

PROFILE OF THE DISABLED POPULATION IN ALBANIA

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EXECUTIVE SUMMARY

Disability and vulnerability are dynamic and intricately linked phenomena. In developed countries, a large body of empirical research shows that persons with disabilities experience inter-alia comparatively lower educational attainment, lower employment and higher unemployment rates, worse living conditions, and higher poverty rates. In developing countries, the still limited body of empirical research points toward individuals with disabilities being often economically worse off in terms of employment and educational attainment, while at the household level, the evidence is mixed. Deriving any conclusions on the association between disability and poverty in developing countries from this literature is problematic, given the lack of comparability of the disability measures, economic indicators, and methods in these studies.

This study aims to contribute to the empirical research on social and economic conditions of people with disabilities in Albania. Using data which not only covers extensively the entire country, but also that includes a thorough measure of disability, this study presents a snapshot of economic and poverty situation of persons with disabilities and their households as of 2011/2012 in Albania. The study uses data from the 2011 Census and the 2012 Living Standard and Measurement Survey (LSMS), both of which include disability measures. It is essential to note that both datasets are cross-sectional, and hence this study can only describe the socioeconomic situations of persons with disabilities at one point in time. No conclusions about the causality between disability and poverty should be drawn based on the descriptive statistics this study presents.

This research is relevant for several reasons. First, it represents the first attempt to quantify and profile the population with disability in Albania. Prior information on health limitations was collected in previous versions of the Albanian LSMS, but the data collected were not thorough. Second, by providing a baseline data on the socioeconomic situation of people with disability in Albania and their households in 2011/2012, it can inform additional disability policies.

The report identifies six major groups of individuals with disabilities. The first two groups of individuals with multiple severe disabilities and no education should be supported through social transfers in order to afford medical support. The next two groups of individuals with disabilities are pensioners, with limited disability, who are too old to work, and need support to go through retirement. The last two groups of individuals with disabilities are people in age of working, with secondary education and either hearing or seeing disabilities, who need support to be included in the labor market.



ACRONYMS

INSTAT	Albania Institute of Statistics
LCA	Latent Class Analysis
LSMS	Living Standard and Measurement Survey
SA	Social Assistance
SP	Social Protection
WG	Washington Group
WHO	World Health Organization

6.2% *of the adult population
in Albania is disabled*

*Disabled working-age adults are **2** times
more likely to be out of the labor force
than non-disabled adults*

1 *in* **5** *youth (15-24 year-old) with vision restriction
is looking for a job but cannot find one*

*Disability prevalence does NOT vary across
income quintiles*

*Disabled persons from the bottom quintile are
2 times more likely to experience
or more disabilities than the top quintile*

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RATIONALE

In both developing and developed countries, disability is believed to be a correlate of poverty and social exclusion, with implications for individuals' access to services, educational attainment, labor force participation, and consumption.

Disability and poverty are complex, dynamic and intricately linked phenomena with two-way causation: the onset of disability may increase the risk of poverty and social exclusion, while poverty and social exclusion may increase the risk of disability. While these relations are commonly assumed and have been noted in literature, there has been little systematic empirical evidence in developing countries. Indeed, difficulties in measuring disability and the lack of good statistical information have conspired against the efforts to empirically disentangle the causal pathways between poverty and disability status. Mitra, Posarac, & Vick (2012) draw a detailed overview of the potential causal pathways between poverty and disability, from which this report will be extensively drawing. The evidence presented in their article uses a subset of 15 developing countries, but only offers an economic profile of people with disabilities due to data limitation – cross-sectional surveys with no recall information. The World Bank (2008) makes an attempt at identifying the impact of disability and chronic illness on schooling, employment, and earnings, using a subset of Eastern Europe and former Soviet Union countries.

On the other hand, in developed countries, multiple data sources are available and descriptive statistics on various aspects of social and economic wellbeing of persons with disabilities is commonly compiled and published. Some countries, notably the United States and members of the European Union, also have longitudinal panel surveys which are necessary for empirical analysis of the linkages between disability and poverty; for example, for answering the questions on how the onset of disability affects the socioeconomic situation of an individual and her/his family and how poverty affects the onset of disability. In contrast, in developing countries descriptive statistics are rare, fragmented and sporadic and longitudinal surveys are altogether lacking.

This study aims to contribute to the empirical research on social and economic conditions of people with disabilities in Albania. Using data which not only covers extensively the entire country, but also that includes a thorough measure of disability, this study presents a snapshot of economic and poverty situation of persons with disabilities and their households as of 2011/2012 in Albania. The study uses data from the 2011 Census and the 2012 Living Standard and Measurement Survey (LSMS), both of which include disability measures. It is essential to note that both datasets are cross-sectional, and hence this study can only describe the socioeconomic situations of persons with disabilities at one point in time. No conclusions about the causality between disability and poverty should be drawn based on the descriptive statistics this study presents.

This research is relevant for several reasons. First, it represents the first attempt to quantify and profile the population with disability in Albania. Prior information on health limitations was collected in previous versions of the Albanian LSMS, but the data collected were not thorough. Second, by providing a baseline data on the socioeconomic situation of people with disability in Albania and their households in 2011/2012, it can inform additional disability policies.

This study is structured as follows. Section 1 provides definitions and some background on disability and exclusion, it describes the data and methods used. Section 2 presents disability prevalence and results on the economic wellbeing of the population with disability at the individual and household levels. Section 3 presents the barriers faced by people with disability that can lead to social exclusion and poverty. Section 4 investigates how well social protection programs cover people with disability. Section 5 displays the results of a profiling of people with disability using Latent Class Analysis. Section 6 concludes.



1. BACKGROUND

This section presents definitions and some background information on disability.

Definitions

Measuring disability

Because disability is not a readily identifiable attribute such as gender or age, but a complex, dynamic interaction between a person's health condition and physical and social environment, it has proven very difficult to measure. Three disability measures have been commonly used in applied disability research: measures of impairment, functional limitation measures, and activity limitation measures. Impairment measures of disability focus on the presence of impairment intrinsic to the individual. For example, individuals may be queried about impairments that might include blindness, deafness, mental retardation, speech impairment and stuttering, complete or partial paralysis. These measures were widely used in the past. More recently, measures of functional limitations focus on limitations experienced with particular bodily functions such as seeing, walking, hearing, speaking, climbing stairs, lifting and carrying, irrespective of whether the individual has an impairment or not. Finally, activity limitations measures focus on limitations in activities of daily living such as bathing or dressing. Activity limitations may also include participation limitation in major life activities such as going outside the home, work or housework for working-age persons, and school or play for children.

The Washington Group (WG) General Measure on Disability

This report uses the second disability measure, i.e. functional limitations. The Washington Group (WG) general measure on disability identifies persons who are at greater risk than the general population of experiencing restrictions in performing tasks (such as activities of daily living) or participating in roles (such as working). Measurements intended to identify this "at risk" population represent the most basic end of the spectrum of activities (i.e. functional activities such as walking, remembering, seeing, hearing). This "at risk" group includes persons with limitations in basic activities, people who may or may not also experience limitations in more complex activities and/or restrictions in participation depending in some instances on whether or not they use assistive devices, have a supportive environment or have plentiful resources.

The Washington Group has developed a question set for use on national Censuses for gathering information about limitations in basic activity functioning among national populations. The questions were designed to provide comparable data cross-nationally for populations living in a great variety of cultures with varying economic resources. The objective is to identify persons with similar types and levels of limitations in basic activity functioning regardless of nationality or culture. It is not designed to identify every person with a disability within every community, neither should it be considered to be a substitute for populations evaluated across a wider range of domains that would be possible in other forms of data collection or in administrative data.

For the reasons of simplicity, brevity and comparability, the choice was made to identify limitations in six domains of basic activity functioning that are found universally, which are most closely associated with social exclusion, and which occur most frequently. The information that results from the use of these questions is expected to (i) represent the majority, but not all persons with limitation in basic activity functioning in any one nation; (ii) represent the most commonly occurring limitations in basic activity functioning within any country; and (iii) capture persons with similar problems across countries.

Data

The analytical work on profiling people with disability is performed using the 2011 Census and the Washington Group (WG) general measure on disability. In addition, the linkages between disability and social exclusion are studied using the 2012 Living Standard and Measurement Survey (LSMS), along with a slightly different measure of disability.

As highlighted in Box 1, the 2012 LSMS and 2011 Census are not perfectly comparable in their measurement of disability, as they ask a different set of questions to measure people's difficulties in performing everyday tasks. Because the most widely accepted measure of disability is that designed by the Washington Group and applied in the Census, incidence and severity of disability will be measured exclusively using Census data. The census however, has limited information on wealth status and social protection transfers. The analysis of the interaction of disability, poverty, and social assistance transfers will thus be conducted using the 2012 LSMS.

Box 1: Differences between 2011 Census and 2012 LSMS

The 2011 Census and 2012 LSMS lead to different estimates of disability prevalence: 6.2 and 2.5 respectively. Three major methodological differences may explain why the numbers vary between the two surveys.

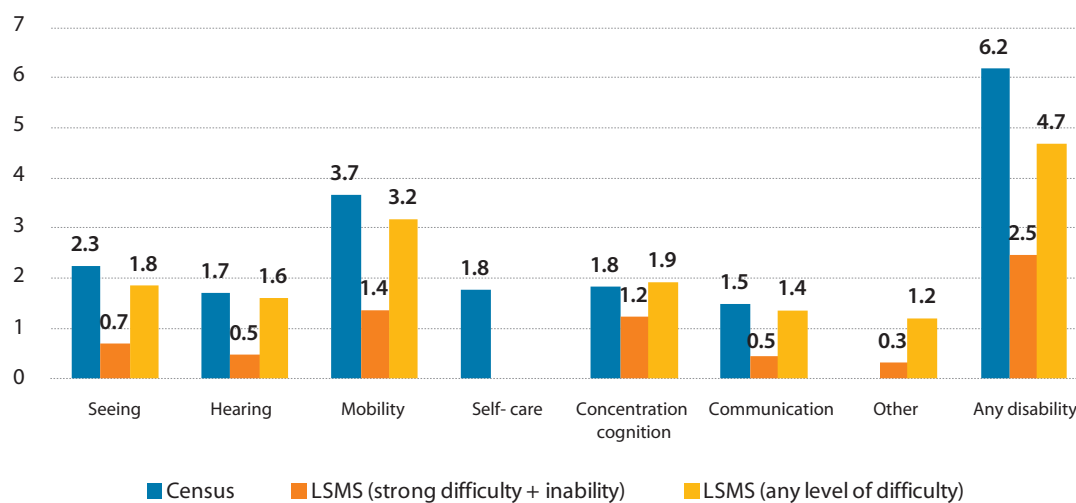
Firstly, the set of questions identifying in which dimensions individuals face difficulties are slightly different. The Census follows to the letter the set of six questions defined by the WG: seeing, hearing, mobility, self-care, cognition, and communication. An individual is considered disabled if s/he reports strong difficulty or inability to perform at least one of the above-mentioned activities. On the other hand, the LSMS questionnaire includes seven questions, including difficulties in seeing, hearing, body deformation, limbs, cognition, communication and other. The two questionnaires overlap exactly on four questions (seeing, hearing, cognition and communication) and the mobility question from the Census corresponds roughly to the body deformation and limbs questions from the LSMS. The LSMS thus misses difficulties in self-care.

Secondly, the Census asks every individual if s/he faces any difficulty in any of the 6 categories mentioned above, while the LSMS first asks individuals if they face any kind of disability over the course of the past 3 months, and only then asks the type and level of difficulty each person faces, only for those who answered "yes" to the initial filter question on disability. The presence of the filter question will mechanically lower the disability prevalence rate, even if the questions are the same afterwards.¹

Finally, the main objective of the LSMS is to measure the socioeconomic situation of the Albanian households, and the survey was designed to capture that information above all. The measurement of disability was not the main objective of the survey, which can explain why disability estimates may slightly differ from those obtained by the 2011 Census, which was specifically designed to estimate disability.

Figure 1 shows that estimates of disability prevalence are significantly lower when using the LSMS data, especially when concentrating on the population with severe difficulties – i.e. the Census definition. As mentioned in Box 1, this is probably due to the "filter" question which will mechanically lower the disability prevalence rate among the national population.

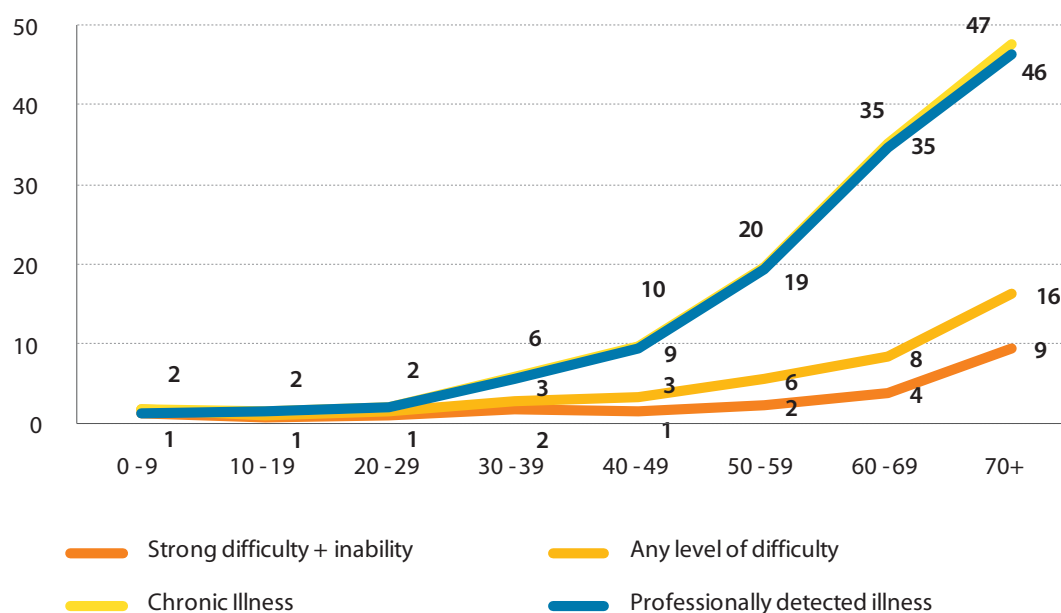
¹ For a complete view of the questions asked in the 2011 Census and the 2012 LSMS, refer to Annexes 2 and 3.

Figure 1: 2011 Census and 2012 LSMS – Comparability issues

Note: Data from the LSMS are presented first in **orange** using the same level of difficulty as in the Census, and second **yellow** using any level of difficulty in performing daily tasks (which includes some difficulty, strong difficulty and complete inability).

Source: 2011 Census, 2012 LSMS.

But even though different disability proxies lead to significantly different disability prevalence estimates, they are correlated with one another. Figure 2 shows that severe, soft disability, chronic illnesses and professionally detected illnesses are strongly correlated. Furthermore, evidence from the LSMS confirms the sharp age gradient in the reporting of health ailments, especially for the reporting of chronic and professionally detected illnesses. This may be explained by the fact that invalidity pensions are tied to professional detection by a medical doctor: older individuals may have more incentives to go to a medical doctor to assess their health status.

Figure 2: Different definitions of disability incidence by age group

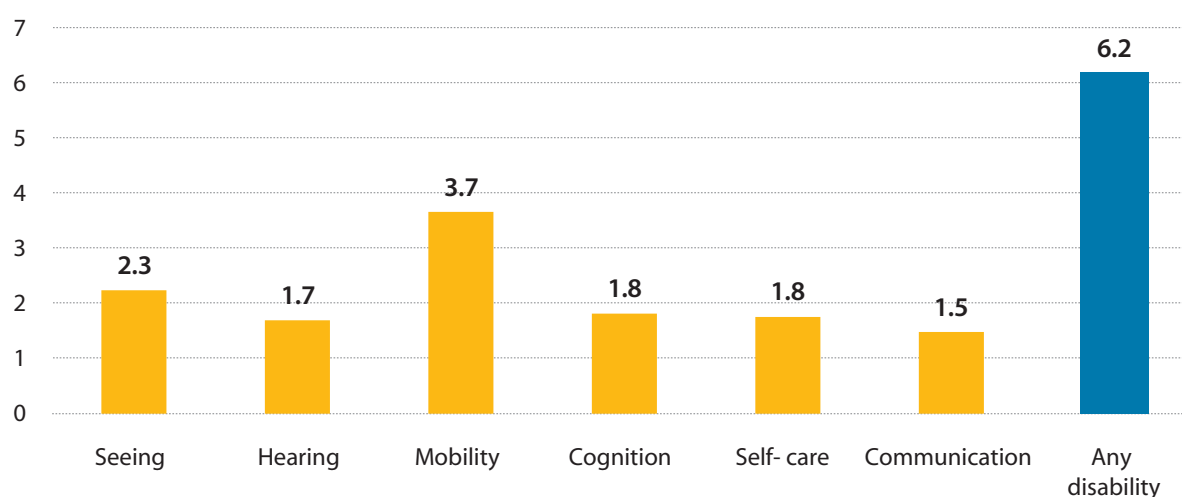
Source: 2012 LSMS.

2. PROFILE OF DISABLED POPULATION

National estimates

6.2 percent of the adult population² in Albania - or 2,084,137 persons - suffer from some sort of disability (see Figure 3). The figure refers to people who identify themselves as having severe or extreme difficulty in at least one of the following: seeing, hearing, mobility, cognition, self-care, communication, or disability. The most commonly encountered type of disability is movement restrictions (3.7 percent), and the least common ones are hearing and communication (1.7 and 1.5 percent respectively), while vision, learning and self-care fall somewhere in between. These results are consistent with the evidence from other Eastern European and former Soviet Union countries (World Bank, 2008).

Figure 3: Disability prevalence by type of impairment (percent, %)



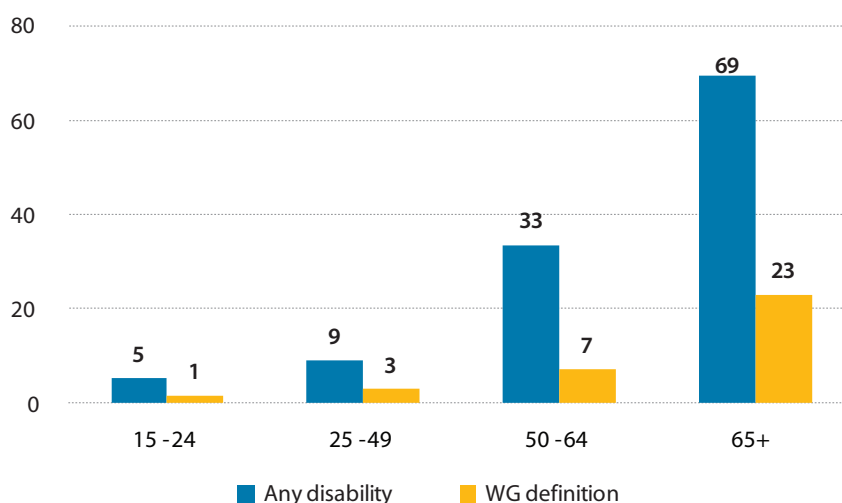
Note: sample restricted to the population aged 15 years and above. The last column shows people with at least one of the six disabilities displayed in yellow.

Source: 2011 Census.

Severity

While 6.2 percent of the adult population in Albania is disabled according to the WG definition, the numbers rise to 22 percent when "some difficulty" is included. 22 percent of the population thus reports having some difficulty, strong difficulty or inability to perform daily tasks. The gradient between "some limitation" in carrying out tasks and the WG measure of disability is steepest for the oldest working-age group: individuals with strong disability usually constitute one third of the population with at least some disability, but among people aged 50-64 that share drops to one fifth. A disproportionately large share of individuals 50-64 starts experiencing some restrictions in their daily activities (see Figure 4).

² Population aged 15 years and above. Statistics are presented on a restricted sampled of the population due to the large number of erroneous responses for children: mothers often qualified their children as experiencing difficulties in walking for instance, when they were not yet in age of walking, or self-care, when they were still being taken care of by their mothers.

Figure 4: Severity of disability (percent, %)

Note: sample restricted to the population aged 15 years and above. WG definition refers to individuals with strong difficulty or inability to perform a task, while “any disability” refers to individuals who report some difficulty, strong difficulty, or inability to perform a task.

Source: 2011 Census.

Table 1: Correlation of scores for domains of disability

	Seeing	Hearing	Mobility	Cognition	Self-care	Communication
Seeing	1					
Hearing	0.61	1				
Mobility	0.55	0.59	1			
Cognition	0.47	0.58	0.60	1		
Self-care	0.45	0.53	0.62	0.75	1	
Communication	0.40	0.54	0.52	0.79	0.79	1

Source: 2011 Census.

The measures of disability by type are all positively correlated with one another (see Table 1). A priori, there is no need to expect high levels of correlation: an illness that leads to the inability to see might have no effect on the person's ability to walk a kilometer, and an accident that might limit a person's ability to walk could well have no impact on his or her ability to communicate. In fact, physical limitations such as seeing, hearing and mobility are the least strongly correlated with one another, and even less strongly correlated with cognitive, communication and self-care limitations. On the other hand, indicators of various functioning limitations can be highly correlated if the incidences of these limitations are driven by common factors such as aging, poverty, poor health care infrastructure, or unfavorable environmental conditions. Looking at the last three categories of limitation, i.e. cognition, self-care and communication, one can detect much stronger correlation between one another.

Geographic breakdown

The results don't vary much across regions. The capital city, Tirane, displays the lowest incidence of disability, with less than 5 percent of its adult population self-reporting disability. On the other end of the spectrum, Gjirokaster records 8 percent of its adult population as disabled. There are no drastic differences between prefectures in the prevalence of each of the daily limitations that people face.

Annex 6 shows maps of disability incidence by commune and disability concentration. As with poverty and social exclusion, disability incidence is higher in less connected areas, but concentrated – in terms of absolute numbers – around the biggest agglomerations: Tirane, Durrës, Shkodra, Elbasan.

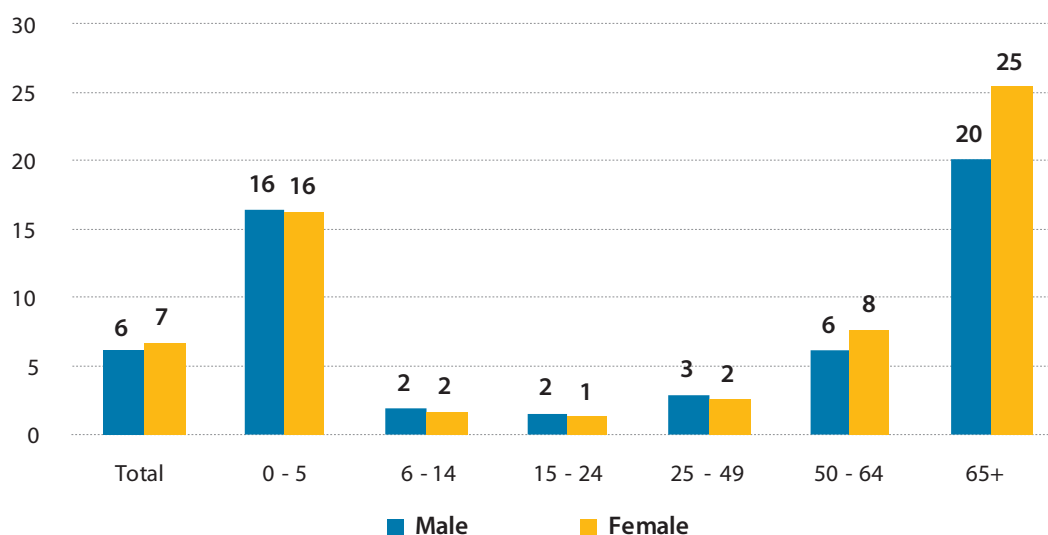
Table 2: Population with disability by region (15 years and above)

Prefecture	Seeing	Hearing	Mobility	Cognition	Self-care	Communication	Any disability
Berat	2.7	1.9	4.2	2.2	2.2	1.8	7.3
Diber	1.8	1.6	3.7	2.0	1.9	1.9	6.0
Durres	2.1	1.6	3.5	1.6	1.7	1.3	5.8
Elbasan	2.6	2.0	4.2	2.2	2.0	1.7	7.1
Fier	2.5	1.9	3.8	2.2	2.1	1.8	6.6
Gjirokaster	3.3	2.5	4.7	2.4	2.2	2.0	8.0
Korce	2.1	1.8	3.5	1.9	1.6	1.4	6.4
Kukes	1.8	1.6	3.9	2.2	2.0	1.8	6.0
Lezhe	2.6	1.7	4.3	1.8	2.0	1.5	6.8
Shkoder	2.5	1.8	4.6	1.9	2.0	1.6	7.3
Tirane	1.7	1.3	2.8	1.3	1.3	1.0	4.8
Vlore	3.0	2.1	4.1	2.2	2.1	1.8	7.2
Total	2.3	1.7	3.7	1.8	1.8	1.5	6.2

Source: 2011 Census.

Age and gender

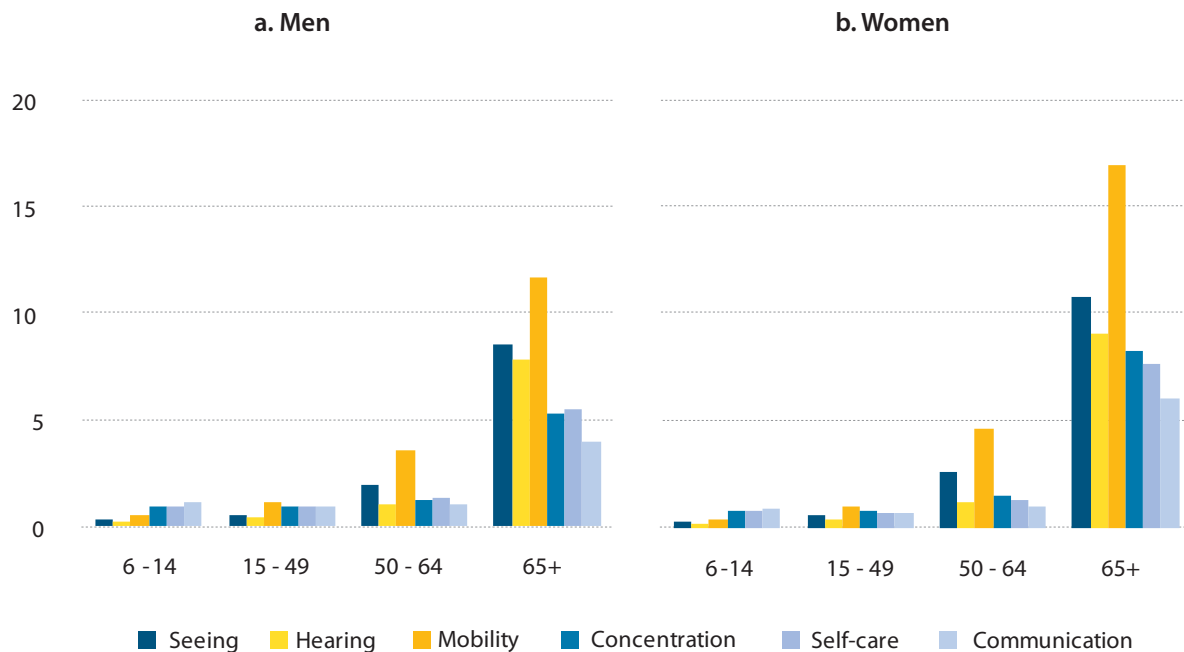
Disability prevalence is very much linked to age, with older age cohort being more affected by difficulties in performing daily tasks (see Figure 5). Youth and prime age population record low levels of disability, below 3 percent for both sexes. On the other hand, older working-age cohorts (50 to 64 years old) already start displaying larger incidence of disability: 6 and 8 percent respectively for men and women. Finally, the gradient between men and women sharpens, as individuals become older: respectively 20 and 25 percent of men and women above 65 report experiencing at least one severe difficulty in carrying out daily tasks.

Figure 5: Disability prevalence by age group

Source: 2011 Census.

Looking more closely at the type of disability experienced and age and gender groups, one notices a sharp increase of physical difficulties with age, especially among women (see Figure 6): 17 percent of women over 65 have limited mobility (15 percent for men), and about 10 percent of men and women have either vision or hearing limitations. Mobility restrictions can already be observed among the 50-64 year-old group, where about 5 percent of men and women report such a limitation. Cognitive, communication and self-care restrictions are less common and only rise among those 65 years and above, again with a strong gender gradient: 5 percent of men are affected while about 8 percent of women over 65 are.

Figure 6: Disability prevalence by type of disability and age group



Source: 2011 Census.

The sharp rise in disability, mirroring those from the LSMS in Figure 2, may have to do with the fact that disability benefits are highly concentrated among people over age 50, affecting whether the surveyed individuals identify themselves as disabled when approached by interviewers. One implication of these findings is that aging populations can expect the prevalence of disability to increase substantially over time. Even if medical advances, positive changes in preventive health behavior, and improvements in health care service delivery slow down this trend, their impact is unlikely to be large enough to undo the aging effect.

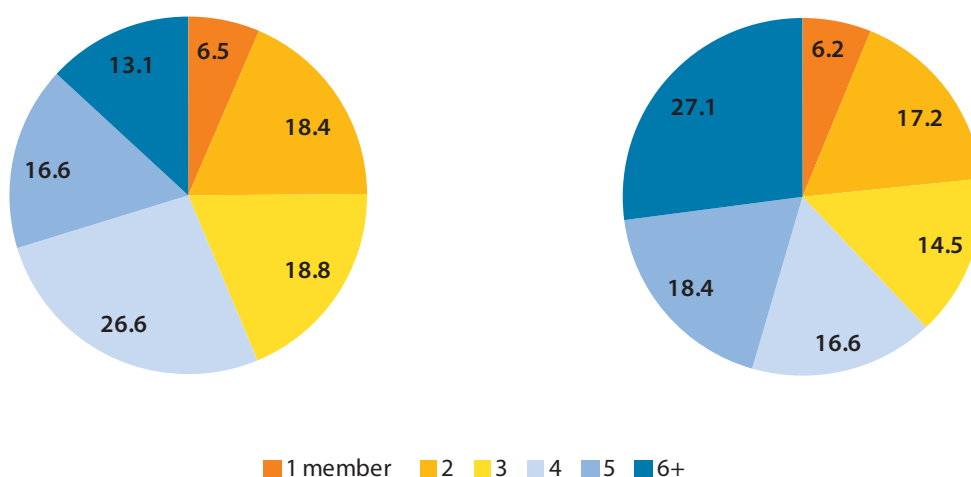
Household composition

Individuals with disabilities are concentrated in larger households (see Figure 7). Only 13 percent of households with no disabled member have 6 or more members, while 27 percent – or two times as much – of households with at least one disabled member have 6 or more members.

Figure 7: Population with disability by household composition

a. No disabled household member

b. At least one disabled household member



Source: 2011 Census.

3. DISABILITY, POVERTY AND SOCIAL EXCLUSION

Poverty and ill health are shown to be interconnected. Numerous WHO publications show that (i) higher income and social status are linked to better health; (ii) low education levels are linked with poor health, more stress and lower self-confidence; (iii) safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health; (iv) people in employment are healthier, particularly those who have more control over their working conditions; (v) greater support from families, friends and communities is linked to better health; (vi) access and use of services that prevent and treat disease influences health; and finally (vii) customs and traditions, and the beliefs of the family and community all affect health.

Disability, poverty and social exclusion

Mitra et al. (2012) show that the onset of disability may lead to lower living standards and poverty through adverse impact on education, employment, earnings, and increased expenditures related to disability. Stigma associated with a health condition may lead to activity limitations and participation restrictions given a particular social and cultural context and it might be worsened by the stigma associated with poverty. Environmental factors due to limited resources in the community, leading for instance to an inaccessible physical environment, make it difficult for an individual with a disability to have activities and participate in the community, further reinforcing poverty and social exclusion.

Conversely, poverty may also increase the likelihood that a health condition may result in disability, through malnutrition, diseases whose incidence and prevalence are strongly associated with poverty, lack of inadequate public health interventions (for example, immunization), poor living conditions (for example, lack of safe water and sanitation), environmental exposures (for example, unsafe work environments), and injuries (intentional and unintentional; for instance, vulnerable buildings in the context of natural disasters).

Poverty may also increase the likelihood that a health condition may result in impairment, activity limitation, or participation restriction. This could be the case if there is a lack of health care and rehabilitation services or a lack of resources to access those that are available. In poor communities where such services are not provided or are of low quality, health conditions may be more likely to lead to disability. And even when such services are available, they may not be affordable.

Individual education

Disability may prevent school attendance of children and youth with disabilities and restrict human capital accumulation and may later on lead to limited employment opportunities and reduced productivity for persons with a disability onset at birth or during childhood. As mentioned by Mitra et al (2012), standard labor economics theory predicts more limited investments in education for children with disabilities due to lower expected returns from education in terms of employment outcomes. The relevance and intensity of this link will vary depending on many factors, including the socioeconomic status of a family before the onset of childhood disability, the timing of disability onset (for example, at birth, early childhood, towards old age), the type and severity of disability, the interaction between individual's disability and the school environment in the community, as well as the cultural and education policy background.

In Albania, disabled children are overrepresented in the category of primary-school-aged children *not* attending school, especially when having hearing and mobility difficulties. While 96 percent of children aged 6 to 14 in the non-disabled population are attending school, only 75 percent of children with some disabilities are enrolled. The numbers are slightly higher for girls compared to boys – respectively 7 and 4 percent. The picture varies greatly by type of disability faced by children: more than two thirds of the children with eyesight, communication, cognition and self-care impairments are enrolled in school. On the other hand, only half of children with hearing difficulties or mobility difficulties are attending schools (see Table 3).

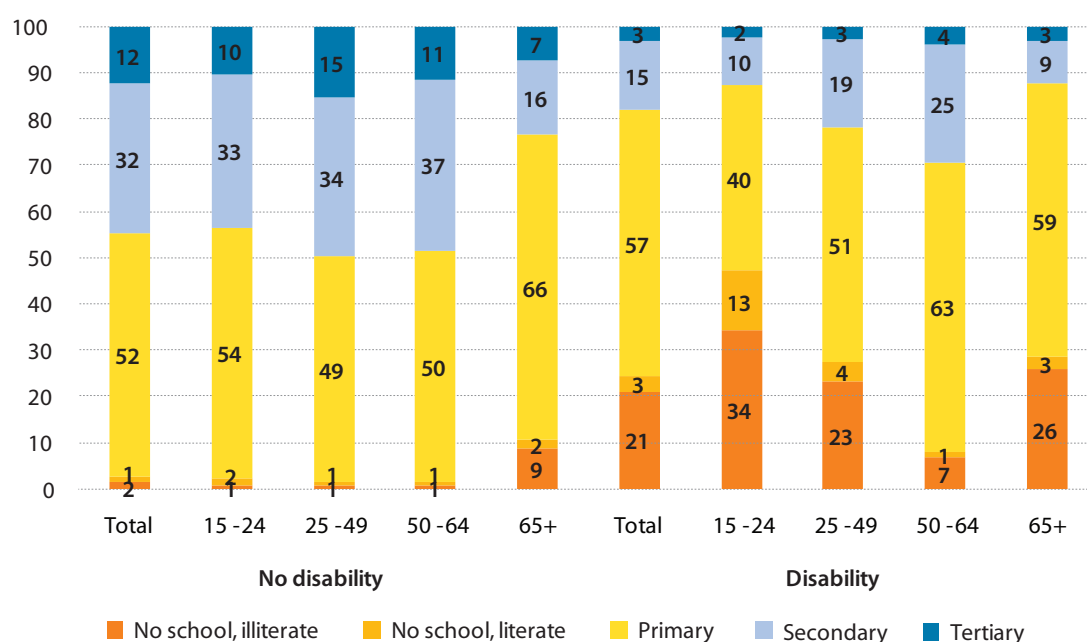
Table 3: School enrollment (6-14 year-old)

		Yes	No, but attended in the past	No, never attended
No disability		96.0	2.8	1.2
Any disability	Male	73.4	3.2	23.4
	Female	76.6	3.8	19.6
	Total	74.8	3.4	21.7
Seeing		74.6	4.7	20.7
Hearing		48.3	5.8	45.9
Mobility		51.9	5.9	42.2
Cognition		66.1	3.1	30.8
Self-care		64.6	3.4	32.0
Communication		68.6	2.4	29.0

Source: 2011 Census.

Consequently, disabled persons display lower educational attainment than their valid peers (see Figure 8). While less than 3 percent of non-disabled adults never attended school, one in four disabled adult was not able to attend school, the vast majority of which remained illiterate. This is particularly true for youth (15-24 years-old) who experienced physical and cognitive restrictions early on in their lives, as educational facilities adapted to their needs may not be available, accessible and/or affordable. In addition, two thirds of the non-disabled population graduates from secondary school and another 12 percent graduates from university, while less than two thirds of people with disability make it to secondary school, and only 3 percent attend university. As expected, older generations have lower educational attainments, for both disabled and non-disabled persons. But the educational gap is especially high for two groups: the youngest cohorts (15-24 years old) and the oldest cohort (65 years and above). The education gap between non-disabled and disabled individuals is thus huge: individuals with disabilities are much more likely to stay out of the school system, and when they do attend, they are more likely to stop after primary school.

In addition, children living in households led by a disabled household head are less likely to attend school. The difference is not so stark for primary-school-aged children, who are 1.8 percentage points less likely to go to school when their father or mother has a disability. But it is quite significant when looking at youth aged 15 to 24: if the household head is valid, the probability of their children being enrolled in school is 49 percent, but if your household head is disabled, that probability drops to 38 percent, or 20 percent less.

Figure 8: People with disability have lower school achievements

Note: sample restricted to the population aged 15 years and above.

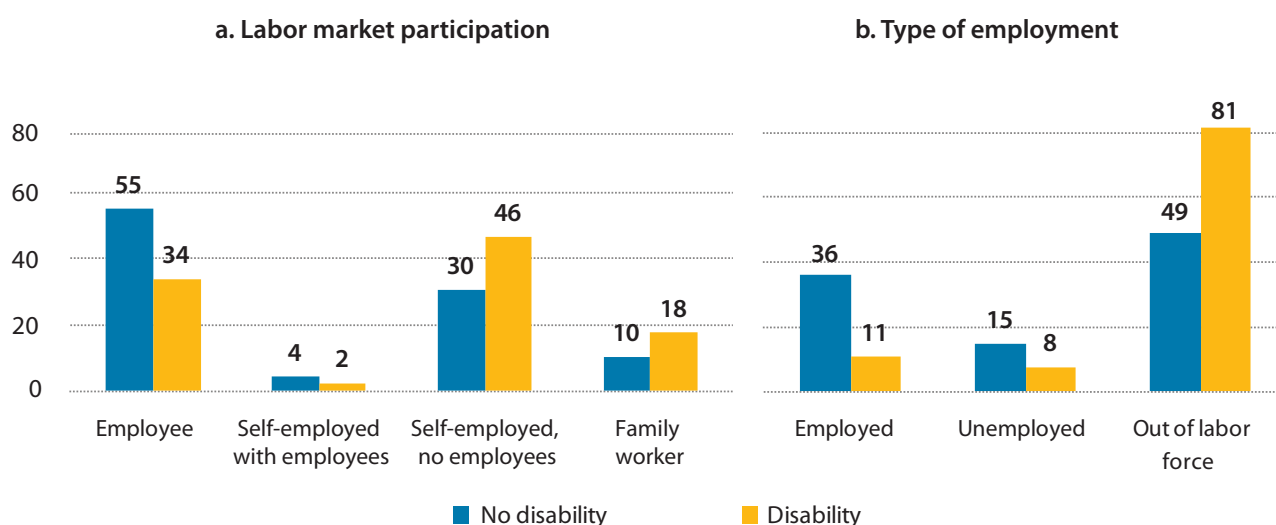
Source: 2011 Census.

Individual employment

Disability may prevent work, or constrain the kind and amount of work a person can do. Mitra et al (2012) show that the employment rate is expected to be lower for persons with disabilities due to higher reservation wages (as individuals with disabilities sometimes face work disincentives as a result of the availability of benefits) and lower market wages as a result of lower productivity and/or discrimination.

In practice, the extent of this negative effect of disability on employment will vary depending on a variety of factors, starting with the individual's type of disability, the timing of disability onset (at birth, during childhood or adulthood), its duration (temporary or permanent) and how it relates to his/her occupation. In an agrarian economy, as is often the case in developing countries, most jobs are in the primary sector (agriculture, forestry) and may involve heavy manual labor, which persons with walking or carrying limitations may not be able to do. The effect of disability on employment will also depend on the work place, its accessibility, available accommodations, and whether there is discrimination that might prevent access to employment and/or might lead to lower wages. Additionally, the relevance and intensity of this pathway depend on the cultural context in so far as negative attitudes toward the employment potential of persons with disabilities in society at large or within the household might limit access to work. The policy context is also relevant and depends on the availability of vocational rehabilitation programs, disability insurance or social assistance program.

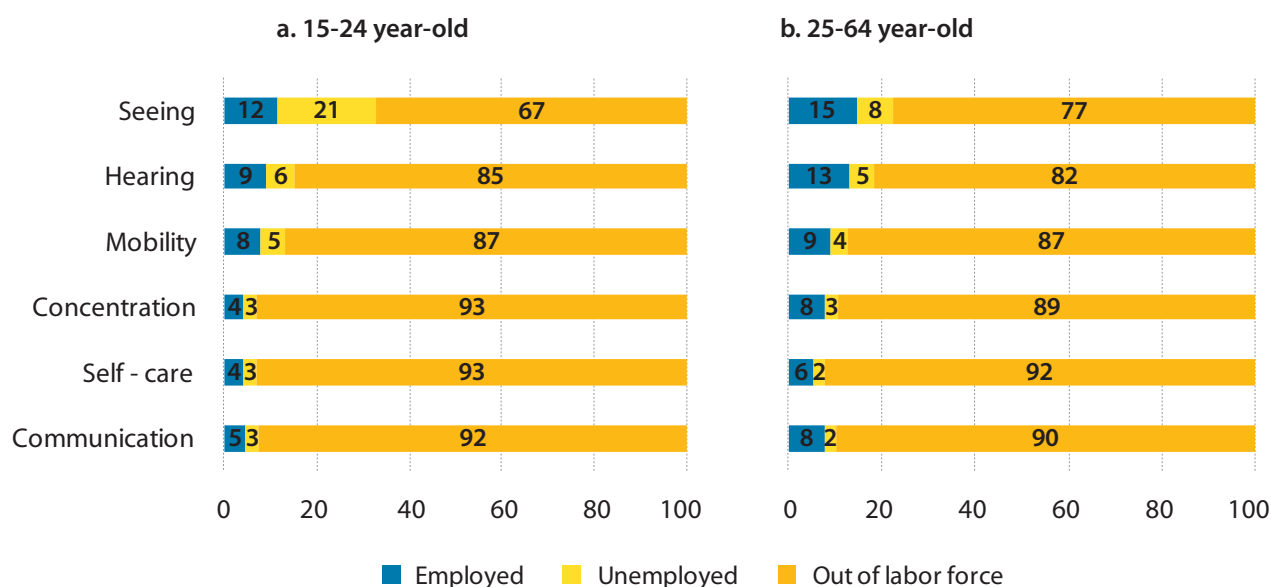
In Albania, disabled adults are much less likely to be participating in the labor market than their non-disabled peers (see Figure 9). Half of the non-disabled adult population is engaged in the labor market, either because they are employed, or because they are looking for work (unemployed). On the other hand, 8 in 10 disabled working-age adults are out of the labor force, i.e. neither working nor looking for work. Consequently, disabled adults are 5 times less likely to be working than the non-disabled population. There are no stark gender disparities, as both non-disabled men and women are both 5 times more likely to be engaged in employment as respectively disabled men and women. Evidence on transition countries shows that disabled working-age adults are systematically less likely to work than non-disabled adults: this ranges from a high of 60 percentage points less likely to work in Moldova, to a low of 20 percentage points in Bosnia and Herzegovina (Mete, 2008). In addition, workers with disability are much more likely to be working as family workers or self-employed without employees than their valid counterparts.

Figure 9: Disabled individuals are less integrated in the labor market

Note: sample restricted to the population aged 15 to 64 years old.

Source: 2011 Census.

In addition, it is useful to recognize the heterogeneity among the disabled population in this context, because some of the disabled may be more disadvantaged in terms of employment compared to the rest. Those with cognitive, self-care and communication restrictions emerge as the most disadvantaged in terms of employment prospects (see Figure 10). Individuals with physical restrictions are more likely to work, and also more likely to want to work: people with vision, hearing and mobility impairments are 2 to 3 times more likely to be employed than people with severe difficulties in concentration, self-care and communication. Furthermore, people with vision limitations, especially the youth, record very high probabilities of being unemployed: 1 in 5 visually-impaired youth is not working but looking for a job and ready to take one, suggesting strong barriers to employment for people who would prefer to work.

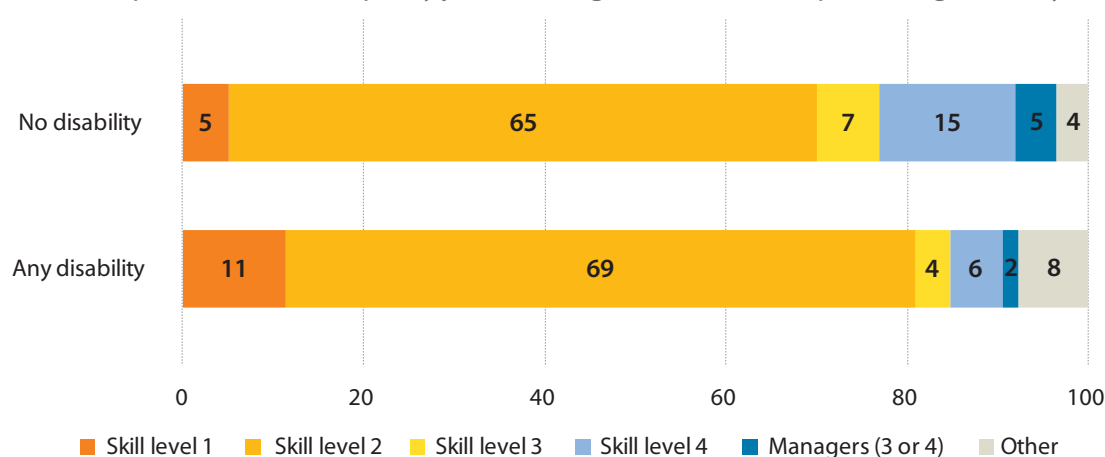
Figure 10: Disability and employment

Note: sample restricted to the population aged 15 to 64 years old.

Source: 2011 Census.

There is a higher prevalence of holders of low quality jobs in the disabled working population (see Figure 11). Disabled workers are twice as likely to be engaged in activities with the lowest skill level, i.e. people engaged in elementary occupations (ISCO-08 code 9). They are also more likely to be engaged in the second lowest skill level, i.e. clerical support, services and sales, skilled agricultural, forestry and fishery, crafts, and plant and machine operations (ISCO-08 codes 4 to 8).³ The correlation between low quality jobs and disability may highlight two factors: (i) low quality jobs may pose higher health hazard, resulting in higher share of low skilled workers experiencing disability, and (ii) low productivity jobs and the resulting lack of resources may lead to the lack of or limited access to health and rehabilitation leading to onset of disability.

Figure 11: People who hold low-quality jobs have higher chances of experiencing disability



Note: sample restricted to the working population aged 15 to 64 years old. Skill levels were derived from the ISO classification.

Source: 2011 Census.

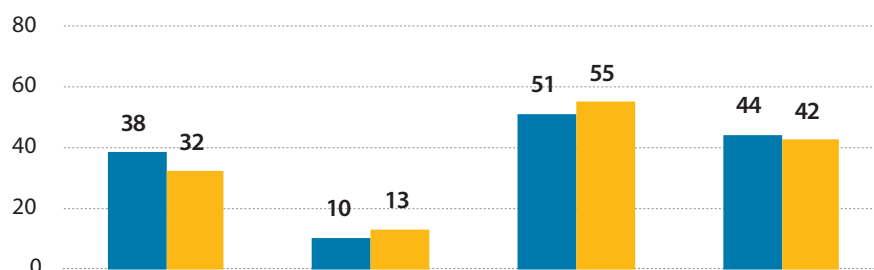
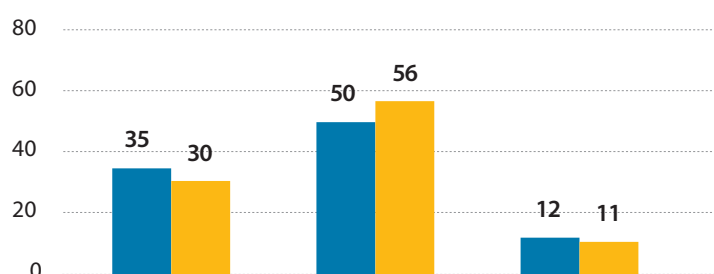
Employment of informal caregiver

Disability may lead to limited employment and forgone earnings of other family members who care for a disabled family member. The relevance of this pathway is endogenous to intra-household decision making and such decision will depend on whether a disabled family member is a child or an adult, the availability and accessibility of care services outside the family, the opportunity cost of care, the existing labor market status of the family members, the household decision on how to share the care between family members and whether family members co-reside with the disabled person, and on customs and traditions. For instance, if a family member is not employed and assumes a care-provider role there will be no foregone earnings (Mitra et al, 2012).

Working-age valid members of households with at least one disabled household member are less likely to be employed, and more likely to be unemployed or out of the labor force than those who don't have to care for a disabled person (see Figure 12). As a consequence, work intensity among valid adults is much lower in households with a person with disability: 29 versus 38 percent (2012 LSMS). Valid adults in households with a disabled person also work on average three hours per week. In addition, they are more likely to work for the private sector: 56 percent of valid adults who have a disabled member in the household work for a private company, as compared to 50 percent for individuals with no disabled person to care for.

Furthermore, when looking at gender disparities, the gender gap is larger for men. While 51 percent of valid men in households with a no disabled individual work, only 44 percent do so in households with a disabled person. The numbers are more similar for valid women, with respectively 26 and 21 percent working in households with no disabled person, and households with at least one disabled member. The data do not allow us to identify who the exact caregiver is in any given family, but what they tell us is the following: households with a disabled person have lower work intensity, more unemployed valid men, and slightly more out-of-labor force women.

³ The correspondence between ISCO-08 and skill levels is taken from International Labor Office. (2012). *International Standard Classification of Occupations: ISCO-08*. Geneva: ILO.

Figure 12: Valid adults with disabled persons are less integrated in the labor market**a. Labor market participation****b. Sector of activity**

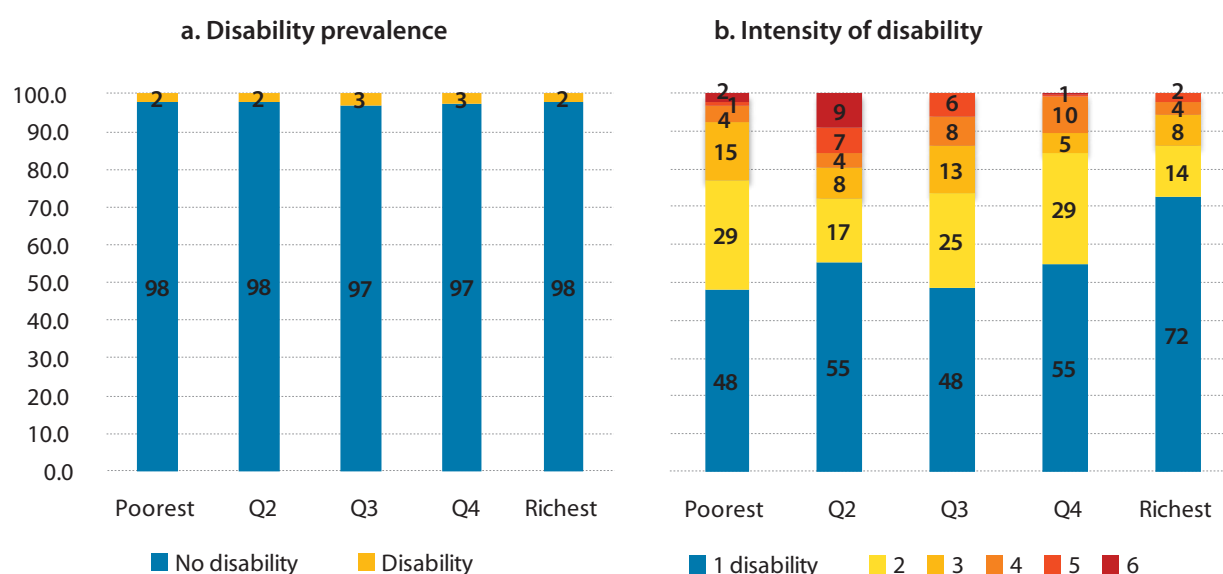
Note: sample restricted to the valid population aged 15 to 64 years old, i.e. working-age individuals who do not declare any type of strong difficulty in carrying out daily tasks.

Source: 2012 LSMS.

Household and health expenditure

Through the earnings handicap (by affecting an individual's ability to earn), disability may lead to lower income for the individual and the household and may result in worsening of the living standard and eventually poverty, if the household cannot compensate for the loss of income and has to adjust its expenditures accordingly. On the other hand, disability may also lead to additional expenditures for the individual and the household with disabilities, in particular in relation to specific services (health care, transportation, assistive devices, personal assistance, and house adaptation).

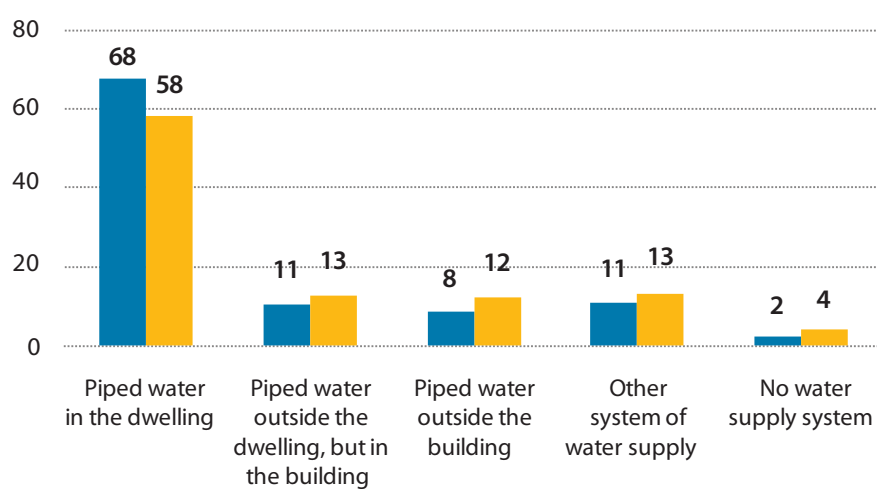
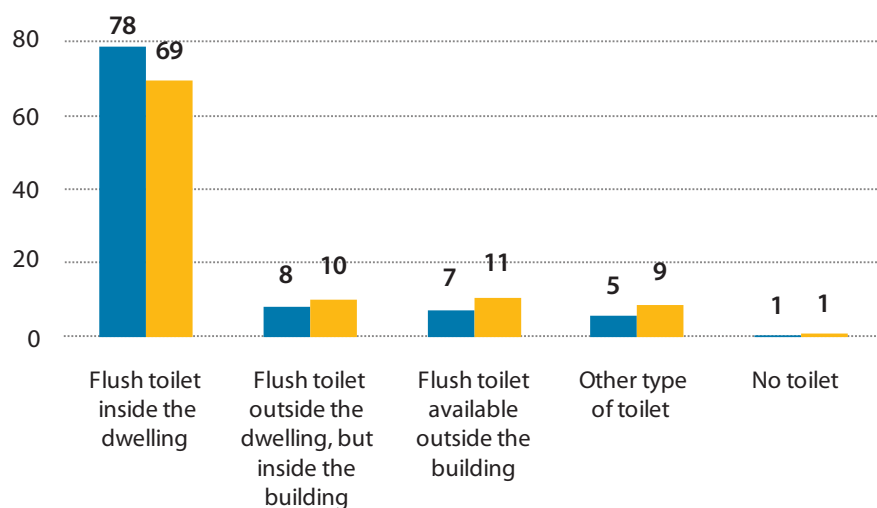
In Albania, there is no higher prevalence of disability among lower expenditure groups (see Figure 13). These results are similar to the findings on Romania from World Bank (2008). Yet the population in the top quintile appears to suffer more from partial limitations: 48 percent of disabled individuals in the poorest income quintile suffer from at most one disability, while that number rises to 72 percent for the richest quintile. In other words, the poorest households are twice as likely to have a disabled member who suffers from 2 or more disabilities than households in the richest quintile with a disabled member.

Figure 13: Intensity of disability is higher among lower expenditure groups

Source: 2012 LSMS.

Moreover, health conditions may increase the risk of poverty through lost earnings and health expenditures. Indeed, households with at least one disabled member spend on average 5.2 percent of their income on health expenditure, while people with no disabled household member spend an average of 2.9 percent of their total household income. In other words, households with a disabled member spend 4 times as much in terms of health expenditures than a household with no disabled member.

Finally, there is higher disability prevalence among households with worse living conditions. 58 percent of households with a disabled member have piped water within their dwelling, whereas this number rises to 68 percent among households with no disabled member. Similarly, access to sanitation is better among households with no disabled member: 78 percent of households with no disabled member have access to a flush toilet within their dwelling, while this number drops to 69 percent when households have a disabled member.

Figure 14: Living conditions**a. Access to water****b. Access to sanitation**

■ HH with no disabled members ■ HH with at least one disabled member

Source: 2011 Census.

4. SOCIAL PROTECTION AND DISABILITY

As discussed previously, there is room for significant improvement in the labor market environment in transition countries if disabled individuals are to contribute to, and take advantage of, economic growth through gainful employment. One such improvement would be the formalization of informal sector employment, which contributes to the particularly dreadful labor market outcomes for the disabled. The curbing of the informal sector would also boost a government's tax base, in turn generating much-needed resources for the social protection system, which will have to remain as a key policy device to improve the living standards of disabled people who are unable to participate in the labor force. But what are the levels of disability benefits, and to what extent are these benefits targeted to the most vulnerable groups?

Households with disabled members are quite dependent on social protection (SP) transfers (see Table 4). Households with at least one disabled household member are twice as likely to receive any SP transfer: respectively 42 and 79 percent of the households with and without disabled member are covered by at least one social assistance transfer. Households with a disabled household member are also more likely to be covered by the disability assistance benefit or the work invalidity transfer: 38 percent of households with one disabled member receive the work invalidity transfer and 12.5 percent receive the disability assistance benefit.

Table 4: Social assistance coverage by disability status

	No disabled household member	At least one disabled household member	Total
Share of households			
Any SP transfer	41.7	79.4	44.5
Economic benefit (Ndhme Ekonomike)	8.1	11.7	8.4
Disability assistance benefit	0.4	12.5	1.3
Work invalidity transfer	3.7	38.0	6.3
Totals number of households			
Disability assistance benefit	2,793	6,686	9,479
Work invalidity transfer	25,028	20,245	45,273

Source: 2012 LSMS.

Coverage of the two main disability programs – namely the disability assistance benefit and the work invalidity transfer – is quite low. Table 5 shows the inclusion and exclusion errors of the disability insurance and invalidity transfer, based on self-declared disability status. Ideally, the data should show that households with no disabled member do not receive either the disability assistance benefit, or the work invalidity transfer. On the other hand, all households with at least one disabled member should receive either the disability assistance benefit, or the work invalidity transfer. However, because of reporting and administrative errors, and because some people who report having a disability were not diagnosed by a medical doctor, one may see inclusion (non-disabled households receiving benefits) and exclusion (disabled households not receiving benefits) errors.

Half of the households who receive the disability assistance have no disabled member: 2,793 households receive the disability assistance while no member (self-)identifies as having a limitation. The invalidity transfer shows lower inclusion error with only one in ten beneficiary household not having a disabled household member (1,362 households). Both programs display very large exclusion errors, i.e. households who should receive the transfer but are not actual beneficiaries. Nine in ten households who have a disabled member do not receive the disability assistance or the invalidity transfer. Of course, this diagnostic has to be taken cautiously as the disability status of household member is self-diagnosed, and not subject to a medical assessment, and the work invalidity transfers are tied to medical diagnosis.

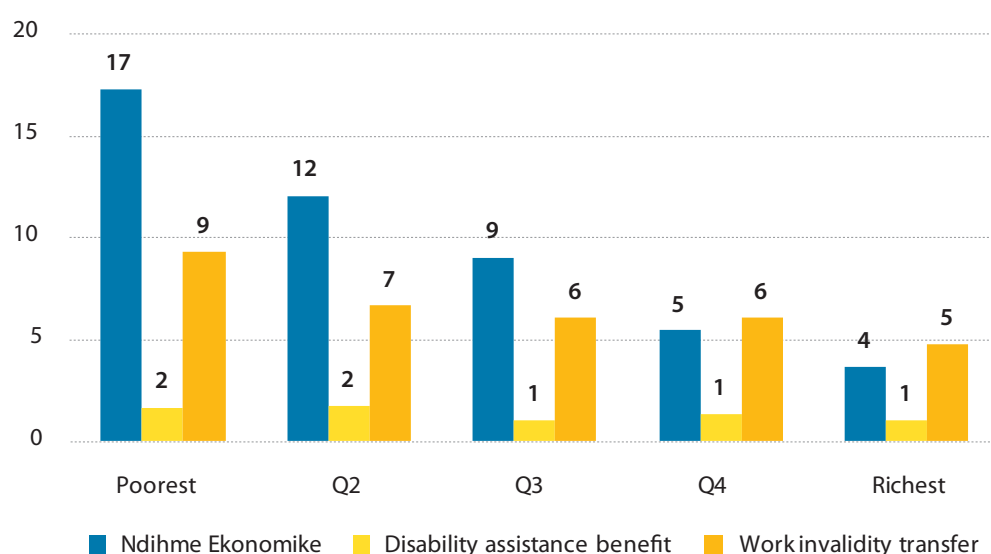
Table 5: Inclusion and exclusion errors of disability assistance and work invalidity transfer

	No disabled household member	At least one disabled household member
Disability assistance		
Beneficiary	2,793	6,686
Not beneficiary	666,180	46,654
Invalidity transfer		
Beneficiary	1,362	8,117
Not beneficiary	524,854	87,980

Source: 2012 LSMS.

Finally, the disability assistance and invalidity transfer display different correlations to income quintiles (see Figure 15). The work invalidity transfer, like the Ndihme Ekonomike, which is targeted to lower income households, has much better coverage of the lower income quintiles. This may be explained by the fact, as mentioned earlier, that individuals in the lower income groups are more likely to engaged in hazardous jobs, and suffer from work-related disability, thus receiving the work invalidity transfer. 9 percent of the poorest quintile receive the invalidity transfer, while the share drops to 5 percent of the top quintile. On the other hand, the disability assistance benefit is quite evenly distributed across income groups, reaching on average 1 to 2 percent of the households.

Figure 15: Social protection coverage of households by expenditure quintile



Source: 2011 Census.

5. LATENT CLASS ANALYSIS ON PEOPLE WITH DISABILITIES

Traditional methods of profiling a given population of interest (here, disabled individuals) include cross-tabulations of socio-demographic characteristics of individuals at risk. This is what was presented in the first sections of this report. But the methodology gives one- or two- dimensional results: cross-tabulations cannot group people on more than 2 or 3 characteristics (tables of more than 3 dimensions are difficult to display).

On the other hand, Latent Class Analysis (LCA) allows to create sub-groups of people using more than 2 or 3 characteristics. The main idea behind the LCA methodology is that, using disabled individuals' observables (age, gender, education, family composition, etc), one can construct groups of individuals that are the most homogeneous between themselves, while each group remains as distant as can be from one another. LCA methodology was thus used in this note to identify groups of disabled individuals. The defining characteristics and the relative size of each sub-group are presented in Annex 6.

The analysis focuses on individuals 15 years and above only. The LCA methodology enables profiling of individuals on the basis of variables ('*active variables*'). Once the profiles have been constructed, they can be described through complementary variables ('*inactive variable*'), which do not intervene in the construction of the profiles.

The first group of variables consists of the individual characteristics that are believed to explain each individual's disability status ('*active indicators*'). The different groups of vulnerable individuals are *constructed* using these active indicators: age, gender, and type of disability (seeing, hearing, mobility, self-care, communication, cognitive). In addition, a second set of variables was used, consisting of '*inactive covariates*', i.e. characteristics that help explain the nature of each group, but that are not taken into account to *construct* the clusters. This second sets of variables are considered either to have less explanatory power for the construction of the clusters, either to be an outcome of the class, and not a driver of it. For instance, education is not a direct reason for being disabled but an indirect one (through skills and type of job for instance). These inactive covariates consist of: education, activity status, urban/rural location.⁴

Figure 16 shows the results of the latent class analysis and displays groups decreasing level of barriers to be socially included.

Multiple severe disabilities

A first group representing 11.8 percent of the disabled population consists of illiterate individuals with all types of disabilities, older than 65, in single households.

A second group representing 17.5 percent of the disabled population consists of individuals with multiple cognitive disabilities: concentration, self-care and communication. These are rather young (15 to 50 year-old), illiterate, and single. Among all groups, they are more likely to receive social welfare transfers.

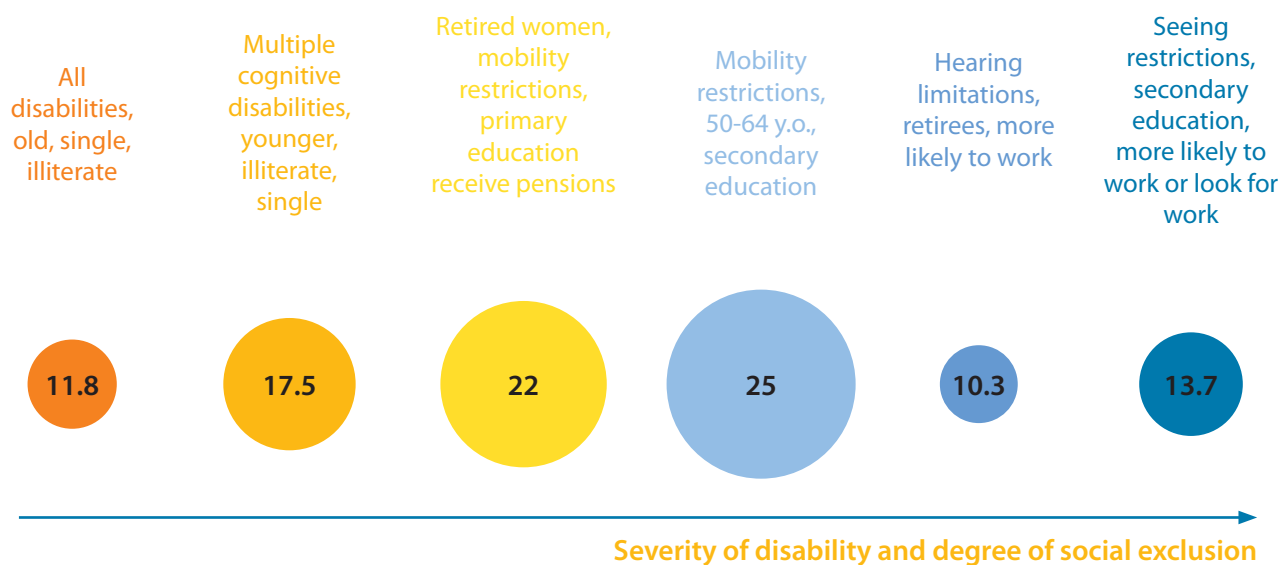
Old-age disabled

A third group consists of retired women with mobility restrictions. A vast majority receives pension, but few receive social protection transfers. They represent 22 percent of the disabled population.

A fourth group consists of individuals with mobility restrictions, reaching retirement age (50-64 year-old), with secondary education, and mostly out of the labor force. These individuals are mostly married, without children to take care of. They represent 25 percent of the disabled population.

⁴ A few additional variables were tried out and not selected, as their explanatory power was not deemed sufficient.

Figure 16: Latent class analysis of disabled population



Note: Population restricted to individuals aged 15 and above.

Source: 2011 Census.

Individuals with limited disabilities who could work

A fifth group representing 10.3 percent of the disabled population consists of people with hearing restrictions, retired, with primary or lower secondary education, more likely to be employed than the other groups.

A sixth group representing 13.7 percent of the disabled population consists of people with seeing impairment, secondary education, in age of working, and more likely to be active, but with half of the active population looking for a job.

CONCLUSION

This report is the first effort to profile the disabled population in Albania, and should be the stepping-stone for more in-depth future work. Given data limitation, this analysis presents a static picture of the correlation between the onset of disability and poverty and social exclusion, but does not draw causal links between both statuses.

The composition of the disabled population has economic implications, because individuals with movement restrictions are the most disadvantaged group in terms of employment prospects, along with those with congenital disabilities. The present report identifies three types of disabled groups: first, disabled individuals who could be integrated in the studying and working population, and need adapted programs to help them integrate on the labor market; second, pensioners who suffer from disabilities related to age and need support to go through retirement; and third, individuals whose disabilities are too impairing to participate in the mainstream education system nor the workforce, and need adapted social assistance transfers.

Finally, a few steps could be taken to improve the quality and depth of future research on people with disabilities in Albania. Firstly, INSTAT should develop a household survey module on disability in the LSMS that is comparable to the short WG module in the 2011 Census. Because LSMS enumerators have more time to spend with each interviewed household, the LSMS could even include the longer version of the WG module on disability. Secondly, the next round a census should aim at collecting reliable information on children and teenagers (0 to 15 years-old), in order to include that part of the population whose onset of disability starts early on in life. Thirdly, the LSMS could include a more detailed questionnaire about social welfare transfers, barriers/discrimination faced on the school and work premises, and the timing of the onset of disability (congenital, progressive, etc). Finally, a tailored-made survey on disability with a nationally-representative sample would help study in depth and with good confidence intervals the disabled population, and would help identify in detail barriers faced by the disabled population when it comes to social integration.



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ANNEXES

Annex 1: Rationale for the Washington Group (WG) general measure on disability

Disability as an umbrella term refers to problems, such as impairment, activity limitation or participation restrictions that indicate the negative aspects of functioning. While it is important to collect information on all aspects of the disablement process, it is not possible to do so in censuses or surveys not dedicated to disability. However, important information on selected aspects of disability can be obtained from censuses.

In their ongoing deliberations, the Washington Group (WG) has agreed that measurement of disability is associated with a variety of purposes, which relate to different dimensions of disability or different conceptual components of disability models. A fundamental agreement of the WG was the need for a clear link between the purpose of measurement and the operationalization of indicators of disability.

Equalization of opportunities was agreed upon and selected as the purpose for the development of an internationally comparable general disability measure. This purpose was chosen because:

- (i) It was relevant (of high importance across countries with respect to policy), and;
- (ii) It was feasible (it is possible to collect the proposed information using a comparable general disability measure that includes a small set of 6 census-like questions).

In order to address this purpose, we begin by identifying persons who are at greater risk than the general population of experiencing restrictions in performing tasks (such as activities of daily living) or participating in roles (such as working). Measurements intended to identify this 'at risk' population represent the most basic end of the spectrum of activities (i.e. functional activities such as walking, remembering, seeing, hearing). This 'at risk' group would include persons with limitations in basic activities who may or may not also experience limitations in more complex activities and/or restrictions in participation depending in some instances on whether or not they use assistive devices, have a supportive environment or have plentiful resources.

Based on these decisions, the Washington Group has developed this question set for use on national Censuses for gathering information about limitations in basic activity functioning among national populations. The questions were designed to provide comparable data cross-nationally for populations living in a great variety of cultures with varying economic resources. The objective was to identify persons with similar types and levels of limitations in basic activity functioning regardless of nationality or culture. It was not our purpose to identify every person with a disability within every community. We recognize that this may not meet all the needs for disability statistics, nor will it replicate a population evaluated across a wider range of domains that would be possible in other forms of data collection or in administrative data.

The census format requires that a limited number of questions be devoted to any one statistic that needs to be produced. For the reasons of simplicity, brevity and comparability, the choice was made to identify limitations in domains of basic activity functioning that are found universally, which are most closely associated with social exclusion, and which occur most frequently. The information that results from the use of these questions is expected to:

- (i) Represent the majority, but not all persons with limitation in basic activity functioning in any one nation.
- (ii) Represent the most commonly occurring limitations in basic activity functioning within any country.
- (iii) Capture persons with similar problems across countries.

The proposed questions identify the population with functional limitations that have the potential to limit independent participation in society. The intended use of this data would compare levels of participation in employment, education, or family life for those with disability versus those without disability to see if persons with disability have achieved social inclusion. In addition the data could be used to monitor prevalence trends for persons with limitations in the particular basic activity domains. It would not represent the total population with limitations nor would it necessarily represent the 'true' population with disability which would require measuring limitation in all domains and which would require a much more extensive set of questions.

Annex 2: Census Questions on Disability

The 2011 Albania Census includes the following 6 questions to measure disability in the country. Any person who answers at least C or D once will be considered as someone who suffers from disability

1. Do you have difficulty seeing, even if wearing glasses?

- a. No - no difficulty
- b. Yes – some difficulty
- c. Yes – a lot of difficulty
- d. Cannot do at all

2. Do you have difficulty hearing, even if using a hearing aid?

- a. No- no difficulty
- b. Yes – some difficulty
- c. Yes – a lot of difficulty
- d. Cannot do at all

3. Do you have difficulty walking or climbing steps?

- a. No- no difficulty
- b. Yes – some difficulty
- c. Yes – a lot of difficulty
- d. Cannot do at all

4. Do you have difficulty remembering or concentrating?

- a. No – no difficulty
- b. Yes – some difficulty
- c. Yes – a lot of difficulty
- d. Cannot do at all

5. Do you have difficulty (with self-care such as) washing all over or dressing?

- a. No – no difficulty
- b. Yes – some difficulty
- c. Yes – a lot of difficulty
- d. Cannot do at all

6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

- a. No – no difficulty
- b. Yes – some difficulty
- c. Yes – a lot of difficulty
- d. Cannot do at all

Annex 3: LSMS Questions on Disability

1. Do you suffer from a chronic illness that has lasted more than 2 months (including severe depression)?

Yes

No

2. Do you suffer from any disability that has lasted more than 3 months?

Yes

No

3. Have you difficulties in:

	None	Some	A lot	Completely unable
Seeing				
Hearing				
Body deformation				
Remembering/Concentration				
Difficulties in using limbs				
Communication				
Other				

Annex 4: Differences between 2011 Census and 2012 LSMS in measuring disability

Prefecture	Seeing	Hearing	Mobility		Self-care	Cognition	Communication	Other	Total
LSMS - 2012			Body deformation	Limbs					
Berat	0.57	0.44	0.44	0.46		0.76	0.07	0.00	1.60
Diber	0.60	0.57	0.61	1.29		1.12	0.61	0.13	2.42
Durres	0.58	0.86	1.00	0.77		1.98	0.48	1.00	3.56
Elbasan	1.29	1.02	0.95	1.12		2.04	0.81	0.89	4.12
Fier	0.57	0.51	0.51	0.75		0.68	0.4	0.12	1.96
Gjirokaster	1.30	0.57	0.83	0.85		1.26	0.55	0.24	3.42
Korce	1.08	0.89	1.17	0.97		0.95	0.64	0.19	3.20
Kukes	0.58	0.55	0.33	1.06		1.92	0.38	0.22	3.09
Lezhe	0.79	0.29	0.86	0.47		1.11	0.31	0.29	2.59
Shkoder	0.79	0.18	0.66	0.49		1.52	0.48	0.15	2.26
Tirane	0.40	0.20	0.41	0.50		1.00	0.36	0.11	1.58
Vlore	0.63	0.28	0.44	0.46		0.83	0.25	0.27	2.03
Total	0.69	0.49	0.65	0.71		1.23	0.45	0.31	2.47
Census - 2011									
Berat	2.73	1.90	4.22		2.17	2.24	1.83		7.31
Diber	1.76	1.64	3.72		1.86	2.02	1.93		5.98
Durres	2.12	1.58	3.50		1.66	1.64	1.33		5.76
Elbasan	2.60	1.97	4.18		1.95	2.25	1.74		7.10
Fier	2.48	1.88	3.84		2.07	2.15	1.79		6.55
Gjirokaster	3.26	2.53	4.67		2.16	2.38	1.96		8.00
Korce	2.07	1.80	3.45		1.63	1.87	1.39		6.37
Kukes	1.80	1.63	3.94		2.01	2.18	1.77		6.01
Lezhe	2.57	1.75	4.33		2.00	1.83	1.54		6.85
Shkoder	2.54	1.81	4.60		2.03	1.86	1.59		7.30
Tirane	1.75	1.31	2.81		1.32	1.28	1.02		4.75
Vlore	2.96	2.13	4.09		2.13	2.19	1.80		7.24
Total	2.25	1.71	3.67		1.77	1.83	1.49		6.19

Source: 2011 Census and 2012 LSMS.

Annex 5: LSMS Methodology

The Albania Institute of Statistics (INSTAT) conducted the Living Standards Measurement Survey (LSMS) in 2002, 2005, 2008 and 2012 in order to study various socioeconomic characteristics of the population, including consumption and poverty. The main objective of LSMS is to collect information for measuring the Albanian household's welfare and to identify factors that determine it. Welfare has been measured by the consumption aggregate, providing information on the level and distribution of poverty in the country. LSMS is also a powerful tool for assessing and determining the social costs. It provides a baseline for monitoring the progress in reducing poverty and achieving the Millennium Development Goals (MDG).

The sampling frame for the 2012 LSMS was based on summary data for the enumeration areas (EAs) defined for the 2011 Albania Census of Population and Housing. The availability of this recent sampling frame ensures that an effective and representative sample was selected for the survey. A stratified two-stage sample design was used for selecting the sample households for the 2012 LSMS. The primary sampling units (PSUs) selected at the first stage are the EAs, and those selected at the second stage are the households listed from the selected EAs. The survey includes a sample of 6,671 households, which constitute the survey units. In the first round, 834 PSUs were chosen randomly to represent the whole territory of the country. Then, 8 households for each PSU were chosen for interviews in the second round through a systematic sample procedure. To handle cases of non-response or no contact, 4 additional households for each PSU were chosen as substitutes that ensured the target of 6,671 completed questionnaires.

The 2012 LSMS included a module on health and individuals with functioning limitations in basic activities (seeing, hearing, mobility, cognition, and communication). The table below shows the sampling errors, confidence intervals, coefficient of variation associated with the measure of severe disability, in order to determine the level of precision for the survey results. The Complex Samples module of SPSS was used for the tabulation of sampling errors, which uses a linearized Taylor series variance estimator for calculating the standard errors of survey estimates.

Severe Disability	Estimate	Standard Error	95% Confidence Interval: Lower	95% Confidence Interval: Upper	Coefficient of Variation
Yes	556	15	527	585	2.6
No	506	14	478	534	2.9
Total	1062	12	1039	1085	1.1

The level of precision for the estimates of severe disability from the 2012 LSMS data are very good at the national level. The coefficient of variation is below 5% for all categories which is also considered good. A small coefficient of variation means cases are tightly clustered around the mean, while a large coefficient of variation means that there is a large amount of variation, and observations are spread out around the mean.⁵

Coefficient of variation (%)	Release category
0.0 – 1.0	Unrestricted
1.0 – 2.5	"
2.5 – 5.0	"
5.0 – 10.0	"
10.0 – 16.5	"
16.5 – 25.0	Restricted
25.0 – 33.3	"
> 33.3	Do not release

⁵ <http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11643/ds-sd-eng.htm>

Annex 6: Latent Class Analysis

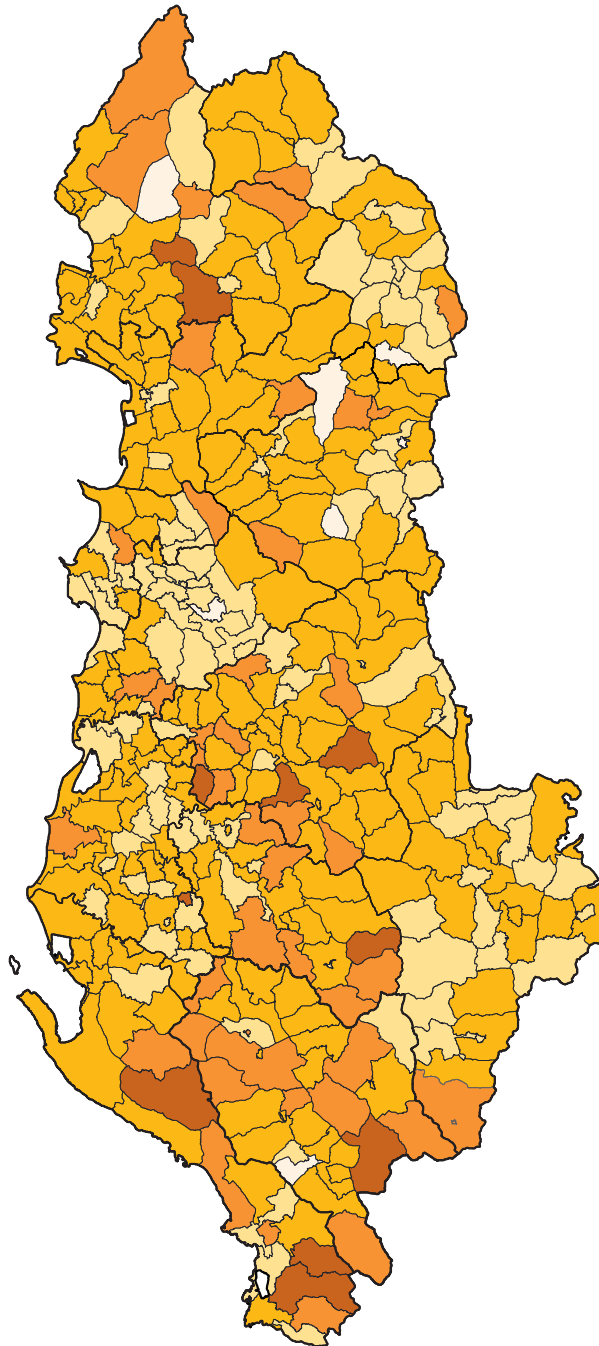
	Cluster1	Cluster2	Cluster3	Cluster4	Cluster5	Cluster6
Cluster Size	0.25	0.22	0.18	0.14	0.12	0.10
Indicators						
Seeing						
No	0.90	0.64	0.97	0.00	0.23	0.73
Yes	0.10	0.36	0.03	1.00	0.77	0.27
Hearing						
No	0.99	0.74	0.91	1.00	0.18	0.00
Yes	0.01	0.26	0.09	0.00	0.82	1.00
Mobility						
No	0.00	0.23	0.73	1.00	0.04	0.84
Yes	1.00	0.77	0.27	0.00	0.97	0.16
Concentration						
No	0.96	0.79	0.32	0.98	0.03	0.94
Yes	0.04	0.21	0.68	0.02	0.97	0.06
Self Care						
No	0.89	0.81	0.43	0.99	0.03	0.99
Yes	0.11	0.19	0.57	0.01	0.97	0.01
Communication						
No	1.00	0.95	0.36	1.00	0.05	0.95
Yes	0.00	0.05	0.64	0.00	0.95	0.05
Age categories						
15-24	0.03	0.00	0.14	0.07	0.07	0.02
25-49	0.23	0.00	0.41	0.16	0.12	0.10
50-64	0.47	0.03	0.23	0.35	0.10	0.22
65+	0.27	0.97	0.22	0.42	0.72	0.65
Gender						
Male	0.48	0.30	0.55	0.48	0.39	0.57
Female	0.52	0.70	0.45	0.52	0.61	0.43
Covariates						
Education						
Literate	0.02	0.03	0.03	0.07	0.03	0.03
Illiterate	0.02	0.31	0.36	0.06	0.45	0.13
No degree	0.01	0.03	0.02	0.01	0.02	0.02
Primary	0.13	0.52	0.13	0.19	0.27	0.30
Lower Secondary	0.51	0.07	0.31	0.38	0.15	0.33
Upper Secondary	0.27	0.03	0.12	0.23	0.07	0.15
Tertiary 1	0.04	0.02	0.02	0.06	0.02	0.04
Tertiary 2	0.00	0.00	0.00	0.00	0.00	0.00
Working Status						
Employed	0.08	0.00	0.07	0.11	0.02	0.08
Unemployed	0.04	0.00	0.04	0.13	0.01	0.03
Out of labor force	0.88	1.00	0.90	0.76	0.98	0.89

Urban	0.53	0.44	0.44	0.56	0.43	0.53
Rural	0.47	0.56	0.56	0.44	0.57	0.47
Prefecture						
BERAT	0.06	0.06	0.07	0.06	0.06	0.06
DIBER	0.04	0.05	0.06	0.03	0.05	0.04
DURRES	0.09	0.08	0.08	0.09	0.09	0.08
ELBASAN	0.12	0.12	0.12	0.12	0.12	0.12
FIER	0.10	0.12	0.13	0.11	0.14	0.11
GJIROKASTER	0.03	0.04	0.03	0.04	0.04	0.04
KORCE	0.08	0.09	0.09	0.08	0.07	0.10
KUKES	0.03	0.03	0.03	0.02	0.03	0.02
LEZHE	0.05	0.06	0.05	0.05	0.05	0.05
SHKODER	0.10	0.09	0.08	0.09	0.08	0.08
TIRANE	0.23	0.18	0.19	0.23	0.20	0.23
VLORE	0.07	0.08	0.07	0.08	0.08	0.08
Civil Status						
Single	0.08	0.02	0.41	0.15	0.18	0.05
Married	0.78	0.51	0.46	0.67	0.42	0.70
Divorced	0.00	0.00	0.00	0.00	0.00	0.00
Sperated	0.01	0.00	0.02	0.01	0.01	0.01
Widowed	0.12	0.47	0.11	0.16	0.38	0.24
Number of children						
1 child	0.17	0.16	0.18	0.16	0.17	0.16
2 children	0.13	0.15	0.14	0.13	0.14	0.14
3 children+	0.05	0.08	0.07	0.06	0.07	0.06
None	0.65	0.62	0.60	0.65	0.62	0.65
Number of working-age adults						
1 person	0.11	0.12	0.11	0.12	0.10	0.13
2 persons	0.24	0.23	0.20	0.23	0.21	0.23
3 persons	0.24	0.19	0.23	0.23	0.22	0.20
4 persons	0.19	0.12	0.20	0.17	0.18	0.14
5 persons +	0.12	0.06	0.16	0.11	0.12	0.08
None	0.10	0.28	0.09	0.14	0.17	0.22
Number of members 65+						
1 person	0.29	0.56	0.32	0.34	0.50	0.40
2 persons	0.16	0.41	0.16	0.22	0.31	0.33
3 persons	0.00	0.01	0.00	0.00	0.01	0.01
4 persons	0.00	0.00	0.00	0.00	0.00	0.00
None	0.55	0.02	0.52	0.44	0.18	0.26
Number of workable adults (15-64)						
1 person	0.28	0.25	0.26	0.27	0.27	0.25
2 persons	0.13	0.14	0.13	0.14	0.14	0.13
3 persons	0.04	0.04	0.05	0.04	0.05	0.04
None	0.55	0.57	0.56	0.55	0.54	0.58
Has income from work						
Yes	0.40	0.39	0.38	0.41	0.41	0.38
No	0.60	0.61	0.62	0.59	0.59	0.62
Has income from pensions						
Yes	0.54	0.72	0.50	0.56	0.59	0.65
No	0.46	0.28	0.50	0.44	0.41	0.35
Has income from social protection						
Yes	0.20	0.11	0.25	0.14	0.16	0.12
No	0.80	0.89	0.75	0.86	0.84	0.88

Annex 7: Disability Map

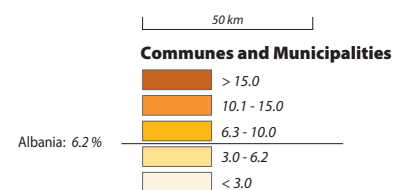
Persons with at least one disability reported

2011



Ratio of the number of persons aged 15 and over who reported one or more disabilities to the total population aged 15 and over, in %.
The disable population includes persons for whom a severe level of disability was reported.

Source: 2011, Population and Housing Census of Albania



The boundaries of communes and municipalities have been designed for statistical purposes and may not reflect exactly the territory of the local units.

