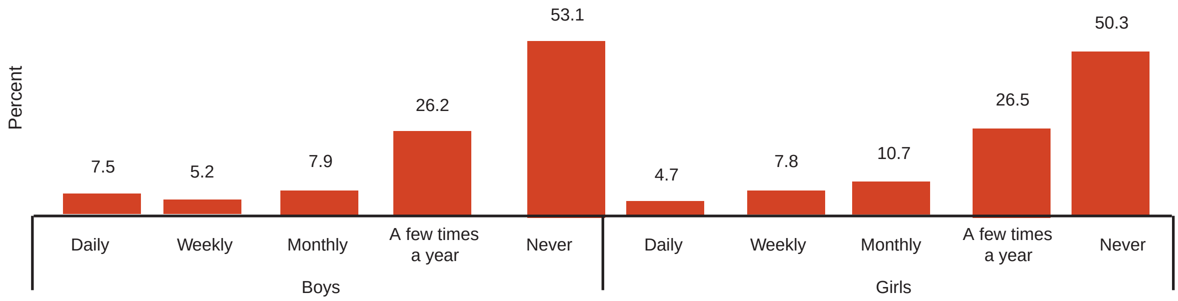
More girls (12.1 percent) than boys (8.7 percent) reported experiencing sadness or depression weekly (Figure 7.95). No pronounced age-related pattern was revealed.

Figure 7.95 Percentage of disabled children by how often they seemed sad or depressed and by sex (5–17 years) (N=794)



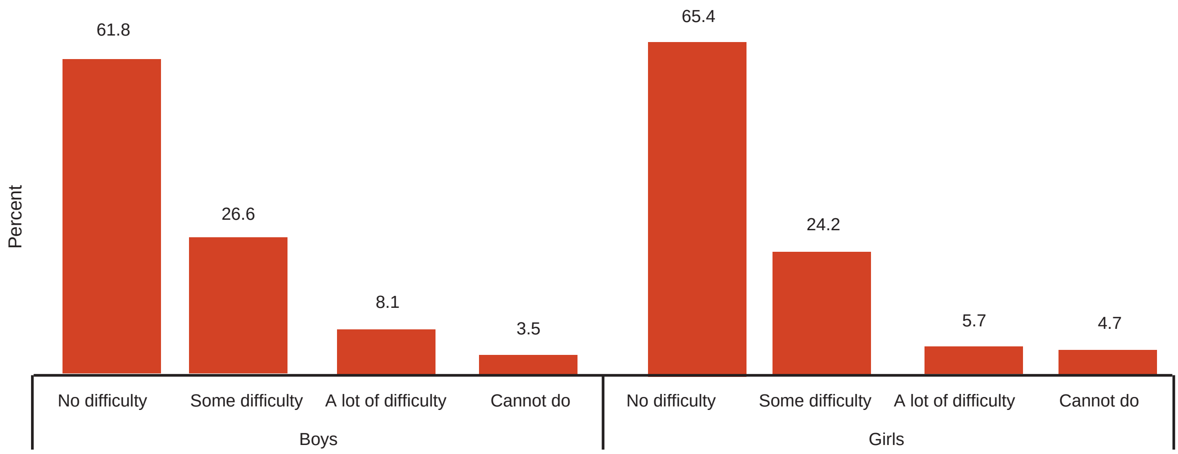
Girls reported being anxious, nervous or worried more frequently than boys, although more boys than girls were anxious, nervous or worried on a daily basis (7.5 percent vs. 4.7 percent) (Figure 7.96). No pronounced age-related pattern was revealed.

Figure 7.96 Proportion of disabled children who were anxious, nervous or worried (5–17 years) (N=794)



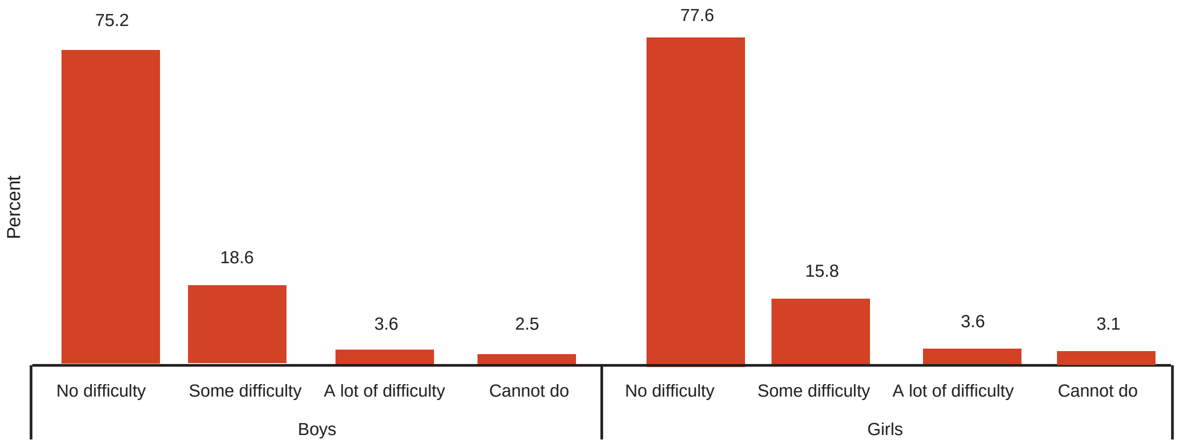
There was a tendency for boys to have more problems in completing a task than girls, although a higher proportion of girls than boys reported being unable to complete a task (4.7 percent vs. 3.5 percent) (Figure 7.97).

Figure 7.97 Proportion of disabled children who experienced di culty completing a task (5–17 years) (N=794)



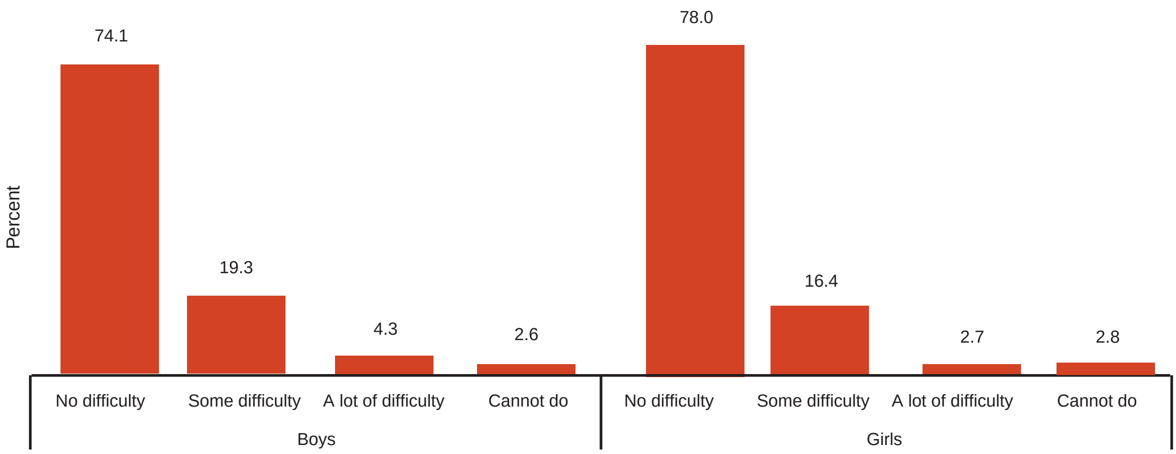
0RUH ER\V SHUFHQW WKDQ JLUOV SHUFHQW UHSRUWHG KDYL
HQMR\HG 7KHUH ZHUH VPDOO VWDWLVWLFDOO\ LQVLJQL¿FDQW GLIIH
(Figure 7.98).

Figure 7.98 Proportion of disabled children who had di culty focusing on an activity that they enjoyed (5–17 years) (N=794)



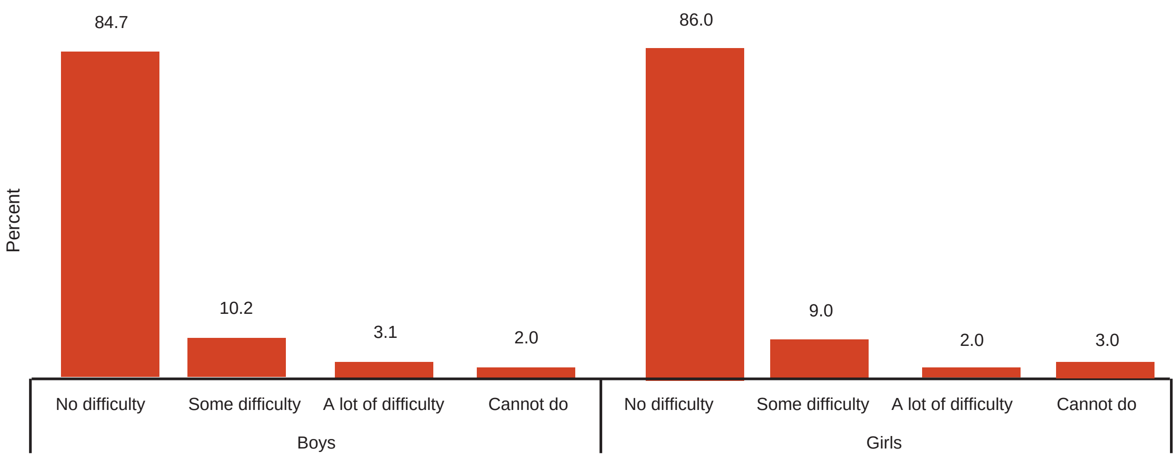
0RUH JLUOV SHUFHQW WKDQ ER\V SHUFHQW KDG QR GLI¿FXO
ER\V SHUFHQW WKDQ JLUOV SHUFHQW KDG VRPH GLI¿FXOW
VLJQL¿FDQW (Figure 7.99).

Figure 7.99 Proportion of disabled children who had di culty accepting change in plans or routines (5–17 years) (N=794)



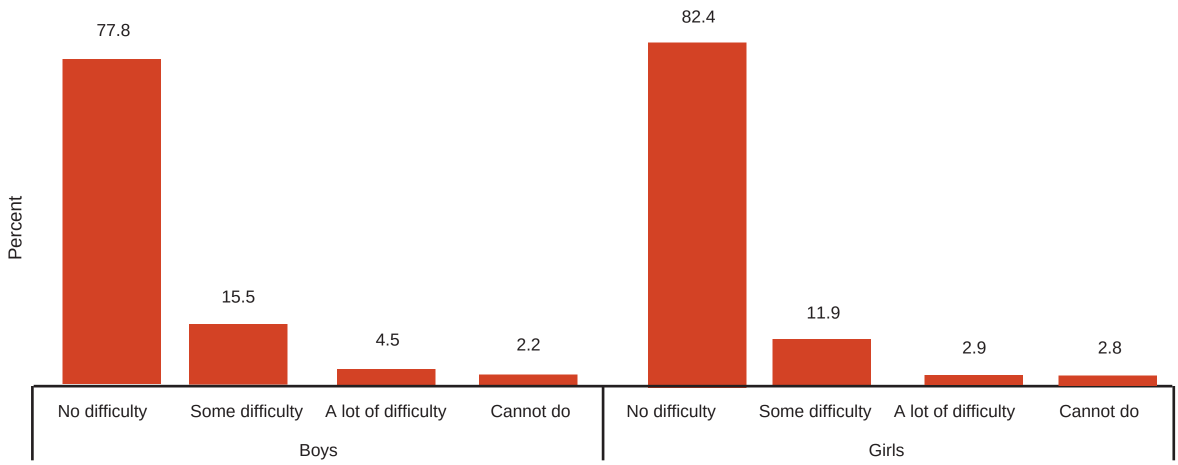
2I FKLOGUHQ ZLWK GLVDELOLWLHV VOLJKWO\ PRUH JLUOV KDG QR GLI¿
VOLJKWO\ PRUH ER\V KDG VRPH GLI¿FXOW\ SHUFHQW YV SHUFHQW
and slightly more girls were unable to make friends (3.0 percent vs. 2.0 percent) (these differences are not statistically
VLJQL¿FDQW (Figure 7.100).

Figure 7.100 Proportion of disabled children who had di culty making friends (5–17 years) (N=794)



2I FKLOGUHQ DJHG ± ZLWK GLVDELOLWLHV PRUH JLUOV WKDQ ER\V
WKLQJV ZLWK RWKHU FKLOGUHQ WKRXJK (Figure 7.101) LIIHUHQFH LV QRW VWDW

Figure 7.101 Proportion of disabled children who had di culty doing things with other children (5–17 years) (N=794)



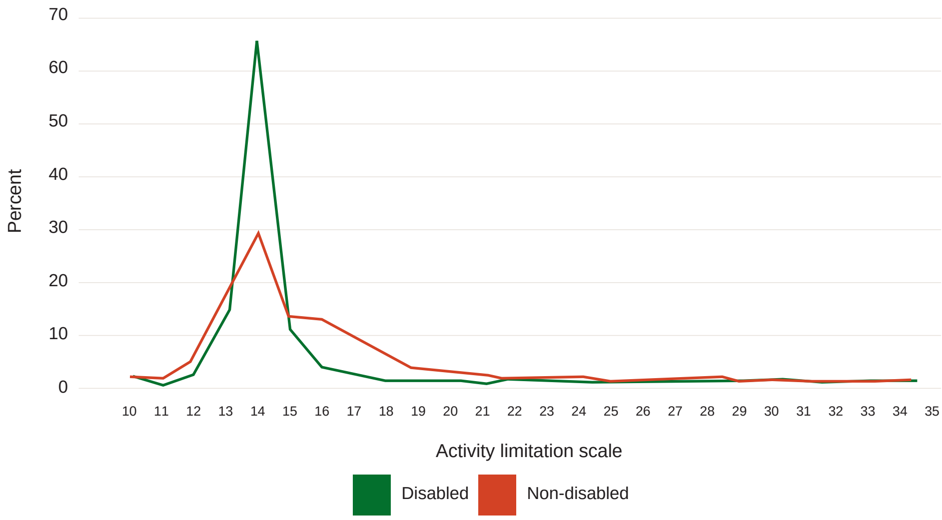
)RU WKH DJH JURXS ± \HDUV WKH IROORZLQJ DFWLYLW\ OLPLWDWLR
OLPLWDWLRQV

- &RPSDUHG ZLWK FKLOGUHQ RI WKH VDPH DJH GRHV « KDYH GLI¿FX
- &RPSDUHG ZLWK FKLOGUHQ RI WKH VDPH DJH GRHV « KDYH GLI¿FX
- 'RHV « KDYH GLI¿FXOW\ ZLWK VHOI FDUH VXFK DV IHHGLQJ GUHVV
- &RPSDUHG ZLWK FKLOGUHQ RI WKH VDPH DJH GRHV « KDYH GLI¿FX
- &RPSDUHG ZLWK FKLOGUHQ RI WKH VDPH DJH GRHV « KDYH GLI¿FX
- 'RHV « KDYH GLI¿FXOW\ UHPHPEHULQJ WKLQJV WKDW KH VKH KDV O
- +RZ PXFK GLI¿FXOW\ GRHV « KDYH FRQWUROOLQJ KLV KHU EHKDYLF
- How often does … seem sad or depressed?
- How often does …. seem anxious, nervous or worried?
- 'RHV « KDYH GLI¿FXOW\ FRPSOHWLQJ D WDVN"
- 'RHV « KDYH GLI¿FXOW\ IRFXVLQJ RQ DQ DFWLYLW\ WKDW KH VKH H
- 'RHV « KDYH GLI¿FXOW\ DFFHSWLQJ FKDQJH WR SODQV RU URXWLQH
- 'RHV « KDYH GLI¿FXOW\ PDNLQJ IULHQGV"

)RU DOO WKH TXHVWLRQV WKHUH ZHUH IRXU DQVZHU FDWHJRULHV H[SU
RQ PHQWDO KHDOWK ZKLFK KDG ¿YH DQVZHU FDWHJRULHV 7KH VFDO
and standard deviation of 1.15. The mean value for children with disabilities was 15.67 and 14.03 for non-disabled
FKLOGUHQ S

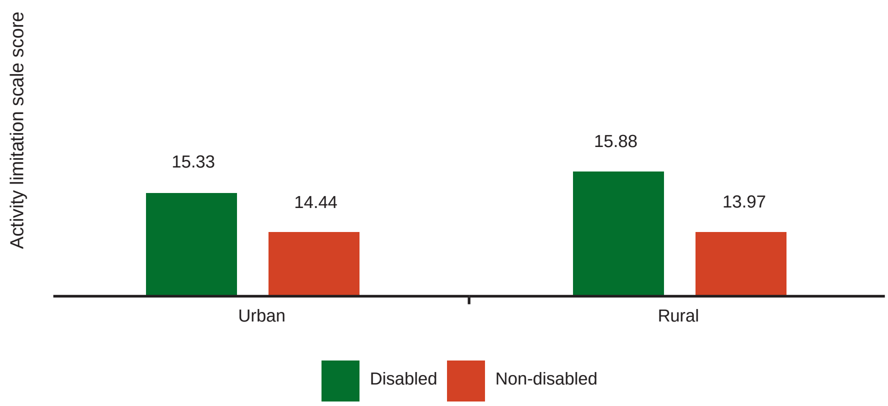
Figure 7.102 shows the differences in the distribution of the scale values between children with and without disabilities. The curve for non-disabled children has a high number of low scores and then falls quickly down to zero. The curve for children with disabilities, on the other hand, spreads further on moderately high scores. The high number of
ORZHU VFRUHV DPRQJ QRQ GLVDEOHG FKLOGUHQ UHÀHFWV WKH IDFW W
FRQFHUQ D EURDGHU JURXS RI FKLOGUHQ WKDQ PHUHO\ WKRVH ZKR KD
method and the threshold in this particular study.

Figure 7.102 Activity limitation scale values, by disability status (5–17 years) (N=2,863)



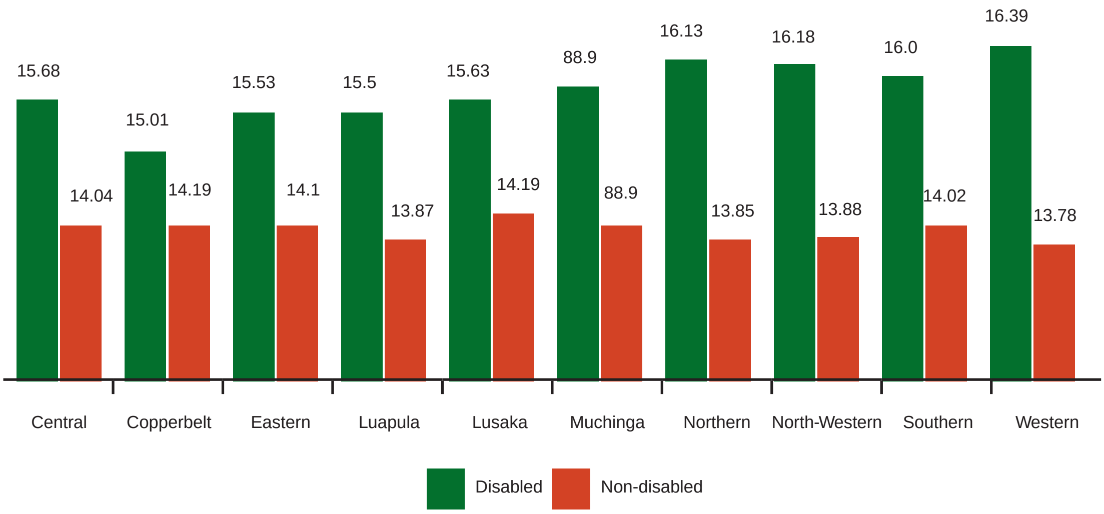
7KH PHDQ VFRUH RQ DFWLYLW\ OLPLWDWLRQV DPRQJ ER\V ZDV DQG D
WKHVH DUH VPDOO GLIIHUHQFHV WKDW UHDFK VLJQL¿FDQFH GXH WR WKH
are also shown. Children with disabilities score higher on the activity limitation scale in both rural and urban areas
S

Figure 7.103 Activity limitation scale values, by disability status and location (5–17 years) (N=2,863)



:H DOVR REVHUYH GLIIHUHQFHV DFURVV WKH SURYLQFHV WKH PHDQ VFD
LV KLJKHVW LQ :HVWHUQ 3URYLQFH DQG ORZHVW LQ &RSSHUEHOW
limitations thus seem to be somewhat higher in the least central provinces of Zambia.

Figure 7.104 Activity limitation mean scale values, by disability status and province (5–17 years) (N=2,863)



CAUSES OF DISABILITIES

The survey also investigated the causes of the reported disability (Table 7.33). In all, 40.4 percent reported that the disability was congenital (from birth) and 31.2 percent said it was due to disease/illness, while 16.9 percent did not know. The mean age of onset of disability was 6.4 years for boys and 7.9 years for girls (n.s.).

Table 7.33 Cause of disability, by sex (2–17 years) (N=309)

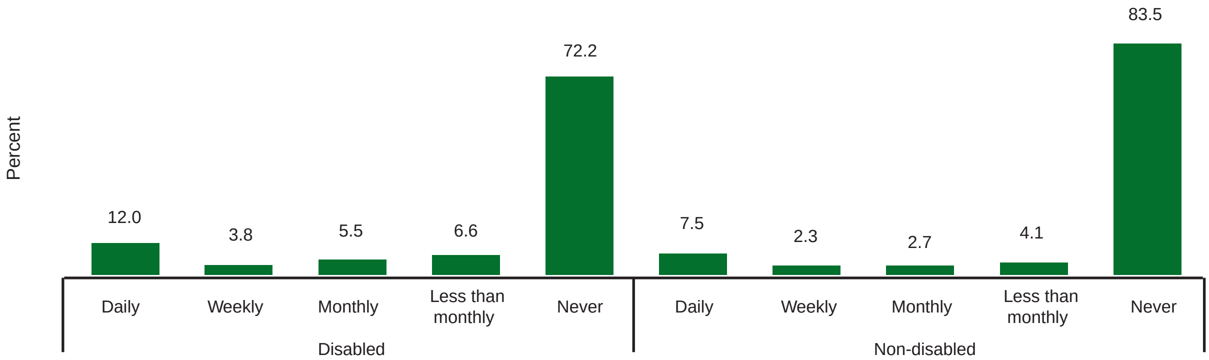
REASON FOR DISABILITY	BOYS	GIRLS	TOTAL
From birth/congenital	41.3	39.4	40.4
Accident/fall/burns	8.0	2.5	5.4
Disease/illness	26.4	36.2	31.2
Violence	2.3	0.8	1.6
Animal related	0.0	0.8	0.4
Stress related	0.0	0.9	0.4
Witchcraft	1.9	2.4	2.2
Other	3.0	0.4	1.7
Don't know	17.1	16.7	16.9

ENVIRONMENTAL BARRIERS

7KLV VHFWLRQ SUHVHQWV WKH ¿QGLQJV RQ KRZ HQYLURQPHQWDO ID participation of children with disabilities, compared to children without.

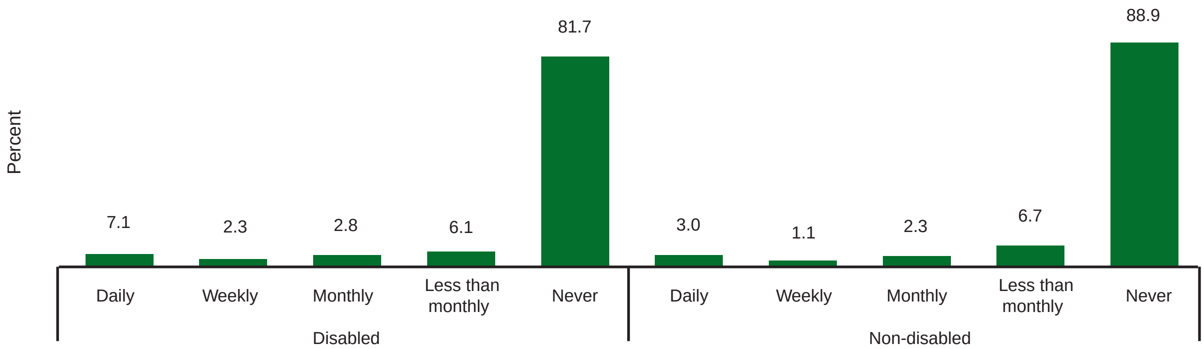
)HZHU FKLOGUHQ ZLWK GLVDELOLWLHV UHSRUWHG QR SUREOHPV ZLWK children). Daily problems with transport were reported by 12.0 percent of children with disabilities and 7.5 percent of FKLOGUHQ ZLWKRXW (Figure 7.105).

Figure 7.105 Proportion of children, by how often transportation had been a problem and disability status (12–17 years) N=932)



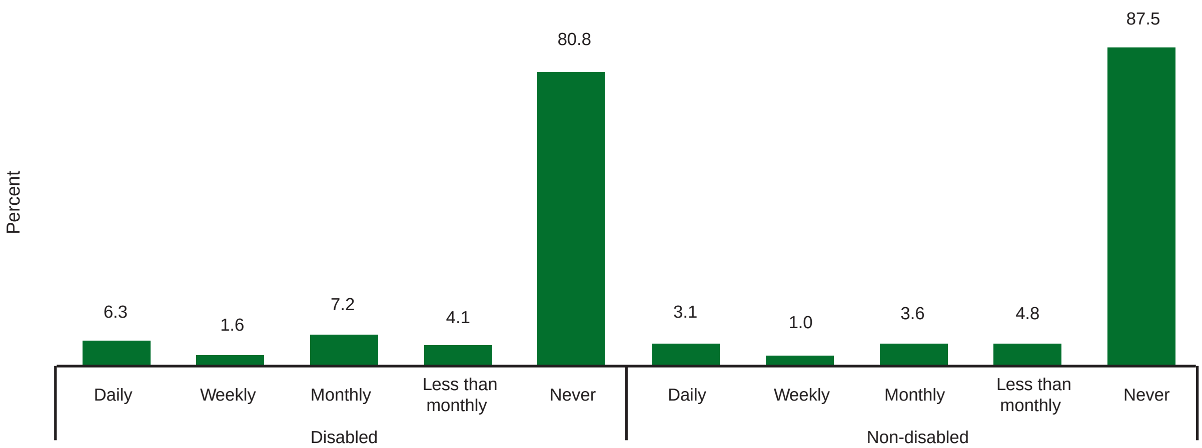
0RVW FKLOGUHQ DJHG ± ZLWK GLVDELOLWLHV SHUFHQW DQG ZL
attitudes towards them had never been a problem. People's attitudes were a daily problem experienced by 7.1 percent
RI FKLOGUHQ ZLWK GLVDELOLWLHV DQG S SHUFHQW RI FKLOGUHQ ZLWKR (Figure 7.106)

Figure 7.106 Proportion of children, by how often people's attitudes at school or work had been a problem and disability status (12–17 years) (N=875)



,Q DOO SHUFHQW RI FKLOGUHQ DJHG ± ZLWK GLVDELOLWLHV DQG
and discrimination had never been a problem. Prejudice and discrimination were experienced daily by 6.3 percent of
FKLOGUHQ ZLWK GLVDELOLWLHV D(3.95) (Figure 7.107) HQW RI FKLOGUHQ ZLWKRXW

Figure 7.107 Proportion of children, by how often they experienced prejudice or discrimination and disability status (12–17 years) (N=963)



SERVICE GAPS

Gaps in services were measured by means of questions on the need for services and whether respondents had received them. Assistive devices, counselling and educational services were those mainly relevant for persons with disabilities. $PRQJ FKLOGUHQ ZLWK GLVDELOLWLHV DJHG ± SHUFHQW UHSRU 44.7 percent needed one. This leaves a gap of 85.7 percent. The corresponding gap for counselling (for persons ZLWK GLVDELOLWLHV ZDV SHUFHQW)RU KHDOWK VHUYLFHV WKH 4.2 percent for children without disabilities; and for health information the gaps were 12.0 percent and 0 percent, respectively. This means that even though there was high coverage of health services/health information, children with disabilities managed to access what they needed to a lesser extent than children without disabilities. With regard to vocational training, there was a 100 percent gap for children with disabilities and a 95 percent gap for children ZLWKRXW LQGLFDWLQJ WKDW WKLV VHUYLFH ZDV DFFHVVHG E\ YHU\ I GLVDELOLWLHV)RU HGXFDWLRQDO VHUYLFHV WKH JDS IRU FKLOGUHQ (Table 7.34).

Table 7.34 Service gap, by disability status (12–17 years) (N=1,006)

	AWARE		NEEDED		RECEIVED		SERVICE GAP	
Services	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Assistive devices	47.3	N/A	44.7	N/A	6.4	N/A	85.7	N/A
Educational services	36.4	N/A	46.9	N/A	23.8	N/A	49.3	N/A
Vocational training	17.9	18.7	14.2	5.9	0.0	0.3	100.0	95.0
Counselling	13.4	N/A	29.8	N/A	5.0	N/A	83.2	N/A
Health information	76.2	74.7	70.6	59.2	62.1	60.1	12.0	0.0
Health services	82.4	81.4	87.3	69.4	75.9	66.5	13.1	4.2

[1] Gap = [1-(Received/Needed)]*100.

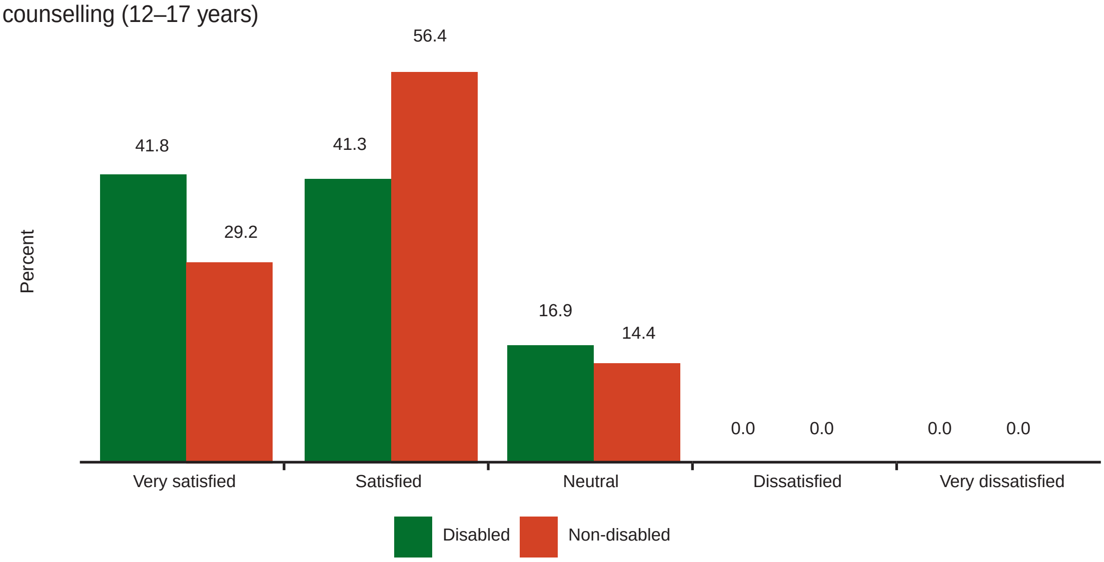
N/A: Not applicable.

SATISFACTION WITH SERVICES

This section presents information on levels of satisfaction with services and assistive devices.

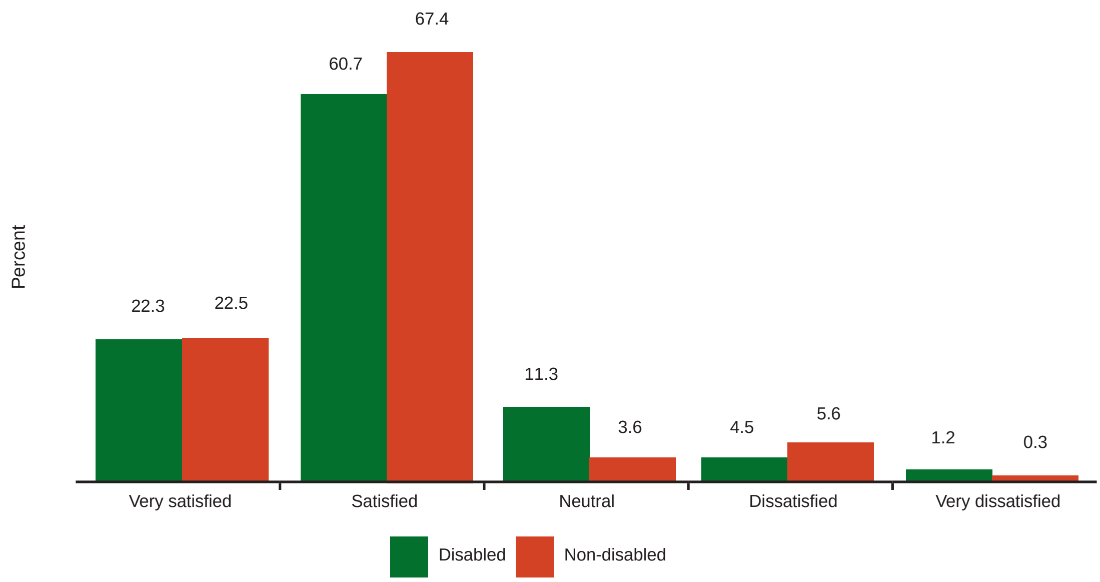
Among children with disabilities, very few had received either assistive devices or counselling. Of those who FRQ¿UPHG UHFHLYLQJ WKHVH VHUYLFHV SHUFHQW DVVLVWLYH GHYL ZLWK WKH VHUYLFHV DQG SHUFHQW DQG SHUFHQW ZHUH VDWLV¿ DQG QRQH ZHUH GLVVDWLV¿HG Figure 7.108 RU YHU\ GLVVDWLV¿HG

Figure 7.108 Proportion of children with disabilities, by satisfaction with assistive devices and counselling (12–17 years)



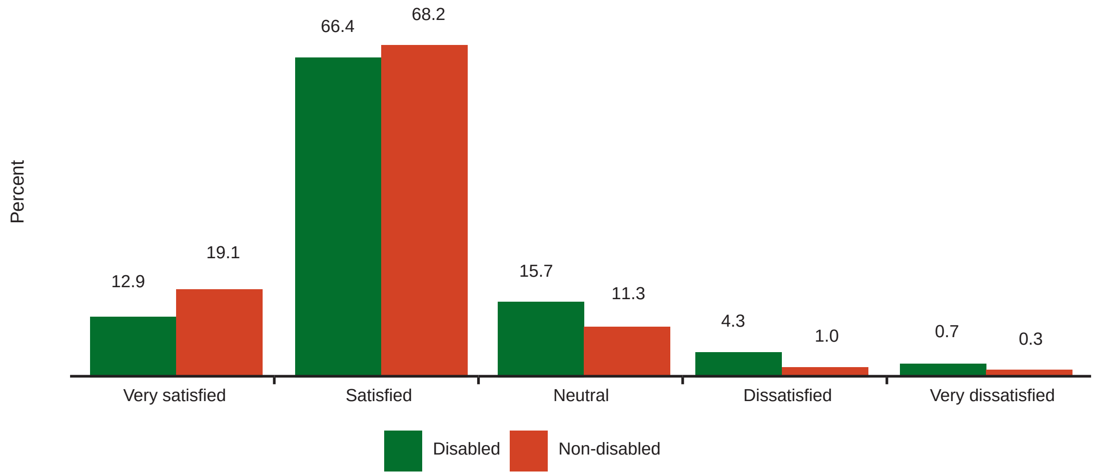
0RVW UHVSRQGHQWV ZHUH VDWLV¿HG ZLWK WKH HGXFDWLRQDO VHUYLFHV FKLOGUHQ ZLWK DQG ZLWKRXW GLVDELOLWLHV UHVSHFWLYHO\ DQG RYH of disabled and 22.5 percent of non-disabled children). More children with than without disabilities were neutral SHUFHQW YV SHUFHQW ZKLOH IHZ ZHUH Figure 7.109 reveals that G DQG HYH FKLOGUHQ ZLWKRXW GLVDELOLWLHV ZHUH VOLJKWO\ PRUH VDWLV¿HG WK VLJQL¿FDQW

Figure 7.109 Proportion of children, by satisfaction with educational services and disability status (12–17 years) (N=201)



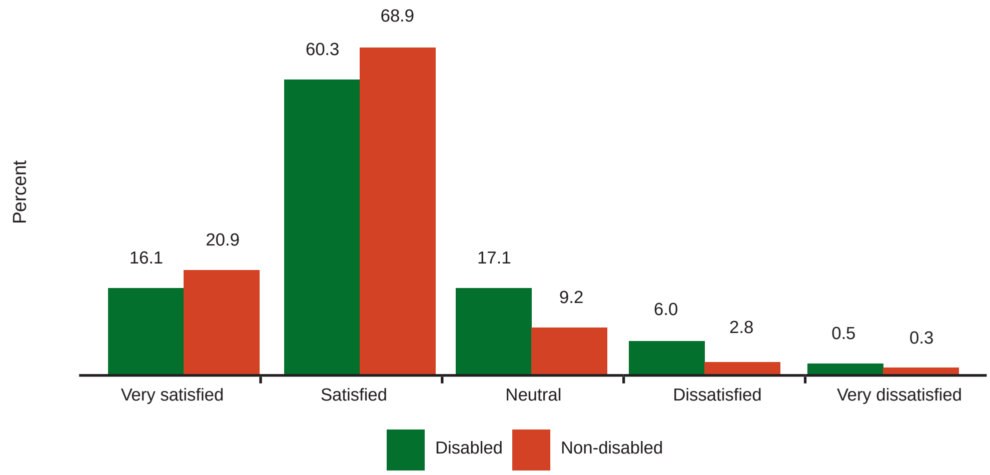
0RVW UHVSRQGHQWV ZHUH VDWLV¿HG ZLWK WKH KHDOWK LQIRUPDWLR
FKLOGUHQ ZLWK DQG ZLWKRXW GLVDELOLWLHV UHVSHFWLYHO\ DQG F
SHUFHQW YV SHUFHQW RI FKLOGUHQ ZLWK GLVDELOLWLHV)XUW
QHXWUDO SHUFHQW YV SHUFHQW ZKLOH IHZ ZHUH GLVVDWLV
SHUFHQW ZHUH Figure 7.110 VKRZV WKDW¿HGW FKLOGUHQ ZLWKRXW GLVDELOLWL
ZLWK GLV²DELOLWSLHV $

Figure 7.110 Proportion of children, by satisfaction with health information services and disability status (12–17 years) (N=618)



0RVW UHVSRQGHQWV ZHUH VDWLV¿HG ZLWK WKH KHDOWK VHUYLFHV WI
ZLWK DQG ZLWKRXW GLVDELOLWLHV UHVSHFWLYHO\ DQG PRUH FKLOG
vs. 20.9 percent). More children with disabilities than without disabilities were neutral (17.1 percent vs. 9.2 percent),
ZKLOH VRPH ZHUH GLVVDWLV¿HG SHUFHQW RI FKLOGUHQFigure ZLWK GLVD
7.111 VKRZV WKDW FKLOGUHQ ZLWKRXW GLVDELOLWLH²V ZHUHS PRUH VDWLV

Figure 7.111 Proportion of children, by satisfaction with health services and disability status (12–17 years) (N=706)



ACCESSIBILITY

Respondents were asked about the accessibility of a range of different types of rooms/facilities in and outside the home. Given the disparities that exist between urban and rural areas (as well as within urban areas), the different facilities may not have been applicable to all respondents.

There were generally marginal differences between children with and without disabilities in terms of accessing rooms in the home. Between 80 percent and 90 percent indicated that they had access to most of the rooms at home (Table 7.35).

Table 7.35 Proportion of children, by accessibility to facilities at home and disability status (12–17 years) (N=1,006)

	DISABLED			NON-DISABLED		
	Yes	No	N/A	Yes	No	N/A
Kitchen	87.8	2.2	10.0	89.1	0.8	10.1
Bedroom	96.0	1.4	2.5	95.7	0.8	3.4
Living room	90.3	0.5	9.2	88.8	0.5	10.7
Dining room	36.7	2.2	61.1	39.1	2.9	59.0
Toilet	90.9	2.4	6.7	91.6	0.6	7.8
Bathroom	83.1	2.4	14.4	88.5	0.8	10.7

Table 7.36 reveals the differences between children with and without disabilities when it comes to accessibility outside the home (in the community). Access to facilities such as banks, sports facilities and schools was more limited among children with disabilities than among those without.

Table 7.36 Percentage of children by accessibility to facilities outside home, by disability status (12–17 years) (N=448–953) [1]

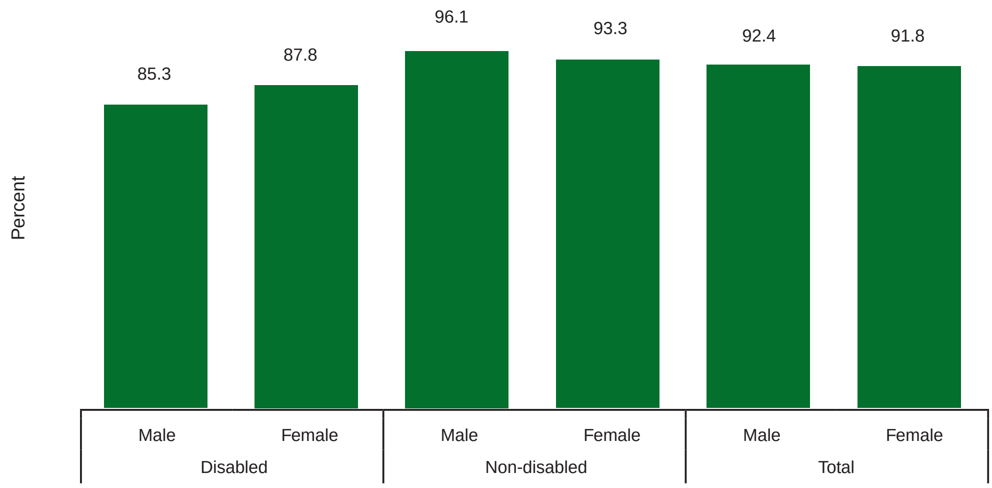
	CHILDREN WITH DISABILITIES			CHILDREN WITHOUT DISABILITIES			CHI-SQUARED	P
	Yes	No	N/A	Yes	No	N/A		
Place of work	20.4	1.6	78.0	24.1	0.7	75.2		n.s.
The school you attend	69.9	4.5	25.9	82.5	1.3	16.2	12.51	<.001
The shop you go to most often	81.6	8.7	9.7	94.4	1.3	4.3	37.27	<.001
Place of worship	88.3	4.5	7.1	94.1	1.4	4.4	9.32	<.01
Recreational facilities	37.9	16.2	46.0	47.5	11.6	40.9	7.17	<.01
Sports facilities	66.0	15.9	18.1	80.8	7.5	11.8	20.76	<.001
Police station	46.9	21.0	32.0	55.5	13.8	30.7	10.07	<.01
Magistrates' office/traditional courts	42.7	24.6	32.7	53.4	15.4	31.3	14.97	<.001
Post office	37.9	23.9	38.2	49.2	17.5	33.3	10.11	<.01
Bank	24.9	19.4	55.7	33.9	14.6	51.5	8.05	<.01
Hospital	64.7	22.3	12.9	71.2	13.5	15.4	11.35	<.01
Primary health care clinic	88.7	8.7	2.6	89.7	5.2	5.2	4.20	<.05
Public transport	80.9	14.2	4.9	86.4	8.2	5.5	8.56	<.01
Other government offices	23.3	20.7	56.0	27.8	16.9	55.2	5.76	<.01

[1] Chi-square test based on recoded into (1,2 = Yes, No).

EDUCATION

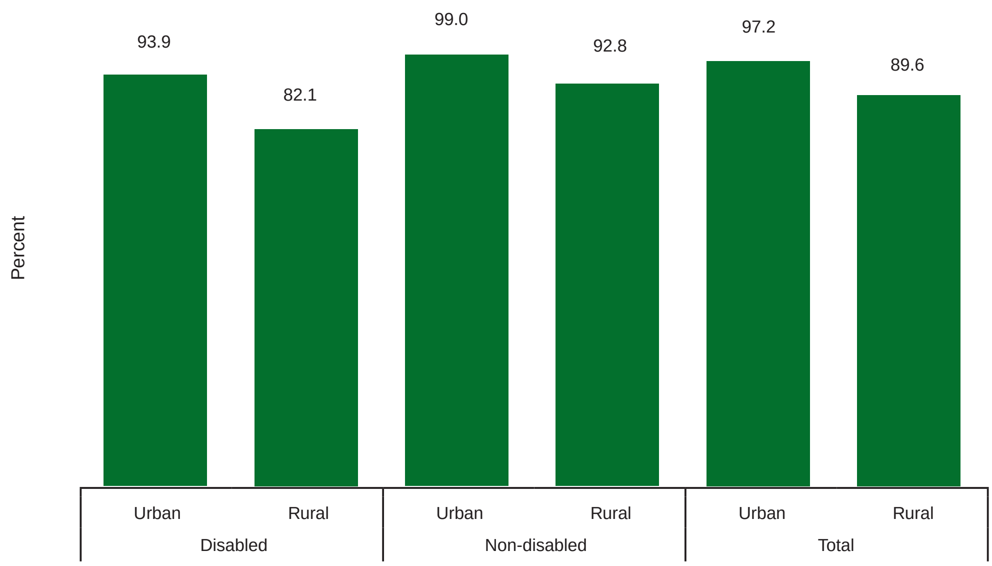
2YHUDOO SHUFHQW RI ER\V DQG SHUFHQW RIFigure 7.112)DJHG ±
However, fewer children with disabilities than without had been enrolled in primary education (86.8 percent vs. 95.0
SHUF²HQW $S $OWKRXJK UHODWLYHO\ VPDOO WKH GLIIHUHQFH EH
ZDV VLJQL¿FDQW² IRU ERWK PDOHV DQG F²=14.88, p=0.05) $

Figure 7.112 Percentage of children who have ever received primary education, by disability status and sex (12–17 years) (N=1,006)



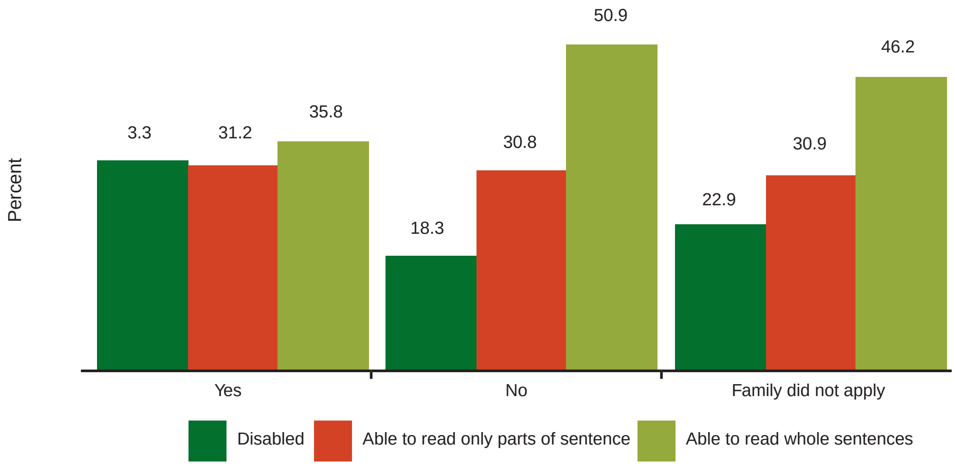
0RUH FKLOGUHQ DJHG ± \HDUV LQ XUEDQ DUHDV WKDQ LQ UXUDO DU
89.6 percent); and more children without disabilities than with had received primary education in both rural and urban locations.

Figure 7.113 Percentage of children who have ever received primary education, by disability status and urban/rural (12–17 years) (N=1,006)



Overall, 77.1 percent of children were literate (able to read whole sentences or part of a sentence). Literacy was higher
DPRQJ FKLOGUHQ ZLWKRXW GLVDELOLWLHV ² SHUFHQW WKDQ DPRQJ
one third (30.9 percent) of all children were able to read part of a sentence, whereas 50.9 percent of those without disabilities and 35.8 percent of those with were able to read the whole sentence (Figure 7.114).

Figure 7.114 Percentage of children who are able to read, by disability status (12–17 years) (N=1,006)



Figures 7.115, 7.116 and 7.117 show that few children had been refused entry to pre-school, primary school or VHFRQGDU\ VFKRRO $ERXW D ¿IWK SHUFHQW RI FKLOGUHQ ZLWK GLV enrolment in secondary school.

Figure 7.115 Percentage of children refused entry to pre-school, by disability status (12–17 years) (N=856)

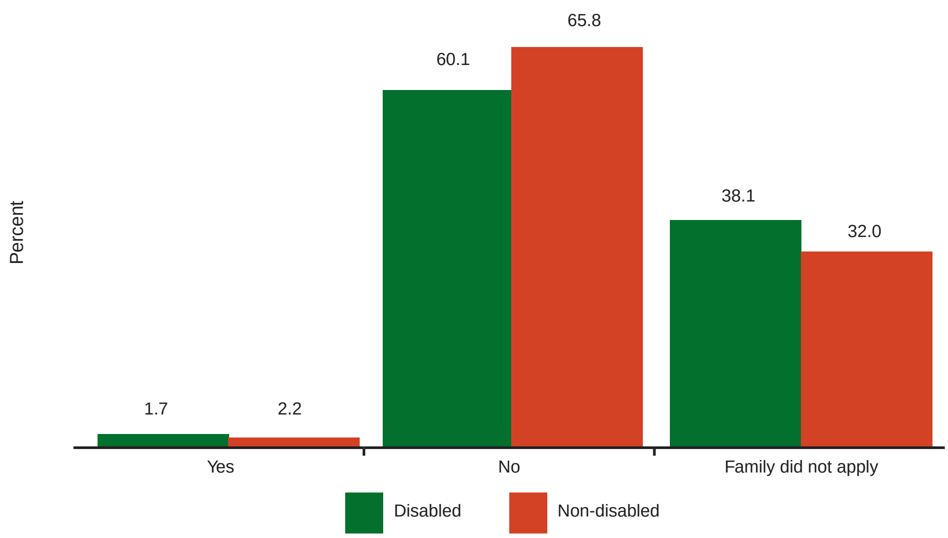


Figure 7.116 Percentage of children refused entry to primary school, by disability status (12–17 years) (N=968)

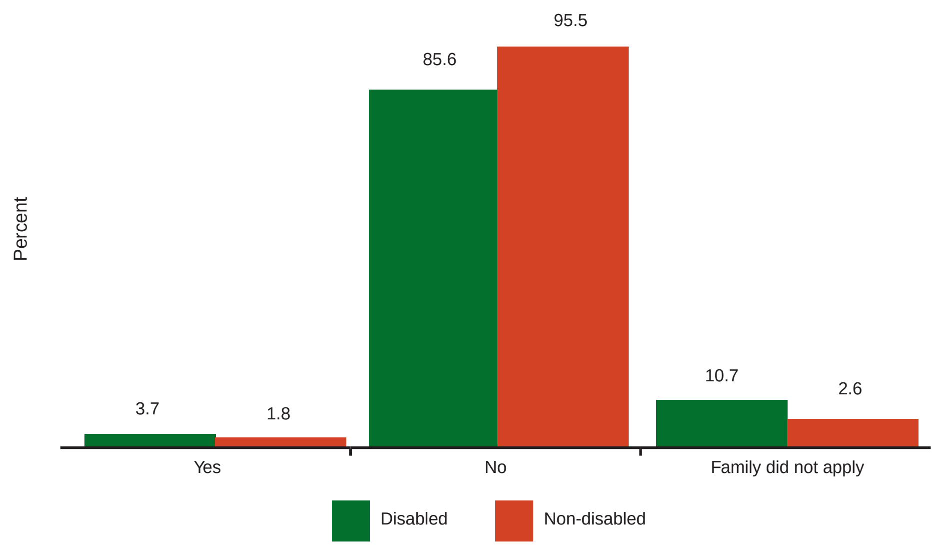
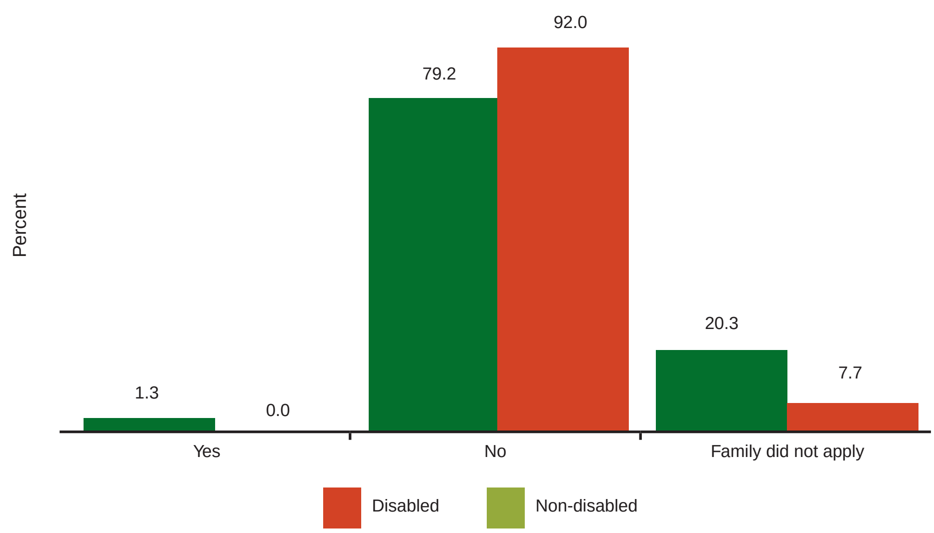


Figure 7.117 Percentage of children refused entry to secondary school, by disability status (12–17 years) (N=968)



Most respondents were still studying at the time of data collection (71.9 percent of disabled and 77.4 percent of non-disabled). In both categories (disabled and non-disabled), more girls had ceased to study and more boys were still studying. More children (boys and girls alike) with disabilities than without reported that they had not studied as far DV WKH\ KDG SODQQHG SHUFHQW YV SHUFHQW 7KH GLIIHUHQ RQO\ ZKHQ ER\V DQG JLUOV DUH FRPELQHG (Figure 7.118) $

)RU WKRVH GLVDEOHG FKLOGUHQ ZKR ZHUH VWLOO VWXGJLQJ UXUDO percent vs. 83.7 percent (Figure 7.119).

Figure 7.118 Percentage of children who have studied as far as planned, by disability status and sex (12–17 years) (N=994)

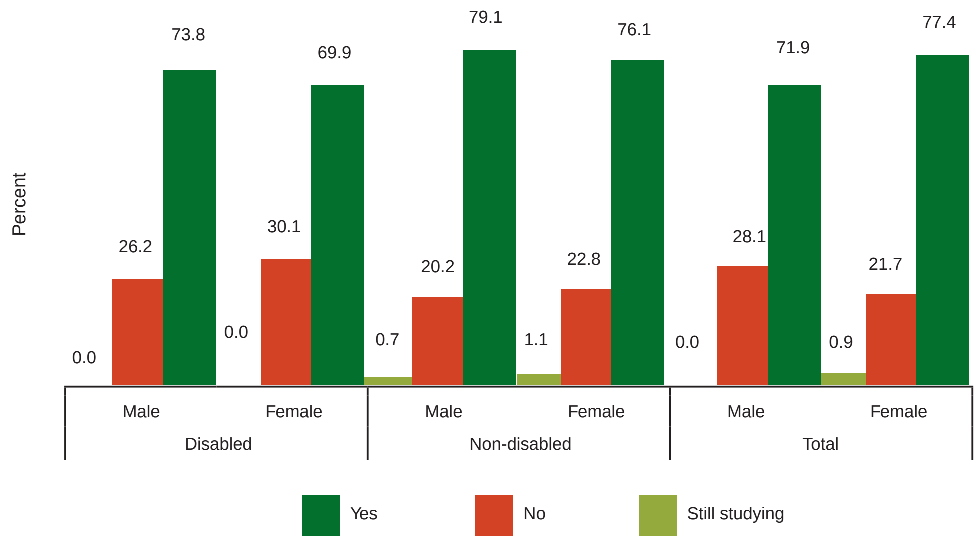
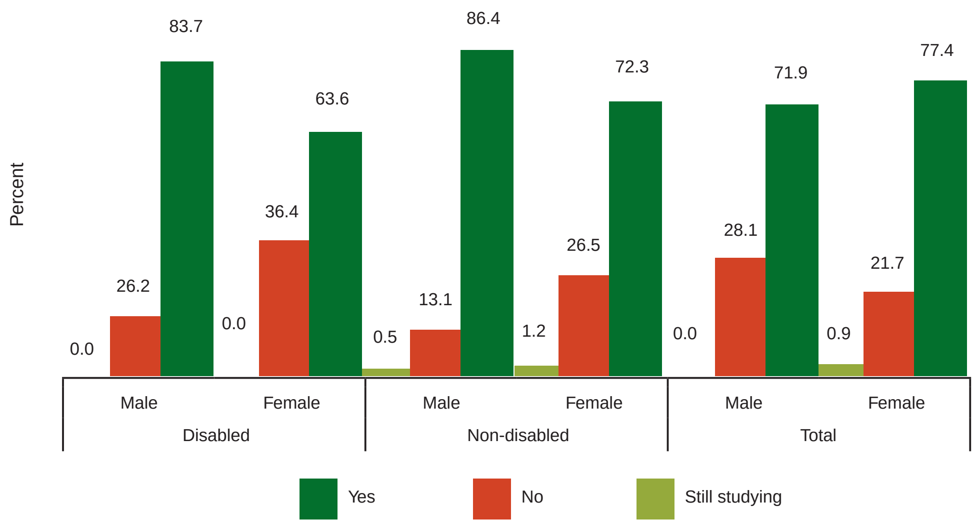


Figure 7.119 Percentage of children who have studied as far as planned, by disability status and rural/ urban (12–17 years) (N=994)



ECONOMIC ACTIVITY

&KLOGUHQ DJHG ± ZHUH DVNHG ZKDW WKH\ KDG PDLQO\ EHHQ GRLQJ WKDW WKH\ KDG EHHQ DW VFKRRO PRUH FKLOGUHQ ZLWKRXW GLVDELO SHUFHQW $ERXW D ¿IWK SHUFHQW RI FKLOGUHQ ZLWK GLVDELOLW not been available for work, compared to 7 percent of children without disabilities (Table 7.37).

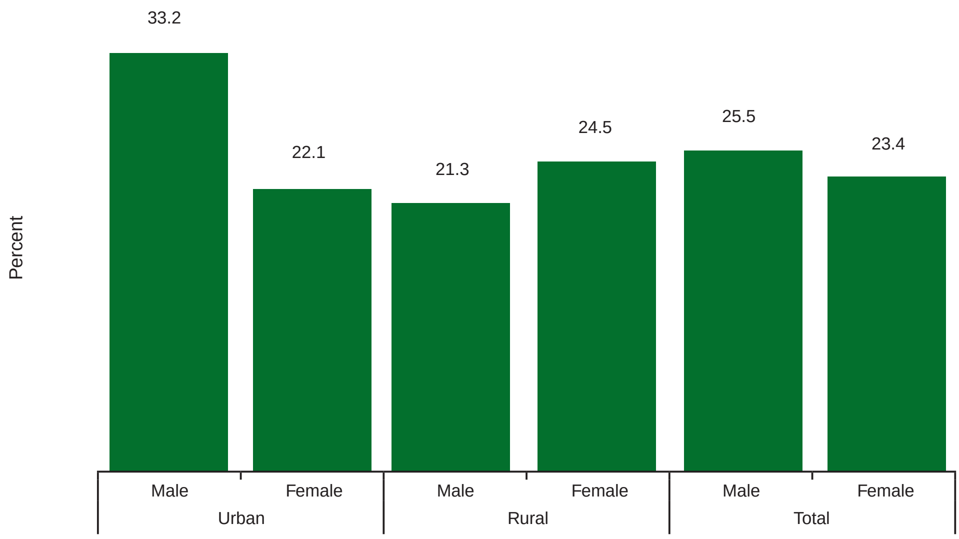
Table 7.37 Main activity during the seven days preceding the survey (15–17 years) (N=505)

ACTIVITY	PERSONS WITH DISABILITIES	PERSONS WITHOUT DISABILITIES
Paid employment/business	0.9	0.9
Volunteer work	0.5	0.2
Contributing family worker	13.1	8.5
Intern/apprentice	0.0	0.2
Own-use production worker	0.0	3.1
Not working but looking for work/business	0.0	3.5
Looking but not available for work	0.0	0.3
Available but not looking for work	0.9	1.3
Neither looking nor available but want to work	1.5	0.5
Housewife/housemaker	3.2	3.7
In school	59.4	70.6
Not working, not looking for work and not available	20.5	7.0

MEDICATION AND ASSISTIVE DEVICES

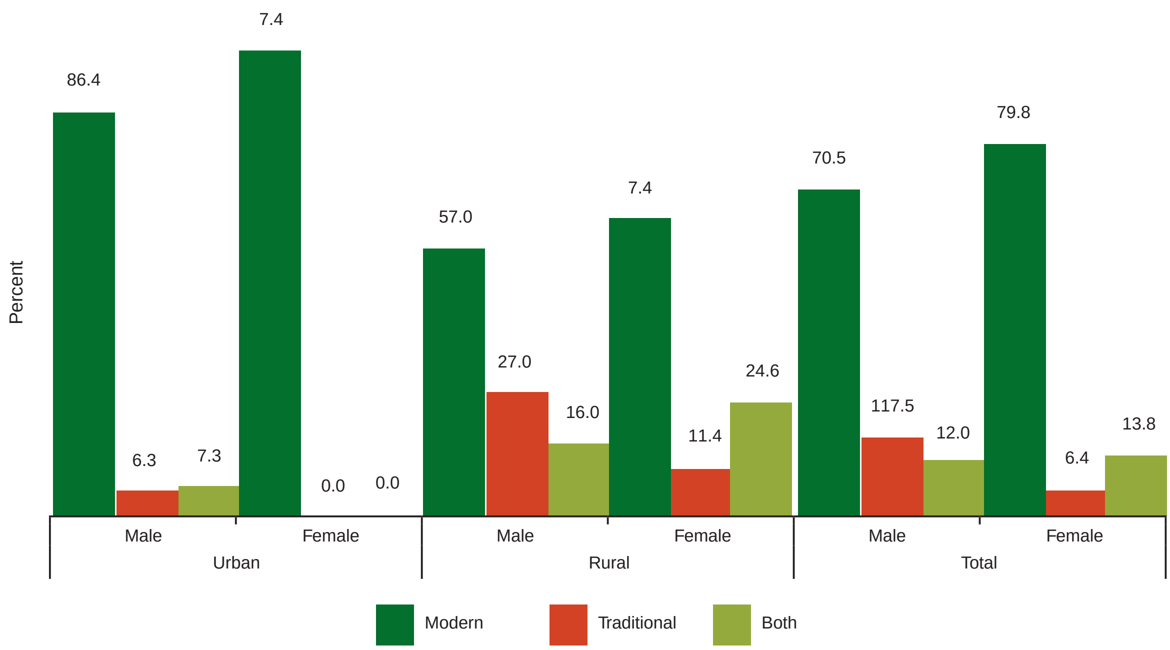
2YHUDOO SHUFHQW RI ER\V DQG SHUFHQW RI JLUOV ZLWK GLV medicine for their disability. None of the urban/rural or male/female differences shown in Figure 7.120 were VWDWLVWLFDOO\ VLJQL¿FDQW 1HYHUWKHOHVV PRUH XUEDQ WKDQ U PHGLFDWLRQ RU WUDGLWLRQDO PHGLFLQH XUEDQ PDOHV DQG IHPDOHV 21.3 percent and 24.5 percent). In urban areas, the proportion of boys (33.2 percent) using medication was higher than that of girls (22.1 percent), whereas the opposite was true among rural respondents (24.5 percent girls vs. 21.3 percent ER\V QRW VLJQL¿FDQW (Figure 7.125).

Figure 7.120 Percentage of children who use medication or traditional medicine, by sex and rural/urban (12–17 years) (N=309)



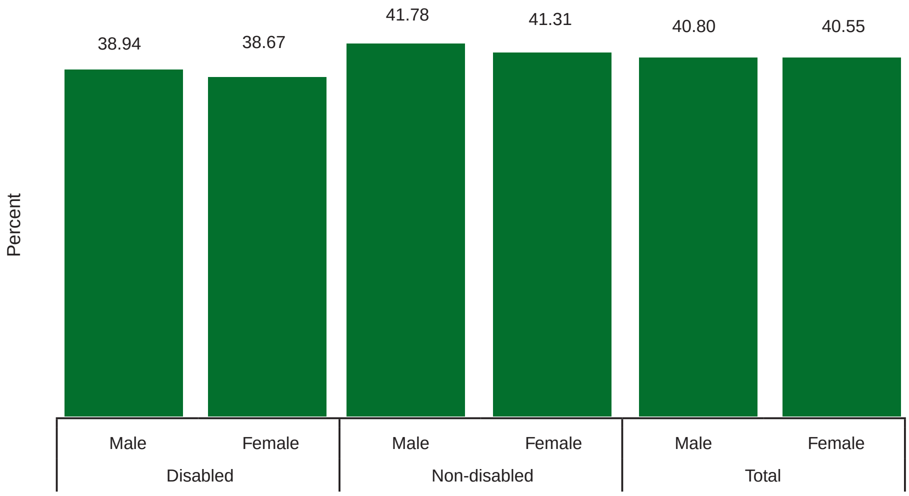
Among those boys who reported using some type of medicine, 70.5 percent used modern medicine, 17.5 percent XVHG WUDGLWLRQDO DQG SHUFHQW XVHG ERWK 7KH FRUUHVSRQGLQJ percent. In urban areas, very few used anything other than modern types of medicine. In rural areas, more girls than boys used only modern medicine (64.0 percent vs. 57.0 percent). More rural boys than girls used traditional medicine only, while more girls used both (Figure 7.121 7KH XUEDQ UXUDO GLIIHUHQFH LV VLJQL¿FDQW EXW QRW DPRQJ ER\V 'LIIHUHQFHV EHWZHHQ ER\V DQG JLUOV DUH QRW V

Figure 7.121 Type of medicine used by children with disabilities who used medicine, by sex and rural/urban (12–17 years) (N=76)



Overall, 5.3 percent of boys and 6.4 percent of girls used assistive devices. Among both boys and girls, more children
LQ XUEDQ WKDQ LQ UXUDO VHWWLQJV XVHG DVVLVWLYH (N=105)LFHV 7KH
S EXW QRW DPRQJ ER\V 'LIIHUHQFHV EHWZHH(Figure 7.122)DQG JLUOV DU

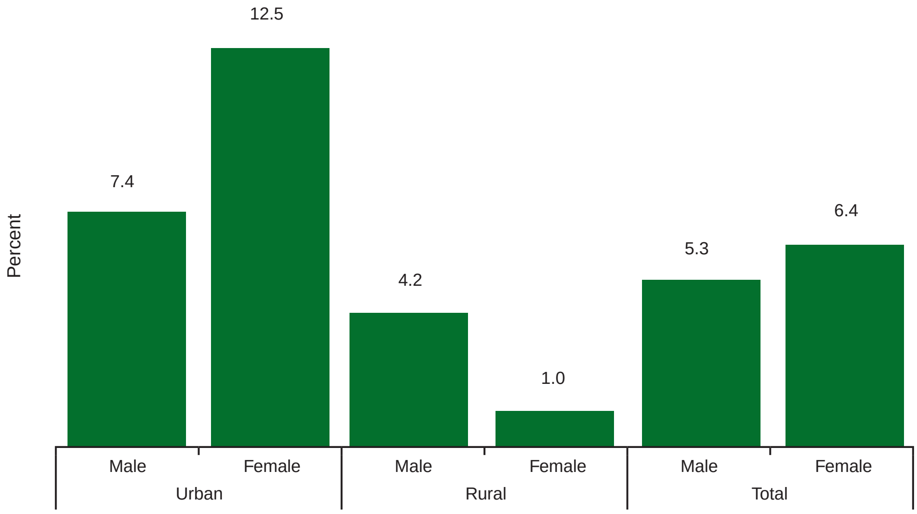
Figure 7.122 Percentage of children who used an assistive device, by rural/urban and sex (12–17 years) (N=309)



HEALTH

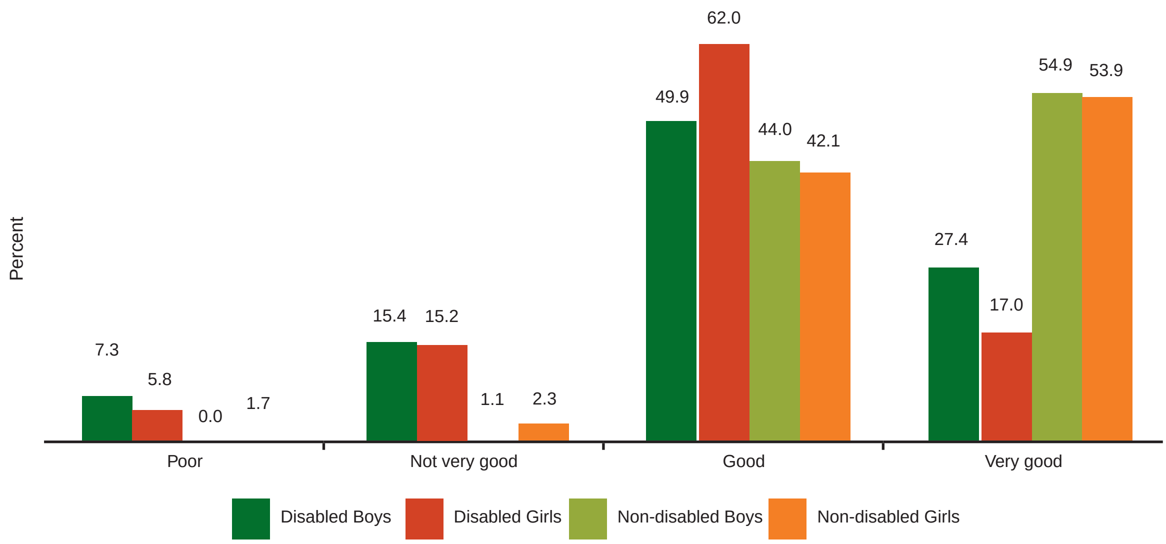
Wellbeing was measured using the General Health Questionnaire (GHQ), developed to tap into levels of anxiety and
GHSUHVVLRQ 7KH *+4 XVHV D LWHP VFUHHQLQJ ZHOOEHLQJ VFDOH Z
scale indicating greater wellbeing. Figure 7.123 reveals that children with disabilities score lower on the wellbeing
VFDOH WKDQ FKLOGUHQ ZLWKRXW GLVDELOLWLHV) S

Figure 7.123 Percentage of children, by wellbeing and disability status and sex (12–17 years) (N=1,006)



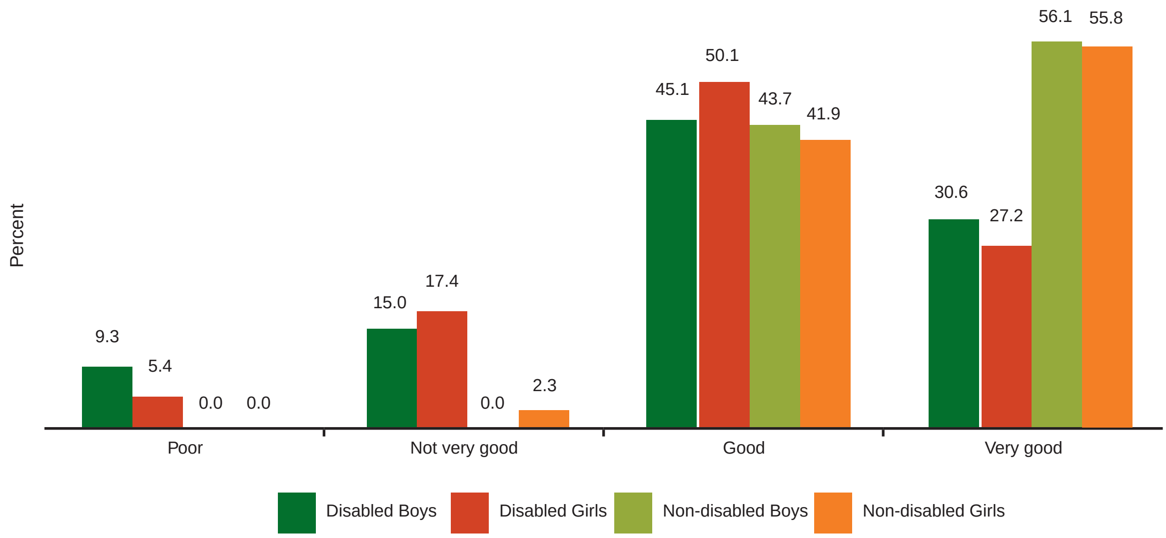
Physical health was measured by means of a simple question asking the respondents to assess their physical health on a four-category scale. Figure 7.124 shows that more children with than without disabilities assessed their physical health as poor or not very good, and that more children without disabilities than with assessed their physical health as
YHU\ JRRG $ S 7KH GLIIHUHQFHV EHWZHHQ ER\V DQG JLUOV ZHUH
but more girls with disabilities than boys reported that their physical health was good and more boys with disabilities than girls indicated that their physical health was very good.

Figure 7.124 Percentage of children, by physical health, disability status and sex (12–17 years) (N=1,006)



&KLOGUHQ ZLWK GLVDELOLWLHV UHSRUWHG ŜRRUHUSPHQWDO KHDOWK WKDQ
ER\V DQG JLUOV. 1R VLJQL¿FDQW GLIIHUHQFHV ZHUH IRXQG Figure EHWZHHQ EF
7.125).

Figure 7.125 Percentage of children, by mental health, disability status and sex (12–17 years) (N=1,005)



HEALTH INFORMATION

Generally speaking, more children without disabilities than with had knowledge of HIV/AIDS, STIs, diabetes and TB (Table 7.38). Most of the children had knowledge of HIV/AIDS, followed by TB, STIs and lastly diabetes. The ¿QGLQJV DOVR LQGLFDWH WKDW LUUHVSHFWLYH RI ZKHWKHU WKH\ ZHU the diseases. In addition, more children in urban areas than in rural areas had some knowledge of the four diseases (Table 7.39).

Table 7.38 Percentage of children by knowledge of four common diseases, disability status and sex (12–17 years) (N=1,006)

DO YOU HAVE ANY KNOWLEDGE OF	CHILDREN WITH DISABILITIES			NON-DISABLED		
	Total	Boys	Girls	Total	Boys	Girls
HIV/AIDS	77.4	76.2	78.6	89.6	86.5	92.0
STI	47.2	42.6	52.1	61.5	58.3	64.1
Diabetes	28.2	25.1	31.5	30.1	27.9	31.9
TB	57.2	55.3	59.1	68.7	63.8	72.6

Table 7.39 Percentage of children by knowledge of four common diseases, disability status and rural/urban (12–17 years) (N=1,006)

DO YOU HAVE ANY KNOWLEDGE OF	CHILDREN WITH DISABILITIES			NON-DISABLED		
	Total	Urban	Rural	Total	Urban	Rural
HIV/AIDS	77.4	86.2	71.3	89.6	91.6	88.4
STI	47.2	52.9	43.4	61.5	59.8	62.5
Diabetes	28.2	40.6	19.7	30.1	32.8	28.5
TB	57.2	64.4	52.2	68.7	63.8	71.5

School was reported as the main source of information on HIV/AIDS, STIs, diabetes and TB, as Table 7.40 shows. More children with disabilities than without got their information about the four diseases at school. The other notable sources of information were health facilities, the family and friends.

Table 7.40 Percentage of children by source of information for four common diseases and disability status (12–17 years) (N=1,006)

SOURCE	HIV/AIDS		STI		DIABETES		TB	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Health facility	13.5	14.3	12.2	16.7	12.8	17.7	13.4	19.5
Doctor	0.5	0.1	0.0	0.0	1.2	0.5	0.0	0.0
At work	0.0	0.4	0.0	0.5	0.0	0.7	0.0	0.3
Newspaper/ magazine	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.2
Friends	4.4	7.1	10.5	8.4	12.3	10.5	4.6	7.8
Family	8.0	4.7	8.0	7.3	10.4	15.7	17.1	9.5
Radio/TV	2.8	3.9	2.3	3.0	6.0	5.7	2.6	4.6
Poster/ pamphlet	0.3	0.5	0.0	0.0	0.0	0.6	0.0	0.1
School	70.6	68.7	66.9	63.6	57.3	48.7	62.4	57.9
Other	0.0	0.3	0.0	0.2	0.0	0.0	0.0	0.0

Children were asked whether they had any problem obtaining and/or understanding information about HIV/AIDS, STIs, diabetes and TB (Table 7.41). Children with disabilities reported more problems in understanding information DERXW DOO IRXU GLVHDVHV WKDQ GLG FKLOGUHQ ZLWKRXW GLVDELOLWL problem understanding or obtaining information about HIV/AIDS, and 17 percent had a problem with information about sexually transmitted infections.

Table 7.41 Proportion of children with a problem in obtaining or understanding information about the four common diseases (12–17 years) (%)

PROBLEM OBTAINING/ UNDERSTANDING	HIV/AIDS (N=824)		STI (N=286)		DIABETES (N=642)		TB (N=642)	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Yes	19.0	7.9	17.0	9.3	13.0	7.9	13.1	8.7

Table 7.42 indicates that no children reported having had a sexually transmitted infection, and very few had experienced 7% $URXQG RQH FKLOG LQ ¿YH KDG EHHQ WHVWHG IRU +,9

Table 7.42 Disease experience, by disability status (%) (12–17 years) (N=843, 296, 297)

	HIV/AIDS[1]		STI		TB	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Yes	19.2	20.3	0.0	0.0	1.3	1.0
No	80.8	79.7	100.0	100.0	98.7	99.0

[1] The question was if the respondent had been tested.

8. DISCUSSION

The study estimates the prevalence of disability among persons aged 18 over in Zambia at 10.9 percent. This falls below the WHO estimate of 15 percent, but is still higher than previous estimates for Zambia and for many other low-income countries; it is in line, for instance, with a recent similar study in Zimbabwe (unpublished). The prevalence DPRQJ FKLOGUHQ ± \HDUV ZDV DW SHUFHQW 7KLV VWXG\ LV DF GHYHORSHG E\ 81,&() :* 7KLV PRGXOH ZDV VSHFL¿FDOO\ GHYHORSHG LGHQWL¿HG WKH ZHDNQHVV RI WKH :* VFDOH LQ FDSWXULQJ GLVDELOLW LQ WKH SRSXODWLRQ DJHG \HDUV LV SHUFHQW

It should be noted that when using the Washington Group questionnaire, the threshold for qualifying as being disabled was set as low as possible, in order to capture even those people with mild disability. The study required extensive training, and experienced personnel were used for data collection; but there remains the possibility that unfamiliarity ZLWK WKH FXUUHQW FRQFHSWXDOL]DWLRQ RI GLVDELOLW\ KDV LQÀXHQF as disabled have either mild or moderate disability suggests that this is not the case. The study also used a screening SURFHGXUH ZKLFK ± DW OHDVW LQ WKHRU\ ± VKRXOG SURYH PRUH WKRU

The study established a basis for describing and analysing the situation pertaining to persons with disabilities and households with disabled members across a range of indicators, and for drawing comparisons with persons without disabilities and households without disabled members. The study thus provides a unique tool for the authorities to address disparities at both the household and the individual level, for monitoring development and for assessing the impact of policies and interventions.

This study adds to a growing body of information on living conditions among persons with disabilities and their IDPLOLHV LQ GHYHORSLQJ FRXQWULHV 7KH 81 &RQYHQWLRQ RQ WKH 5 for data on the situation of persons with disabilities, particularly in low-income countries (UNCPRD, 2006). With WKH DGRSWLRQ RI WKH ,QWHUQDWLRQDO &ODVVL¿FDWLRQ RI)XQFWLRQ RI GLVDELOLW\ PHDVXUHV IRU FHQVXVHV DQG VXUYH\V FDPH WR EH GH Disability Statistics[8]. 7KH PRVW UHFHQW LV WKH 81,&()[9] 0RGXOH RQ &KLOG)XQFWLRQLQJ of a medical and a social model, disability has at least partly moved into the realms of daily and social life, and has acquired the complexities of a relational view of disability. In collecting the data on disability, this study has used the PRVW UHFHQW PHDVXUHV ZKLFK KDYH EHHQ LQWHUQDWLRQDOO\ DFNQR are of interest and should be taken into consideration, it is comparison between groups and patterns in the comparative analyses that are of primary interest.

HOUSEHOLD SECTION

The household-level data show that there are only small differences in all four socio-economic indicators between households with persons with and without disabilities. The overall impression is thus that there is hardly any difference. This may run counter to expectations that households with disabled members are poorer because of the extra burden placed on them by having to care for one or more disabled individuals. The results from other countries in the region have generally shown that, as expected, there are differences; although these differences are fairly consistent, by and large they are relatively small. One interpretation could be that the populations are largely poor and there are only small variations in the level of poverty. The main socio-economic difference in this population is between urban and UXUDO ORFDWLRQV ZKLFK LV DOVR UHÀHFWHG LQ GLIIHUHQFHV EHWZH economic status. However, it is important to note that the household comparison does not control for any additional

8 http://www.cdc.gov/nchs/washington_group/
9 https://www.cdc.gov/nchs/washington_group/wg_questions.htm

H[SHQVHV WKDW DFFUXH EHFDXVH RI GLVDELOLW\ ± IRU LQVWDQFH KLJ
assistive devices, transport needs due to reduced mobility or any additional support that has to be paid for.

Similar studies have shown that households with disabled members tend to be larger than households without disabled members (i.e. they have a higher mean number of members). In this study, the difference is very small and LV QRW VXI¿FLHQW WR XVH DV DQ DUJXPHQW IRU D KLJKHU EXUGHQ RU the number of members. It may, however, be argued that the differences in the two dependency ratios indicate that there are qualitative differences in the care burden, in that households which have persons with disabilities have more dependants aged 65 and older, and households without persons with disabilities have more children as dependents.

INDIVIDUAL SECTION (18 YEARS AND OLDER)

In contrast to the household-level data, individual-level comparison revealed a number of differences to the detriment RI SHUVRQV ZLWK GLVDELOLWLHV ± SDUWLFXODUO\ IRU ZRPHQ ZLWK GLV

Persons with disabilities have a higher mean age, more often have a spouse with a disability, more often report having D KLJKHU QXPEHU RI FKLOGUHQ DQG DUH OHVV RIWHQ PDUULHG :KLOH expected age gradient associated with disability, it is nevertheless important that greater age to some extent also implies greater vulnerability to health problems; in a country with a very limited welfare support system, this also means a higher level of dependence on other family members. The results that persons with disabilities are less likely to be married and are likely to have more children further adds to the argument about increased vulnerability, since being unmarried indicates less support from a spouse, while having more children means that they have more GHSHQGDQWV WR FDUH IRU 9XOQHUDELOLW\ PD\ EH UHÀHFWHG LQ WKH WKDQ QRQ GLVDEOHG ZRPHQ WR UHSRUW WKDW WKH FKLOGUHQ ORRN D RWKHU UHVRXUFHV 7KH ¿QGLQJ RI LQFUHDVHG YXOQHUDELOLW\ SDUWLF ¿QGLQJV IURP WKH VWXG\ RI ZRPHQ ZLWK GLVDELOLWLHV LQ 0DODZL E\ reveal the additional vulnerability of women in rural areas, they also indicate differences between men and women that may be of importance for health and rehabilitation services.

Disease is reportedly the most common cause of disability, followed by falls/accidents and congenital disability. This is consistent with previous studies in the region. Taken together, disease and congenital disability suggest that a substantial proportion of disability in the population may be preventable, and that the impact of these two causes UHÀHFWV D QHHG IRU LPSURYHPHQWV LQ WKH KHDOWK VHUYLFHV IRU PR\ have data that can pinpoint whether this situation is due to issues of access or of quality, based on relevant literature it is fair to assume that it is a combination.

The level of abuse and discrimination that emerges from this study is somewhat lower than in other comparable studies. The results nevertheless reveal that around 1 disabled person in 10 has experienced abuse or discrimination. While such incidents take place both within and outside the family, the results indicate that within-family abuse is more common. Although the study does not explain why this happens, there is clearly a need to raise awareness among parents (and the extended family) about children with disabilities, as well as to sensitize health and welfare workers who engage with families with children with disabilities. It is, of course, particularly serious that abuse and discrimination increase with the severity of disability, since the most severely disabled are those who are most vulnerable and who have fewer possibilities of avoiding negative treatment. Comparison of persons with and without disabilities did not reveal any clear and systematic differences, although there is a tendency for persons with disabilities to be more prone to physical DEXVH)HPDOHV DUH PRUH H[SRVHG WR VH[XDO DEXVH EXW LW LV RQO\ fact females without disabilities are more exposed to such abuse than are females with disabilities.

7KH VHFWLRQ RQ VHUYLFHV LGHQWL¿HG JDSV ± PHDVXUHG DV WKH UH
WKRVH UHFHLYHG ± DFURVV WKH ZKROH UDQJH RI VHUYLFHV ,W LV D
in other parts of the region, the gaps in health services and health information are small. The largest gaps are to be found for services that are less available, for instance welfare services, which are very limited. Very big gaps were also found for some other services, for instance assistive devices. Clearly, any gaps in basic services are particularly problematic for persons with disabilities and reduce the opportunities for their optimal participation in society. The
SRVLWLYH DVVHVVPHQW E\ UHVSRQGHQWV RI VHUYLFHV H J KHDOWK
perception that any service is better than no service at all; this result should thus not necessarily be taken as an indication of a high quality of services.

:KLOH WKH JDS LQ DVVLVWLYH GHYLFH VHUYLFHV LV VXEVWDQWLDO W
they use an assistive device is somewhat above the average across a series of similar studies in the region. The urban
ELDV LQ VHUYLFHV LV YHU\ FOHDU DQG WKH SDUWLFXODUO\ YXOQHUD
further indicate a narrow range of devices, as well as limited services particularly in rural areas. The study reveals many of the same weaknesses in assistive device service delivery that are to be found in neighbouring countries, with limited supply and lack of services.

,Q D FRQWH[W ZLWK OLPLWHG EDVLF VHUYLFHV SHUVRQV ZLWK GLVDEL
family members, but less help with personal care. It is interesting that emotional support emerges as the most common form of support from the family. This is in accordance with other studies. In some respects, it thus seems that the family provides persons with disabilities with necessary support. However, the study has also shown that persons with disabilities are less involved/included in family and social life than are those without disabilities. This result indicates that the social inclusion of persons with disabilities is relevant not only in a societal, but also in a family/household perspective.

9RWLQJ PD\ EH VHHQ DV D UDWKHU VLPSOH LQGLFDWRU RI SDUWLFLSD
fewer females voted and that there was a slight drop in voting as the severity of disability increased; however, the
GLIIHUHQFHV EHWZHHQ JURXSV GLG QRW DSSHDU WR EH V\VWHPDWLF)
as a surprising and positive result. Awareness of DPOs is lower in rural areas and among women, although in rural areas actual membership is higher among women. The positive association between membership and increased
VHYHULW\ RI GLVDELOLW\ LV DVVXPHG WR UHÀHFW WKH IDFW WKDW GL
ODUJHO\ YLVLEOH LPSDLUPHQWV 7KH PRVW FULWLFDO ¿QGLQJ LV WKH
challenge to the disability movement, which in principle should represent all persons with disabilities in the country.

Accessibility inside the home seems to be a problem for around 1 person with disabilities in 10, though there is
VRPH YDULDWLRQ :KLOH WKLV LV D SUREOHP IRU TXLWH D QXPEHU R
IRU DFFHVVLELOLW\ DQG WKH KLJK ¿JXUH IRU DYDLODELOLW\ UHÀHFW
people in Zambia. It should normally be possible to address accessibility problems at home by means of simple adaptations, and this is an area requiring intervention by the health and welfare system or others who could quickly and cheaply minimize accessibility problems. Outside the home, in the local community, there seems to be a more serious accessibility problem; this needs thorough mapping, the sensitization of the private and public sectors and for regulations to be put in place and enforced.

The focus of disability measurement has shifted from the body and how it functions to social/environmental factors, but disability is still associated with physical health. The results of this study clearly show that persons with disabilities have more health problems than persons without disabilities. While this is not surprising (since many health conditions are also disabling), it is important to emphasize that persons with disabilities need more attention from health professionals.

It is well known that mental health problems receive minimal attention in many low-income contexts, and that this is
UHODWHG WR SRYHUW\ 3DWHO DQG .OHLQPDQ DQG WR GLVDELOL

that mental health problems are more common among persons with disabilities and that there is an additional disability severity gradient. While overstretched health and welfare services may have limited possibilities to address mental KHDOWK SUREOHPV LW LV YHU\ LPSRUWDQW WKDW PHQWDO KHDOWK SU should show up on the radar of health personnel, and that they should be given the necessary support to prevent, identify and treat common mental disorders. This may be a key issue in the efforts of health and welfare services to work for the inclusion of persons with disabilities in society.

Education is another key indicator. Although the great majority of the population have accessed formal education, persons with disabilities, rural respondents and females report lower levels of access and shorter duration of education. The same pattern is revealed for literacy. It seems, however, that among those who enter formal education, there are only small differences in terms of education leading to employment. A greater number of illiterate respondents may LQGLFDWH SUREOHPV ZLWK WKH TXDOLW\ RI VFKRROLQJ ± SDUWLFXODUO\ that they had been refused entry to school, it does seem that the major obstacle for those who have not accessed formal education lies within the family. Thus there is a need for increased awareness among the families of children with GLVDELOLWLHV WKDW IRUPDO HGXFDWLRQ LV D ULJKW DQG WKDW DOO FK

As is to be expected, the results show that persons with disabilities are less engaged in formal employment than are those without disabilities, and that persons with disabilities tend not to be engaged in economic activity. People residing in urban areas are more likely to be engaged in formal employment than are their rural counterparts, and men are more likely than women to be formally employed.

,Q FRQFOXVLRQ WKH VWXG\ KDV FRQ¿UPHG WKDW DPRQJ DGXOWV \HD than persons without disabilities, in the sense that they face challenges that are not properly addressed and are less included in society. Bearing in mind the low threshold for qualifying as disabled in this study, the relatively modest differences on several of the indicators are also as expected. Analysis shows bigger differences between persons with DQG ZLWKRXW GLVDELOLWLHV ZKHQ WKH WKUHVKROG IRU EHLQJ LQFOXGH of disability that is currently promoted (WHO, 2011), the differences between groups (disabled and non-disabled) are consequently smaller.

CHILD SECTION (2–17 YEARS)

There are variations in disability prevalence by province, with more than 7 percent of children in Luapula Province disabled, but less than 3 percent in Western Province. While the two major urban locations (Lusaka and Copperbelt) have a relatively high prevalence of child disability, the need for further research and intervention seems to be particularly acute in Luapula.

7KLV VWXG\ SURYLGHV D SUR¿OH RI FKLOG GLVDELOLW\ LQ =DPELD VXS functional problems among the country's children. The results illustrate very clearly the need to identify a range of IXQFWLRQDO SUREOHPV VXFK DV OHDUQLQJ GLI¿FXOWLHV FRJQLWLRQ relevant for evaluating and revising the current methods for identifying children with disabilities in Zambia.

7KH VH[VSHFL¿F GLIIHUHQFHV DUH LPSRUWDQW DOWKRXJK PDQ\ RI WKRV with care in order to avoid over-interpretation. However, these differences are relatively consistent, with boys having more functional problems in terms of mobility, movement, cognition and behaviour, and girls having more problems RQ LQGLFDWRUV RI PHQWDO KHDOWK DQG SOD\LQJ :KLOH WKH &KLOG 0RG a range of functions not included in the WG6, the module is limited as a clinical tool and should be supplemented with expertise in child development.

The causes of disability among children differ in several respects from the causes among adults. Substantially more children are reported to have been born with their disability. Disability is acquired at all ages, and the proportion who became disabled early in life will logically decline over the years as the proportion of other causes increases. Child disability is much closer in time (on average) and parents (the main respondents for the youngest) will know better when and how the functional problem started. Disability acquired during pregnancy, at birth or shortly thereafter thus seems to be high in this population; this requires more intervention in the health care system for mothers and children.

:KLOH RWKHU GLIIHUHQFHV DUH VPDOO VRPH VH[VSHFL¿F GLIIHUHQFH might be expected, boys are more likely to suffer accidents (including burns and falls), but the much higher incidence of disease/illness as a cause among girls is harder to explain.

There are substantially bigger gaps in services for children than for adults. In a disability perspective, it is particularly serious that very few receive counselling or assistive devices. Vocational training is a more general problem, given that the gap was also very high among non-disabled children. Almost half of all children with disabilities who needed educational services did not receive them. In those services that enjoyed relatively small gaps (i.e. health information and health services), clearly bigger gaps were found among children with disabilities. These results indicate that health and welfare services need to be improved substantially to cater adequately for children with disabilities. Awareness of disability and health among parents/family must also be increased.

Accessibility in the home was generally not a problem, and there were only small differences between children with DQG ZLWKRXW GLVDELOLWLHV $FFHVVLELOLW\ ZDV PRUH RI D SUREOH listed, more children with disabilities reported that they were inaccessible. This gap in accessibility between children with and without disabilities varies from 1 to 15 percentage points, with the smallest gap being found for primary health clinics and the biggest for sports facilities. The general accessibility (and availability) problems revealed in the study and the higher accessibility problems among children with disabilities imply that many children, but in particular children with disabilities, are prevented from accessing services. This is important for their participation and inclusion in society.

School was either not accessible or not available to 3 out of 10 children with disabilities. A large proportion (86.8 percent) of children with disabilities had accessed formal education at some time, which implies that many had access to formal (primary) education in spite of the accessibility problems. However, fewer children with than without disabilities were literate, had accessed formal education, had studied as far as they had planned and were still studying. Since education is key to inclusion, prosperity and participation in society, it is crucial that there should be equity in access to education.

The health differences found between persons with and without disabilities in the adult population were also found among children. Disability is associated with lower wellbeing and poorer physical and mental health. This implies that children with disabilities (and their families) require more attention from health and welfare services than children without disabilities. The marginal difference in access to primary health services and the lower access for children with disabilities to specialized services (hospital) mean that children with disabilities get less treatment and attention than they need.

CONCLUSION

The National Disability Survey undertaken in Zambia in 2015 provides a unique set of data on which to assess the situation facing persons with disabilities and their households. The study was very broad, covering many different areas. More in-depth or topically narrower studies may be necessary to generate further knowledge in particular areas of priority.

The fact that there are relatively small differences in the household-level indicators of living conditions but pronounced differences at the individual level (to the detriment of persons with disabilities) indicates that efforts to achieve an
LQFOXVLYH VRFLHW\ PD\ QHHG WR SXUVXH WKUHH GLIIHUHQW SDWKV)L
potential of persons with disabilities needs to be raised both within the general population and among various service providers. Second, the capacity to support people with disability within the household and the local community and
WR SURYLGH EDVLF VHUYLFHV LQ WKH FRPPXQLW\ QHHGV WR EH VWUHQJ
made to support the inclusion of people with disabilities in areas where this is particularly important. In all efforts to improve the situation of persons with disabilities, it is vital to bear in mind that females with disabilities face more
EDUULHUV WKDQ PDOHV DQG WKDW FKLOG GLVDELOLW\ QHHGV WR EH V
%HDULQJ LQ PLQG WKH VWXG\¶V ¿QGLQJV WKDW D VXEVWDQWLDO SURSR
result from disease very early in life, the prevention of disability also needs to be prioritized.

7KH UHVXOWV RI WKLV VWXG\ VKRXOG EH WKRURXJKO\ GLVFXVVHG E\ DO
action. Persons with disabilities have greater needs than persons without disabilities and will need additional support if they are to get the most out of life and contribute to society like everyone else.

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APPENDICES

APPENDIX 1: ACTIVITY LIMITATIONS AMONG PERSONS AGED 18 YEARS AND ABOVE

		MALE		FEMALE		RURAL		URBAN		TOTAL	
		Number	%	Number	%	Number	%	Number	%	Number	%
SEEING	No	3,230,146	94.2	3,514,876	93	3,860,201	94.2	2,884,820	92.7	6,745,022	93.6
	Some	171,729	5	225,188	6	195,171	4.8	201,746	6.5	396,917	5.5
	A lot	23,362	0.7	32,998	0.9	35,180	0.9	21,180	0.7	56,360	0.8
	Unable	4,952	0.1	5,472	0.1	7,690	0.2	2,733	0.1	10,424	0.1
	Total	3,430,189	100	3,778,534	100	4098243	100	3,110,480	100	7,208,723	100
HEARING	No	3,364,682	98.1	3,707,705	98.1	4,015,243	98	3,057,145	98.3	7,072,388	98.1
	Some	51,439	1.5	59,465	1.6	67,578	1.6	43,326	1.4	110,904	1.5
	A lot	10,856	0.3	9,740	0.3	11,837	0.3	8,759	0.3	20,596	0.3
	Unable	3,211	0.1	1,624	0	3,586	0.1	1,249	0	4,835	0.1
	Total	3,430,189	100	3,778,534	100	4,098,243	100	3,110,480	100	7,208,723	100
WALKING	No	3,314,179	96.6	3,606,201	95.4	3,936,137	96	2,984,243	95.9	6,920,380	96
	Some	80,532	2.3	128,290	3.4	116,977	2.9	91,846	3	208,822	2.9
	A lot	29,667	0.9	39,519	1	38,120	0.9	31,065	1	69,185	1
	Unable	5,811	0.2	4,524	0.1	7,009	0.2	3,326	0.1	10,335	0.1
	Total	3,430,189	100	3,778,534	100	4,098,243	100	3,110,480	100	7,208,723	100
REMEMBERING	No	3,372,154	98.3	3,687,054	97.6	4,024,585	98.2	3,034,624	97.6	7,059,209	97.9
	Some	45,603	1.3	73,724	2.0	57,474	1.4	61,853	2.0	119,327	1.7
	A lot	11,512	0.3	16,841	0.4	14,350	0.4	14,003	0.5	28,353	0.4
	Unable	919	0.0	914	0.0	1,834	0.0	-	0.0	1,834	0.0
	Total	3,430,189	100.0	3,778,534	100.0	4,098,243	100.0	3,110,480	100.0	7,208,723	100.0
SELF-CARE	No	3,391,579	98.9	3,744,606	99.1	4,054,271	98.9	3,081,914	99.1	7,136,185	99.0
	Some	24,606	0.7	22,794	0.6	28,714	0.7	18,686	0.6	47,400	0.7
	A lot	9,708	0.3	8,887	0.2	11,150	0.3	7,446	0.2	18,595	0.3
	Unable	4,296	0.1	2,246	0.1	4,108	0.1	2,434	0.1	6,542	0.1
	Total	3,430,189	100.0	3,778,534	100.0	4,098,243	100.0	3,110,480	100.0	7,208,723	100.0
COMMUNICATING	No	3,394,809	99.0	3,757,957	99.5	4,065,756	99.2	3,087,009	99.2	7,152,765	99.2
	Some	21,772	0.6	15,007	0.4	22,117	0.5	14,662	0.5	36,779	0.5
	A lot	10,307	0.3	4,154	0.1	7,207	0.2	7,255	0.2	14,462	0.2
	Unable	3,301	0.1	1,416	0.0	3,163	0.1	1,554	0.0	4,717	0.1
	Total	3,430,189	100.0	3,778,534	100.0	4,098,243	100.0	3,110,480	100.0	7,208,723	100.0

APPENDIX 2: SOCIO-ECONOMIC STATUS SCALE BY ACTIVITY LIMITATION

DIFFICULTY SEEING				
Region		Mean	Number	Std. deviation
Rural	No	6.0858	138,223	4.04680
	Some	7.5403	6,684	5.00835
	A lot	3.6175	1,561	2.42569
	Unable	4.4907	752	2.50165
	Total	6.1175	147,220	4.09650
Urban	No	10.0350	118,967	5.62512
	Some	10.7956	9,602	5.79710
	A lot	9.0000	386	0.00000
	Total	10.0886	128,956	5.63353
Total	No	7.9126	257,191	5.22637
	Some	9.4596	16,286	5.71588
	A lot	4.6844	1,947	3.05349
	Unable	4.4907	752	2.50165
	Total	7.9717	276,175	5.26207

DIFFICULTY HEARING				
Region		Mean	Number	Std. deviation
Rural	No	6.1647	143,992	4.10389
	Some	3.9866	2,751	3.32177
	A lot	4.1661	476	.98715
	Total	6.1175	147,220	4.09650
Urban	No	10.0957	128,482	5.64237
	Some	9.0000	275	0.00000
	A lot	7.0000	199	0.00000
	Total	10.0886	128,956	5.63353
Total	No	8.0183	272,474	5.26905
	Some	4.4426	3,026	3.47981
	A lot	5.0000	675	1.53546
	Total	7.9717	276,175	5.26207

DIFFICULTY WALKING				
Region		Mean	Number	Std. deviation
Rural	No	6.1891	141,028	4.10066
	Some	3.9307	3,794	1.99414
	A lot	5.8111	2,120	5.33169
	Unable	2.0000	278	0.00000
	Total	6.1175	147,220	4.09650
Urban	No	10.1574	123,941	5.66583
	Some	9.3826	3,077	4.32530
	A lot	6.5091	1,551	4.59113
	Unable	8.0000	386	0.00000
	Total	10.0886	128,956	5.63353
Total	No	8.0453	264,969	5.28073
	Some	6.3724	6,871	4.23363
	A lot	6.1060	3,671	5.04322
	Unable	5.4897	664	2.96200
	Total	7.9717	276,175	5.26207

DIFFICULTY REMEMBERING				
Region		Mean	Number	Std. deviation
Rural	No	6.1247	142,412	4.09587
	Some	4.7670	3,390	2.34566
	A lot	8.6266	1,417	5.80076
	Total	6.1175	147,220	4.09650
Urban	No	10.1886	123,277	5.63153
	Some	7.3198	4,742	5.41583
	A lot	10.9394	936	2.46240
	Total	10.0886	128,956	5.63353
Total	No	8.0103	265,689	5.27395
	Some	6.2556	8,133	4.58040
	A lot	9.5468	2,354	4.89368
	Total	7.9717	276,175	5.26207

DIFFICULTY WITH SELF-CARE				
Region		Mean	Number	Std. deviation
Rural	No	6.0850	145,835	4.06716
	Some	2.0000	275	0.00000
	A lot	11.4121	1,110	4.47893
	Total	6.1175	147,220	4.09650
Urban	No	10.1440	126,890	5.62153
	Some	7.0888	1,293	6.50402
	A lot	4.0000	386	0.00000
	Unable	8.0000	386	0.00000
	Total	10.0886	128,956	5.63353
Total	No	7.9735	272,725	5.25809
	Some	6.1958	1,569	6.21477
	A lot	9.4995	1,496	5.04046
	Unable	8.0000	386	0.00000
	Total	7.9717	276,175	5.26207

DIFFICULTY COMMUNICATING				
Region		Mean	Number	Std. deviation
Rural	No	6.1150	146,200	4.09993
	Some	5.0000	265	0.00000
	A lot	7.0000	755	4.00265
	Total	6.1175	147,220	4.09650
Urban	No	10.0867	127,534	5.63973
	Some	11.0927	1,036	5.68876
	A lot	8.0000	386	0.00000
	Total	10.0886	128,956	5.63353
Total	No	7.9655	273,734	5.26515
	Some	9.8532	1,300	5.63855
	A lot	7.3384	1,141	3.28927
	Total	7.9717	276,175	5.26207

APPENDIX 3: PERSONS WITH DISABILITY AGED 18 YEARS AND ABOVE WHO APPLIED FOR A GRANT, BY DISABILITY SEVERITY, SEX AND RURAL/URBAN

		MALE		FEMALE		RURAL		URBAN		TOTAL	
		Number	%	Number	%	Number	%	Number	%	Number	%
Mild	Ever applied for a grant	21	3.3	23	3.3	27	3.4	17	3.1	42	3.3
	Never applied for a grant	621	96.7	680	96.7	765	96.6	536	96.9	1,300	96.7
Moderate	Ever applied for a grant	20	6.1	15	3.4	22	4.9	13	4.1	32	4.5
	Never applied for a grant	307	93.9	429	96.6	429	95.1	307	95.9	732	95.5
Severe	Ever applied for a grant	5	4.9	8	7.1	10	7.2	3	3.8	16	6.0
	Never applied for a grant	98	95.1	105	92.9	128	92.8	75	96.2	200	94.0

APPENDIX 4: PERSONS WITH DISABILITY AGED 18 YEARS AND ABOVE CURRENTLY RECEIVING SOCIAL SECURITY, GRANT OR ANY OTHER FORM OF PENSION, BY DISABILITY SEVERITY, SEX AND RURAL/URBAN

		MALE		FEMALE		RURAL		URBAN		TOTAL	
		Number	%	Number	%	Number	%	Number	%	Number	%
Mild	Currently receiving	29	69.0	13	1.9	22	2.8	20	3.6	42	3.1
	Not receiving	611	47.0	689	98.1	767	97.2	533	96.4	1,300	96.9
Moderate	Currently receiving	16	50.0	16	3.6	18	4.0	14	4.4	32	4.2
	Not receiving	307	41.9	425	96.4	430	96.0	302	95.6	732	95.8
Severe	Currently receiving	7	43.8	9	8.0	9	6.5	7	9.0	16	7.4
	Not receiving	96	48.0	104	92.0	129	93.5	71	91.0	200	92.6

APPENDIX 5: ACTIVITY LIMITATION AMONG PERSONS WITH DISABILITY AGED 5 YEARS AND OVER BY HIGHEST LEVEL OF SCHOOL ATTENDED

		NURSERY/ KINDERGARTEN		PRIMARY		SECONDARY		HIGHER		TOTAL	
		Number	%	Number	%	Number	%	Number	%	Number	%
SEEING	No	375	26.5	152,650	46.7	95,291	41.4	12,075	15.0	260,390	40.8
	Some	386	27.4	148,539	45.4	119,190	51.7	64,349	80.2	332,463	52.0
	A lot	650	46.1	22,818	7.0	13,695	5.9	3,186	4.0	40,349	6.3
	Unable	0	0.0	2,909	0.9	2,239	1.0	639	0.8	5,787	0.9
	Total	1,411	100.0	326,916	100.0	230,413	100.0	80,248	100.0	638,988	100.0
HEARING	No	1,036	73.5	269,252	82.4	198,583	86.2	73,187	91.2	542,059	84.8
	Some	375	26.5	48,969	15.0	25,820	11.2	4,413	5.5	79,576	12.5
	A lot	0	0.0	7,126	2.2	5,010	2.2	2,648	3.3	14,784	2.3
	Unable	0	0.0	1,570	0.5	1,000	0.4	0	0.0	2,570	0.4
	Total	1,411	100.0	326,916	100.0	230,413	100.0	80,248	100.0	638,988	100.0
WALKING	No	375	26.5	196,068	60.0	166,970	72.5	66,907	83.4	430,319	67.3
	Some	650	46.1	102,062	31.2	41,253	17.9	9,621	12.0	153,587	24.0
	A lot	386	27.4	24,327	7.4	21,044	9.1	3,121	3.9	48,878	7.6
	Unable	0	0.0	4,458	1.4	1,146	0.5	600	0.7	6,204	1.0
	Total	1,411	100.0	326,916	100.0	230,413	100.0	80,248	100.0	638,988	100.0
REMEMBERING	No	1,025	72.6	261,165	79.9	191,501	83.1	74,196	92.5	527,887	82.6
	Some	386	27.4	52,934	16.2	33,475	14.5	5,574	6.9	92,369	14.5
	A lot	0	0.0	12,440	3.8	5,437	2.4	478	0.6	18,355	2.9
	Unable	0	0.0	377	0.1	0	0.0	0	0.0	377	0.1
	Total	1,411	100.0	326,916	100.0	230,413	100.0	80,248	100.0	638,988	100.0
SELF-CARE	No	1,411	100.0	296,636	90.7	214,835	93.2	78,058	97.3	590,940	92.5
	Some	0	0.0	21,285	6.5	10,238	4.4	822	1.0	32,346	5.1
	A lot	0	0.0	8,223	2.5	4,954	2.1	445	0.6	13,622	2.1
	Unable	0	0.0	772	0.2	386	0.2	923	1.2	2,081	0.3
	Total	1,411	100.0	326,916	100.0	230,413	100.0	80,248	100.0	638,988	100.0
COMMUNICATING	No	1,411	100.0	302,502	92.5	218,249	94.7	78,278	97.5	600,440	94.0
	Some	0	0.0	16,595	5.1	8,283	3.6	1,481	1.8	26,360	4.1
	A lot	0	0.0	6,797	2.1	3,523	1.5	275	0.3	10,596	1.7
	Unable	0	0.0	1,022	0.3	358	0.2	214	0.3	1,593	0.2
	Total	1,411	100.0	326,916	100.0	230,413	100.0	80,248	100.0	638,988	100.0

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Hello. My name is ____. I am working with the Central Statistical Office (CSO) in collaboration with Ministry of Community Development, Mother and Child Health. We are conducting a survey about difficulties people might be experiencing all over Zambia. The information we collect will help the government to plan for services for people living with difficulties. Your household was selected for the survey. The questions usually take about 20 to 30 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your household.

Do you have any questions? May I begin the interview now?

SIGNATURE OF INTERVIEWER: ________________________________ DATE: ____________________

RESPONDENT AGREES TO BE INTERVIEWED 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEW. . . 2 → END

IS THIS A FACE-TO-FACE INTERVIEW WITH THE PERSON WITH DISABILITY?

YES (I.E. DIRECTLY WITH THE PERSON WITH DISABILTY)	1
NO (I.E. SOMEONE ELSE IS REPORTING ON BEHALF OF THE PERSON WITH DISABILITY)	2
BOTH (I.E. SOMEONE ELSE IS REPORTING TOGETHER WITH THE PERSON WITH DISABILITY) .	3

NAME OF PERSON REPORTING ____

SECTION 1. ACTIVITY LIMITATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME.	HOUR . . . . [ ][ ] MINUTES .... [ ][ ]	
	I would like to ask you about difficulties you may have in carrying out daily activities.		
102	How old were you at your last birthday?	AGE IN COMPLETED YEARS . . . . [ ][ ]	
102a	CIRCLE SEX OF RESPONDENT.	MALE . . . . 1 FEMALE 2	
102b	CIRCLE IF RESPONDENT IS ALBINO.	YES . . . . 1 NO 2	
103	How difficult is it for you **watching/looking/seeing** without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
104	How difficult is it for you **listening/hearing** without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
105	How difficult is it for you learning to **read/write/count/ calculate** without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
106	How difficult is it for you **acquiring skills** (sewing, drawing, driving, manipulating tools, painting, carving etc.) without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
107	How difficult is it for you **thinking/concentrating** without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
108	How difficult is it for you **reading/writing/counting/ calculating** without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
109	How difficult is it for you **solving problems** (e.g. playing chess, solving a puzzle e.t.c) without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
110	How difficult is it for you **understanding others** (spoken, written or sign language) without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
111	How difficult is it for you **producing messages** (spoken, written or sign language) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
112	How difficult is it for you **communicating directly** with others <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
113	How difficult is it for you **staying in one body** position <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
114	How difficult is it for you **changing a body position** (sitting/standing/bending/lying) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
115	How difficult is it for you moving from one surface to another (**transferring oneself**) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
116	How difficult is it for you **lifting/carrying/moving/ handling objects** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
117	How difficult is it for you picking up/grasping/ manipulating/releasing (**fine hand use**) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
118	How difficult is it for you pulling/pushing/reaching/ throwing/catching (**hand and arm use**) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
119	How difficult is it for you **walking** without any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
120	How difficult is it for you **moving around** (crawling/ climbing/running/jumping/hopping) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
121	Please describe your difficulty as it is without the use of assistive devices or any person helping you. (WRITE WHAT THE RESPONDENT SAYS IN THEIR OWN WORDS). ____ ____		

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
313	In the past 12 months, how often has the availability of health care services and medical care been a problem for you?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 315
314	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	
315	In the past 12 months, how often did you need someone else's help (assistance) in your home and could not get it easily?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 317
316	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	
317	In the past 12 months, how often did you need someone else's help at school or work and could not get it easily?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 319
318	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	
319	In the past 12 months, how often have other people's attitudes toward you been a problem at home?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 321
320	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	
321	In the past 12 months, how often have other people's attitudes toward you been a problem at school or work?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 323
322	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	
323	In the past 12 months, how often did you experience prejudice or discrimination?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 325
324	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	
325	In the past 12 months, how often did the policies and rules of businesses and organisations make problems for you?	DAILY . . . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . 3 LESS THAN MONTHLY . . . . . 4 NEVER . . . . . 5 NOT APPLICABLE 7	5, 7 → 327
326	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . 1 BIG PROBLEM 2	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
609	Are you currently receiving social security, grant or any other form of pension?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	2, 8 → 701
610	What type of grant or pension do you receive?	YES NO SOCIAL CASH TRANSFER . . . . 1 2 ECONOMIC EMPOWERMENT . . . . 1 2 SCHOLARSHIP . . . . 1 2 WORKMAN'S COMPENSATION . . . . . 1 2 PRIVATE INSURANCE/PENSION . . . . . 1 2 PUBLIC WELFARE ASSISTANCE . . . . . 1 . 2 OTHER ______________________ 1 2 (SPECIFY)	
611	What are the TWO MAIN THINGS that the money from your grant or pension is spent on? ***[DO NOT READ OUT RESPONSES; CIRCLE ONLY ONE IN CHOICE A AND ONE IN CHOICE B ANSWERS]***	(CHOICE) A B INCOME GENERATING ACTIVITIES . . . 1 2 HOUSEHOLD NECESSITIES I.E. FOOD, GROCERIES ETC. . . . . 1 2 CLOTHING . . . . 1 2 RENT/ACCOMMODATION . . . . 1 2 RECREATION/ENTERTAINMENT . . . . . 1 2 TRANSPORT . . . . 1 2 EDUCATION . . . . 1 2 WATER AND ELECTRICITY . . . . 1 2 REHABILITATION AND HEALTH CARE SERVICES . . . . 1 2 ASSISTIVE DEVICES . . . . 1 2 PERSONAL ASSISTANT/CARER (CARE FOR SELF) . . . . 1 2 OTHER ______________________ 1 2 (SPECIFY)	
612	Are you the one who mainly decides how to spend your grant or pension?	YES . . . . 1 NO 2	

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MOST IMPORTANT

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
718	Are you a member of a Disabled People's Organisation (DPO)?	YES . . . . 1 NO 2	
719a	Do you participate in local community meetings?	YES, ALWAYS . . . . 1 YES, SOMETIMES . . . . 2 NO . . . . 3 DON'T KNOW 8	3, 8 → 720
719b	Do you feel your voice is being heard?	YES, ALWAYS . . . . 1 YES, SOMETIMES . . . . 2 NO . . . . 3 DON'T KNOW 8	
720	Do you make important decisions about your own life?	YES, ALWAYS . . . . 1 YES, SOMETIMES . . . . 2 NO . . . . 3 DON'T KNOW 8	
721	Are you married or in a relationship?	YES . . . . 1 NO 2	2 → 723
722	Does your spouse/partner have a difficulty?	YES . . . . 1 NO 2	
723	Do you have children?	YES . . . . 1 NO 2	2 → 726
724	How many children do you have?	CHILD/CHILDREN . . . . [ ][ ]	
725	Who MAINLY takes care or helps you take care of your children?	SELF . . . . 01 MY SPOUSE/PARTNER . . . . 02 MY PARENTS . . . . 03 FAMILY MEMBER . . . . 04 FRIEND . . . . 05 SOMEONE IS PAID TO TAKE CARE OF THE CHILD/CHILDREN . . . . 06 CHILDREN ARE OLD ENOUGH TO TAKE CARE OF THEMSELVES . . . . 07 OTHER ________ 96 (SPECIFY)	
726	Do you have a National Registration Card (NRC)?	YES . . . . 1 NO 2	
727	Are you a registered voter?	YES . . . . 1 NO 2	2 → 801
728	Did you vote in the last general election (2011)?	YES . . . . 1 NO 2	1 → 801
729	Why didn't you vote?	VOTE AREA NOT ACCESSIBLE . . . . 1 NOT INTERESTED IN POLITICS . . . . 2 BELOW VOTING AGE . . . . 3 OTHER ________ 6 (SPECIFY)	

SECTION 8A. HEALTH AND GENERAL WELL-BEING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Now I'm going to ask about your health and general well being over the past few weeks.		
801	For the past few weeks have you been able to concentrate on what you're doing?	BETTER THAN USUAL . . . . 1 SAME AS USUAL . . . . 2 LESS THAN USUAL . . . . 3 MUCH LESS THAN USUAL 4	
802	For the past few weeks have you lost much sleep over worry?	NOT AT ALL . . . . 1 NO MORE THAN USUAL . . . . 2 RATHER MORE THAN USUAL . . . . 3 MUCH MORE THAN USUAL 4	
803	For the past few weeks have you felt you were playing a		

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
818b	Did you experience any problems in obtaining/ understanding information about the diabetes disease?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
818c	Have you ever had this disease?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	NO, DON'T KNOW → 819
818d	Do you have Diabetes 1 or 2?	DIABETES 1 . . . . 1 DIABETES 2 2	
818e	Do you have access to medicines?	YES . . . . 1 NO 2	
819	Do you have any knowledge about TB?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	NO, DON'T KNOW → 820
819a	Where did you get most of the information about TB disease from?	HEALTH FACILITY . . . . 01 DOCTOR . . . . 02 AT WORK . . . . 03 NEWSPAPER/MAGAZINE . . . . 04 FRIENDS . . . . 05 FAMILY . . . . 06 RADIO/TV . . . . 07 POSTER/PAMPHLET . . . . 08 SCHOOL . . . . 09 OTHER ______ 96 (SPECIFY) DON'T KNOW 98	
819b	Did you experience any problems in obtaining/ understanding information about TB disease?	YES . . . . 1 NO . . . . 2 DON'T KNOW 6	
819c	Have you ever had this disease?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
820	Have you ever experienced being physically abused as a child (before 18 years of age)?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
821	Have you ever experienced being sexually abused as a child (before 18 years of age)?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	

SECTION 9. REPRODUCTIVE HEALTH OF FEMALE MEMBERS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES . . . . 1 NO 2	 906

SECTION 1. ACTIVITY LIMITATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME.	HOUR . . . . [ ][ ] MINUTES .... [ ][ ]	
	I would like to ask you about difficulties you may have in carrying out daily activities.		
102	How old were you at your last birthday?	AGE IN COMPLETED YEARS . . . . [ ][ ]	
102a	CIRCLE SEX OF RESPONDENT.	MALE . . . . 1 FEMALE 2	
103	How difficult is it for you **watching**/**looking**/**seeing** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
104	How difficult is it for you **listening**/**hearing** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
105	How difficult is it for you learning to **read**/**write**/**count**/ **calculate** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
106	How difficult is it for you **acquiring skills** (manipulating tools, painting, carving etc.) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
107	How difficult is it for you **thinking**/**concentrating** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 6 NOT SPECIFIED/NOT APPLICABLE 7	
108	How difficult is it for you **reading**/**writing**/**counting**/ **calculating** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
109	How difficult is it for you **solving problems** <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	
110	How difficult is it for you **understanding others** (spoken, written or sign language) <u>without</u> any kind of assistance at all? *[Without the use of any assistive devices – either technical or personal]*	NO DIFFICULTY . . . . 1 MILD DIFFICULTY . . . . 2 MODERATE DIFFICULTY . . . . 3 SEVERE DIFFICULTY . . . . 4 UNABLE TO CARRY OUT THE ACTIVITY . 5 NOT SPECIFIED/NOT APPLICABLE 7	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
403E	Why has (NAME) stopped receiving health information?	YES NO NOT SATISFIED WITH THE SERVICES . 1 2 SERVICES TOO EXPENSIVE . . . . 1 2 TOO FAR OR HAVE NO TRANSPORT . . . 1 2 NOT REALLY HELPING ME . . . . 1 2 DISCRIMINATING PRACTICES 1 2	
404A	Is (NAME) aware of health services (e.g. at a primary health care clinic, hospital, home health care services etc.)?	YES . . . . 1 NO 2	
404B	Has (NAME) needed health services (e.g. at a primary health care clinic, hospital, home health care services etc.)?	YES . . . . 1 NO 2	
404C	Has (NAME) received health services (e.g. at a primary health care clinic, hospital, home health care services etc.)?	YES . . . . 1 NO 2	 →405A
404D	How satisfied is (NAME) with the health services they have received or still receiving?	VERY SATISFIED . . . . 01 SATISFIED . . . . 02 NEUTRAL . . . . 03 DISSATISFIED . . . . 04 VERY DISSATIFIED . . . . 05 NEVER RECEIVED . . . . 06 STOPPED RECEIVING 07	 → 405A
404E	Why has (NAME) stopped receiving health services?	YES NO NOT SATISFIED WITH THE SERVICES . 1 2 SERVICES TOO EXPENSIVE . . . . 1 2 TOO FAR OR HAVE NO TRANSPORT . . . 1 2 NOT REALLY HELPING ME . . . . 1 2 DISCRIMINATING PRACTICES 1 2	
405A	Is (NAME) aware of services from traditional healer/faith healer?	YES . . . . 1 NO 2	
405B	Has (NAME) needed services from traditional healer/faith healer?	YES . . . . 1 NO 2	
405C	Has (NAME) received services from traditional healer/faith healer?	YES . . . . 1 NO 2	 → 406A
405D	How satisfied is (NAME) with the services received from traditional healing/faith healing or still receiving?	VERY SATISFIED . . . . 01 SATISFIED . . . . 02 NEUTRAL . . . . 03 DISSATISFIED . . . . 04 VERY DISSATIFIED . . . . 05 NEVER RECEIVED . . . . 06 STOPPED RECEIVING 07	 → 406A
405E	Why has (NAME) stopped receiving traditional healing/faith healing?	YES NO NOT SATISFIED WITH THE SERVICES . 1 2 SERVICES TOO EXPENSIVE . . . . 1 2 TOO FAR OR HAVE NO TRANSPORT . . . 1 2 NOT REALLY HELPING ME . . . . 1 2 DISCRIMINATING PRACTICES 1 2	
406A	Is (NAME) aware of Legal aid?	YES . . . . 1 NO 2	
406B	Has (NAME) needed Legal aid?	YES . . . . 1 NO 2	
406C	Has (NAME) receive Legal aid?	YES . . . . 1 NO 2	 →501

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
609	Are you currently receiving social security, grant or any other form of pension?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	 → 701
610	What type of grant or pension do you receive?	YES NO SOCIAL CASH TRANSFER . . . . 1 2 ECONOMIC EMPOWERMENT . . . . 1 2 SCHOLARSHIP . . . . 1 2 WORKMAN'S COMPENSATION . . . . . 1 2 PRIVATE INSURANCE/PENSION . . . . . 1 2 PUBLIC WELFARE ASSISTANCE . . . . . 1 . 2 OTHER ______________ 1 2 (SPECIFY)	
611	What are the TWO MAIN THINGS that the money from your grant or pension is spent on? ***[DO NOT READ OUT RESPONSES; CIRCLE ONLY ONE IN CHOICE A AND ONE IN CHOICE B ANSWERS]***	(CHOICE) A B INCOME GENERATING ACTIVITIES . . . 1 2 HOUSEHOLD NECESSITIES I.E. FOOD, GROCERIES ETC. . . . . 1 2 CLOTHING . . . . 1 2 RENT/ACCOMMODATION . . . . 1 2 RECREATION/ENTERTAINMENT . . . . . 1 2 TRANSPORT . . . . 1 2 EDUCATION . . . . 1 2 WATER AND ELECTRICITY . . . . 1 2 REHABILITATION AND HEALTH CARE SERVICES . . . . 1 2 ASSISTIVE DEVICES . . . . 1 2 PERSONAL ASSISTANT/CARER (CARE FOR SELF) . . . . 1 2 OTHER ______________ 1 2 (SPECIFY)	
612	Are you the one who mainly decides how to spend your grant or pension?	YES . . . . 1 NO 2	

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SECTION 8B. HIV/AIDS, STI, DIABETES AND TB (15 YEARS AND OLDER)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
816	Do you have any knowledge about HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 6	 → 817
816a	Where did you get most of the information about HIV/AIDS from?	HEALTH FACILITY . . . . . 01 DOCTOR . . . . . 02 AT WORK . . . . . 03 NEWSPAPER/MAGAZINE . . . . . 04 FRIENDS . . . . . 05 FAMILY . . . . . 06 RADIO/TV . . . . . 07 POSTER/PAMPHLET . . . . . 08 SCHOOL . . . . . 09 OTHER ______ 96 (SPECIFY) DON'T KNOW 98	
816b	Did you experience any problems in understanding information about HIV/AIDS?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
816c	Have you ever been tested for HIV?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
817	Do you have any knowledge about STI?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 6	 → 818
817a	Where did you get most of the information about the STI?	HEALTH FACILITY . . . . . 01 DOCTOR . . . . . 02 AT WORK . . . . . 03 NEWSPAPER/MAGAZINE . . . . . 04 FRIENDS . . . . . 05 FAMILY . . . . . 06 RADIO/TV . . . . . 07 POSTER/PAMPHLET . . . . . 08 SCHOOL . . . . . 09 OTHER ______ 96 (SPECIFY) DON'T KNOW 98	
817b	Did you experience any problems in obtaining/ understanding information about the STI?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
817c	Have you ever had an STI?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
818	Do you have any knowledge about diabetes?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 6	 → 819
818a	Where did you get most of the information about the diabetes disease from?	HEALTH FACILITY . . . . . 01 DOCTOR . . . . . 02 AT WORK . . . . . 03 NEWSPAPER/MAGAZINE . . . . . 04 FRIENDS . . . . . 05 FAMILY . . . . . 06 RADIO/TV . . . . . 07 POSTER/PAMPHLET . . . . . 08 SCHOOL . . . . . 09 OTHER ______ 96 (SPECIFY) DON'T KNOW 98	

Hello. My name is ______________________________________. I am working with the Central Statistical Office (CSO) in collaboration with Ministry of Community Development, Mother and Child Health. We are conducting a survey about difficulties people might be experiencing all over Zambia. The information we collect will help the government to plan for services for people living with difficulties. Your household was selected for the survey. The questions usually take about 20 to 30 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your household.

Do you have any questions? May I begin the interview now?

SIGNATURE OF INTERVIEWER: ______________________________ DATE: ____________________

RESPONDENT AGREES TO BE INTERVIEWED 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIE . . . 2 → END

IS THIS A FACE-TO-FACE INTERVIEW WITH THE PERSON WITH DISABILITY?

YES (I.E. DIRECTLY WITH THE PERSON WITH DISABILTY) 1
NO (I.E. SOMEONE ELSE IS REPORTING ON BEHALF OF THE PERSON WITH DISABILITY) 2
BOTH (I.E. SOMEONE ELSE IS REPORTING TOGETHER WITH THE PERSON WITH DISABILITY) . 3

NAME OF PERSON REPORTING ______________________________________

SECTION 1. MODULE ON CHILD FUNCTIONING AND DISABILITY (WG/UNICEF)

TO BE RESPONDED BY THE MOTHER/MAIN CAREGIVER (TOGETHER WITH THE CHILD).

READ: The next questions ask about difficulties your child may have in doing certain activities.

READ OUT RESPONSES.

	IF AGED 2-17 YEARS OLD					
LINE NO.	Does (NAME) wear glasses?	If (NAME) wears glasses, does he/she have difficulty seeing? Would you say….	If (NAME) does not wear glasses, does he/she have difficulty in seeing? Would you say….	Does (NAME) use a hearing aid?	If (NAME) uses a hearing aid, does he/she have difficulty in hearing? Would you say….	If (NAME) does not use a hearing aid, does he/she have difficulty in hearing? Would you say….
	(1)	(2A)	(2B)	(3)	(4A)	(4B)
	YES NO	ND SD A LOT CANT	ND SD A LOT CANT	YES NO	ND SD A LOT CANT	ND SD A LOT CANT
01	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
02	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
03	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
04	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
05	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
06	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
07	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
08	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
09	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4
10	1 2 GO TO 2B	1 2 3 4 GO TO 3	1 2 3 4	1 2 GO TO 4B	1 2 3 4 GO TO 5	1 2 3 4

CODES FOR Q2A, Q2B, Q4A AND Q4B: CHILD MODULE

1 = NO DIFFICULTY
2 = SOME DIFFICULTY
3 = A LOT OF DIFFICULTY
4 = CANNOT DO AT ALL

IF AGE 2-17 YEARS	IF AGE 5-17 YEARS	IF AGE 2-4 YEARS	IF AGE 5-17 YEARS	
Compared with children of the same age, does [NAME] have difficulty learning to do new things? Would you say….	Compared with children of the same age, does [NAME] have difficulty remembering things that they have learned? Would you say….	Compared with children of the same age, how much does [NAME] kick, bite or hit other children or adults? Would you say….	Compared with children of the same age, how much difficulty does [NAME] have controlling [his/her] behaviour? Would you say….	How often does (NAME) seem sad or depressed? Would you say….
(23)	(24)	(25)	(26)	(27)
ND SD A LOT CANT 1 2 3 4	ND SD A LOT CANT 1 2 3 4	N ALL TSL MOR AMOR 1 2 3 4	NONE TSL MOR AMOR 1 2 3 4	DAILY WKLY MONLY A FEW A YR NEVER 1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4 5

CODES FOR Q23 AND Q24: CHILD MODULE

1 = NO DIFFICULTY
2 = SOME DIFFICULTY
3 = A LOT OF DIFFICULTY
4 = CANNOT DO AT ALL

CODES FOR Q25: CHILD MODULE

1 = NOT AT ALL
2 = THE SAME OR LESS
3 = MORE
4 = A LOT MORE

CODES FOR Q26: CHILD MODULE

1 = NONE
2 = THE SAME OR LESS
3 = MORE
4 = A LOT MORE

CODES FOR Q27: CHILD MODULE

1 = DAILY
2 = WEEKLY
3 = MONTHLY
4 = A FEW TIMES A YEAR
5 = NEVER

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
311	In the past 12 months, how often have other people's attitudes toward you been a problem at school or work?	DAILY . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . . 3 LESS THAN MONTHLY . . . . . . 4 NEVER . . . . . . 5 NOT APPLICABLE 7	5, 7 → 313
312	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . . 1 BIG PROBLEM 2	
313	In the past 12 months, how often did you experience prejudice or discrimination?	DAILY . . . . 1 WEEKLY . . . . . 2 MONTHLY . . . . . . 3 LESS THAN MONTHLY . . . . . . 4 NEVER . . . . . . 5 NOT APPLICABLE 7	5, 7 → 401
314	When this problem occurs has it been a big problem or a little problem?	LITTLE PROBLEM . . . . . . 1 BIG PROBLEM 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
408E	Why has (NAME) stopped receiving health information?	YES NO NOT SATISFIED WITH THE SERVICES . 1 2 SERVICES TOO EXPENSIVE .... 1 2 TOO FAR OR HAVE NO TRANSPORT ... 1 2 NOT REALLY HELPING ME .... 1 2 DISCRIMINATING PRACTICES 1 2	
409A	Is (NAME) aware of health services (e.g. at a primary health care clinic, hospital, home health care services etc.)?	YES .... 1 NO 2	
409B	Has (NAME) needed health services (e.g. at a primary health care clinic, hospital, home health care services etc.)?	YES .... 1 NO 2	
409C	Has (NAME) received health services (e.g. at a primary health care clinic, hospital, home health care services etc.)?	YES .... 1 NO 2	2 → 410
409D	How satisfied is (NAME) with the health services they have received or still receiving?	VERY SATISFIED .... 01 SATISFIED .... 02 NEUTRAL .... 03 DISSATISFIED .... 04 VERY DISSATIFIED .... 05 NEVER RECEIVED .... 06 STOPPED RECEIVING 07	01–06 → 410
409E	Why has (NAME) stopped receiving health services?	YES NO NOT SATISFIED WITH THE SERVICES . 1 2 SERVICES TOO EXPENSIVE .... 1 2 TOO FAR OR HAVE NO TRANSPORT ... 1 2 NOT REALLY HELPING ME .... 1 2 DISCRIMINATING PRACTICES 1 2	

ACCESSIBILITY

Now I am going to ask you about your surroundings and how easy it is for you to get around. If you use one or more assistive devices or someone is helping you, answer as if you are using them.

ASK BOTH DIRECT & PROXY REPORTERS. PLEASE REMEMBER THE INFORMATION MUST BE ABOUT THE PERSON WITH DISABILITY.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	YES	NO	N/A	SKIP
410	Let's look at your home first. Are the rooms and toilet accessible to you? PROBE:	KITCHEN	1	2	3	
		BEDROOM	1	2	3	
		LIVING ROOM	1	2	3	
		DINING ROOM	1	2	3	
		TOILET	1	2	3	
		BATHROOM	1	2	3	
411	Now let's look at various places you might go to. Think of getting in and out of the places, and tell me for each place whether it is generally accessible to you or not.					
	The place where you work	THE PLACE OF WORK	1	2	3	
	The school you attend	SCHOOL YOU ATTEND	1	2	3	
	The shops that you go to most often	SHOPS YOU GO TO OFTEN	1	2	3	
	Place of worship	PLACE OF WORSHIP	1	2	3	
	Recreational facilities (e.g. cinema, theatre, pubs, etc) – think of the last three months	RECREATION FACILITY	1	2	3	
	Sports facilities	SPORTS FACILITY	1	2	3	
	Police station	POLICE STATION	1	2	3	
	Magistrates office/Traditional courts	MAGISTRATES/TRADITIONAL COURTS	1	2	3	
	Post office	POST OFFICE	1	2	3	
	Bank	BANK	1	2	3	
	Hospital	HOSPITAL	1	2	3	
	Primary Health Care Clinic	PRIMARY HEALTH CARE CLINIC .	1	2	3	
	Public transportation (bus, taxi, train)	PUBLIC TRANSPORT	1	2	3	
	Hotels	HOTELS	1	2	3	

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SECTION 7. ASSISTIVE DEVICES (12 -17 YEARS OLD)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Now I would like to ask you about assistive devices. ASK BOTH DIRECT & PROXY RESPONDENTS: PLEASE REMEMBER THE INFORMATION MUST BE ABOUT THE PERSON WITH DISABILITY		
701	Do you use any medication or traditional medicine due to your difficulty?	YES . . . . . 1 NO 2	 → 703
702	What type of medication?	MODERN . . . . . 1 TRADITIONAL . . . . . 2 BOTH 3	
703	Do you use an assistive device?	YES . . . . . 1 NO 2	 → 801

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	YES	NO	N/A	SKIP
704	Please specify which assistive devices you use.					
	a) Information (e.g. eye glasses, hearing aids, magnifying glass, telescopic lenses/glasses, enlarge print, Braille)?	INFORMATION	1	2	7	
	b) Communication (sign language interpreter, fax, portable writer, computer)?	COMMUNICATION	1	2	7	
	c) Personal mobility (wheelchairs, crutches, walking sticks, white cane, guide, standing frame)?	PERSONAL MOBILITY	1	2	7	
	d) Household items (Flashing light on doorbell, amplified telephone, vibrating alarm clock)?	HOUSEHOLD ITEMS	1	2	7	
	e) Personal care & protection (special fasteners, bath & shower seats, toilet seat raiser, commode chairs, safety rails, eating aids)?	PERSONAL CARE & PROTECTION	1	2	7	
	f) For handling products & goods (gripping tongs, aids for opening containers, tools for gardening)?	HANDLING PRODUCTS & GOODS	1	2	7	
	g) Computer assistive technology (keyboard for the blind)?	COMPUTER ASS. TECHNOLOGY .	1	2	7	
	h) Other devices?	OTHER ______________	1	2	7	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	YES	NO	DK	N/A	SKIP
705	Is the assistive device(s) that you use in good working condition/order: IF MORE THAN ONE DEVICE IN ONE CATEGORY, CHOOSE **MOST IMPORTANT** DEVICE.						
	a) Information?	INFORMATION	1	2	8	7	
	b) Communication?	COMMUNICATION	1	2	8	7	
	c) Personal mobility?	PERSONAL MOBILITY	1	2	8	7	
	d) Household items?	HOUSEHOLD ITEMS	1	2	8	7	
	e) Personal care & protection?	PERSONAL CARE & PROTECTION	1	2	8	7	
	f) For handling products & goods?	HANDLING PRODUCTS & GOODS . . .	1	2	8	7	
	g) Computer assistive technology?	COMPUTER ASS. TECHNOLOGY	1	2	8	7	
	h) Other devices?	OTHER ______________	1	2	8	7	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
814	Do you have any of the following health conditions?	YES NO	
	a) Asthma/breathing problem	ASTHMA/BREATHING PROBLEM 1 2	
	b) Arthritis/rheumatism	ARTHRITIS/RHEUMATISM 1 2	
	c) Back or neck problem	BACK OR THE NECK PROBLEM 1 2	
	d) Fracture or bone/joint injury	FRACTURE OR BONE/JOINT INJURY . 1 2	
	e) Heart problem	HEART PROBLEM 1 2	
	f) Stroke problem	STROKE PROBLEM 1 2	
	g) Hypertension/high blood pressure	HYPERTENSION/HIGH BLOOD PRESSURE 1 2	
	h) Kidney, bladder or renal problem	KIDNEY, BLADDER OR RENAL PROBLEM 1 2	
	i) Diabetes	DIABETES 1 2	
	j) Cancer	CANCER 1 2	
	k) Mental retardation	MENTAL RETARDATION 1 2	
	l) Developmental problem	DEVELOPMENTAL PROBLEM 1 2	
	m) Depression/anxiety/emotional problem	DEPRESSION/ANXIETY/EMOTIONAL PROBLEM 1 2	
	n) Missing limbs, amputee	MISSING LIMBS, AMPUTEE 1 2	
	o) Neurological disorder such as Multiple sclerosis (MS) or Muscular Dystrophy (MD)	NEUROLOGICAL DISORDER SUCH AS MULTIPLE SCLEROSIS (MS) OR MUSCULAR DYSTROPHY (MD) ... 1 2	
815	Thinking about your general mental health (things like: anxiety, depression, fear, fatigue, tiredness, hopelessness etc.) – on a scale on 1 (poor) to 4 (very good) – How would you describe your overall mental health today?	POOR .... 1 NOT VERY GOOD .... 2 GOOD .... 3 VERY GOOD .... 4 DON'T KNOW 8	

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