STATUS AND PROSPECTS:
AN INTERNATIONAL REVIEW OF THE STATE OF INTELLECTUAL DISABILITY SURVEILLANCE

Country Report: Indicators and Indices for

IRELAND
This Ireland summary is part of a larger project exploring the feasibility of creating national benchmarks on the status and prospects of people with intellectual disabilities. The review included the identification and evaluation of national statistical systems that could capture the status of persons with intellectual disabilities from census systems, service registries, and specialized household surveys based on an organizing theme of equalization of opportunity.

Other nations included in the review were Brazil, China, Egypt, Germany, India, Japan, Nigeria, Northern Ireland, Russia, South Africa, and the United States.

The study was commissioned by Special Olympics and conducted by the Department of Disability and Human Development at the University of Illinois at Chicago. Project staff included Glenn T. Fujiura, Ph.D., Violet Rutkowski-Kmitta, MPH, and Randall Owens, MS. Special Olympics staff support was provided by Dr. Stephen Corbin, Senior Vice President of Constituent Services and Support and Darcie Mersereau, Manager, Research and Evaluation.

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What are the status and prospects of persons with intellectual disabilities (ID) across the globe? Simply put, we do not know. The current state of monitoring allows only the most basic portrait; a data driven characterization of life experiences and life quality cannot be produced. But there are compelling reasons for trying. In the World Programme of Action concerning Disabled Persons, the UN resolution recognizing the rights of persons with disabilities to full participation as a core international goal, the statistical monitoring of national progress was seen as an essential step in effecting successful implementation (United Nations, 1982).

Significant progress has been made in the international assessment of disability generally. Yet a quarter century after the publication of the World Programme, the world’s citizens with intellectual disabilities remain largely ignored by national statistical agencies.

Status of Irish Data on Intellectual Disabilities
Among the countries studied, the Irish model represents the closest approximation of a national surveillance system upon which benchmarking could be built. The National Intellectual Disability Database, a service registry system, has long been an impressive albeit incomplete source for ID data. With the newly implemented ID codes in the Census, and National Disability Survey, Ireland can now establish a reasonably comprehensive statistical portrait of both services and living status using various indicators of well-being (e.g., employment, income, family relationships, occupational type, class, and as caregiver data).

Future Directions

- Integrate the National Disability Survey (NDS) into existing systems. While the NDS will add to an already impressive array of data sources, there is a history of expensive, one-time specialized surveys in Ireland.

- Integrate ID surveillance across systems and registries. Significant amounts of ID data are collected in Ireland, but global portraits are still very difficult to develop due to fragmentation across agencies and government departments. Greater integration across systems and service registries would better leverage the data currently collected.
Our review of Irish data systems included: (1) identification and evaluation of statistical systems that were national in scope, (2) identification of systems that capture either general disability or intellectual disability, and (3) a review of indicators currently captured in these data systems. The review included census systems, service registries, and specialized household surveys.

Data and Intellectual Disabilities
- There are four primary statistical agencies coordinating recurring disability data collection: Central Statistics Office (CSO), Department of Social, Community & Family Affairs (DSCFA), Department of Education & Science (DES), and Department of Health & Children (DHC).
- Ireland is unique among the nations profiled in that it has maintained a comprehensive database on persons with ID annually since 1995. Ireland’s interest in maintaining ongoing surveillance of its population with ID began in the early 1960’s (Pillinger, 2003). Regional health boards coordinate data activities for their catchment areas. In addition, the revised census and the NDS provide a rich base of ID statistics.
- Ireland’s ID database carries the caveat that it does not represent a “true prevalence” since those with mild levels of intellectual impairment are not typically in contact with the service system (Dawson, 2006). Based on service registries, the prevalence is estimated at 6.5 per 1,000, a figure comparable to most ID prevalence figures for severe ID in developed countries. The most recent Census (Central Statistics Office Ireland, 2006) included for the first time an ID screen, which yield a rate of 1.7% for learning and intellectual disabilities (Central Statistics Office of Ireland, 2007).

<table>
<thead>
<tr>
<th>IRELAND</th>
<th>Features</th>
<th>Indicators Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance System</td>
<td>Type</td>
<td>Agency</td>
</tr>
<tr>
<td>Annual Census of Primary Schools</td>
<td>R</td>
<td>DES</td>
</tr>
<tr>
<td>Census of Population</td>
<td>C</td>
<td>CSO</td>
</tr>
<tr>
<td>Disability Living Allowance</td>
<td>R</td>
<td>DSCFA</td>
</tr>
<tr>
<td>National Disability Survey of 2006</td>
<td>PS</td>
<td>CSO</td>
</tr>
<tr>
<td>National Employment Survey</td>
<td>PS</td>
<td>CSO</td>
</tr>
<tr>
<td>Quarterly National Household Survey</td>
<td>PS</td>
<td>CSO</td>
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<tr>
<td>National ID Database</td>
<td>R</td>
<td>DHC</td>
</tr>
<tr>
<td>Physical &amp; Sensory Disability Database</td>
<td>R</td>
<td>DHC</td>
</tr>
<tr>
<td>Post Primary Data</td>
<td>R</td>
<td>DES</td>
</tr>
<tr>
<td>EU Survey on Income &amp; Living Conditions</td>
<td>PS</td>
<td>CSO</td>
</tr>
<tr>
<td>Survey of Lifestyles, Attitudes, Nutrition</td>
<td>PS</td>
<td>DHC</td>
</tr>
</tbody>
</table>

Notes: R = registry, C = census, PS = household probability survey; Central Statistics Office (CSO), Department of Social, Community & Family Affairs (DSCFA), Department of Education & Science (DES), and Department of Health & Children (DHC); GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf (housing & family) / Wrk (work) / Ed (education) / He (health) / Inc (income) / Sp (social participation) / Ss (service & supports)
Apart from prevalence rates and regional employment, indicators are rarely employed in international summaries of disability data. With the exception of the EUMAP (education and employment) and Pomona (health) initiatives, both in Europe, there have been no cross-national ID evaluations based on statistical indicators (European Intellectual Disability Research Network, 2003; Pomona, 2006).

### National Indicators

As the summary of data systems indicates, ID is limited to educational data in the recurring Indian national statistical programs. In lieu of a common set of internationally comparable statistical indicators, we developed an ad hoc benchmark based on common disability indicators: % school-age children having access to education, % school-age children in integrated schools, % children in inclusive education, % employed (open and sheltered), and national disability policy as evaluated through the Standard Rules. The selection of these domains was driven by practical rather than conceptual reasons; these are statistics commonly studied and most likely to be reported. Important outcome domains were omitted due to lack of data, and the derived index should be treated only as an illustration. (see Appendix 3).

**IRELAND Index Values**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>All Ireland</th>
<th>Disability</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to education</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Integrated schools</td>
<td>1.00</td>
<td>0.99</td>
<td>0.86</td>
</tr>
<tr>
<td>Inclusive classrooms</td>
<td>1.00</td>
<td>0.61</td>
<td>0.26</td>
</tr>
<tr>
<td>Labor Force Participation</td>
<td>1.00</td>
<td>0.63</td>
<td>0.26</td>
</tr>
<tr>
<td>Non Sheltered Employment</td>
<td>na</td>
<td>0.40</td>
<td>0.07</td>
</tr>
<tr>
<td>Policy Implementation</td>
<td>na</td>
<td>0.69</td>
<td>0.69</td>
</tr>
<tr>
<td>Non-Institutionalization</td>
<td>na</td>
<td>0.98</td>
<td>0.83</td>
</tr>
</tbody>
</table>

Based on a standard 0 to 1.0 scale, where 1.0 approximates full inclusion or equity with the general population on an indicator, Ireland averaged 0.54 for persons with intellectual disabilities and 0.76 for general disabilities; averages for the other nations in the review (excluding Nigeria) were 0.46 for persons with intellectual disabilities and 0.63 for general disabilities.

**Notes on Index Scoring and Scaling**

We employed a modification of the general approach used in the UNDP's Human Development Index (HDI) (United Nations Development Programme, 2007). The HDI is a standardized measure, scaled and normalized against a pre-established international standard. The standard score formula reduces statistical indicators measured on different scales to a common 0 to 1.0 scale (Jahan, 2002). In contrast to the HDI, we employed a mixture of absolute and relative indicators. Absolute indicators focused on national performance relative to a fixed value. Relative indicators measure performance relative to the national average. Combining absolute and relative values is an indirect method for accounting for local circumstances; absolute national performance is not compared but rather the equalization of access and opportunity.

**Standard Rule Scoring**

The UN Standard Rules provide a useful international convention for an indicator representative of policy and legislation (United Nations, 1993). The Standard Rules emerged from the World Programme of Action (United Nations, 1982). There are a total of 22 rules, which are legally non-binding standards for nations aspiring to achieve equalization of opportunity. The 22 rules are organized across three domains: (1) preconditions required for equalization, (2) targeted areas for equalization actions, and (3) actions to ensure implementation. The Rules are widely used as criteria for evaluation of nations (Michailakis, 1997; South-North Center for Dialogue and Development, 2006). We employed a content analysis methodology in which over 1,000 reports, studies, and other
narratives were reviewed. “Narrative units” were extracted; these were evaluations, commentaries, statistical references, and similar material in the reviewed documents. Three analysts worked independently to rate each nation on five-point implementation scale (0 = no evidence to 5 = full implementation). Major discrepancies were discussed and resolved. For the purposes of creating an index, the same score was assigned to both ID and general disability populations.

3

INDICATORS & INDICES (CONTINUED)

1 School access includes all children under 18 years in the NIDD in 2006 (Health Research Board, 2006b).
2 School inclusion includes all children under 18 years in the NIDD in 2006 (Health Research Board, 2006a) and excludes home support and home help from calculation of percentage. Regular school attendance for primary and secondary students with physical and sensory disabilities estimated using the Health Research Board (2006b) figure of total registered children 5-17 years (7,095) and those not enrolled in residential primary (23) or secondary schools (42).
3 Mainstreaming includes all children under 18 years in the NIDD in 2006 (Health Research Board, 2006b) and excludes home support and home help from calculation of percentage. Mainstreamed primary and secondary students with physical and sensory disabilities estimated using the Health Research Board (2006b) figure of total registered children in primary and secondary education (6,725) and mainstream primary and secondary school enrolment (4,102). Home support (22) excluded from calculation of totals and percentages.
4 Labor Force Participation includes those in sheltered work (4,678), sheltered employment (131), and vocational training (348) (From Health Research Board 2006a). General employment for 2006 from Central Statistics Office Ireland (2006). Denominator is general population of all ages.
5 Non Sheltered employment includes those 18 yrs and over in enclaves (27), supported employment (1,608), and open employment (388). From Health Research Board (2006a). Denominator is general population of all ages.
6 We employed a content analysis methodology in which reports, studies, and other narratives were reviewed and “narrative units” related to any of the 22 Standard Rules for the Equalization of Opportunity were extracted. Three analysts worked independently to rate each nation on five-point implementation scale (0 = no evidence to 5 = full implementation). Major discrepancies were discussed and resolved. For the purposes of creating an index, the same score was assigned to both ID and general disability populations.
7 Total institutional population includes persons in long-stay hospitals and residential nursing homes, residential centres, and other intensive care provisions (4,556) out of a total estimated 2007 population of 26,750. Institutional rate for other disability based on Physical and Sensory Disability report (Health Research Board, 2006b) for residential services in 2006 (713), less those serviced in elderly care units (60), or in supported living (61). Estimated population (41,244) based on HRB estimate of having served 65.6% of the total population was used as denominator.
While it is widely acknowledged that persons with intellectual disability are disadvantaged, excluded, and denied throughout the world, the intellectual disability movement lacks simple indicators of national policies or progress. While statistical data cannot directly impact policy change, it is one of the most potent tools advocates and policymakers can use to inform and galvanize the actions of the agents of change.

The quality and scope of population statistics on intellectual disability is problematic throughout the world. Rich and poor nations alike fail to monitor intellectual disability to any degree of rigor or depth. The project initially set out to develop a working index based on data drawn from the surveillance systems, but even the most rudimentary demographic data were difficult to access in the national systems. The need for greater interest by national surveillance agencies and ministries is the most salient message to be drawn from our effort.

The task of developing a broad-based index using common international indicators will require advocacy to elevate the prominence of intellectual disabilities within national data systems. The development of an index appears feasible, though significant additional data integration would be required beyond what is currently available. Nonetheless, some general observations can be drawn from the limited data. First, the disadvantage of all persons with disabilities is consistent internationally, in poor and rich countries alike. Secondly, there are even greater disparities for those with intellectual disabilities; persons with ID remain among the most marginalized groups. Our data suggest the importance of not neglecting intellectual disability in the broader push for rights and access in the international disability movement.

The lack of quality data on the life circumstances of the world’s citizens with intellectual disabilities should command our attention. Information per se cannot change policy, but it can dramatically affect the nature of choices made by governments (Braddock, Hemp, & Fujiura, 1987). At its most fundamental level, policy making is the allocation of limited national resources among many competing interests. And the compilation of national statistics can influence political debate.
WHO HAS ID?

Who has an intellectual disability? The simplicity of the question belies the profound complexity of the answer. Who is identified will depend on the purposes and structure of measurement. There are multiple reasons for the uncertainty, mostly discussed in terms of the technicalities of definition and method of measurement. These details have been the source of debate for generations, and the matter of identification is only compounded across cultures in international assessments.

There is, however, a more profound reason for the ambiguity. Intellectual disability is not a "thing," invariant across time, places, and cultures. Rather, it encompasses overlapping groups of considerable diversity, sharing a core of set of features related to impaired cognitive function. This is more than a challenge of methodology and measurement. Intelligence, functioning, adaptation, and other dimensions of ID are so contextually bound that the exercise of dichotomizing a population as having or not having an ID will always be subject to challenge for all but the most profoundly impaired.

Estimates

Our review evaluated censuses, recurring household surveys, and registries. More often than not, these data systems were inadequate sources for ID data and we turned to local surveys and other epidemiological studies to better understand the occurrence of ID in the country. Rates ranged from 0.36% in Japan to 2.7% in Egypt, where parental consanguinity is a widely acknowledged etiological risk factor. The consolidated prevalence rate was 1.02% across the 12-nation population base of 4.2 billion persons. Although ID is often referred to as a "low prevalence" condition, the label conservatively applies to some 42 million citizens in these 12 countries.

Notes on National Prevalence Estimates

BRAZIL: "Mental Disability" is captured in the decennial Census, National Household Sample Survey, and School Census. There were approximately 2.83 million people with mental disability representing a prevalence rate of 1.67% in the 2000 Census (IBGE, 2002).

CHINA: ID is an evolving diagnostic concept in China (Tao, 1988) and thus identification is highly variable across the few systems that attempt to code for it. The first population estimate was established in the 1987 Survey of Disabled People with an overall prevalence of intellectual disability of 1.27%. A 0.43 prevalence rate was reported in the Second China National Sample Survey on Disability: the higher rate in the 1987 survey is likely attributable to the inclusion of those with mild intellectual impairments; rates by level of severity were 0.63% mild, 0.41% moderate, and 0.23% severe (Xu, Wang, Xiang, & Hu, 2005). Higher rates (1% - 1.27%) have been derived in epidemiological studies (Li, Li, & Qian, 1994; Wang et al., 2002; Zhang & Ji, 2005).

EGYPT: A relatively high 0.27% general population prevalence rate was derived in a regional (the Assiut Governorate) epidemiological screening of 3,000 randomly selected urban and rural Egyptians. Reported values were much lower in the 1996 census (0.08%), and 0.33% among children in the Egypt Multiple Indicator Cluster Survey (El Tawila, 1997), where survey rather than screening procedures were employed (Tentmam et al., 1994).

GERMANY: There are no official ID statistics apart from those registered with a "handicapped service pass" (Pomona, 2006) which yielded a value of about 0.3% general population. In contrast, the four large professional associations for ID in the Federal Republic estimated a rate of nearly 0.6% (approximately 420,000 persons in 2001), a value more in line with epidemiological screenings in Western nations.

INDIA: Much of the official statistical data on disability is met with scepticism within the Indian disability community. Recent decennial, census-based data (from 2001) yielded prevalence rates for all forms of disability comparable to many national estimates of ID (1.05%). The 2002 National Sample Survey (NSS) reported the prevalence at 0.09% population (NSS, 2003). In contrast, a meta-analysis of 13 psychiatric
epidemiological studies yielded an estimate of 0.69% (Reddy & Chandrashekar, 1998). Similar results were found in other meta-analyses of psychiatric conditions though rates were wildly variable in the individual studies, ranging from 0.14% to 2.53% (Madhav, 2001).

**JAPAN:** The Basic Survey of Persons with Mental Retardation is the primary source of official prevalence data for Japan and reported a prevalence rate of 0.36%. Epidemiological studies of childhood ID have yielded higher rates among children and youths averaging approximately 0.7% (Suzuki, Aihara, & Sugai, 1991; Yoshida, Sugano, & Matsuiishi, 2002).

**NORTHERN IRELAND:** Two systems are the primary sources of service registry data: the Child Health System and SOSCARE. The health system includes children with special needs who are monitored into adulthood. SOSCARE tracks all persons in contact with social services. ID is coded in both systems (McConkey, Spollen, & Jamison, 2003). Administrative prevalence was reported to be 0.7% for persons aged 20+ years (McConkey, Mulvany, & Barron, 2006) and 1.63% for children aged 0-19 years (McConkey et al., 2003). Administrative coverage is considered comprehensive for those in need of services.

**RUSSIA:** ID data (and social data generally) is problematic for Russia; concepts and yield terminology differ from international standards as do the diagnostic approaches. Some reports have yield prevalence rates for “mental defects” far higher than typically reported and likely represent use of imprecise terminology and a diagnostic process that can be arbitrary in labeling (Mental Disability Rights International, 1999). The primary official sources of data come from State Reports on population health that incidentally report on ID. A prevalence rate of 0.633% was reported in the State Report on population health in the Russian Federation (Koloskov, 2001).

**SOUTH AFRICA:** The primary base for ID data is taken from the 2001 Census and most recently the 2007 Community Survey. Prevalence was estimated at 0.5% in 2001 and 0.27% in the 2007 survey. As in all our reviews of national figures, these conservative values have been challenged as undercounts (Statistics South Africa, 2005). Two large-scale epidemiological efforts found significantly higher rates generally, 1.1% across all age cohorts (Community Agency for Social Enquiry, 1997; Christianson (2002), however, found major differences across subpopulations with rates as high as 3.5% among rural children).

**UNITED STATES** There is no primary base of ID data but rather different estimates taken from different federal systems. Survey based identification converges on a 0.7% rate though identification is based on self report in the major federal systems (Fujiura, 2003).
The quality and scope of population statistics on intellectual disability is problematic throughout the world. Rich and poor nations alike fail to monitor intellectual disability to any degree of rigor or depth.

There were three primary sources of national data: national or regional censuses, sample-based surveys, and administrative registries. Censuses were an enumeration of every person in a national population. The detail and depth of information in censuses tends to be severely limited due to the great cost and substantial data collection demands of national coverage. Sample-based surveys were systematic data collections conducted to provide national estimates on very specific characteristics of the population. While these specialized surveys provide greater detail on topics of relevance to the status of persons with intellectual disability, they typically fail to identify forms of disability, and the topics are largely limited to health status and employment. The third major category is the service registry, essentially an administrative tally of individuals who are the recipients of public services or benefits. While an important source of information on access to government programs or extent of service need, registry data often represents only a small fraction of the total population.

In total, we identified 128 systems (22 census, 76 recurring sample surveys and, 30 registries). Across these systems, 65.6% identified general disability in some form, while only 26.6% separately coded persons with intellectual disabilities. Thus, while the nations in our analysis have extensive systems of statistical surveillance, intellectual disability is not typically monitored.

<table>
<thead>
<tr>
<th>Domain</th>
<th>General Disability</th>
<th>Intellectual Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Demographics</td>
<td>70.5</td>
<td>27.9</td>
</tr>
<tr>
<td>Work</td>
<td>61.3</td>
<td>20.0</td>
</tr>
<tr>
<td>Education</td>
<td>76.9</td>
<td>29.5</td>
</tr>
<tr>
<td>Health</td>
<td>75.9</td>
<td>32.8</td>
</tr>
<tr>
<td>Income</td>
<td>60.4</td>
<td>18.9</td>
</tr>
<tr>
<td>Social Participation</td>
<td>58.3</td>
<td>33.3</td>
</tr>
<tr>
<td>Services and Supports</td>
<td>84.1</td>
<td>45.5</td>
</tr>
</tbody>
</table>

In addition, the identification of intellectual disability in 26.6% of all systems reviewed in our canvas vastly overstates our national capacity to actually quantify status and prospects. When assessed, ID is typically found in sampling systems where the numbers are too small to extrapolate stable national estimates from and the type of data collected are often very limited.

Lessons drawn from our review and analysis indicate that comprehensive and timely data on intellectual disability populations does not exist in even the most data rich developed nations of the world.
### BRAZIL

<table>
<thead>
<tr>
<th>Surveillance System</th>
<th>Features</th>
<th>Indicators Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Relations of Social Information</td>
<td>C ML</td>
<td>✓ 1 yr ✓</td>
</tr>
<tr>
<td>Communications of Work Accidents</td>
<td>R MSS</td>
<td>✓ 1 yr ✓</td>
</tr>
<tr>
<td>Demographic Census</td>
<td>C IBGE</td>
<td>✓ 10 yrs ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Hospital Information System</td>
<td>R MH</td>
<td>1 yr ✓</td>
</tr>
<tr>
<td>National Household Sample Survey</td>
<td>PS IBGE</td>
<td>✓ 1 yr ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>School Census</td>
<td>R ME</td>
<td>✓ 1 yr ✓</td>
</tr>
</tbody>
</table>

**Notes:**
- R = registry, C = census, PS = household probability survey; IBGE [National Statistical Office], Ministry of Education (ME), Ministry of Health (MH), Ministry of Labor (ML), and Ministry of Social Security (MSS); GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf (housing & family)/Wrk (work)/Ed (education)/He (health)/Inc (income)/Sp (social participation)/Ss (service & supports)

### CHINA

<table>
<thead>
<tr>
<th>Surveillance System</th>
<th>Features</th>
<th>Indicators Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st National Survey of Disability</td>
<td>PS multiple</td>
<td>✓ ✓ 1987 ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>2nd National Survey of Disability</td>
<td>PS multiple</td>
<td>✓ ✓ 2006 ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>China National Population &amp; Housing Census</td>
<td>C NBS</td>
<td>✓ 10 yrs ✓ ✓</td>
</tr>
<tr>
<td>Comprehensive Labour Statistics Reporting System</td>
<td>C NBS</td>
<td>✓ 1 yr ✓</td>
</tr>
<tr>
<td>Education Statistics</td>
<td>R MOE</td>
<td>✓ ✓ 1 yr ✓ 3</td>
</tr>
<tr>
<td>Health &amp; Nutrition Survey</td>
<td>PS CCDCP</td>
<td>✓ ✓ 3 yrs ✓ ✓ ✓ ✓ ✓ ✓</td>
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<tr>
<td>National Health Services</td>
<td>PS MH</td>
<td>5 yrs ✓ ✓</td>
</tr>
<tr>
<td>Survey Poverty Monitoring</td>
<td>PS NBS</td>
<td>1 yr ✓ ✓ ✓</td>
</tr>
<tr>
<td>Survey</td>
<td>PS NBS</td>
<td>1 yr ✓ ✓ ✓</td>
</tr>
<tr>
<td>Rural Household Survey</td>
<td>PS NBS</td>
<td>1 yr ✓ ✓ ✓</td>
</tr>
<tr>
<td>Statistical Reporting System Training &amp; Employment</td>
<td>R MLSI</td>
<td>✓ 1 yr 3</td>
</tr>
<tr>
<td>Urban Household Survey</td>
<td>PS NBS</td>
<td>1 yr ✓ ✓ ✓</td>
</tr>
<tr>
<td>Urban Labour Force Survey</td>
<td>PS NBS</td>
<td>1 yr ✓ ✓ ✓</td>
</tr>
</tbody>
</table>

**Notes:**
- R = registry, C = census, PS = household probability survey; China Centers for Disease Control & Prevention (CCDCP), Ministry of Education (MOE), Ministry of Health (MH), Ministry of Labour & Social Insurance (MLSI), and National Bureau of Statistics of China (NBS); "multiple = CCDCP and NC Chapel Hill Carolina Population Center; GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf (housing & family)/Wrk (work)/Ed (education)/He (health)/Inc (income)/Sp (social participation)/Ss (service & supports)

### EGYPT

<table>
<thead>
<tr>
<th>Surveillance System</th>
<th>Features</th>
<th>Indicators Included</th>
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</thead>
<tbody>
<tr>
<td>Census of Population</td>
<td>C CAPMAS</td>
<td>✓ ✓ 10 yrs ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Demographic &amp; Health Survey</td>
<td>PS MHP</td>
<td>3 yrs ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Labor Force Sample Survey</td>
<td>PS CAPMAS</td>
<td>✓ 6 mos ✓ ✓ ✓</td>
</tr>
</tbody>
</table>

**Notes:**
- R = registry, C = census, PS = household probability survey; Central Agency for Public Mobilization & Statistics (CAPMAS) and the Ministry of Health & Population (MHP); GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf (housing & family)/Wrk (work)/Ed (education)/He (health)/Inc (income)/Sp (social participation)/Ss (service & supports)

### GERMANY

<table>
<thead>
<tr>
<th>Surveillance System</th>
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</tr>
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### Appendixes xii


<table>
<thead>
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Appendices xiii
### Nigeria

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**Notes:**
- R = registry, C = census, PS = household probability survey; Ministry of Education, Culture, Sports, Science & Technology (MECSST), Ministry of Health, Labour & Welfare (MHLW), National Tax Administration Agency (NTAA), National Institute of Population and Social Security Research (NIPSSR); GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf = housing & family; Wrk = work; Ed = education; He = health; Inc = income; Sp = social participation; Ss = service & supports.

### Northern Ireland

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**Notes:**
- R = registry, C = census, PS = household probability survey; Federal Ministry of Education (FME), National Bureau of Statistics (NBS), National Population Commission (NPC), and the Universal Basic Education Commission (UBEC); GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf = housing & family; Wrk = work; Ed = education; He = health; Inc = income; Sp = social participation; Ss = service & supports.

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Health & Social Wellbeing Survey
Labour Force Survey
Mental Health Inpatients System
N Ireland Population Census
N Ireland Household Panel
N Ireland Longitudinal Study
N Ireland Omnibus Survey
N Ireland Population Census
N Ireland Household Panel
N Ireland Longitudinal Study
N Ireland Survey of Activity Limitation and Disability
Secondary School Census
School Leavers Census
SOSCARE
Travel Survey for Northern Ireland
Young Persons Behavior & Attitudes

Notes:
R=registry, C=census, PS=household probability survey; Department of Health & Social Services & Public Safety (DHSSPS), Northern Ireland Statistics & Research Agency (NISRA), Department of Economic Development (DED), Department of Education (DOE), Institute for Social & Economic Research (ISER), and Social Services Client Administration and Retrieval Environment (SOSCARE); GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf (housing & family) / Wrk (work) / Ed (education) / He (health) / Inc (income) / Sp (social participation) / Ss (service & supports)

South Africa
Annual School Survey
Community Survey
Demographic & Health Survey
Education Management Information Systems
Higher Education Management Information Systems
General Household Survey
Income & Expenditure Survey
Labour Force Survey
Population and Housing

Notes:
R=registry, C=census, PS=household probability survey; All four recurring systems attempt to identify recipients of pensions, within which disability is a code option; GD = general disability screened; ID = intellectual disability screened; Freq = frequency of administration; Hf (housing & family) / Wrk (work) / Ed (education) / He (health) / Inc (income) / Sp (social participation) / Ss (service & supports)

Appendices xv
### United States

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Notes:
- PS=household probability survey; DE=Department of Education; DH=Department of Health; SSA=Statistics South Africa
- GD=general disability screened; ID=intellectual disability screened
- Freq=frequency of administration; Hf=housing & family; Wrk=work; Ed=education; He=health; Inc=income; Sp=social participation; Ss=service & supports

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**Notes:**
- R=registry, C=census, PS=household probability survey; GD=general disability screened; ID=intellectual disability screened; Freq=frequency of administration; Hf=housing & family; Wrk=work; Ed=education; He=health; Inc=income; Sp=social participation; Ss=service & supports

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The construction of national “indicators” is a common application for national statistical data, and one that is growing in importance with the increased integration of the world’s economies. The indicator concept is simple, yet challenging in its implementation. National statistics are used as a proxy to represent a dimension of a country in a single quantitative value. Gross domestic product, for example, combines multiple statistics on consumer and government spending, import and export activity, and other indicators as a representation of the size of a nation’s economy. Examples of social indicators include development, educational achievement, health, human development, human rights, and others.

**Starting Point**

As a starting point we considered a core set of indicators: access to education, education within “regular” schools, inclusive education (integrated classes), employment (open and sheltered), institutionalization, and national disability policy as evaluated through the Standard Rules. While many important domains are omitted in this list (e.g., health, participation, quality of life, and others), others such as education, employment, and deinstitutionalization are core policy objectives for intellectual disability communities across nations and cultures, and as a practical matter, the types of outcomes most likely to be monitored in national statistics.

**Comparing Across or Within?**

An important conceptual issue is the benchmark’s intended use -- to compare nations on a standard set of criteria, (such as, “no institutions”) or to focus on equity within a nation (for example, “equal access to primary education”). The former is most often employed in establishing goalposts for nations, but the latter application has the advantage of communicating goals more meaningful to local circumstances.

The index employed in our exploration contained elements of both approaches. Some indicators were based on fixed criteria or outcomes represented in absolute values: persons with ID should be educated with their peers, should not be institutionalized, and the home country should adhere to the Standard Rules. Education and employment, however, cannot be readily set at absolute values without taking into consideration national capacity. If the local economy provides minimal salaried employment, is there utility in promoting a benchmark for full employment for those with intellectual disabilities? This is an extension of the concept of statistically measuring equalization of opportunity recently explored in international disability statistics forums (Altman et al., 2003). Of course, the determination of fixed versus relative is based on our values; indicators employed and the manner in which they are benchmarked ultimately represent a conversation of profound importance for those who measure. For now, the index construction serves, albeit simplistically, the purposes of our exercise.

**Availability of Indicators**

Not unexpectedly our access to data and domains of indicators was variable across nations. In the aggregate, international data as currently constructed is not adequate for the construction of a reliable or valid benchmark. Data is limited in both quantity and quality. As our summary of surveillance systems indicates, ID is rarely systematically considered in the national statistical programs. For the most part, the index as shown on the following pages is cobbled together from estimates, imputed values, special studies, and extrapolations.

<table>
<thead>
<tr>
<th>Number of Computed Indicators by Country</th>
<th>ID</th>
<th>Other Disability</th>
<th>ID</th>
<th>Other Disability</th>
<th>ID</th>
<th>Other Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>China</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Egypt</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Germany</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

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Findings
National data consistently portray a population that is largely marginalized, regardless of national development or wealth. A nation’s citizens with intellectual disability are at a significant disadvantage, even when compared those with other disabilities. Shown in the table below are the index scores averaged across nations for persons with intellectual disability and those with other forms of disability. A value of 1.0 would indicate full parity to the general population in the same country. While our data are exploratory at best, they indicate that persons with intellectual disability are marginalized throughout the world.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Other Disability</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to education</td>
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<td>.63</td>
</tr>
<tr>
<td>School inclusion</td>
<td>.68</td>
<td>.52</td>
</tr>
<tr>
<td>Classroom inclusion</td>
<td>.47</td>
<td>.10</td>
</tr>
<tr>
<td>Participation in labor</td>
<td>.51</td>
<td>.33</td>
</tr>
<tr>
<td>Non sheltered work opportunity</td>
<td>.64</td>
<td>.14</td>
</tr>
<tr>
<td>Institutionalization</td>
<td>.96</td>
<td>.87</td>
</tr>
</tbody>
</table>

*excludes Nigeria for which indicators were not available


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