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A Multi-stakeholder Report
for the Global Disability
Summit 2025

Global Disability Inclusion Report

Accelerating Disability Inclusion in a Changing and Diverse World

The
Federal Government

IDA
International
Disability Alliance

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Executive summary

Inclusion is not merely an aspiration, but a fundamental human right. It requires ensuring that all individuals, regardless of their background, abilities or circumstances, are recognized, respected and afforded equitable access to resources and opportunities. Inclusive societies are better equipped to leverage the strengths and contributions of all their populations, enhancing their ability to withstand economic, environmental, social and other shocks and respond to technological shifts, climate change and other global trends. However, exclusion has significant economic consequences. For instance, underemployment of persons with disabilities costs up to 7 per cent of gross domestic product (GDP) in low- and middle-income countries. Economic losses are even greater if considering other sources, such as the opportunity costs of unpaid care and support that is provided primarily by women and girls.

The journey towards a truly inclusive world for children and adults with disabilities – who represent more than 16 per cent of the world's population – is marked by both remarkable progress and persistent challenges. In preparation for the Global Disability Summit 2025, it is imperative to reflect on the advancements made, acknowledge the remaining gaps and chart a course for transformative action. This report, drawing from global consultations and the expertise and previous reports of various United Nations agencies, civil society, Organisations of Persons with Disabilities (OPDs) and academia, offers a comprehensive analysis of the current landscape and proposes pathways to accelerate inclusion.

Understanding diversity and intersecting inequalities (Chapter 1)

The Convention on the Rights of Persons with Disabilities (CRPD), ratified by nearly all United Nations Member States, has been a pivotal catalyst for change, driving national legislation and policy change globally. However, progress has been uneven, with persistent or widening gaps in critical areas such as education, food security, health, employment and poverty reduction.

Persons with disabilities are not a homogenous group. Their life experiences, overlapping identities and varied contexts shape the types and intensity of barriers, costs and inequalities they face. An intersectional approach is crucial to understand how factors such as gender, age, socioeconomic status, the type of and level of support required, and barriers faced combine to affect inclusion. 'One-size-fits-all' approaches are inadequate, and creating inclusive systems and societies requires adaptations to reflect the diverse experiences of persons with disabilities across the life cycle.

Structural efforts to implement the CRPD (Chapter 2)

Over the past decade, structural efforts to implement the CRPD have been the cornerstone of progress. These efforts include developing and enforcing legislation, establishing national coordination mechanisms, improving data collection and analysis and resourcing implementation. However, significant gaps remain.

- **Legal frameworks:** While many countries have adopted or amended stand-alone disability laws, alignment with the CRPD remains uneven. There is selective focus on certain rights (e.g., accessibility, health, employment) with less attention to others (e.g., legal capacity). Further, provisions for accountability and enforcement are often insufficient, and wide-scale harmonization of all relevant legislation with the CRPD is lacking.
- **National coordination mechanisms:** Many countries have adopted national coordination and/or monitoring mechanisms, which can play a critical role in fostering multi-stakeholder and intersectoral implementation and accountability. However, they often have limited convening power and resources, and inconsistent participation of OPDs.
- **Data:** Many countries have made significant strides in collection of data on disability in censuses and routine surveys. Yet there is a lack of systematic analysis of existing data and disaggregation of standard policy indicators, limiting their use in informing policy design and monitoring. Few countries have collected data on barriers to inclusion and related support needs. Opportunities arise from the emergence of interconnected management information systems and disability data harmonization across sectors.
- **Public financing:** Due to insufficient data and reporting, it is challenging to adequately monitor the level of both domestic and international financing for disability inclusion. Available data show that many countries have increased disability-related public expenditures, drawing from both domestic and international sources. However, funding remains largely insufficient to deliver changes at scale in most contexts and is often concentrated in a few ministries (e.g., social protection, education and health). The adoption and expansion of disability-targeted cash transfers have been a key driver of increased spending.

Challenges and opportunities of a changing world (Chapter 3)

Global trends are reshaping societies and economies worldwide. They present both challenges, and in some cases opportunities, for advancing the inclusion of persons with disabilities.

- **Climate change** disproportionately impacts persons with disabilities due to their increased exposure and vulnerability to climate hazards. Persons with disabilities are also frequently excluded from climate action. Ensuring a just transition requires actively involving persons with disabilities in developing, implementing and monitoring climate-related policies. This approach not only mitigates the disproportionate impacts they face but also harnesses opportunities presented by inclusive green economies, shock-responsive social protection systems and integrating universal design into climate-resilient infrastructure.

- **Technological advances** are offering potential solutions to overcome barriers to information, communication and participation. The digital economy is creating job opportunities, online platforms can facilitate entrepreneurship, and mainstream products are increasingly embedding accessibility features. However, there are valid concerns about the digital divide exacerbating existing inequalities; technology replacing critical human interaction; automation and other disruptions disproportionally affecting persons with disabilities' employment; and issues of bias, accessibility, privacy and safety, particularly with the expansion of artificial intelligence. Co-design of products, systems and services with persons with disabilities can mitigate these risks and create better outputs for all users.
- **Urbanization** contributes to the concentration of needed services and socioeconomic opportunities in urban areas, widening gaps with rural areas. Within urban areas, persons with disabilities continue to face exclusion due to inaccessibility of transportation, housing, digital infrastructure and public spaces. They also encounter additional challenges, such as heightened accessibility difficulties in informal settlements, elevated risk of homelessness, and managing higher living costs, weakened community support, social isolation and health risks associated with cities. Addressing these issues requires systematically integrating universal design in urban development, promoting inclusive community engagement, expanding inclusive services and developing care and support systems.
- **Migration and displacement** can present distinct experiences for persons with disabilities. They may have additional push and pull factors such as seeking better access to services or to escape disability-based discrimination and persecution. Persons with disabilities can face heightened risks during journeys and significant barriers to integration due to inaccessible services, negative social attitudes, discriminatory migration laws and inaccessible application processes, including refugee status determinations. Change is needed towards accessible migration procedures, targeted support during journeys, inclusive community services, improved social attitudes and protection of legal rights for migrants and displaced persons with disabilities.
- The evolving **care and support economy** challenges a status quo of inadequate support to persons with disabilities and stark gender inequalities in provision of unpaid work. Ageing populations, rising labour participation of women and lack of inclusive environments are increasing the demand for care and support. At the same time, women, care workers and persons with disabilities are advocating for systems promoting equal opportunities, dignity, autonomy, choice and decent work for all. Developing inclusive, age-sensitive and gender-responsive care and support policies and systems will require rights-based frameworks, adequate investment in community-based services and commitment to de-institutionalization. Equal participation of OPDs and persons with disabilities (particularly women with disabilities and persons with high support needs), alongside women's groups and other persons providing and requiring care and support, is essential to effective reforms.
- **Humanitarian crises and emergencies** disproportionately impact persons with disabilities. They are at heightened risk of death, violence, abuse and negative effects on their health, livelihoods, education and participation. These gaps are in danger of widening, as shortfalls in humanitarian financing may lead to de-prioritization of support to persons with disabilities. Inclusive humanitarian actions and emergency responses are therefore critical, and may include accessible early-warning systems, preparedness planning and comprehensive vulnerability, needs and risk assessments. Recovery and reconstruction should also promote accessibility and inclusion. OPDs must play critical roles across these actions, through participation in all decision-making, coordination, implementation and monitoring processes.

Pathways to accelerating inclusion (Chapter 4)

Many countries face persistent challenges to ensuring the rights of all persons with disabilities as guaranteed by the CRPD, including inadequate resources, inconsistent political commitment and insufficient coordination. These challenges are more pronounced in lower-income and fragile contexts, including humanitarian settings, although high-income countries also fall short of CRPD commitments. Fragmented approaches to inclusion in turn hinder systemic impact.

The capacity of education, health, employment and social protection and other sectors to advance the inclusion of persons with disabilities depends in part on the underlying strength of these systems. Yet 15 years of global efforts to implement the CRPD have shown that pathways to accelerate inclusion exist in all contexts, whatever the level of maturity and resources of those systems.

Embedding disability inclusion at the outset and throughout the development of national systems is central to achieving change at scale, rather than considering it an add-on that can be addressed when more resources are available. Practical steps can be taken in all sectors, including creating laws and regulations to guarantee equitable access, enhancing data collection to monitor inclusion and identify specific support needs, training front-line staff and other key actors, and systematic engagement with persons with disabilities and OPDs to design and implement inclusive policies, programmes and environments.

Efforts to maximize inclusion will be most successful with cross-sectoral and multi-stakeholder coordination. For instance, ensuring children with disabilities receive a quality, inclusive education depends not only on education sector policies and programmes but on a wide range of actions by other sectors and actors (e.g., timely early intervention and other health-care services to enhance functioning and well-being, appropriate assistive technology to support learning and mobility, accessible transport to and from school and stigma reduction in communities). This implies coordinated investment in a set of enablers that contribute to inclusion efforts in all sectors, such as:

- **Improving the accessibility** of infrastructure, systems, products and services for persons with diverse access needs through creating, implementing and enforcing accessibility standards and action plans
- **Combatting stigma and discrimination** around disability, including through anti-discrimination laws and policies, awareness-raising and opportunities for positive interactions between persons with and without disabilities
- **Building care and support systems** that enable independent living and autonomy of persons with disabilities, while redistributing and valuing unpaid care and support provided predominantly by women and girls and progressing deinstitutionalization
- **Increasing access to affordable and quality assistive technology** by strengthening supply chains, cross-sector coordination and workforce capacity
- **Enhancing the participation of persons with disabilities and OPDs in decision-making,** including through removal of barriers to political participation, ensuring accessible and inclusive feedback mechanisms to inform policies and programmes, and sustainable financing for OPDs.

Financing acceleration of inclusion (Chapter 5)

Adequate and sustainable financing is essential to translate policy commitments into action. Yet, **disability-related public spending remains marginal in many low- and middle-income countries**. Further, the lack of systematic consideration of accessibility and inclusion requirements in national development plans, financing strategies and public finance management leads to inefficiencies and may create or perpetuate barriers rather than removing them.

Analysis of public expenditures in selected low- and middle-income countries shows that basic disability-related interventions in health, education and social protection are typically achieved with public spending of around 0.1 per cent of GDP, while more comprehensive social protection measures require investments closer to 0.5 per cent of GDP. In many low- and middle-income countries, significant increases in disability-related public spending will be required to reach these levels.

Adequate financing requires more consistent investment by all ministries to ensure equitable access of persons with disabilities to their services and programmes. It also necessitates strengthening cross-sector coordination and resource pooling to address key cross-cutting enablers. Similarly, earmarked transfers to local authorities are essential to equip them with the necessary resources to meet their growing responsibilities in promoting disability inclusion.

Official Development Assistance (ODA) and philanthropy are important funding streams for setting up required support systems and catalysing scale-up in low- and middle-income countries. However, **a commitment to systematic disability inclusion across all relevant ODA-funded programmes, and better reporting and use of these resources, is required to adequately support domestic financing efforts**. As many low- and middle-income countries face significant debt burdens, innovative instruments such as debt-for-development swaps present an opportunity to ease debt pressures while creating fiscal space to support financing of disability inclusion efforts at scale.

To optimize the use of existing resources for inclusion, data and evidence to inform and monitor national and local budgets, and engagement of persons with disabilities in budget discussions, are critical. Meanwhile, public procurement is a key yet underutilized opportunity to ensure that commissioned goods, services and infrastructure are accessible, while also promoting employment opportunities for persons with disabilities and incentivizing innovation. While some settings may have limited room for efficiency gains due to low levels of spending overall, CRPD-compliant budgeting can contribute to progressively reallocating funds from segregated services, such as institutional care, to community-based and inclusive ones.

Overall recommendations to accelerate inclusion of persons with disabilities in a diverse and changing world

While governments are responsible for protecting and ensuring the realization of all rights for all persons with disabilities, achieving inclusion requires a whole-of-society approach, involving the private sector, communities, families, OPDs, civil society and development agencies, among others. Even where government resources are more limited, authorities can prioritize core programmes supporting persons with disabilities and their families and initiate removal of barriers across sectors. They can facilitate mobilization of all stakeholders by providing quality data; removing administrative obstacles and reducing costs of interventions; incentivizing positive actions and coordinating contributions of public entities, civil society and the private sector; and fostering meaningful participation of persons with disabilities.

Recognizing the diversity of contexts, resources and constraints, the conclusion proposes a set of differentiated recommendations for governments, OPDs, development agencies and other stakeholders to accelerate inclusion in a diverse and changing world around the following:

Harmonize laws and policies with the CRPD and in close consultation with OPDs, including in response to global trends (e.g., technology, climate change, migration).

Strengthen data systems to generate and use data and evidence for designing and monitoring inclusive policies and programmes.

Mainstream accessibility and inclusion across all sectors, with dedicated funding and cross-sectoral coordination mechanisms.

Identify and address individual support needs to enable access to a comprehensive package of inclusive, accessible services, including assistive technology, care and support, and social protection.

Scale up financing for disability inclusion, which will involve tracking expenditures, closing funding gaps, and leveraging and optimizing use of public, private, domestic and international resources.

Ensure meaningful participation of persons with disabilities in their diversity, with representation of OPDs in decision-making, and engagement in policy monitoring.

Promote collaboration and coordination among governments, OPDs, civil society, development agencies, and the private sector to drive innovation, share best practices, and ensure accountability for disability inclusion.

Introduction

As of June 2024, all but eight United Nations Member States have ratified the Convention on the Rights of Persons with Disabilities (CRPD), marking a critical step towards disability inclusion globally. Across regions, governments have revised legislation, policies and programmes to promote inclusion across sectors. Key milestones include the entry into force of the African Disability Protocol, the European Union's 10-year Disability Strategy and the implementation of the Incheon Strategy in the Asia-Pacific region. The adoption of United Nations Security Council resolution 2475 on protection of persons with disabilities in conflict, the World Health Assembly resolution on the highest attainable standard of health for persons with disabilities, the Inter-Agency Standing Committee (IASC) Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, along with the Global Disability Summits in 2018 and 2022, has catalysed commitments from multilateral agencies, governments and civil society.

Globally, the disability movement has emerged as a critical stakeholder in both development and human rights processes, with significant contributions to the 'Leaving no one behind' framing of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs). Global mobilization efforts such as the #WeThe15 campaign have amplified visibility. Initiatives with and by the private sector, such as the International Labour Organization (ILO) Global Business and Disability Network and the Valuable 500, have also highlighted the role of businesses in fostering inclusion.

Today, there is unprecedented awareness of the barriers faced by persons with disabilities across regions, along with an increase in the availability of disability data and technical guidance informing stakeholders' efforts towards greater inclusion. In the past decade, the CRPD Committee reviewed more than 140 reports by States Parties and issued eight general comments. Additionally, more than 17 reports were published by the Special Rapporteur on the Rights of Persons with Disabilities, and 22 thematic reports were submitted by the Office of the United Nations High Commissioner for Human Rights (OHCHR) to the Human Rights Council. Other United Nations agencies, including United Nations Department of Economic and Social Affairs (UN-DESA), World Health Organization (WHO) and United Nations Educational, Scientific and Cultural Organization (UNESCO), as well as UNICEF and ILO, have published significant reports on disability inclusion in the last few years.[1] Numerous thematic guidance documents and training materials have also been developed by United Nations agencies.

The *2024 Disability and Development Report* (DDR) highlights uneven progress in achieving the SDGs for persons with disabilities, with persistent and, in some cases, widening gaps in food security, health, employment, access to energy and information and communications technology (ICT), and poverty reduction. Marginalized groups, such as women, Indigenous persons, individuals with intellectual or psychosocial disabilities, and those in rural areas, face even greater disparities. Despite legal advances in education, children with disabilities remain more likely to be out of school and face bullying and social exclusion. The COVID-19 pandemic exacerbated many inequalities, leading to discriminatory practices, reduced access to services, job losses and heightened violence. The 2024 DDR highlights the urgency of accelerating efforts towards greater inclusion, estimating that progress must be 2 to 65 times faster, depending on the SDG targets, if the SDGs are to be realized for persons with disabilities.

To keep the promise of both the CRPD and the SDGs, and to achieve the required scale and comprehensiveness, collective efforts towards inclusion must evolve to reflect the diversity and complexity of today's and tomorrow's world – one shaped by interconnected economies, social transformations and mounting global challenges such as climate change; conflicts, migration and displacement; technological shifts; and debt burdens.

Shaped by findings from global consultations among organizations of persons with disabilities (OPDs) led by the International Disability Alliance (IDA), the current report, developed with contributions from multiple United Nations agencies, civil society and academia, builds on the 2024 DDR and other global thematic reports. Contributing to the Global Disability Summit 2025, it provides policymakers, OPDs and development agencies with pathways to accelerate the inclusion of the diversity of children and adults with disabilities in different contexts, as they work to build more resilient communities and societies.

Framing inclusion in a diverse and changing world

Inclusion represents an aspiration, a process and a practice aimed at ensuring that all individuals – regardless of their background, abilities or circumstances – are recognized, respected and afforded equitable access to resources and opportunities. At its core, inclusion promotes environments where everyone can access resources and opportunities, voice their issues and participate in decisions that affect them. It enables all individuals and communities to engage, grow and contribute on an equal footing, including groups who face systemic barriers – whether related to disability, gender, ethnicity, socioeconomic status or other intersecting factors.

The benefits of fostering inclusive societies, infrastructure, services and communities extend beyond marginalized groups traditionally seen as the target of ad hoc inclusive policies; inclusive societies are better equipped to leverage the strengths and contributions of a broad spectrum of their populations and enhance their ability to withstand and recover from economic and social shocks.

By ensuring access to inclusive education, health care, employment and support systems, societies unlock the potential of a significant population segment, enhancing productivity, innovation and equitable growth; inclusive education systems deliver better outcomes for all learners; inclusive and gender-responsive care and support systems empower families, particularly women and girls, to pursue educational and economic opportunities; technological innovation for persons with disabilities can lead to transformative products for general consumers and businesses, such as voice-activated technology or text-to-speech software. Conversely, the costs of exclusion are high; exclusion of persons with disabilities from the labour market can cost economies up to 7 per cent of gross domestic product (GDP) in low- and middle-income countries. Globally, millions of adults – primarily women – are prevented from joining the labour force by unpaid care responsibilities, including for persons with disabilities. Both of these factors limit economic growth and entrench cycles of poverty and inequality.

Inclusion pathways vary depending on context and the social, economic, political and structural barriers that restrict opportunities for any given group. For persons with disabilities, inclusion requires both removing barriers and creating supportive environments that address the lasting impact of systemic discrimination and respond to their specific support requirements. This involves interventions across sectors and communities to overcome institutional and attitudinal biases; ensure accessibility in public spaces, services, transportation, digital platforms, communication and information; and provide specific support, such as assistive technologies, social protection, care and support systems. These measures enable the diversity of persons with disabilities to live, learn, work and engage fully, with dignity, autonomy and choice on an equal basis with others.

Inclusion efforts must address the diversity of persons with disabilities, reflecting the wide range of functional difficulties and intersecting factors that shape their experiences. Individuals face distinct barriers and opportunities based on their age, gender, ethnicity, socioeconomic status and geographic location, among others. Women and girls with disabilities often face compounded discrimination due to both gender and disability, and individuals living in informal urban settlements or belonging to marginalized ethnic groups may encounter additional systemic exclusion that limits their access to essential services and opportunities. For example, the situation of a deaf woman in a remote Pacific Island will differ significantly from that of an older man with mobility difficulties in a polluted metropolis, or a girl with a developmental disability and her single mother in a conflict zone.

While there are common steps in building inclusive infrastructure systems and services across sectors, factors such as cultural attitudes, economic resources, political priorities and institutional capacities can significantly shape how disability inclusion is practised. For example, low-income countries may face challenges related to resources and infrastructure; rural areas may lack accessible transportation and facilities; while urban environments might be better equipped but could still struggle with overcrowding and design challenges. In highly decentralized countries, while localization can promote innovation and more responsive governance, local political dynamics may lead to uneven implementation of inclusive policies, with some regions progressing towards inclusion, while others lag behind, generating or reinforcing significant territorial inequalities.

A key difference between contexts is the level of resources available and mobilized for inclusion. Higher-income countries dedicate on average at least 1.5 per cent of GDP to support persons with disabilities, while most low- and middle-income countries' efforts remain below 0.5 per cent of GDP. While insufficient financing risks unscaled, fragmented and unsustainable efforts, money alone does not buy inclusion, as shown by the persistent inequalities faced by persons with disabilities in high-income countries with significant disability-related public expenditures. Adequate financing has to be combined with inclusive vision, design and implementation, to accelerate the transition towards accessible and inclusive infrastructure, services and communities, as well as to provide the required support to the diversity of persons with disabilities and their families.

The pursuit of such inclusion efforts may encounter political challenges that vary according to local, national and regional contexts. Political commitment to inclusion often fluctuates, influenced by shifting priorities, resource constraints and differing levels of public awareness and support. In many cases, making policies, systems and services inclusive requires structural reforms, legislative changes and reallocation of, or additional, resources, which may appear to conflict with competing policy priorities. Some of the socioeconomic gains of inclusion may be perceived as long term, in contrast with short-term fiscal constraints faced by many governments, particularly in low- and middle-income countries. These challenges are magnified by the combined effect of climate change, technological and demographic shifts, urbanization, migration and crises, as governments balance short-term political pressures with the longer-term investment required to build equitable and resilient societies.

Adequate resourcing of acceleration of inclusion at scale will require making the most of all available resources – public and private, domestic and international – by activating and mobilizing multiple normative and policy frameworks and streams of financing, joining and building stakeholder coalitions that go beyond current disability-related efforts.

In some contexts, cultural and societal norms may further complicate political support for inclusion. In societies where there are deep-rooted biases or stigma associated with certain groups – such as persons with psychosocial disabilities, women, ethnic minorities or LGBTQIA+ communities – political leaders or champions within governments may face opposition from constituents or influential interest groups when advocating for inclusive policies overall or for one group or another. This resistance can deter governments from enacting inclusive measures, particularly where inclusion is perceived as a deviation from traditional social values or as an issue of lesser importance compared with more immediate political concerns.

Addressing these political challenges requires advocacy, education and policy alignment at multiple levels. Broad-based support is built by highlighting the economic, social and cultural benefits of inclusion and aligning it with wider development and equity goals, addressing collectively the challenges and opportunities that those changes require, in combination with climate action, technological and demographic shifts. No single group or sector can address these complex and overlapping challenges alone. By integrating disability, ageing, gender equality, poverty eradication and climate action, among others, coalitions across sectors, communities and political constituencies can promote solutions benefiting all. For example, investments in energy-efficient infrastructure and accessible housing will contribute to autonomy of persons with disabilities but also support ageing populations, while inclusive care and support systems will enhance autonomy and reduce gender inequalities in caregiving, contributing to sustainable escape from poverty and economic growth.

Coalitions can share resources, expertise and influence across government, civil society, private enterprise and advocacy groups to drive large-scale, lasting change. However, sustaining coalitions is challenging due to diverse priorities, agendas and resources of different groups. Political and social contexts further shape coalition dynamics, with heightened discrimination or opposition sometimes forcing groups to navigate advocacy pragmatically. Balancing bold inclusion efforts with political sensitivities is crucial for maintaining alliances, avoiding backlash and fostering sustainable, broad-based support for systemic change.

OPDs are playing a critical role in advocating for inclusion and contributing to these broader coalitions. Global frameworks such as the CRPD and SDGs have elevated disability rights, and OPDs have seized opportunities for greater openness and engagement across sectors and movements. While barriers remain in ICT, the combined effect of greater accessibility and the rise of digital advocacy allows greater outreach and mobilization for a diversity of persons with disabilities who would typically not be in a position to voice their issues. However, limited funding, political barriers and fragmented priorities among diverse disability groups can hinder their impact. Many OPDs struggle to access and contribute to decision-making spaces, face resistance in politically sensitive contexts and do not have the resources to invest in all policy agendas and reform processes. Additionally, emerging global challenges such as climate change, digitalization and economic crises require OPDs to adapt their strategies and ensure disability is integrated into broader development efforts. Some of the basic requirements and enablers of the engagement of their members in terms of accessibility and support systems are insufficient in most contexts, especially for those most marginalized.

A multi-stakeholder report to contribute to diverse and converging agendas

By recognizing the diversity of persons with disabilities, the varied contexts in which they live and the differentiated impact of major trends, this report acknowledges that accelerating disability inclusion requires solutions, resources and political momentum that extend beyond traditional disability policy frameworks and stakeholders. While there are clearly identified enablers for disability inclusion, as well as steps required for achieving inclusion across sectors and contexts, reaching the scale of mobilization and resources required necessitates integration and alignment of other broad global trends, agendas and development priorities.

As governments, development agencies, OPDs and civil society prepare to meet at the Global Disability Summit 2025, this report seeks to provide a platform for identifying and fostering convergence between disability inclusion actors and the interests and concerns of diverse groups and agendas while emphasizing the shared benefits of inclusion.

To achieve this, the report begins by exploring the ways in which factors such as age, gender, socioeconomic status and geography shape inequalities and experiences among persons with disabilities (Chapter 1). It examines how overlapping identities and structural barriers create distinct challenges, highlighting the need for intersectional approaches to inclusion.

Building on this foundation, the report then assesses structural efforts to implement the CRPD over the past decade, focusing on key elements such as legal frameworks, national coordination and monitoring mechanisms, data-collection systems, and domestic and international public financing for disability inclusion (Chapter 2). This analysis provides critical insights into the progress made, as well as persistent gaps and challenges in ensuring effective policy implementation and accountability.

The discussion then shifts to the broader global landscape, analysing the risks and opportunities posed by megatrends such as climate change, digitalization, demographic shifts, the care economy, urbanization, migration and humanitarian crises (Chapter 3). These trends are reshaping societies and economies worldwide, presenting both challenges and entry-points for advancing the inclusion of persons with disabilities. The report examines how these forces impact persons with disabilities and identifies strategies to ensure that emerging policies and investments are inclusive and equitable.

Recognizing the need for practical, context-specific approaches, the report then outlines key pathways for accelerating disability inclusion via enabling factors such as accessibility, participation, assistive technology, care and support systems and critical sectors such as education, health care, employment and social protection (Chapter 4). By providing key steps and milestones and showcasing effective practices, this chapter provides actionable strategies for governments, development agencies and other stakeholders to strengthen inclusion.

Finally, the report introduces an initial consideration for financing the acceleration of disability inclusion, particularly in low- and middle-income countries, where resource constraints and competing policy priorities often limit progress (Chapter 5). Acknowledging that accelerating inclusion is a key responsibility of states and requires a whole-of-society approach, the report explores the financing gap in selected low- and middle-income countries, as well as the options to make the most of available public and private domestic and international resources to support sustainable, systemic change at scale.

The report concludes by presenting critical recommendations for advancing disability inclusion in an evolving world, offering insights for policymakers, practitioners and advocates. By integrating disability inclusion into broader development and policy agendas, acknowledging diverse contexts, and leveraging global shifts and trends as catalysts for change, this report contributes to the ongoing efforts to find and resource pathways towards a more inclusive and equitable future for all.

Chapter 1

Diversity of persons with disabilities, inequalities and progress

According to the Convention on the Rights of Persons with Disabilities (CRPD), disability results from the interaction between persons with impairments and barriers that hinder their full and effective participation in society on an equal basis with others.[2] These barriers can include negative attitudes, such as stigma and misconceptions about disability; insufficient access to support, such as assistive technology, reasonable accommodation and personal assistance; inaccessible environments and communication; and non-inclusive health, education, transport and other systems. If unaddressed, these barriers can prevent persons with impairments from fully participating in various aspects of life and exercising the rights guaranteed by the CRPD.

Persons with disabilities are not a homogeneous group. They have diverse life experiences and identities and live in a range of contexts.[3,4] They therefore face different barriers to inclusion and require varying supports and strategies to achieve equal participation in society; 'one-size-fits-all' approaches to inclusion are not sufficient. Creating inclusive systems and societies will require adaptations to reflect the varied experiences of persons with disabilities. An intersectional approach – exploring how factors such as gender, age, socioeconomic status, type of impairment, the level of support required and context overlap with disability – is crucial for developing comprehensive, effective solutions.[5]

This chapter will focus on how different factors affect inclusion among persons with disabilities across the life course, with the acknowledgement that there are many others that merit further research and policy attention. The remainder of this report will explore how laws, policies (Chapter 2), sectors, systems (Chapter 4) and financing mechanisms (Chapter 5) can be adapted to achieve inclusion of all persons with disabilities, including in the face of global trends such as climate change, humanitarian crises and technological advances (Chapter 3).

What factors affect inclusion?

Many factors can affect the inclusion of persons with disabilities. Lack of data, or limitations of available data, have made analysing intersectionality among persons with disabilities challenging, although there has been increasing progress in this area (*see Chapter 2*).

Context

Barriers and enablers to inclusion can be significantly shaped by national and local contexts. **Policy and legislative environments** define persons with disabilities' legal rights and can shape the opportunities, services and supports that they have access to. Countries are increasingly enacting CRPD-aligned laws that protect the rights of persons with disabilities (*see Chapter 2*).[6] These laws can have important impacts: for example, in Uganda, implementation of inclusive education laws resulted in a 56 per cent increase in school attendance for children who are blind, partially sighted or have physical disabilities.[7] However, implementation, monitoring and enforcement remains a challenge in many settings. Strong legal commitments to inclusion and non-discrimination, while necessary, are not alone sufficient to guarantee the rights of persons with disabilities.

Resources to facilitate inclusion differ both within (e.g., between rural and urban areas) and between countries (e.g., by income and level of development) (*see Box 1.1*). Wealthier countries often have more financial, human and material resources to invest in structures and systems that promote the participation and well-being of persons with disabilities. For example, they may have more established and well-funded health, education, transport, social protection and other systems; reliable supply chains for assistive technology, medications and health-care supplies, and inclusive education resources; accessible infrastructure and information and communication systems; and a larger pool of skilled personnel such as rehabilitation and other health-care professionals, care and support staff, teachers trained in inclusive education, and government and judicial officials to monitor and enforce legal frameworks on inclusion. Within countries, key goods and services to support participation are often concentrated in urban centres. These resources are essential for inclusion: for example, one study in Viet Nam found smaller differences in the risk of poverty between persons with and without disabilities in areas with better infrastructure and health care.[8]

Consideration of both countries' resource levels and the overall maturity of key systems is important when designing strategies to accelerate inclusion, particularly in least developed countries and fragile States. It is also essential that all countries focus on equity and disability inclusion across sectors, initiatives and localities, to avoid worsening inequalities between persons with and without disabilities and among persons with disabilities as countries progress (*see Box 1.2*).

Box 1.1 Country resources and disability inclusion

Countries with more resources have a greater capacity to invest in inclusion, which can translate to better participation and well-being outcomes for persons with disabilities. Some examples include:

- *Life expectancy:* Life expectancy is on average 14 years shorter for persons with disabilities compared with persons without disabilities.[9] There are substantial variations by country income level: persons with disabilities are expected to live on average 23 years less than persons without disabilities in low-income countries, 19 years less in lower-middle-income countries, 12 years less in upper-middle-income countries and 10 years less in high-income countries. Some of these differences can be explained by varying exposure to extreme poverty and access to health care, education, care and support and other essential services.[10,11,12,13,14]
- *Access to assistive technology:* In a study of 29 countries, need for and access to assistive technology increased with a country's Human Development Index (HDI) score.[a] Overall, 11 per cent of people in countries with a low HDI score, 33 per cent in medium HDI countries, 65 per cent in high HDI countries and 88 per cent in very high HDI countries had access to needed assistive technology.[15] Men had higher access in most countries, particularly in lower HDI countries. Access was lower in rural areas in almost all surveyed countries.
- *Availability of and access to health services, including rehabilitation and other specialist services:* There are substantial differences globally in the number of available health-care professionals who can deliver rehabilitation and other specialist services.[16] For example, data from 107 countries suggest that, on average, high-income countries have over 900 physiotherapists per 1 million population, compared with fewer than 30 per 1 million in many low- and middle-income countries. Similarly, multiple low-income countries in Africa had no speech and language therapists, while high-income countries such as the United States and Australia had over 300 per 1 million population.[17] A different study using data from 84 countries estimated that 33 per cent of persons with major depressive disorders in high-income countries had access to mental health services, compared with 15 per cent in upper-middle-income and 8 per cent in lower-middle-income and low-income countries.[18]

It is important to note that these figures represent trends across several countries, and individual countries can be performing worse or better than expected for their resource level. Many high-income countries are still far from meeting commitments in the CRPD and their own legal frameworks, even though they have a greater capacity to spend on inclusion. Meanwhile, many low- and middle-income countries are committing to financing disability inclusion across sectors (*see Chapter 5*).

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[a] The Human Development Index is an indicator of a country's level of development. It ranges from 0–1, with higher values indicating a higher level of development. The HDI has three dimensions: a long and healthy life (life expectancy at birth), knowledge (mean years of schooling) and a decent standard of living (GNI per capita). HDI of less than 0.550 is considered low human development, 0.550–0.699 medium human development, 0.700–0.799 high human development and 0.800 or greater very high human development.

Box 1.2 Are people with disabilities at risk of being left behind from socioeconomic growth and development?

- *Multidimensional poverty:* Across 40 low- and middle-income countries, a higher HDI score was associated with larger inequalities in multidimensional poverty between persons with and without disabilities[19] – indicating that development efforts are not adequately disability-inclusive. For every 0.1 increase in the HDI score, the gap in the multidimensional poverty headcount between persons with and without disabilities increased by 5.6 percentage points (pp).[20] There are also often large urban/rural differences: in Brazil, Chile, Colombia, Costa Rica and Mexico, the proportion of persons with disabilities considered multidimensionally poor was at least twice as high in rural compared with urban areas,[21] suggesting an unequal division of resources and opportunities within countries.
- *Employment:* Across 40 low- and middle-income countries, differences between persons with and without disabilities in employment-to-population ratios widened as development levels increased: for each 0.1 increase in HDI score, inequalities increased by 7 pp.[22] This difference could be due to a range of factors, including the development of stronger social protection systems (e.g., unemployment insurance), which provide an alternative to low-paid, precarious or dangerous work.[23] It could also be linked to increasing formalization of work, which can present more barriers to entry for persons with disabilities (e.g., lack of sufficient skills and training from earlier exclusion from education, attitudinal barriers from employers, inaccessible travel to work).

Cultural context and societal norms on disability influence attitudinal barriers to inclusion. For example, there are differences in how disability is conceptualized within and between countries, affecting prevailing attitudes about disability and the inclusion of persons with different impairments in school, work and social life.[24] The extent to which persons with disabilities are included within communities can shape attitudes towards disability and the well-being of persons with disabilities: studies from a range of contexts (e.g., Austria, Chile, Hong Kong, India, Kenya, Poland, Saudi Arabia) found that children without disabilities had more positive attitudes and behaviours towards children with disabilities when they attended inclusive schools.[25,26,27,28,29,30,31]

Finally, certain contexts face additional challenges to inclusion and need adapted responses. For example, in remote areas and areas with challenging natural environments (e.g., mountainous, difficult terrain or climate) persons with disabilities often face heightened barriers to movement, autonomy and access to services. Many common strategies for inclusion may not be appropriate in these contexts (e.g., standard assistive technology may be unsuitable). Similarly, settings affected by humanitarian crises or public health emergencies, or areas most impacted by the effects of climate change, should incorporate a disability lens into broader crisis planning (*see Chapter 3*).

Type and level of support required

Persons with disabilities have different requirements for inclusion depending on their impairment, functional limitation(s) and level of support needs. Generally, persons with higher support needs and/or multiple disabilities have worse outcomes across many indicators, including multidimensional poverty, education, health and well-being, compared with persons with no disability or lower support needs.[32,33,34]

Creating inclusive systems and sectors necessitates tailored approaches to account for the different needs of persons with disabilities (*see Chapter 4*). For example, some strategies for promoting inclusive, quality education are important for all students with disabilities (e.g., training teachers, addressing discrimination from school staff and peers). Other strategies are based on the type of impairment and level of support required by students with disabilities, which can include: delivering bilingual, bicultural education in the national sign language and with deafblind interpretation for children, adolescents and young people who are deaf, hard of hearing or deafblind; ensuring physical accessibility of schools and facilitating transport to and from schools for children with physical disabilities; providing access to information in preferred alternative formats (e.g., Braille, large text, audio) for children who are blind or partially sighted; and adapted curricula, individualized learning plans and other accommodations for children with learning and intellectual disabilities.[35]

The magnitude and scope of disability-related extra costs also varies by support required (*see Box 1.3*). Persons with disabilities often require, and frequently have to pay out-of-pocket for, additional goods and services to support their participation and well-being, such as assistive technology, personal assistance, health care (including rehabilitation and other specialist services) and transportation.[36] The quantity and types of goods and services required vary considerably by a person's type of impairment and level of support needed.[37] Requirements also depend on whether the environment is accessible and the system inclusive: for example, persons with mobility limitations may use taxis and private cars when public transportation options are inaccessible or unavailable, or people may require more personal assistance if they must navigate schools, workplaces and community spaces that are not accessible or inclusive.

Coverage of goods and services required by persons with different support needs is not equitable. Access and affordability vary based on the availability and quality of needed items in different contexts, and the extent to which costs are covered by governments. Some groups have more unmet needs, or needs that are met but require high out-of-pocket spending. For example, across 29 countries, access to assistive technology was higher for certain products (e.g., 54 per cent of those who needed spectacles could access them; 47 per cent for walking sticks, 28–35 per cent for manual wheelchairs) than for others (e.g., 2 per cent for communication boards, 0 per cent for communication software).[38] Another example is the coverage of rehabilitation services and assistive products within public health systems: in a study of Cambodia, the Lao People's Democratic Republic and Viet Nam, most of the services and products that were covered by health systems were relevant for persons with physical disabilities, with less coverage for services required by persons with other types of impairment.[39]

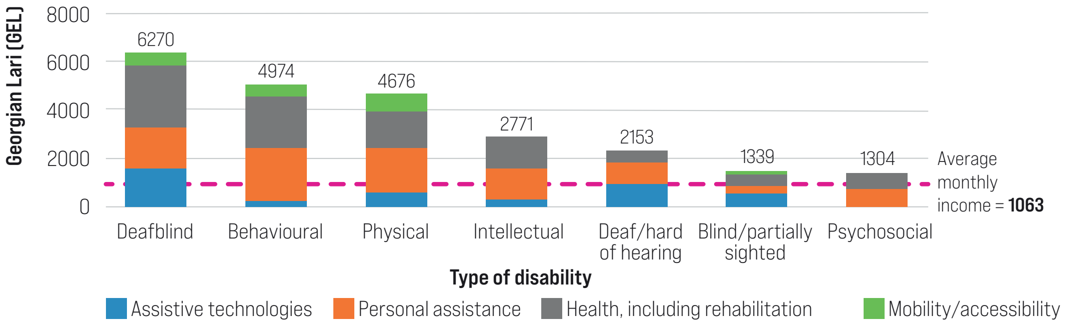
Box 1.3 The disability-related ‘extra costs’ of equal participation

Persons with disabilities are more likely to be living in poverty than persons without disabilities.[40,41] Standard poverty lines – and social protection packages – often assume that all people need the same level of income and other resources to achieve the same standard of living.[42] However, persons with disabilities require additional goods and services for equal participation; allowing for even modest estimates of these ‘extra costs’ significantly increases the number of persons with disabilities living in poverty.[43] For example, across 19 countries the proportion of persons with disabilities living in poverty nearly doubled after accounting for extra costs.[44]

Estimating the magnitude of extra costs can be difficult. Simply measuring what persons with disabilities are spending almost always underestimates the true amount required for equal participation: families may not have the necessary funds to purchase all goods and services required, or they may lack knowledge about or access to certain items. A growing number of studies (including in Fiji, Georgia, India, Ireland, Peru, Spain and the United Kingdom) are providing estimates of these extra costs – both met and unmet – and their breakdown by category (e.g., health care, care and support, transport).[45,46,47,48,49] These studies reveal that the true disability-related extra costs are substantial. For example, in Tamil Nadu, India, the costs of all goods and services required for equal participation of persons with deafblindness would be equivalent to 10 times the average monthly income.[50]

The total value and types of goods and services required also vary substantially by impairment type and level of support needed. *Figure 1.1* demonstrates differences in costs for different groups of children with disabilities in Georgia. This wide variation in costs demonstrates why the provision of a one-size-fits-all cash transfer – which is the main strategy for covering extra costs in many countries – is insufficient to cover the diverse needs of all persons with disabilities.

Figure 1.1. Monthly required disability-related costs for children with disabilities in Georgia by type of expenditure



Instead, multipronged strategies are needed to cover these costs. In addition to cash transfers, costs can be reduced through direct provision of goods and services, universal health coverage, concessions, subsidies or tax policies. The communication, attitudinal and physical access barriers that create these costs should be addressed (e.g., by accessible transport and information and communications technology (ICT) systems, inclusive education and health-care systems).

Legal recognition, and the extent to which different impairment types are prioritized in national and subnational policies and programmes, varies between countries (*see Box 1.4* for an example). For example, a review of official reports submitted by 19 countries to the CRPD Committee found there were no listed initiatives for accessibility and reasonable accommodations for persons with psychosocial disability and only two for intellectual disability, compared with 71 initiatives for persons with physical disabilities, 35 for persons who are blind or partially sighted and 28 for persons who are deaf or hard of hearing.[51] Similarly, disability certifications, which are a prerequisite for disability-targeted social protection and other programmes, can have restrictive eligibility criteria: some countries prioritize persons requiring the highest level of support or those with certain types of impairments.

Social attitudes towards disability and inclusion are often not uniform. Discriminatory and negative attitudes can be heightened for persons with certain impairments or higher support needs, increasing their risk of violence and exclusion. Multi-country studies have reported a particularly high risk of sexual violence for persons who are deaf, hard of hearing, blind or partially sighted,[52] while persons with psychosocial disability are most likely to experience violence overall.[53] In some contexts, harmful beliefs and practices exist around specific types of impairments and health conditions: for example, persons with albinism can face murder, trafficking and torture, while persons with psychosocial and intellectual disabilities can experience forced confinement, restraint and involuntary treatment.[54,55,56]

The attitudes of others towards inclusion can also vary by type of impairment and level of support required. For example, employers and teachers tend to have more favourable attitudes towards the inclusion of persons with disabilities who they perceive as requiring fewer accommodations or changes to standard practice.[57,58] Studies have found that teachers – particularly those without adequate inclusion training and in schools with few resources for inclusive education – tend to be more willing to include children with physical disabilities in mainstream classrooms than children with intellectual disabilities or behavioural difficulties.[59,60]

Box 1.4 Legal recognition of deafblindness[61]

Awareness and official recognition of deafblindness as a distinct disability is a critical step to ensuring persons with deafblindness receive appropriate supports and services. Often, persons with deafblindness are listed as having 'multiple disabilities', which can mean they are offered a combination of services for persons who are deaf and for persons who are blind. However, such an approach does not meet the requirements of most persons with deafblindness: most need deafblind-specific services and communication approaches, such as touch or tactile communication, adapted (e.g., Makaton, visual frame) sign language and interpreter-guides/deafblind interpreters.

Gender

Women and girls with disabilities face additional inequalities in many areas due to intersecting discrimination related to gender and disability. In addition to attitudinal, financial, accessibility and other barriers linked to disability, they must also contend with restrictive gender norms and unequal power dynamics (e.g., expectations around work, education, marriage and their roles in the household, community and governance structures). Promisingly, gender inequalities globally have decreased in the past 20 years, although they remain high in many contexts.[62] Yet women with disabilities continue to fare worse on many indicators compared with men with disabilities and women without disabilities.

As will be discussed below, women with disabilities experience higher levels of **economic exclusion**, including reduced participation in work and education, lower earnings and job security, and reduced autonomy in controlling personal and household finances. They also often have reduced **autonomy in decision-making** at the household, community and national level. Women with disabilities are frequently under-represented in Organizations of Persons with Disabilities (OPDs), women's organizations, national coordination mechanisms on disability, and local and national government bodies.[63,64,65] As an illustration, across 14 countries in the East Asia and Pacific region, women with disabilities were less than half as likely as men with disabilities to be part of the consultative and coordination bodies that oversee national disability policies and programmes, and 6 countries had no representation from women with disabilities at all.[66]

Women and girls with disabilities also face a **heightened risk of violence, discrimination and harmful practices**. Multiple studies have found that women and girls with disabilities are more likely to experience physical, sexual, emotional and financial violence, including from intimate partners, peers, teachers, family members and persons providing care and support, compared with women and girls without disabilities.[67,68,69,70,71,72] For example, pooled data from 11 low- and middle-income countries showed that women with disabilities had a 6 pp higher risk of intimate partner violence compared with women without disabilities.[73] Women and girls can also be subjected to harmful practices, including forced or coerced contraceptive use, sterilization and marriage.[74,75] When violence occurs, women and girls with disabilities may face additional challenges in being believed, reporting their perpetrators and accessing services for survivors, including justice mechanisms, child protection and support services.[76,77] National policies and programmes to reduce and address violence against women also largely ignore disability: a review of 190 countries' policies reported that 27 per cent of domestic violence laws had no explicit mention of women with disabilities, 84 per cent of countries had no legislation on sexual harassment against women with disabilities and only 9 per cent had domestic violence laws that addressed accessibility of services for survivors.[78]

Similarly, women and girls are more likely to face discrimination compared with women without disabilities and men with disabilities. Across 26 countries, women with disabilities were on average twice as likely to report experiencing gender discrimination compared with women without disabilities.[79] In Denmark, women with physical disabilities were approximately 70 per cent more likely to report discrimination in employment, education and when accessing health care, compared with men with physical disabilities, while women with psychosocial disabilities were over twice as likely to report discrimination in employment and education, compared with men with psychosocial disabilities.[80]

Women and girls with disabilities may also face **additional difficulties accessing services, including for gender-related needs**. For example, they often have reduced access to sexual and reproductive health care, including family planning and contraception, pregnancy and maternal health care, and sexual health education and information.[81,82,83,84,85,86,87] Women with disabilities are also less likely to use preventative services such as mammography and cervical cancer screening compared with women without disabilities.[88,89,90] Women and girls with disabilities may also experience heightened barriers to menstrual hygiene management and participation restrictions linked to menstruation (*see Box 1.5*). Drivers of exclusion can include poor accessibility and inclusivity of services, reduced autonomy in decision-making and misconceptions.[91] For example, there are common misconceptions that many of these services are unnecessary for women and girls with disabilities, linked to beliefs such as that women and girls with disabilities are asexual, sexually inactive, unable to bear children, unsuitable as parents or unable to make decisions about their own health and well-being.

Box 1.5 Disability and menstrual hygiene management

Barriers to menstrual hygiene management can include:

- A lack of accessible information. Women and girls with disabilities are 20 per cent less likely to know about menstruation at menarche compared with their peers without disabilities, highlighting gaps in inclusive sexual health education.[92]
- Poorer access to water, sanitation and hygiene services where they can safely change, wash and dispose of menstrual materials. For example, a woman with physical disabilities living in a rural area of Nepal described challenges cleaning menstrual products: "*I have to carry water in a bucket while also managing the crutches … I can't wash [the menstrual] cloths either … I keep it under my bed when I can't wash it, and wash it when I get water.*"[93]
- Discrimination linked to harmful beliefs, such as viewing menstrual blood or people who are menstruating as impure. Difficulties following social norms around menstruation can exacerbate the impacts of this discrimination. For example, a woman with a physical disability in Malawi described how during menstruation "*…blood can go out through the clothes and it is embarrassing to me.*"[94] Caregivers of girls with intellectual disabilities in Vanuatu reported keeping them at home during menstruation to prevent situations where they might leak menstrual blood onto their clothing or handle their used menstrual materials in public.[95] As one caregiver in Vanuatu explained: "*She removed [her menstrual material] and just threw it down … she didn't know what to do because I wasn't there. She pulled it out, then threw it down and walked around.*"[96]

Menstrual health can be particularly complex for women and girls who require care and support. Caregivers often lack adequate guidance, and may resort to long-term contraception or sterilization to prevent pregnancies or to avoid managing menstrual care without the consent of the woman or girl with disabilities,[97,98] which infringes on their rights.

Efforts to support the menstrual health of persons with disabilities are expanding, with interventions tailored to persons with different types of impairment, including those who are blind, partially sighted or have intellectual disabilities.[99,100,101,102,103] In Nepal and Vanuatu, menstrual health interventions for women and girls with intellectual disabilities have increased confidence in managing menstruation independently and enhanced the ability of care and support providers in menstrual care.[104,105] A caregiver who participated in a menstrual health intervention in Vanuatu reported: "*The last month was the first time; we slept, and she went to the … toilet, and she saw [her period] and came and took her towel and bathed … I saw a big change in her.*"[106] While significant barriers remain, these efforts offer promising pathways to enhance menstrual health, dignity and independence for women and girls with disabilities.

Boys and men with disabilities also experience additional challenges due to the intersection of disability and gender. Although typically lower than for women and girls with disabilities, they too have a higher exposure to physical and sexual violence compared with men without disabilities.[107,108,109,110,111] Risks associated with precarious employment – including economic exploitation and dangerous work environments – can be more common among men compared with women with disabilities, given their greater engagement in work. Further, men with disabilities can face greater stigma when they are unemployed due to greater societal expectations in many contexts for men to be earning. Finally, 'deaths of despair', including from suicides, drug overdoses and alcohol use disorders, are more than three times more common among men compared with women globally.[112] Men with disabilities – particularly men with psychosocial disability – face an even greater likelihood, due to heightened exposure to risk factors such as social isolation, financial strain and discrimination.[113,114,115]

Socioeconomic status

Persons with disabilities live across all socioeconomic strata, and their socioeconomic status can play an important role in influencing their opportunities, access to services and overall well-being. Multiple studies have found that persons with disabilities typically have lower socioeconomic status compared with persons without disabilities: they are more likely to be living in monetary and multidimensional poverty, have lower levels of education and weaker social networks, and are more likely to be unemployed or in insecure work.[116,117,118]

Having greater financial resources – income, assets, credit and savings – **improves capacity to pay for required goods and services**, including disability-related extra costs.[119,120,121] In the Philippines, children with disabilities living in wealthier households had fewer unmet health and education needs.[122,123] Similarly, in Indonesia and elsewhere, persons with disabilities both with and without health insurance had increasing health-care utilization and expenditures as wealth increased.[124]

Socioeconomic status, including the education levels of persons with disabilities and other members of their households, also **influences access to information**. Use of internet and uptake of mass media increases with increasing education levels and household wealth (*see Figure 1.2*). Socioeconomic status can also influence knowledge of disability and of goods and services required for participation. This knowledge can in turn influence confidence for self-advocating or advocating on behalf of a family member with a disability. For example, children with intellectual disabilities in Poland were more likely to be placed in segregated rather than integrated classrooms, had less parental engagement in their schooling and lower scholastic achievement if they came from a household with a lower socioeconomic status.[125]

Higher socioeconomic status can **protect against and mitigate the impacts of shocks and crises**. In three mega-cities in Viet Nam, living in poverty and being self-employed increased the risk that persons with disabilities stopped work, had reduced earnings and reported economic hardship during COVID-19 lockdowns.[126] Similarly, in Indonesia and Viet Nam, households in which a member newly developed a disability engaged in coping strategies such as cutting back on education spending and selling assets to offset losses of income and increased health spending; however, only the poorest households had to significantly cut back on food expenditures.[127,128]

Persons with disabilities with lower socioeconomic status are also more **vulnerable to entrenched poverty**. Lack of timely access to required, quality goods and services can lead to worsening health, functioning and participation – which can then result in spiralling costs, further participation restrictions and deepening poverty. For example, in the Republic of Korea, households in the lowest income quintile with members with disabilities were 20–40 per cent more likely to have catastrophic health expenditures.[b,129] In many settings, poverty is associated with lower access to education among children with disabilities,[130] and low educational attainment in turn affects lifetime earnings.[131,132,133,134,135]

Figure 1.2. Uptake of mass media by socioeconomic status

Across 36 low- and middle-income countries, persons with disabilities were

14%
LESS LIKELY
to have had recent exposure to mass media

(i.e., read a newspaper/magazine, listened to the radio or watched TV in the past week) compared with persons without disabilities

Persons with disabilities in the **richest two wealth quintiles** were

70%
MORE LIKELY
to have accessed mass media

Access increased with increasing levels of education

38% for persons with disabilities with no education

57% for primary school education

74% for secondary school education

81% for tertiary education

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b ‘Catastrophic health expenditures’ occur when health spending exceeds a household’s capacity to pay and are defined as health expenditures/total expenditures. Different thresholds are used; in this case, it refers to health expenditures totalling 10–40 per cent of household total expenditures.

c Based on a pooled estimate of MICS datasets. Prevalence ratios were generated using using a modified Poisson regression with robust error variance, adjusting for age and sex.

Other factors

Persons with disabilities can **experience additional marginalization due to overlapping identities** (e.g., sexual orientation, gender identity, belonging to an ethnic, religious, racial, linguistic or Indigenous minority group, or being a migrant or refugee). Marginalization can be due to layers of discrimination: for example, LGBTIQA+ persons with disabilities have reported being excluded from both disability communities and LGBTIQA+ communities.[136] It can also stem from the failure to create services and systems that consider how disability interacts with other characteristics. For example, persons with disabilities who require adapted communication face even greater difficulties receiving it if they also do not speak the dominant language.[137,138]

Persons with disabilities with overlapping identities typically have **low participation in representative bodies and governance structures**, including OPDs and other advocacy and rights-based groups (e.g., for LGBTIQA+, women's or racial minority rights). This exclusion means that their interests, experiences and skills are under-represented in these bodies, which can affect agendas, policies and programmes. However, there are promising examples of how OPDs and disability-rights organizations are increasingly focused on intersectionality (*see Box 1.6*).

Box 1.6 Organizations of persons with disabilities can represent the interests of diverse groups

While many OPDs remain focused on representing as broad a constituency of persons with disabilities as possible, some represent groups of persons with disabilities who are typically excluded. Examples include:

- In Fiji, the Disability Pride Hub arose out of informal gatherings among persons with disabilities with diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC). Now formalized, this grass-roots group envisions a broader role for itself in creating a forum for members of the SOGIESC community in the Pacific.[139]
- In Nepal, the National Indigenous Disabled Women's Association of Nepal (NIDWAN) became the first registered organization for Indigenous women with disabilities at a national level.[140] NIDWAN led the formation of a disability caucus for the rights of Indigenous persons with disabilities in the United Nations Permanent Forum on Indigenous Issues (UNPFII) in 2011.
- In Australia, the National Ethnic Disability Alliance (NEDA) is the national OPD representing the rights and interests of persons with disabilities from non-English-speaking backgrounds, their families and their providers of care and support.[141] NEDA has a range of membership organizations, all of which are organized around different groups of persons with disabilities from culturally and linguistically diverse backgrounds.

Exploring inclusion across the life course

Children and adolescents

Globally, an estimated 1 in 10 children – nearly 240 million – have a disability.[142] The proportion of children with a disability varies by region, from 6 per cent (1 in 17 children) in Europe and Central Asia to 15 per cent (1 in 7 children) in West and Central Africa.

Access to timely, affordable and quality health care is essential for ensuring children with disabilities can live healthy lives. Yet children with disabilities experience health inequities, including a higher risk of serious illness, lower vaccination rates and an increased risk of diseases linked to under-five mortality such as respiratory infections, malaria and diarrheal disease.[143,144,145] Their households are also more at risk of catastrophic health expenditures and financial barriers to accessing required care.[146,147,148] For example, in a study in New Zealand, children with disabilities were over four times more likely to report barriers to accessing primary care because of costs.[149] In the Islamic Republic of Iran, a third of households with children with disabilities had catastrophic health expenditures. This was more common in female-headed households, poorer households, when a child had an intellectual disability and when the child did not have supplemental health insurance.[150]

Malnutrition is more common among children with disabilities: across 32 low- and middle-income countries, children with disabilities were 34 per cent more likely to be stunted and 25 per cent more likely to be wasted;[151] other studies have found the risk can be closer to twice as high.[152] Malnutrition also highlights health inequities among children with disabilities. Children with mobility limitations and multiple disabilities were especially likely to have nutritional deficiencies, as were children with disabilities living in poverty in rural areas: in one analysis, more than 50 per cent of children with disabilities in these groups were stunted or wasted.[153]

Although household factors such as socioeconomic status play a critical role in ensuring access to food, disparities can exist within households: children with disabilities in Turkana, Kenya, were twice as likely to be stunted than their siblings without disabilities.[154] Children with disabilities may face additional barriers to receiving adequate nutrition, due to feeding difficulties linked to specific conditions (e.g., cerebral palsy), unequal division of resources within households and poorer access to interventions.[155,156] For example, children with disabilities are less likely to be in school and have more absences, which reduces their access to school feeding programmes.[157,158]

Early identification of disability and access to assistive technology, rehabilitation and other specialist health services and supports is essential to maximize functioning, health and participation for children with disabilities.[159,160] Gaps in accessing these services, however, are large.[161] For example, across nine countries in Latin America and North America, over 50 per cent of children with psychosocial disabilities did not receive mental health services, up to as high as 81 per cent in Mexico.[162] Socioeconomic status and other factors also affect access: in the United States, children from low-income households and racial or ethnic minorities had worse access to, and quality of, services for autism spectrum disorder.[163]

An inclusive, quality education has many benefits for children with disabilities, including enhanced academic and social-emotional learning and improved future job opportunities and earnings.[164] Yet children with disabilities are consistently excluded from realizing their right to inclusion in education. Globally, children with disabilities are less likely to attend and advance in school compared with children without disabilities.[165,166]

For example, across Organisation for Economic Co-operation and Development (OECD) countries, 1 in 5 young persons with disabilities – and 1 in 3 with high support needs – leave school early, compared with 1 in 10 young persons without disabilities.[167] Data from 34 low- and middle-income countries showed that children with disabilities are 25 per cent less likely to attend early childhood education, 42 per cent less likely to have foundational reading and numeracy skills and 49 per cent more likely to have never attended school compared with children without disabilities.[168]

Access to education also varies significantly among children with disabilities (*see Figure 1.3*), depending on the type and level of support required: over 65 per cent of children who are deaf, blind, deafblind or have significant difficulties in the domains of learning, memory or communication[d] were out of school – more than five to six times higher than for children without disabilities.[169,170] Children with disabilities who were living in poverty were four times more likely to be out of primary school compared with children in the richest households – and living in rural areas doubled the risk. Race and ethnicity can also influence schooling: in the Plurinational State of Bolivia, Chile, Mexico and Panama, Indigenous children with disabilities of primary school age were on average 25 per cent more likely to be out of school compared with non-Indigenous children with disabilities;[171] in the United States, Black children with disabilities were 25 per cent more likely to drop out and were over twice as likely to face a disciplinary removal (e.g., suspension, expulsion) compared with the average for all students with disabilities.[172]

While children with disabilities are increasingly attending school, the quality of education remains a challenge in many settings. Although many countries are moving to more inclusive models of education, many children with disabilities, particularly those with intellectual disabilities, are still taught in segregated settings For instance, in the United States, 17 per cent of children with intellectual disability spent most (80 per cent) of the day or more in mainstream classes, compared with 87 per cent of children with speech and language disabilities.[173] Segregated placement has been linked to lower socioeconomic status and parental education levels, and belonging to ethnic or racial minorities.[174,175,176,177]

Children with disabilities have fewer opportunities for play and interaction with peers, impacting their **social inclusion and well-being**.[178,179] They also report being lonely and having fewer friends than their peers without disabilities. This social isolation is particularly common among children with intellectual, emotional and behavioural disabilities.[180] Strategies such as inclusive sport, school and social environments can have many benefits, including improved relationships between children with and without disabilities, better attitudes towards disability, and increased feelings of belonging and acceptance, as well as improved educational outcomes for all children.[181,182]

Almost one in three children with disabilities experience violence globally – twice as many as children without disabilities.[183] Children and adolescents with disabilities are more likely to experience a range of types of violence, including sexual, verbal and physical violence, intimate partner violence, neglect and bullying.[184,185,186] Risks can differ by type of violence and type of impairment: for example, across multiple countries, children with intellectual and psychosocial disabilities had a heightened exposure to all types of violence, except sexual violence, which was more common for children who are blind, partially sighted, deaf, hard of hearing

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[d] Reported “cannot do” for UNICEF-Washington Group Child Functioning modules for seeing (blind), hearing (deaf), learning, memory or communication; or at least “a lot of difficulty” in both seeing and hearing (deafblindness).

or have physical disabilities.[187] Other reviews have found that children with autism spectrum disorder were more likely to be bullied at school compared with children without disabilities and with other disabilities.[188] Despite children with disabilities' markedly higher risk of violence, many interventions do not actively consider disability: for example, across 160 trials of school-based violence prevention programmes, only three assessed impacts among children with disabilities and none reported meaningful disability-inclusive adaptations to the programme design.[189]

Figure 1.3. Inequalities experienced by children with disabilities

Children with disabilities have worse educational attainment:
across 34 low- and middle-income countries, children with disabilities of primary school age were
47%
MORE LIKELY
to be out of school
compared with children without disabilities

OVER
65%
of children who are deaf, blind, deafblind or have significant difficulties in the domains of learning, memory or communication
were out of school –
MORE THAN FIVE TO SIX TIMES HIGHER
than for children without disabilities

Children with disabilities in poverty
4X
MORE LIKELY
to be out of school
compared to those in richest households

Children with disabilities in rural areas
2X
MORE LIKELY
to be out of school
compared to those in urban areas

Children with disabilities up to
2X
AS LIKELY
to be malnourished

Children with mobility limitations and multiple disabilities, in rural areas and
living in poverty at
PARTICULARLY HIGH RISK

Globally,
1 IN 3
children with disabilities
experience violence –
TWICE AS FREQUENTLY
as children without disabilities

Children with intellectual and psychosocial disabilities tend to have a
HEIGHTENED RISK
across many types of violence

Finally, it is important to **provide support to caregivers and households of children with disabilities**. Multiple studies globally have found caregivers of children with disabilities – particularly children with intellectual and developmental disabilities – are more likely to experience anxiety, depression and stress compared with caregivers of children without disabilities.[190,191] Caregivers of children with disabilities, particularly mothers and other female family members, often have lower engagement in work and reduced earnings compared with caregivers of children without disabilities.[192,193,194] For instance, in Norway, differences between mothers with and without children with disabilities in hours working, labour-force participation and earnings widened once their child reached school age, particularly for children with high support requirements.[195]

Reduced participation of caregivers in work, combined with the extra costs of raising a child with a disability, increases the risk of poverty amongst households: in Uganda, the average economic losses to families with children with developmental disabilities from additional spending on health care, lost income and reduction in wealth (e.g., sale of assets) was US$949 per year, which is more than the average national income.[196] Parental and household interventions, including for peer, financial and psychosocial support, and skills development, have shown promise in improving health, well-being and participation outcomes for both children with disabilities and their caregivers.[197,198,199]

Working-age adults

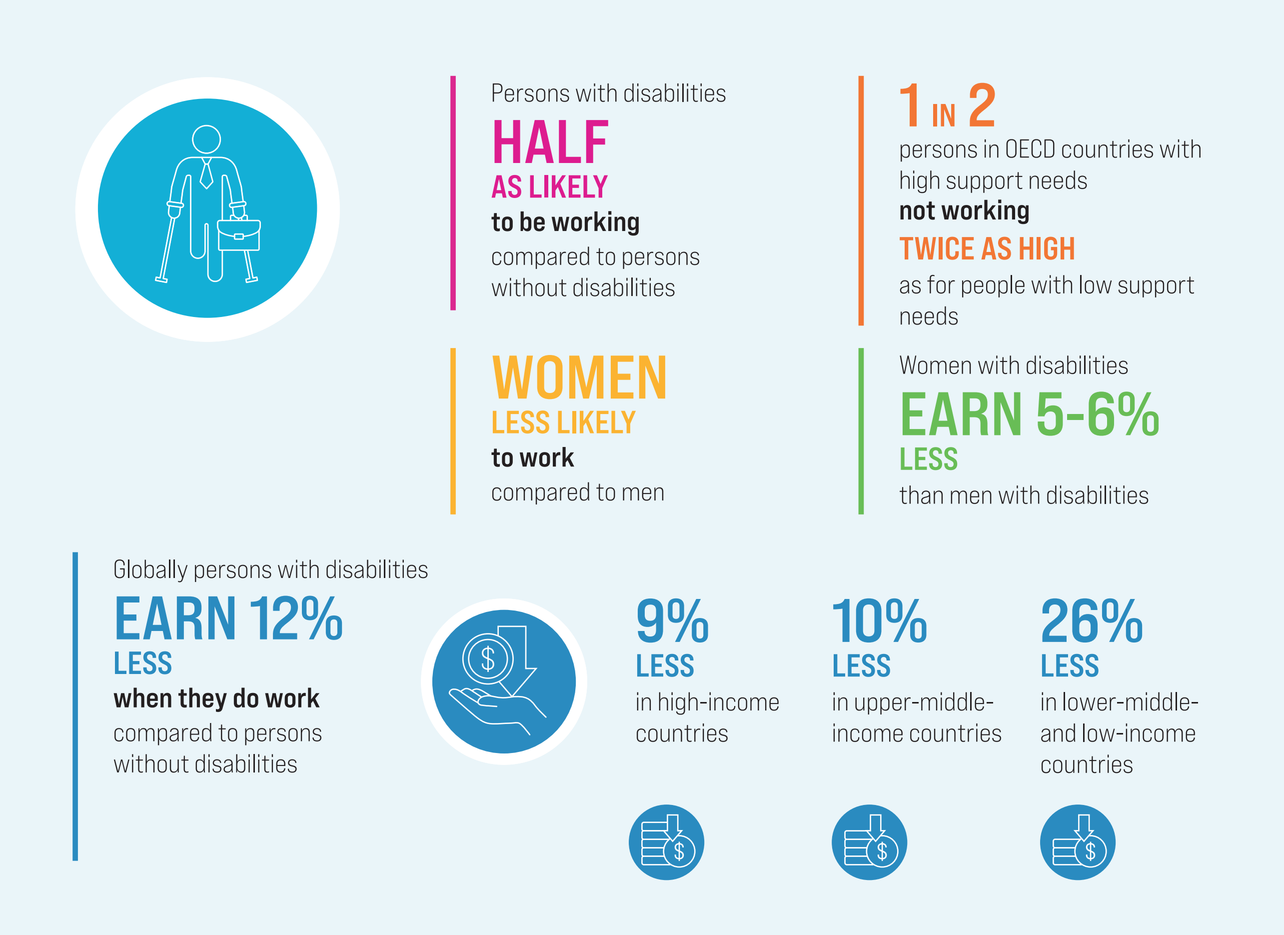
Globally, 16 per cent of the population aged 15–59 years has a disability.[200] Disability is more common among women than men in this age group (18 per cent vs. 14 per cent). This age group includes persons who have had disabilities since childhood, as well as persons who newly develop disabilities during their working years.

Working-age adults with disabilities **often experience health inequities** due in large part to reduced access to and lower quality of needed health care, including rehabilitation and specialist services.[201,202,203] In multiple settings, persons with disabilities are at greater risk of non-communicable diseases such as cancer, diabetes, obesity and hypertension; yet they have greater difficulties accessing preventative care, are more likely to be diagnosed at later stages of disease, report lower quality of care and have worse treatment outcomes compared with persons without disabilities.[204,205,206,207] Similarly, persons with disabilities are 30 per cent more likely to be infected with HIV,[208] yet they have lower levels of knowledge and awareness about HIV.[209] Inadequate maternity care is also a more common issue for women with disabilities: in Ontario, Canada, women with disabilities were more likely to experience severe maternal morbidity and mortality, particularly women with intellectual or multiple disabilities (57 per cent and 74 per cent more likely, respectively, compared with women without disabilities).[210]

Improving opportunities for work is critical to establishing decent and sustainable livelihoods for persons with disabilities during working age and beyond. Yet persons with disabilities contend with multiple barriers that affect their engagement in work, their earnings, job security and progression (*see Figure 1.4*). These barriers include lack of training, earlier exclusion from education, discrimination, inaccessible workplaces and lack of reasonable accommodations.[211,212]

Persons with disabilities are more likely to be out of work.[e] While there have been small increases in employment rates for persons with disabilities in some countries, gaps in employment between persons with and without disabilities have largely remained unchanged over the past 10 years.[213,214] Across 90 countries, persons with disabilities were half as likely to be working compared with persons without disabilities (employment-to-population ratio of 27 per cent vs. 56 per cent).[215] Women often have lower participation in work than men,[216,217,218] due to combined gender- and disability-related barriers to work. Further, persons with higher support needs are much less likely to be working compared with persons with no disabilities and lower support needs:[219] in OECD countries, one in four persons with disabilities with high support needs were employed, compared with one in two persons with disabilities with low support needs.[220]

Figure 1.4. Inequalities in work and employment amongst persons with disabilities



Persons with disabilities **HALF AS LIKELY to be working** compared to persons without disabilities

1 IN 2 persons in OECD countries with high support needs **not working TWICE AS HIGH** as for people with low support needs

WOMEN LESS LIKELY to work compared to men

Women with disabilities **EARN 5-6% LESS** than men with disabilities

Globally persons with disabilities **EARN 12% LESS when they do work** compared to persons without disabilities

9% LESS in high-income countries

10% LESS in upper-middle-income countries

26% LESS in lower-middle- and low-income countries

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[e] There are several commonly used indicators of employment. Labour-force participation refers to the proportion of a given population that is considered economically active (employed or not working but looking for work). Employment-to-population ratio is the proportion of a given population that is in employment. Employment and unemployment rates are the proportion of people who are employed or unemployed (not working but looking for work) among the economically active population.

Women and men with disabilities who work often have less stable and sustainable livelihoods: they are **more likely to be in self-employment, work fewer hours and have lower earnings, are less likely to work in managerial positions and are more at risk of job losses** compared with persons without disabilities.[221,222,223,224,225] In one study, persons with disabilities earned on average 12 per cent less than persons without disabilities across 30 countries.[226] Women with disabilities earn even less, with an additional wage reduction of 5–6 per cent compared with men with disabilities. There are also variations in the disability wage gap by country income: persons with disabilities earn 9 per cent less in high-income countries, 10 per cent less in upper-middle-income countries and 26 per cent less in lower-middle- and low-income countries. Improving access to education could help narrow this gap: in multiple settings, including Nepal, the Philippines, the United States and China, wage returns from each additional year of education were 6–26 per cent.[227,228,229,230,231,232] Yet differences in educational attainment do not explain all of the disability wage gap, indicating a need for other interventions to tackle barriers such as discrimination, poor workplace accessibility and lack of reasonable accommodations.[233] Job security in the face of shocks is also critical: for instance, persons with disabilities in OECD countries had a larger drop in employment as a result of the 2008–2009 financial crisis; and COVID-19 disproportionately affected employment outcomes for persons with disabilities in many countries.[234,235,236]

Adults with disabilities face **other forms of economic exclusion**. They can be denied access to banking and other financial services,[237,238] which can affect their autonomy over their spending. They are also more likely to be excluded from decision-making within the household[239] and contend with high disability-related extra costs, including costs related to seeking and maintaining work (e.g., additional travel, assistive technology and reasonable accommodations not covered by employers).[240] The combination of exclusion from work and disability-related extra costs increases risk of poverty among persons with disabilities.[241] Across 15 European countries, disability-related extra costs increased poverty by 2–16, meaning upwards of one in four persons with disabilities of working age were living in poverty.[242]

Persons with disabilities of working age frequently experience loneliness and poor mental health and report lower happiness and life satisfaction, impacting their **social inclusion and well-being**.[243,244,245] These feelings of exclusion are linked to factors such as stigma and discrimination, weaker social networks and lack of community-based care and support, which can take on new dimensions during working years (e.g., additional stigma from not working or being unmarried, loss of informal care and support as parents age or persons with disabilities leave their childhood home).[246,247,248]

Persons with disabilities are more likely to be victims of a crime and experience multiple types of violence. For example, across over 20 low- and middle-income countries women and men with disabilities aged 18–49 were around twice as likely to report being assaulted in the last three years, and 60–66 per cent more likely to report having been robbed, compared with persons without disabilities.[f]

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[f] Authors' calculation. Based on a pooled estimate of MICS datasets (31 countries for women and 24 countries for men). Prevalence ratios were calculated for each country and combined using a random-effects or fixed-effects meta-analysis, depending on the heterogeneity.

Finally, **adolescents and young people with disabilities contend with additional challenges transitioning into adulthood**. Across 61 countries, young people with disabilities (15–24 years) were twice as likely to not be in employment, education or training (NEET) compared with those without disabilities (48 per cent vs. 25 per cent).[249] Young women with and without disabilities were more likely to be NEET compared with their male counterparts, although gaps were larger between men with and without disabilities. There is considerable research that shows that young persons with disabilities do not gain the support necessary to transition from child to adult services.[250,251,252] Youth with disabilities are therefore at risk of losing access to key services and supports when ageing out of services designed for children, including health care and social protection benefits.[253] Young people with disabilities pre- and post-transition to adult services report unmet needs in knowledge, information and support with housing, benefits and finances, further education, employment and a range of other domains.[254]

Older adults

Ageing is the largest driver of disability globally.[255] An estimated 46 per cent of adults aged over 60 have a disability. This includes people who develop disabilities as a result of ageing and persons with onset of disability earlier in life.[256] Ageing and disability will become an increasingly important policy focus, as the number of people aged 65 years and older is expected to more than double globally by 2050 – and around half of this population will be persons with disabilities.[257] Older adults tend to make up a higher share of the population in higher-income countries: in high-income countries, people aged 65 years and older make up 19 per cent of the population, compared with 12 per cent in upper-middle-income countries, 6 per cent in lower-middle-income countries and 3–4 per cent in low-income and fragile States.[258] While the total number of older adults with disabilities varies by country, almost all countries will experience significant increases in the number of older adults with disabilities in the coming decades.

Income security is an important concern for older adults with disabilities. Across many countries, older adults with disabilities are more likely to be living in poverty compared with older adults without disabilities.[259,260] Social protection programmes, such as old-age pensions, are important sources of income for retired older adults. However, older adults with disabilities can have poorer access to and less financial protection from pensions. For example, in many settings pensions are only available to adults who have worked in formal employment, yet only a small proportion of the labour force engages in formal employment in many low- and middle-income countries.[261] Persons who had a disability during their working years are even less likely to be in formal employment.[262,263] Working-age adults with disabilities also earn less than persons without disabilities,[264] meaning their pension contributions and overall pension value are likely to be lower than for persons without disabilities. Lower pension values can also affect other family members who provide unpaid care and support for persons with disabilities.

Old-age pensions rarely factor in additional disability-related costs that make ageing with a disability more expensive, such as higher needs for health care, assistive technology, or care and support among older adults with disabilities.[265,266] Other forms of social protection (e.g., disability-targeted programmes) can help to offset these costs; however, older adults with disabilities may be ineligible for these programmes, due to age restrictions or limits on receiving more than one type of benefit.[267] Even when older adults are eligible for both old-age and disability-targeted programmes, uptake can be low: in the Maldives, adults aged 65+ had the lowest coverage for the Disability Allowance of any age group (8 per cent vs. 49 per cent for adults 18–39 years), although 87 per cent received an old-age pension.[268] In addition to common barriers to enrolment affecting all age groups (e.g., challenging application processes), many older adults with onset of impairments in later years do not self-identify as having a disability and so many do not consider themselves eligible for disability-targeted programmes.[269,270]

Many older adults with disabilities also require but do not have adequate access to **long-term care and support** (*see Figure 1.5*). Infrastructure, trained workers and other resources to provide these services are severely lacking across most countries.[271] Support responsibilities therefore often fall to other family members, predominantly women.[272,273] Lack of adequate support can affect the dignity, health and well-being of older adults with disabilities. It can also affect their households' economic stability: households in China, Mexico and Peru where older adults required support were more likely to have another member not working and report financial strain compared with households where older adults did not require support.[274] Women are particularly affected by the lack of formal services as they provide the majority of informal support to older adults with disabilities.[275] These largely unpaid responsibilities in turn contribute to lower labour-force participation and earnings among women.[276,277]

Some countries, such as China, Germany and Japan, have introduced insurance schemes for long-term care and support.[278] These programmes can have important benefits for older adults and their families: in China and Japan, they have resulted in a shift in other family members' time use from unpaid care and support to paid work.[279] Other countries, such as Azerbaijan, provide top-up benefits or concessions for services within pensions for older adults with disabilities. Paid family leave has also been shown to reduce income losses for family members who provide care and support.[280] However, 117 of 193 countries do not provide any paid leave for supporting an ageing family member, and those that do frequently have restricted coverage (e.g., up to two weeks off, limited to caring for a parent).[281]

Ageing often leads to the **development of new – or worsening of existing – health conditions**, some of which are more common among older adults with pre-existing disabilities. For example, persons with Down syndrome are six times more likely to develop dementia than the rest of the population.[282] In the Republic of Korea, older adults with disabilities were 42 per cent more likely to have chronic obstructive pulmonary disorder than persons without disabilities, with the risk even higher among persons with high support needs and physical disabilities.[283] Older adults with disabilities can also have worse outcomes from many of these and other health conditions. For instance, older adults with disabilities are at higher risk of hospitalization and mortality from seasonal influenza, yet they – and particularly persons with high support needs – are less likely to be vaccinated.[284]

These **higher health-care needs carry significant financial costs** for older adults with disabilities. For example, in Mexico, older adults with disabilities spent at least twice as much on health care as older adults without disabilities.[285] Out-of-pocket spending can be significantly impacted by a country's health financing system or individuals' access to health insurance: in Europe, where most countries have high coverage social health insurance or tax-funded national health systems, annual health-care spending for older adults with dementia was on average $246 per year, compared with $4,406 in the United States, where health financing is predominantly through private insurance with varying degrees of financial protection.[286] In several settings, older adults with disabilities are less likely to be covered by health insurance than older adults without disabilities.[287,288]

Older adults with disabilities **can face reduced quality of life and social inclusion**. Many older people experience a loss of social networks and social support, which can be accelerated for older persons with disabilities. Indeed, studies from around the world have shown that older adults with disabilities report being lonely and socially isolated and spend less time socializing than older adults without disabilities.[289,290,291,292] Disability is also a risk factor for violence and elder abuse.[293,294] In India, older adults with disabilities were two to three times more likely to experience elder abuse compared with older adults without disabilities, with persons with multiple disabilities facing heightened exposure.[295]

Finally, older adults with onset of disability in later life are less likely to self-identify or be recognized by others as a person with a disability.[296] As a result, they can face barriers to participation within representative bodies, meaning their concerns and experiences are not as well captured in advocacy efforts and in informing policies and programmes.[297] For example, older adults in multiple countries were less likely to be aware of or participate in OPDs compared with younger persons.[298]

Figure 1.5. Unmet needs for care and support among older adults with disabilities

Across 29 countries in Europe

33%

of persons with disabilities aged 65 years and older **reported unmet needs** for assistance in daily life activities

Among persons requiring support, unmet needs were more common among:

Women

18%

MORE LIKELY

to report unmet needs

compared with men

Older adults in rural areas

7%

MORE LIKELY

to report unmet needs

compared with urban areas

Older adults living in poverty, the poorest two quintiles

42%

MORE LIKELY

to have unmet needs

compared with richest

Older adults with higher support needs

89%

MORE LIKELY

to report unmet needs

compared with persons with lower support needs

Older adults living alone

26%

MORE LIKELY

to report unmet needs

compared with couples

Adults with increasing age have increasing unmet needs

25%	33%	39%
aged 65–69	aged 70–79	aged 80+

Source: Authors' calculations.[g]

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[g] Based on analysis of European Health Interview Survey (EHIS) wave 3. Unmet need for assistance defined as the proportion who do not have help but need it or require more help than currently receiving, amongst those reporting at least some difficulty in one or more personal care or household activities. Prevalence ratios adjusted for age and sex.

Endnotes

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Chapter 2

Structural efforts to implement the Convention on the Rights of Persons with Disabilities

Over the past decade, structural changes have formed the cornerstone of global progress towards disability inclusion and the implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). These efforts have included the development and enforcement of legislation, the establishment of national coordination mechanisms, and improved data collection and analysis. **Harmonization of legislation with the CRPD has been a key driver of disability inclusion**, seeking to set the legal frameworks needed to guarantee equal rights, protect against discrimination and promote access to services and opportunities. In many countries, new or strengthened disability rights laws have been instrumental in triggering public debate and shaping policies.

National coordination mechanisms have a critical role to play, given the cross-sectoral ambition of the CRPD and the need for each ministry and level of government to contribute to achieving disability inclusion. These mechanisms bring together stakeholders from government agencies, civil society and organizations of persons with disabilities (OPDs), fostering collaboration and accountability and ensuring that policies are informed by the lived experiences of persons with disabilities.

Reliable data are essential for understanding the scope and nature of the inequalities, barriers and support requirements of children and adults with disabilities, as well as tracking progress towards inclusion. Over the past decade, significant strides have been made in collecting and analysing disaggregated data on persons with disabilities, including through investments in disability management information systems and disability surveys. Such data can inform evidence-based policymaking, highlight gaps in access to services and enable countries to monitor the effectiveness of their disability-inclusive initiatives.

Finally, **greater and better allocation of financial resources** – both domestically and internationally – is crucial in translating those legal and policy commitments into action. While inconsistent, increased public expenditures in some countries on disability-inclusive policies, such as social protection, education or access to assistive technology, show the impact of legislative changes. International development cooperation has played a significant role, with greater emphasis on disability inclusion in development and humanitarian aid.

This chapter explores the progress made in these structural areas over the past decade, highlighting examples of good practices, persistent challenges and opportunities for further advancement.

Legal harmonization

National legislation is essential for translating the CRPD into concrete protections and shaping domestic policy. A core obligation of State parties to the CRPD is to harmonize their domestic laws with the treaty's provisions. This requires enacting legislation to implement the rights enshrined in the CRPD, as well as repealing or amending laws and regulations that are discriminatory.[1] States are also required to refrain from introducing new legislation that conflicts with the CRPD principles.[2] Achieving full legal harmonization with the CRPD demands a thorough review and reform of legal frameworks to ensure alignment with international human rights standards.

This section examines overall trends and key legal provisions critical to CRPD harmonization, using a three-part methodology.[a] First, 148 countries that have submitted initial or subsequent reports to the CRPD committee were considered. Following on from this, the concluding observations available for 114 States were reviewed. Then, an in-depth analysis was conducted of 42 of the 53 countries that have developed disability legislation since the enactment of the CRPD, based on which had readily available legislation online.[b]

Overall trends

The past two decades have seen significant changes in disability legislation. The CRPD ratification has prompted many countries to adopt domestic legislation to protect and promote the rights of persons with disabilities. Notably, 53 countries have enacted or amended stand-alone disability legislation after the CRPD's adoption in December 2006. This represents 46 per cent of the 114 countries with Concluding Observations globally. This trend is particularly notable in Latin America, where 76 per cent of reviewed countries have adopted or amended stand-alone disability laws since 2006.

Adopting a dedicated disability law can provide a unified framework that consolidates protections across critical areas, including health, education, employment and accessibility. It can also assign clear responsibilities to government agencies, facilitating accountability and enabling more streamlined enforcement. Such legislation may help to raise public awareness and simplify advocacy efforts. However, the stand-alone nature of these laws can also pose challenges, as it risks isolating disability issues from broader human rights and policy discussions. If mainstream sectoral legislation inadequately incorporates disability-related protections, there may be gaps or inconsistencies in protections. A comprehensive approach, in which reforms to other sectoral legislation complement a dedicated disability law, is often more effective in embedding the rights of persons with disabilities throughout the legal system.

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[a] See *Appendix 1*.

[b] The analysed countries include Bangladesh, Bolivia, Brazil, Burkina Faso, Chile, China, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Eswatini, Germany, Iceland, India, Iraq, Jamaica, Malawi, Maldives, Malta, Marshall Islands, Mauritius, Mexico, Monaco, Myanmar, Nicaragua, Nigeria, Pakistan, Palau, Panama, Peru, Republic of Korea, Senegal, Sierra Leone, Slovenia, Spain, Thailand, Türkiye, United Arab Emirates, Uruguay, Venezuela, Viet Nam. They were selected on the basis of online availability of their legislation.

To achieve such a cohesive framework, some countries have adopted 'omnibus laws' that not only introduce dedicated disability protections but also amend other pieces of legislation to align with CRPD principles. For example, in Brazil, the Statute of Persons with Disabilities (Law No. 13.146/2015), known as the Brazilian Inclusion Law, includes several provisions modifying and repealing other normative frameworks, including the Civil Code, the Electoral Code and the Consolidation of Labor Laws.[3] However, most countries have yet to extend reforms into other sectoral laws, which limits the full integration of CRPD standards across their legal systems.

While many States have sought to reflect the CRPD shift in their legislation, the transition from charity and medical models of disability remains uneven. Consequently, in many countries laws still have elements of the medical model, even if they adopt rights-based language, reflecting the ongoing challenges in fully realizing the human rights model of disability of the CRPD.

Definition of disability

The CRPD is built around a human rights model of disability, which recognizes disability as arising from the interaction between individuals with impairments and attitudinal and environmental barriers that hinder full participation in society.[4] This approach must be reflected in domestic legislation to ensure that all persons with disabilities are recognized as rights-holders, and that the full range of barriers they encounter are addressed.

This shift has presented a challenge for States, as the broad understanding of disability in the CRPD directly contradicts the narrow definitions traditionally used in their legislation (e.g., medicalized framing that equates disability with impairment). Since the adoption of the CRPD, countries including Egypt,[5] Fiji[6] and Romania[7] have moved away from medical model-based definitions and adopted frameworks more aligned with the rights-based approach.[8] However, overall, the adoption of definitions of disability that reflect the rights-based approach of the CRPD remains limited. The review of the CRPD Committee's Concluding Observations focused on definitions of disability within domestic legislation and whether they align with the CRPD's understanding of disability. The analysis revealed that 94 of the 114 countries have definitions of 'disability' or 'persons with disabilities' that directly conflict with the CRPD's concept of disability. Alignment is lowest in Eastern Europe and the Asia Pacific region.

Alignment problems persist even among countries that have reformed their definitions of disability in legislation. For example, contradictions may arise between the definition of disability and the criteria for recognizing individuals as persons with disabilities for accessing legal entitlements, benefits and protections, as many countries still rely solely on medical disability assessments and certifications (*see Box 2.1*). These challenges indicate a continued reliance on frameworks that fail to fully capture the social and environmental barriers faced by persons with disabilities, thereby limiting the effectiveness of legal protections and the promotion of rights.

Box 2.1 Definition of disability and eligibility criteria

Laws and regulations, as well as stakeholders, often use a definition of disability with two distinct concepts: (1) the overall legal definition of disability of persons with disabilities that provides the broad framework, including for non-discrimination; and (2) the legally defined eligibility criteria for a diversity of disability-related entitlements, services and benefits. The legal definition of disability establishes who is recognized as a person with a disability under the law, ensuring they are covered by legal protections and can exercise their rights on an equal basis with others. This definition should align with the human rights model of disability, as outlined in the CRPD, and be inclusive of the wide diversity of persons with disabilities.

Legally defined eligibility criteria for disability-related supports determine access to specific benefits and services, whether provided as legal entitlements or through ad hoc programmes, often within a country's social protection system or linked to official disability status certification. While there is a growing trend to shift from criteria solely focused on impairment severity towards approaches that consider support needs and participation restrictions, medical-based criteria remain common. Eligibility requirements may differ across sectors and programmes, but it is essential that they are reasonable, non-discriminatory and aligned with the principles of the CRPD. In some countries, the disability law defines the criteria for disability certification, though in most cases these are outlined in by-laws or regulations. Also, for some specific benefits, disability-related eligibility criteria can be combined with other eligibility criteria such as age or means-testing.

A key consideration is ensuring that eligibility criteria and disability certification for the purpose of access to specific benefits or programmes do not undermine the recognition of individuals as persons with disabilities for other purposes, such as protection against discrimination on the grounds of disability (e.g., receiving reasonable accommodations in the workplace). Disability legislation must ensure comprehensive rights protections for all persons with disabilities, irrespective of their official disability status and access to disability benefits.

Diverse approaches

States have adopted various approaches to framing disability law, shaped by their unique legal systems, traditions and practices. Some countries have implemented legislation centred on entitlements, primarily offering benefits, affirmative actions (e.g., quotas) and services. Others have enacted laws that outline state responsibilities for providing services and establishing institutional structures, though these laws may not grant enforceable rights to individuals. In some cases, legislation focuses on prohibiting discrimination based on disability across sectors – a positive step that may nevertheless fall short of addressing systemic barriers. Finally, some countries reviewed have taken a more comprehensive approach that more closely aligns with the CRPD, combining anti-discrimination measures with substantive rights in critical areas of life (e.g., education, health, employment, social protection).

Several concerns remain around these approaches. Provisions within laws are often broad and vague, sometimes modelled after the text of the CRPD but lacking the specificity needed to hold duty-bearers accountable for upholding these rights. Additionally, analysis of the disability legislation of the 42 States shows that across countries and regions, **States selectively choose which rights to focus on within their legislation – most frequently accessibility, health and employment rights**.[c] There are some regional variations: rights to independent living are least mentioned in Latin America and the Caribbean, Africa and Asia-Pacific but are frequently referred to in Europe. In contrast, education and social protection provisions are widespread in legislation in Latin America and the Caribbean, Africa and Asia-Pacific, but less recognized in Europe.

Legal capacity, rights to political participation and to participation in culture and sports are among the issues least frequently addressed in legislation. There was some regional variation among countries reviewed: for example, the recognition of rights to political participation and culture and sports is less common in countries in Europe and Latin America and the Caribbean than in Asia-Pacific and Africa. In contrast, legal capacity is referenced more frequently in Europe and Latin America and the Caribbean. This does not suggest that these rights are recognized in a manner that complies with the CRPD, but that the individual States have prioritized them during the development of their legislation. The absence of robust enforcement mechanisms can compound these issues, limiting the effectiveness of the laws and leaving significant gaps in the protection of persons with disabilities.

The following sections discuss advances and challenges in provisions on equality and non-discrimination, legal capacity, participation in public affairs, and enforcement and implementation; other provisions covered in disability rights legislation, such as education or employment rights, are discussed in Chapter 4.

Equality and non-discrimination

Most countries have protections against discrimination towards persons with disabilities, including within their constitutions.[9] However, **domestic legislation often falls short of the CRPD definition of discrimination** (i.e., any distinction, exclusion or restriction on the basis of disability that impairs or nullifies the recognition, enjoyment or exercise of all human rights and fundamental freedoms on an equal basis with others, including the denial of reasonable accommodation).[10]

An analysis of concluding observations of 114 countries reviewed by the CRPD reveals that 47 fail to substantively address disability discrimination, a gap consistently observed across regions. A further 66 States address disability discrimination but do not fully meet the standard set out by the CRPD, most commonly by failing to explicitly include reasonable accommodation within legislation. The remaining one State met the CRPD definition of non-discrimination, but implementation was identified as an issue.

Some notable examples among countries not yet reviewed by the CRPD committee, such as the Marshall Islands[11] and Mozambique,[12] have successfully integrated the CRPD approach into their legislation, fully covering all forms of discrimination, including indirect discrimination, and recognizing the denial of reasonable accommodation as a form of discrimination.[d]

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[c] This reveals areas of focus not in compliance with CRPD standards.

[d] Neither the Marshall Islands nor Mozambique has completed the reporting cycle, so they and are not included in the review of concluding observations.

Beyond prohibiting discrimination, some countries have taken affirmative action measures as a strategy to promote equality. For example, several countries have established quotas requiring a minimum percentage of employees in public or private sector organizations to be persons with disabilities,[13] or other types of preferential treatment in education or employment. However, according to the CRPD Committee observations, the implementation and effectiveness of these measures vary significantly (e.g., they tend to benefit persons with lower support needs and facing fewer barriers to inclusion), and they are often underenforced.

Some countries include provisions addressing the intersectionality between disability and other factors – such as gender, childhood, older age, LGBTIQA+ populations, and Indigenous or cultural minority groups – but these are often limited to general statements rather than specific provisions.

Legal capacity

Legal capacity is a fundamental right, enabling persons with disabilities to make their own decisions about their lives and to fully exercise their rights. Legal capacity reforms, driven by Article 12 of the CRPD, represent a critical shift from substitute decision-making models to frameworks that uphold the rights and autonomy of persons with disabilities.

Globally, implementation of legal capacity reforms has been limited,[14] although a number of countries have taken progressive steps towards CRPD compliance. In Latin America, countries including Peru[15] and Colombia[16] have developed comprehensive frameworks that recognize the legal capacity of all persons with disabilities, incorporating support mechanisms and prohibiting substitute decision-making.[17] In Europe, countries including Austria, Czechia, Germany, Ireland and Portugal have also introduced significant reforms, incorporating systems that recognize supported decision-making.[18] However, these States have retained substitute decision-making mechanisms, including on the basis of capacity tests or for certain decisions.[19] Consequently, most countries globally still rely heavily on systems that can result in partial or complete denial of legal capacity, or impose ad hoc restrictions, based on a disability diagnosis or capacity assessments.[20,21,22,23]

Even in countries where reforms have been enacted, challenges persist in changing court practices and ensuring the provision of appropriate, practical support for decision-making – both of which are essential for enabling individuals to fully exercise their legal capacity.

The **increasing adoption of mental health laws worldwide can create an additional barrier**. The WHO Mental Health Atlas identified that 111 out of 171 countries (65 per cent) reported having a stand-alone mental health law.[24] These laws can be inconsistent with the CRPD when they fail to protect the legal capacity and autonomy of persons with psychosocial disabilities. In most cases, these laws permit coercive practices – including detention, forced treatment, seclusion and restraint – based on a perceived 'need for care' or 'risk to self or others'.[25,26] Moreover, beyond legal restrictions, it is important to consider de facto denial of legal capacity that can be perpetuated by public officials and service providers, particularly in institutional settings, where decisions are made on behalf of individuals without recognizing their autonomy or preferences.[27,28]

Participation in political and public life

Articles 29 and 4.3 of the CRPD recognize the right of persons with disabilities to fully participate in political and public life and emphasize their active involvement in policy and decision-making processes. These provisions have driven important legislative reforms globally, as countries work to ensure that persons with disabilities can exercise their political rights on an equal basis with others.

Several countries have taken significant steps by removing voting restrictions based on disability status.[29] For example, in 2018, the Spanish Congress reformed the electoral law, reinstating the right to vote for approximately 100,000 individuals with intellectual or developmental disabilities who had previously been disenfranchised.[30] Some States, including France and Slovenia, have amended laws to restore voting rights to individuals deprived of legal capacity.[31]

Similarly, several countries have enacted provisions mandating accessible voting stations and accommodations to support persons with disabilities in exercising their political rights.[32] In Viet Nam, if an elector has a disability and is unable to visit the polling station, the election team will bring an auxiliary ballot box and the ballot to the voter's residence.[33] In Ecuador, legislation mandates the electoral authority to establish regulations to facilitate voting for persons with disabilities,[34] through preferential voting, assisted voting or home-based voting.[35] Other countries have adopted provisions that allow voters, including those with disabilities, to access postal voting or telephone voting or request accessible voting services.[36]

Certain countries have **legislated requirements for consultation with OPDs before enacting legislation or policies that impact them**, aligning with Article 4.3 of the CRPD. For instance, the General Law on Persons with Disabilities in the Plurinational State of Bolivia mandates that public policies, programmes and projects on disability are subject to social scrutiny, accountability measures, and ongoing consultation with OPDs.[37] In Cyprus, legislation affirms the obligation of every public service to consult with the Cyprus Confederation of Organizations of the Disabled before deciding on issues concerning persons with disabilities.[38] Notably, in Mexico, the Supreme Court of Justice of the Nation has annulled legislation for failing to comply with the obligation to consult persons with disabilities, recognizing this as a violation of their human rights.[39]

Some countries have adopted legislation to **ensure that persons with disabilities are represented within government structures**. In Uganda, the Local Government Act mandates that all district councils must include two councillors with disabilities, one of whom must be female,[40] alongside a constitutional mandate for national representatives of persons with disabilities and other groups.[41] Similarly, in Kenya, the 2010 Constitution reserves 12 seats in the National Assembly for 'marginalized' groups, including persons with disabilities, while the Senate reserves two seats specifically for persons with disabilities – one man and one woman.[42]

However, **substantial challenges persist to the democratic representation of persons with disabilities**. They continue to be barred from voting due to restrictive guardianship laws, particularly in countries where individuals under guardianship are automatically disenfranchised. In the European Union alone, an estimated 800,000 people faced this barrier in 2019.[43] Constitutional restrictions further complicate matters, as provisions in some constitutions explicitly limit the right to vote or run for office for individuals with intellectual or psychosocial disabilities. These restrictions, often based on outdated concepts of 'mental capacity' or 'incapacity', are especially difficult to reform because they require constitutional amendments.

Additionally, practical challenges remain due to the lack of legal standards. Inaccessible polling stations, inadequate voting materials and a lack of reasonable accommodations – such as ballot papers in Braille or assistance in polling stations – continue to hinder the voting process for persons with disabilities. Furthermore, persons with disabilities continue to face barriers to participating in public discussions and decision-making processes related to policies and laws that affect them. Addressing these barriers requires legislative measures that mandate positive steps to ensure accessibility and inclusion in all aspects of political and public life.

Enforcement and implementation

The **evidence on the effective implementation of disability laws is limited**, and there is a lack of comprehensive evaluations that systematically assess the effectiveness of these laws across diverse contexts. Much of the available evidence is based on case studies, qualitative observations or regional reports, which provide valuable insights but may not capture the full complexity of implementation challenges or measure long-term impacts.

Evidence suggests that effective implementation of disability laws requires a multifaceted approach that addresses both structural and social barriers. Key factors include strong enforcement mechanisms, high-level political commitment, adequate funding and targeted stakeholder training.[44] Consistent application across urban and rural areas is also crucial, as resource disparities often lead to unequal access. Additionally, robust data collection and participatory monitoring are essential for tracking progress, allocating resources effectively and adjusting policies based on real-world impacts. Without these measures, disability laws risk remaining largely symbolic, with limited impact on the lives of persons with disabilities.

Localization is an increasing focus of CRPD implementation. The understanding of localization is evolving, but loosely it is understood as the means by which regional and international treaties and agreements are transferred and implemented by governments, businesses, non-governmental organizations and individuals in their communities day to day. This focus is necessary to challenge the idea of implementation being only a top-down process – rather, it involves dynamic, continuous action at the international, national and local levels.[45]

Evolution of national institutional frameworks

Establishing national mechanisms for implementing, coordinating and monitoring the CRPD is a cornerstone of effective disability inclusion. Article 33 of the CRPD provides a clear framework for States Parties to establish mechanisms to fulfil these roles: focal points within government, coordination mechanisms across sectors and levels of government, and independent monitoring mechanisms that actively involve civil society, particularly OPDs. Progress varies across countries, with these mechanisms' structure, authority, expertise and resources often shaping their effectiveness and the extent to which they meaningfully engage OPDs.

This section underscores the critical role of national mechanisms in fostering meaningful inclusion and ensuring accountability under the CRPD by examining trends, challenges and best practices. It is primarily based on a mixed-methods study,[46] combining a literature review, interviews with experts and a rapid assessment of 53 countries[e] across a wide geographical, socioeconomic and political spectrum, along with six in-depth country case studies – Bangladesh, Colombia, Greece, Jordan, Kenya and New Zealand – showcasing diverse national approaches. Key indicators were used to assess focal points, coordination mechanisms and monitoring frameworks, including their structure, transparency, mandate and resource allocation.

Box 2.2 International and regional normative frameworks

The CRPD has redefined international human rights law, providing a comprehensive foundation for revisiting international standards. The CRPD Committee has played a critical role in deepening the understanding and implementation of the CRPD through its general comments, concluding observations and guidelines.[f] Similarly, the United Nations Special Rapporteur on the Rights of Persons with Disabilities and various United Nations agencies have issued actionable recommendations and guidance to address gaps in protection and implementation. Together, these efforts have integrated the rights of persons with disabilities within the broader human rights framework.

Beyond disability-specific mechanisms, the CRPD has influenced broader human rights mechanisms. The Human Rights Council, treaty bodies and United Nations Special Procedures increasingly integrate CRPD standards. For example, the Committees of the Convention on the Elimination of Discrimination Against Women and the Convention on the Rights of the Child apply CRPD principles to address issues faced by women, girls and children with disabilities.[47] Annual debates and resolutions by the Human Rights Council further promote the rights of persons with disabilities. Despite progress, challenges remain, such as interpretive tensions around legal capacity, deprivation of liberty and institutionalization.[48,49]

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[e] Albania, Algeria, Argentina, Australia, Austria, Bangladesh, Brazil, Canada, China, Colombia, Costa Rica, Croatia, Czechia, Djibouti, El Salvador, Estonia, Georgia, Germany, Ghana, Greece, Hungary, India, Indonesia, Ireland, Italy, Jamaica, Japan, Jordan, Kenya, Kuwait, Lao People's Democratic Republic, Malawi, Mexico, Morocco, Mozambique, Nepal, New Zealand, Nigeria, Peru, Philippines, Saudi Arabia, Singapore, Slovakia, South Africa, Spain, Switzerland, Tunisia, Turkey, Uganda, United Kingdom, Venezuela, Zambia, Zimbabwe.

[f] As of 31 October 2024, the Committee has adopted seven general comments: Article 12 (equal recognition before the law); Article 9 (accessibility); Article 6 (women and girls with disabilities); Article 24 (right to inclusive education); Article 19 (right to independent living); Article 5 (equality and non-discrimination), and Articles 4.3 and 33.3 (participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention). The Committee has also issued 143 concluding observations and has adopted views on 45 individual communications. In addition, it has issued guidelines on the right to liberty and security of persons with disabilities (2016) and on deinstitutionalization, including in emergencies (2022).

The CRPD has also catalysed significant regional developments. In partnership with the disability community, the African Union developed the African Model Disability Law to provide a legal and institutional framework for the protection and promotion of the rights of persons with disabilities. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities,[50] which entered into force in June 2024, reflects the CRPD principles and provides a regionally tailored framework for advancing the rights of persons with disabilities in Africa.

The CRPD has also informed the work of the Inter-American Human Rights System. Significantly, the Inter-American Court of Human Rights has included references to CRPD standards in interpreting the American Convention on Human Rights.[51]

The Council of Europe and the European Union have adopted various measures to align with CRPD standards. The Parliamentary Assembly of the Council of Europe and the Commissioner for Human Rights have urged member States to adopt policies consistent with the CRPD.[52] The European Court of Human Rights and the European Committee of Social Rights have also incorporated CRPD principles into some of their decisions.[53] However, conflicting interpretations persist, particularly around legal capacity, involuntary hospitalization and treatment, inclusive education and the right to vote.[54,55] The draft Additional Protocol to the Oviedo Convention has further raised concerns by contradicting CRPD standards on involuntary treatment.[56]

In the Asia-Pacific region, initiatives like the Association of Southeast Asian Nations (ASEAN) Enabling Masterplan 2025[57] and the Incheon Strategy[58] promote the rights of persons with disabilities, compensating for the lack of comprehensive human rights mechanisms.

While progress varies, these frameworks underscore a growing global commitment to disability inclusion.

Overall trends

The adoption of the CRPD has led to the establishment of diverse national mechanisms for disability inclusion, shaped by variations in political systems, governance structures, resource availability and levels of commitment to the rights of persons with disabilities. Many countries have introduced disability focal points, coordination mechanisms and independent monitoring mechanisms to facilitate CRPD implementation, although their effectiveness varies.

Fragmentation and challenges in coordination

Fragmentation is a persistent issue within national systems. Focal points, coordinating bodies and independent monitoring mechanisms frequently operate in isolation, leading to overlapping mandates, inefficiencies and a lack of cohesion. The absence of formal guidance for delineating roles among these structures exacerbates inefficiencies. This fragmentation is particularly evident in decentralized systems, where roles and responsibilities are unclear and accountability mechanisms are weak. Independent monitoring mechanisms often struggle to compel government agencies to act on their recommendations.

Funding and resource allocation

Resource constraints are a major barrier to effective CRPD implementation. Many focal points, coordination bodies and monitoring mechanisms operate with inadequate financial and human resources, limiting their ability to perform their functions. This issue is particularly acute in low- and middle-income countries, where state funding is often insufficient, and reliance on external donors raises questions about sustainability and autonomy. While some focal points manage significant national budgets, there is often a lack of transparency and oversight in how these funds are allocated. Ensuring that resources are directed towards transformative initiatives, rather than merely maintaining existing services, is critical. Moreover, international cooperation can play a pivotal role in bridging resource gaps, but a stronger focus on sustainable, long-term funding strategies is necessary to avoid dependency and ensure resilience.

Participation of persons with disabilities

The meaningful participation of OPDs in CRPD implementation and monitoring remains inconsistent. While progress has been made, including individuals serving within focal points and coordination structures, OPDs often face barriers to full engagement. In many cases, participation is tokenistic, with limited opportunities to influence decision-making processes. Marginalized groups within the disability community, such as women, Indigenous persons and those in rural areas, as well as those with intellectual and psychosocial disabilities, autistic persons, persons with deafblindness and others with complex support needs, are particularly under-represented. Greater emphasis is needed on empowering OPDs, ensuring the comprehensive accessibility of consultations and engagements and fostering grass-roots involvement to ensure that policies reflect the diverse realities of persons with disabilities.

Transparency and accountability

Mechanisms for implementing and monitoring the rights of persons with disabilities often lack transparency. In an analysis across 53 States reviewed, 10 had no public information about their composition, activities or outcomes. Strengthening transparency within these mechanisms could foster increased trust and ensure that they serve their intended purpose.

Variations in national knowledge and implementation

Countries demonstrate varying levels of understanding and capacity to implement CRPD obligations. Establishing platforms for mutual learning and sharing of proven approaches across countries can drive improvements, enabling States to align more closely with CRPD standards. Tailored support for countries facing systemic challenges, including technical assistance and peer learning, can help address gaps and foster more consistent implementation across regions.[59]

Box 2.3 Disability in national parliaments

States are increasingly including disability rights as a standard element of parliamentary business, with the establishment of parliamentary committees. Ireland has a disability committee for all 'disability matters', while South Africa includes disability as a named focus in a wider parliamentary committee on women and youth.

The establishment of disability parliamentary caucuses has also expanded in recent years, including Sri Lanka in September 2023, Zambia in October 2023 and Ghana in July 2024. These provide an opportunity for cross-party collaboration on disability rights issues and to build disability rights champions within national systems, and they are an entry-point for engagement with civil society.

Disability focal points

Article 33(1) of the CRPD requires States to **create one or more focal points within government to implement the convention**. These mechanisms are fundamental to ensuring implementation within government structures. Across 53 countries, 50 had created a designated focal point to promote and implement the CRPD.

Authority and positioning

Focal points should be positioned with sufficient authority to provide leadership, prioritize disability inclusion and maintain momentum in the implementation of the CRPD. Their capacity to influence cross-sectoral coordination depends heavily on their status within the government structure, and those with limited authority can struggle to shape policy or effect change.

Most countries designate focal points within a ministry or government body (*see Figure 2.1)*. Five broad areas of ministerial responsibility are most commonly assigned this role: social (including social welfare, services, affairs or protection); disability; women, gender or family;[g] health; and justice or human rights.[h] Additionally, five countries opted to assign a national disability council (NDC) or its equivalent as the focal point.

The location of focal point authority varies: the Director General for Policy on Cohesive Society in Japan is located at the Cabinet Office; Colombia tasked the Presidential Advisory Office for the Participation of Persons with Disabilities as the lead agency; and the Higher Council for the Rights of Persons with Disabilities in Jordan is connected to the Royal Hashemite Court. However, there is no clear evidence that the hierarchical location and effectiveness of the focal point are correlated; rather, whether the focal point has adequate authority, resources and clarity of mandate to ensure its effectiveness is crucial.

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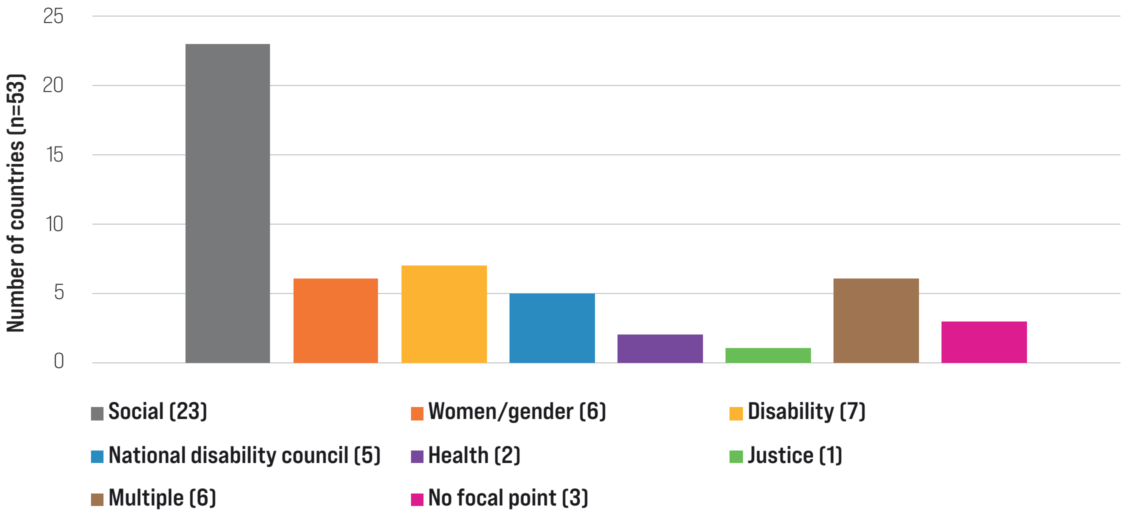
[g] Ministries with responsibility for disability often have portfolios that include families, older people or children, while Peru's Ministry of Women and Vulnerable Populations encompasses women, children, families, older people, veterans, gender and people with disabilities among its responsibilities.

[h] These are not wholly contained categories; the Albanian health ministry also has responsibility for social protection, while the focal point in Croatia is located in the Ministry for Family, Veteran Affairs and Intergenerational Solidarity.

Figure 2.1. Location of focal point (government ministry)



Source: Doyle-Guilloud, Burns and Flynn (2024)[60]

Mandate and functions

Focal points are often tasked with developing disability strategies and action plans, advising on policies and laws, raising awareness, mainstreaming disability across government and facilitating dialogue between government bodies and OPDs. Some focal points also coordinate CRPD reporting and gather data and statistics to support programme development. While they generally hold the responsibility of protecting the rights of persons with disabilities, **they often operate with limited guidance on how to fulfil this obligation effectively**. A small number of focal points are involved in coordinating disability service provision, a practice that is not recommended, as it detracts from their strategic oversight role.

Single versus multiple focal points

Single focal point models provide a streamlined approach to integrating disability into national policies, ensuring clear leadership and accountability. However, these systems often lack the broad representation and reach that multifocal point models can offer. **Multiple focal points enable broader coverage across various levels of government** and so are recommended by the CRPD Committee to ensure comprehensive CRPD implementation.[61] Among the 53 countries reviewed, 31 opted for a single focal point, while 18 established multiple focal points, which were distributed across government bodies at national, state, regional or local levels. The structure typically reflects the political system, with federal systems frequently assigning focal points to ministries or bodies at the state, district or municipal levels.

Despite their advantages, coordination among multiple focal points presents significant challenges, especially in decentralized systems. There is a risk that efforts may become fragmented and inconsistent. Strong coordination frameworks, clear mandates, well-defined roles and robust communication mechanisms are essential to unify efforts and ensure coherent and effective disability inclusion strategies. This can be achieved by appointing a lead focal point to oversee coordination, ensure oversight and promote effective implementation of the CRPD.[62]

Stability and resourcing

The stability and effectiveness of focal points often depend on their legal status and resource allocation. Focal points established through legislation are typically more stable and accountable, as legal frameworks provide clarity on their roles and responsibilities. Many focal points face significant resource constraints, lacking sufficient funding, staff and technical expertise. Only 30 of the 53 countries reviewed reported having a dedicated team or group of staff to oversee the work of the focal point, which may be compounded by the fact that some focal points are tasked with managing directly limited existing disability services, rather than prioritizing their resources to catalyse systemic transformation towards greater inclusion.

Participation of persons with disabilities

Focal points are expected to actively engage with OPDs and other stakeholders to ensure that disability issues are integrated into broader governance processes. However, the review identified a lack of OPD participation: most countries had not introduced domestic legislation obliging the focal point to consult with OPDs.[i] This can result in tokenistic and inconsistent participation that does not adequately reflect the diverse perspectives of the disability community. Meaningful consultation is also hampered by the limited resourcing of OPDs or short time frames and failure to provide accessible materials, such as Easy Read.

Box 2.4 Jordan: Council comprising civil society representatives

The Higher Council for the Rights of Persons with Disabilities (HCD) serves as the focal point in Jordan and is formally recognized as a government body under Law No. 20 on the Rights of Persons with Disabilities.[63] Created in 2008, the HCD transitioned from an advisory role to a government-recognized institution, reflecting a stronger national commitment to disability inclusion.

The HCD has four branches across the country.[64] Governed by a board of trustees, the HCD has 24 members, 13 of whom are persons with disabilities, alongside family members and independent experts. Reporting directly to the prime minister's office, the HCD focuses on policy development, capacity-building, accreditation standards and awareness-raising. Since 2018, service provision responsibilities have been transferred to relevant ministries, enabling the HCD to focus on its strategic mandate.[65]

Coordination mechanisms

Article 33(1) of the CRPD requires States to give 'due consideration' to the **establishment or designation of a coordination mechanism within the government to facilitate related actions across different sectors and levels**. These mechanisms can help prevent policies relating to persons with disabilities from becoming isolated measures and encourage focal points to address disability issues in a coherent manner. Countries with multiple designated focal points or sub-focal points, particularly federal states, may especially benefit from having a coordination mechanism in place. Of the 53 countries reviewed, 41 had established a formal coordination mechanism and 9 had not (the information was unavailable for 3 countries). Some countries without a mechanism, such as Georgia, were in the process of establishing one.

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[i] 18 of the 53 countries reviewed had a legal obligation to consult with OPDs.

Structure and positioning

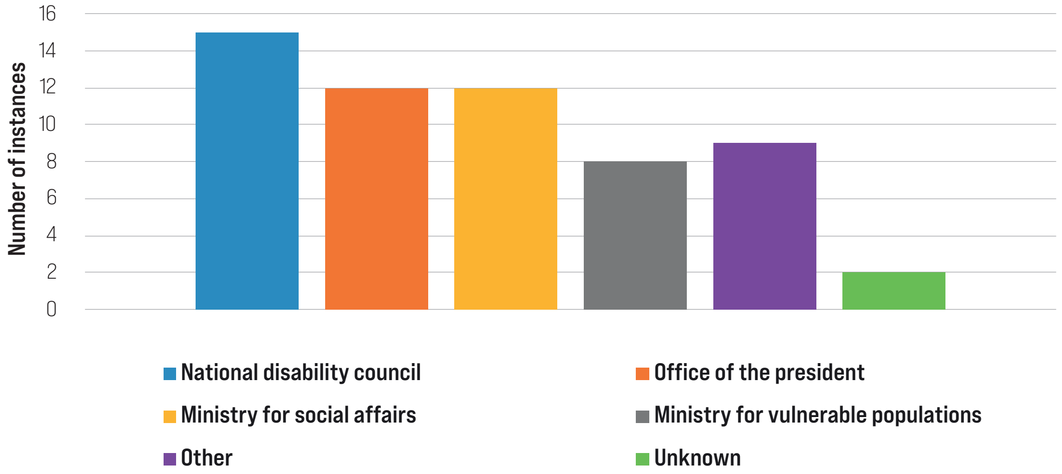
Coordination mechanisms take different forms, including interministerial committees, NDCs or specialized coordinating bodies. In federal systems, multilevel coordination involving national, regional and local authorities is common (*see Figure 2.2*). This approach can enhance coverage and promote collaboration, but requires clear mandates, well-defined roles and effective oversight to prevent fragmentation and inefficiency. Some countries, such as Colombia and Peru, have established national disability systems as a coordination mechanism, with their NDCs chairing these mechanisms and including representatives from national and subnational governments or state bodies.

As with the formation of focal points, the review found no evidence of formal requirements for gender balance or equality in the composition of coordination mechanisms. Bangladesh was the only country to include a formal requirement related to the gender of OPD representatives on the National Coordination Committee on the Rights and Protection of Persons with Disabilities.

Mandate and functions

The primary mandate of coordination mechanisms includes advising policymakers on disability-inclusive laws and policies, harmonizing disability-related activities across government levels (both horizontally at the interministerial level and vertically at the national, regional and local levels), monitoring CRPD action plans, raising awareness of disability issues and facilitating collaboration between government bodies and OPDs to ensure policies are informed by lived experiences. However, **many coordination mechanisms lack a legislative foundation**, leading to instability, limited authority and inconsistent resourcing. More than half of the countries reviewed either had no dedicated team to oversee the work of the coordination mechanism or such a team could not be identified.

Figure 2.2. Location of coordination mechanism



Source: Doyle-Guilloud, Burns and Flynn (2024)[66]

Relationship with focal points

Inadequate differentiation between the roles of focal points and coordination mechanisms often leads to inefficiencies and weak accountability structures. In some countries, the roles of coordination mechanisms and focal points overlap, leading to duplication of efforts and inefficiencies. While focal points are often tasked with both implementation and coordination, this dual role can strain resources and blur lines of accountability. States should clearly define the distinct functions of focal points and coordination mechanisms to optimize their effectiveness.

Participation of persons with disabilities

Most States have not introduced specific legislation to mandate consultation between coordination mechanisms and OPDs. Even where such consultation is required, meaningful participation is rare, with many mechanisms engaging OPDs in limited ways and with under-representation of most marginalized groups, such as migrants, refugees, Indigenous persons with disabilities, and those living in institutions or deprived of legal capacity due to guardianship, who are often excluded in decision-making and civil society activities.

This review highlights the importance of a balanced approach to involving OPDs in coordination mechanisms. Their inclusion enhances accountability and ensures the rights and perspectives of persons with disabilities are directly represented in decision-making processes. However, potential challenges must be anticipated, such as conflicts of interest, difficulties in reaching consensus and undue burdens on OPDs. Shifting responsibilities that should rest with the state onto OPDs risks undermining the principle of shared accountability and must be carefully avoided.

Independent monitoring mechanisms

Article 33(2) of the CRPD requires States to designate a framework, “including one or more independent mechanisms”, to promote, protect and monitor implementation of the CRPD. The institutions comprising the framework and their activities for monitoring implementation of the CRPD should reflect the principles of the convention and adhere to the human rights model of disability.[67] Additionally, Article 33(2) mandates that the monitoring framework complies with the Paris Principles,[68] a set of international standards guiding the work of national human rights institutions (NHRIs).[j]

Of the 53 countries reviewed, the majority (37) had designated a monitoring mechanism, with 26 opting for a single entity and 11 relying on multiple bodies for this function. However, 16 countries did not have an independent monitoring mechanism (IMM) in place.

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[j] The key pillars of the Paris Principles are that the NHRI should be established under primary legislation, have a broad mandate, be functionally independent, be pluralist, have adequate resources and financial autonomy, possess the freedom to address any human rights issue, report annually and cooperate with national and international actors. The accreditation process for NHRIs is managed by the Global Alliance of National Human Rights Institutions (GANHRI). This process assesses compliance of an NHRI with the Paris Principles, which define the essential characteristics and functions necessary for effective NHRIs. Key steps in the process include: (1) Submission of the request: The NHRI applies for accreditation, together with documentation demonstrating its compliance with the Paris Principles. (2) Evaluation by the Sub-Committee on Accreditation (SCA): The SCA reviews the application, focusing on the legal framework, independence and operational capacity of the NHRI, often consulting with various stakeholders in the process. (3) SCA recommendation: Following the review, the SCA makes a recommendation on the accreditation status of the NHRI, which may be categorized as A (fully compliant), B (partially compliant) or C (non-compliant). (4) Final decision by the GANHRI plenary: The final decision on accreditation status is made at a GANHRI plenary meeting where the recommendations of the SCA are discussed and voted on. (5) Reaccreditation: NHRIs are required to undergo periodic reviews and must reapply for accreditation to maintain their status.

Structure and membership

Of the 26 countries that designated a single IMM, 22 opted for their NHRI. Consequently, most of these IMMs are also responsible for monitoring the country's progress on the rights of other groups, including women and minorities.

In the 11 examples of IMMs composed of multiple bodies, the most common structure included a combination of NHRIs or multiple NHRIs (9 countries) with all or some of the NDC (7), OPDs (7) or government ministries (6). In Bangladesh, the national monitoring committee consists of the National Human Rights Commission, all 46 government departments' focal points and a range of OPDs.

Independence

The independence of IMMs is essential. To comply with the Paris Principles, monitoring mechanisms must function independently of government influence and have functional, financial and substantive autonomy. However, IMMs often face challenges in maintaining their independence, especially when reliant on state funding or embedded within governmental structures. Such dependency can restrict their ability to hold governments accountable or engage freely with stakeholders. Countries that adhere to the Paris Principles and adequately resource their IMMs tend to achieve stronger outcomes in CRPD implementation.

Box 2.5 Colombia: A legislated framework for inclusive coordination with challenges in local representation

In Colombia, the coordination mechanism is the National Disability System, established under Law No. 1145/2007. The law outlines three core components:[69]

- Presidential Council for the Participation of Persons with Disabilities: Governing body of the system
- National disability council: Comprising representatives from national ministries (health, education, finance, transport and others), national administrative departments and OPDs, ensuring representation for different impairment groups (physical, hearing, visual, intellectual, psychosocial and multiple)
- Departmental and district disability committees and municipal and local committees: These committees also feature spokespersons with disabilities participating in corresponding social policy councils.[70]

According to the State Report by Colombia to the CRPD Committee, the Ministry of the Interior provides training to OPDs and non-governmental organizations (NGOs) within the mechanism,[71] while the Ministry of Health allocates budgetary resources to support its operation.[72]

The law provides a legislative framework for the coordination process, encompassing both horizontal and vertical coordination.[73] A manageable number of subnational entities are represented, allowing the system to remain effective without becoming overly complex. The law also mandates the inclusion of civil society, including OPDs and NGOs advocating for the rights of persons with disabilities, within the coordination mechanism. However, a 2022 report highlighted ongoing challenges in securing meaningful representation of persons with disabilities at provincial and local levels.[74]

Mandate and functions

IMMs are responsible for a wide range of activities, as part of their mandate to promote, protect and monitor the implementation of the CRPD, including raising awareness, providing training, conducting investigations, issuing policy recommendations and producing regular reports. However, IMMs often lack the authority to enforce compliance with CRPD standards or issue binding recommendations. Effective monitoring mechanisms should have the authority to examine legislation and policies for compliance with the CRPD, investigate violations, engage in strategic litigation, issue binding or highly influential reports and recommendations, and receive and address individual complaints. Consequently, IMMs must have full access to information, databases, records, facilities and premises. They should also be granted unrestricted access to, and engagement with, any individuals, entities, organizations or governmental bodies necessary for their work.

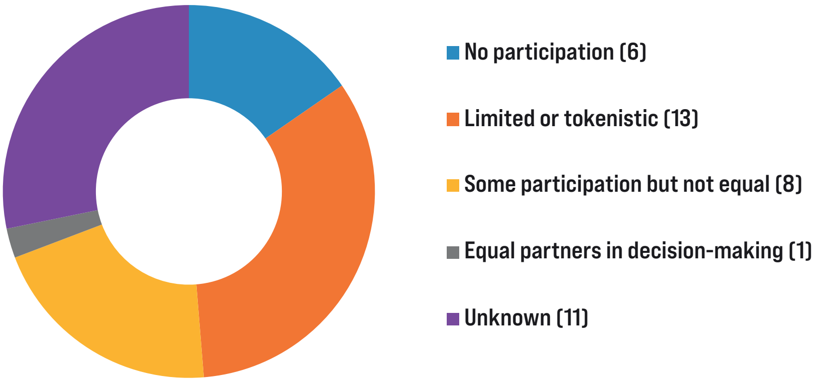
Participation of persons with disabilities

The meaningful involvement of persons with disabilities and their representative organizations is a core requirement for IMMs under Article 33(3) of the CRPD. In most of the countries analysed, there is no explicit legal obligation in domestic legislation for the monitoring mechanism to consult with OPDs. As a result, OPDs are often relegated to advisory roles rather than being treated as equal partners, which significantly limits their influence on decision-making processes *(see Figure 2.3)*.

Resource constraints

IMMs need adequate funding, technical expertise and human resources, along with budgetary autonomy and the authority to determine which issues fall within their remit. However, insufficient financial and human resources and heavy reliance on government funding can compromise their operations, independence and operational autonomy.

Figure 2.3. The nature of participation by OPDs in the monitoring mechanism



Source: Doyle-Guilloud, Burns and Flynn (2024)[75]

Box 2.6 New Zealand: A collaborative framework for disability rights with resource challenges

The New Zealand IMM comprises three main bodies: the Human Rights Commission (HRC), the Office of the Ombudsman and the Disabled People's Organisations (DPO) Coalition. The HRC, which is the NHRI in New Zealand, is tasked with promoting and protecting the rights of persons with disabilities. The Ombudsman investigates complaints about public sector agencies and ensures government practices align with CRPD obligations. The DPO Coalition, consisting of seven OPDs with rotating representation,[76] directly engages in monitoring and advocacy. This tripartite model ensures diverse voices and expertise are included in the monitoring process.

The mandate of the IMM includes promoting rights of persons with disabilities through education, outreach, media engagement and capacity-building. The IMM also protects these rights by receiving, investigating and resolving complaints, mediating conflicts, monitoring activities and reporting – roles jointly undertaken by the Ombudsman and the HRC. The DPO Coalition receives funding to conduct disability-led research and publish reports, actively participating as an equal partner in decision-making.[77] Members are provided with accommodations to support their participation[78] and are recognized as experts, often assisting with specific IMM programmes.[79]

Despite the strengths of the DPO Coalition, the CRPD Committee has raised concerns about its resourcing.[80] It recommended that the New Zealand State provide adequate funding and support, including translations into Māori, to enable the DPO Coalition to fulfil its role effectively. While the New Zealand IMM serves as a strong example of collaborative monitoring under Article 33(2), its success underscores the critical importance of sufficient resources, inclusive participation and a well-structured framework.

Box 2.7 United Nations mechanisms promoting the rights and inclusion of persons with disabilities

The United Nations has played an important role in fostering institutional frameworks that promote the rights and inclusion of persons with disabilities.

Committee on the Rights of Persons with Disabilities (CRPD Committee): This independent body monitors the implementation of the CRPD by States Parties.[81] It provides authoritative recommendations through general comments, concluding observations and guidelines. The CRPD Committee also allows individuals or groups to file complaints alleging CRPD violations and conducts inquiries into grave or systematic rights violations under its Optional Protocol.[82]

Special Rapporteur on the Rights of Persons with Disabilities: Established by the United Nations Human Rights Council in 2014, this independent expert promotes and protects the rights of persons with disabilities.[83] The Special Rapporteur conducts country visits, prepares thematic reports, engages with stakeholders, reviews complaints and reports annually to the United Nations General Assembly and Human Rights Council.[k]

United Nations Human Rights Council: The Council has been instrumental in mobilizing political support for disability inclusion. Since 2009, annual interactive debates on disability rights have provided a platform for dialogue, best practice sharing and addressing emerging challenges. The Council regularly adopts resolutions urging States to uphold CRPD obligations, integrate disability perspectives into development agendas and tackle specific issues such as inclusive education and employment.[84]

United Nations Security Council: Resolution 2475 (2019) highlights the importance of protecting persons with disabilities in armed conflict and ensuring their inclusion in peacebuilding processes. Additionally, Arria-formula meetings have provided a platform for States, United Nations entities and civil society to discuss and advocate for enhanced protection and inclusion of persons with disabilities in conflict and post-conflict settings.

United Nations Disability Inclusion Strategy (UNDIS): Adopted in 2019, this strategy embeds disability inclusion across all pillars of United Nations work: peace and security, human rights and development.[85] UNDIS sets measurable standards, with accountability mechanisms showing marked improvement. For the 2023 programme year, 38 per cent of United Nations entities and 41 per cent of country teams met or exceeded inclusion requirements, reflecting significant progress since 2019.[86]

UN Global Disability Fund (former United Nations Partnership on the Rights of Persons with Disabilities – UNPRPD): Established in 2011, this Multi-Partner Trust Fund drives systemic changes for CRPD implementation and disability-inclusive Sustainable Development Goals (SDGs).[87] Focused on low- and middle-income countries, the UNPRPD has supported 108 joint United Nations programmes in 93 countries, mobilizing over US$77 million by 2023.[88]

IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action: Adopted in 2019, these guidelines provide practical recommendations for disability-inclusive crisis response.[89] To support their implementation, the Disability Reference Group was established as a global platform for collaboration, knowledge-sharing and advocacy among humanitarian actors and OPDs.[90]

Other United Nations treaty bodies, special procedures and mainstream mechanisms also contribute significantly to advancing the rights of persons with disabilities. These initiatives underscore United Nations commitment to monitoring State obligations under the CRPD and fostering collaboration, capacity-building and innovation. However, sustained political will, increased funding and meaningful engagement with OPDs are crucial to fully realize their transformative potential.

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[k] The Human Rights Council first established the mandate on the rights of persons with disabilities in 2014. The mandate was most recently renewed in 2023, through resolution A/HRC/RES/53/14.

Data for inclusion

In the past 15 years, great strides have been made in the availability, comparability and quality of global disability data. This has created a growing evidence base on the situation of persons with disabilities in relation to a wide range of outcome indicators, including poverty, education, employment, violence, food insecurity, access to health services, and access to water and sanitation, as illustrated in the recent *Disability and Development Report 2024*. These data come from a variety of sources – surveys, censuses, administrative and citizen-generated. The data allow estimation of the scale and nature of inequities and can provide information on the barriers and facilitators that influence the many observed outcome gaps.

Despite the dramatic increase in availability of data, challenges remain. These issues include inequalities across regions in data collection, lag between data collection and data analysis, challenges in including disability in administrative data, and the limited role of OPDs in disability data collection.

Progress in inclusion of disability in key quantitative data sources, including censuses and surveys

The formation of the United Nations Statistical Commission Washington Group on Disability Statistics (WG) in 2001 was a major milestone in the increased collection and standardization of data on disability. Its first task was to improve the quality and consistency of data identifying persons with disabilities in censuses and national population surveys by creating a short set of questions that could be easily and uniformly understood by the full range of respondents. This process was challenging, because disability is a complex and varied phenomenon and identification of persons with disabilities varies depending on its purpose (e.g., disability benefit provision, accessibility or assistive technology needs).

The WG took a functional approach in developing its first set of questions, the Washington Group Short Set (WG-SS), which identifies those at risk of exclusion if facing environmental barriers.[91,92] Designed as the minimal set of questions that could fit on a census form to capture disability, the WG-SS includes six questions on functioning – related to difficulties with walking, seeing, hearing, understanding, self-care and communication. Response categories are 'no difficulty', 'some difficulty', 'a lot of difficulty' or 'cannot do at all'. Its standard is that anyone answering that they have 'a lot of difficulty' or 'cannot do' one of six basic activities is classified as a person with disabilities.[93] This threshold was chosen to minimize false positive responses and because cross-national testing found the 'a lot of difficulty' cut-off to be internationally comparable.

There are a number of concerns around the WG-SS for identification of persons with disability. The threshold of 'a lot of difficulty' has been shown to leave out some people who face barriers to participation or self-identify as having a disability. For example, many people answering 'some difficulty' to one, or especially multiple, WG-SS questions have also generally been found to have worse outcomes, evidencing that they too may experience disability-related restriction of participation.[94] However, a more liberal cut-off of 'some difficulty' will include people with chronic conditions or mild impairments who may not currently be experiencing strong functional impacts or restriction of participation.[95] The WG-SS also misses many persons with psychosocial disabilities and children with developmental disabilities.[96,97]

Consequently, a number of other standardized tools have been developed to capture disability. The WG developed the WG-Extended Set (WG-ES), which includes questions on mental health, pain and fatigue, and, with UNICEF, the Child Functioning Module (CFM), which asks about functional issues related to child development.[98] The WG also created the WG-SS Enhanced, which is shorter than the WG-ES but includes questions on anxiety and depression, and the CFM-Teacher Version (CFM-TV), which is a module adapted from the CFM to be suitable in school settings. The WHO Model Disability Survey (MDS) contains even more questions on functioning, which are used to create an index with thresholds delineating different levels of disability. That index is based on the distribution of functional limitations in the population being surveyed. It has more detailed information on functional limitations and creates cut-offs that are country-specific.

The WG-SS, WG-SS Enhanced, WG-ES, CFM, CFM-TV and MDS all identify difficulties in functioning along a continuum. The cut-off point for what constitutes 'disability' can be chosen based on the purpose of identification. However, none of these survey modules identifies all persons with impairments or conditions that may result in exclusion – for example, people with facial disfigurement, albinism, short stature or a chronic condition such as HIV may not be identified.

Despite their limitations, **these standardized approaches to measuring disability have been used widely, increasing the amount, consistency and comparability of international data on disability**. In a recent review of 188 countries undertaken by the Disability Data Initiative, 70 (37 per cent) had used the WG-SS in 141 data sets, representing 11 per cent of data sets included in the study.[99] Examples include 22 Demographic and Health Surveys (DHS) using the WG-SS and the inclusion of CFM into the latest round of the Multiple Indicator Cluster Survey (MICS) supported by UNICEF.[100] Moreover, SINTEF has conducted disability surveys in 23 countries, primarily in Africa.[101] The MDS has been conducted in 25 countries.[102] Overall, according to a 2024 WG survey of its national statistics offices members, 13 of 56 countries undertook a past or current disability survey[l] (typically with the WG-ES), with a further 3 respondents (Argentina, China and Kenya) reporting that they also intend to conduct such a survey. Also, 21 of the 56 respondents intend to include a disability module in a future survey using the WG questions.

Use and challenges of data on disability from censuses and surveys

Collection of disability data in censuses and surveys is critically important, as it **allows estimation of the prevalence of disability and enables comparison of persons with and without disabilities for a number of characteristics** (e.g., poverty, education, employment) to examine gaps in well-being.[103] The *Disability and Development Report* by the United Nations Department of Economic and Social Affairs (DESA), for example, is based on an extensive use of data for these purposes across a range of SDG indicators.[104]

A common concern is that the sample size of routine surveys is often too small to allow disaggregation of characteristics by specific groups with sufficient precision (e.g., type of functional limitation, deafblindness, rural/urban location). A census can have enough observations to allow disaggregation, but it often has limited information on each individual and so only a few indicators can be examined (e.g., educational attainment). Surveys generally collect a greater breadth of information, but they often do not have samples large enough to produce precise estimates for such subpopulations. Moreover, data on children with disabilities are often lacking, as the CFM is relatively long and therefore not frequently used in surveys (e.g., Household Income and Expenditure Survey (HIES)).

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[l] Burkina Faso; Canada; China; China, Hong Kong Special Administrative Region; Costa Rica; Czechia; Egypt; Italy; Japan; New Zealand; Panama; Saint Lucia; Thailand. The author is also aware of similar surveys in the United Republic of Tanzania and Viet Nam.

Consequently, special efforts may be required to obtain appropriate samples if data are required on specific groups (e.g., children) or outcomes (e.g., health status), or to include information on outcomes such as environmental factors or met and unmet needs. For example, the MDS asks whether various places in the community (e.g., health-care facilities, educational institutions, places of worship) are easy or hard to use. It also asks whether people use various forms of assistance, such as personal assistance (including who provides it) and a wide array of assistive products, and for what purpose. It also includes questions on whether there are any goods or services they do not have that could be helpful. Other disability surveys, such as one conducted by Kenya, have collected similar data, but from a sample of persons who already have a disability certification, and have included questions for their family members providing care and support.[105]

Data on environmental barriers associated with accessibility and attitudes have also been incorporated into the recently launched UNICEF/WG Inclusive Education Module (IEM) and the WG/International Labour Organization (ILO) Disability Employment Module (DEM).[106,107] The IEM asks about school type (e.g., regular school, special school, special classroom in a regular school), the needs the child has in getting to school and learning in the classroom, the school environment and the reasons children are not going to school, as they relate to disability. The DEM asks about barriers to employment, the extent and need for workplace accommodations, and attitudes of employers and co-workers. In Viet Nam, the DEM[108] shows that people with severe disabilities report that less than 30 per cent of employers were very willing to work with people with disabilities. However, the largest barrier may come from families, as 84 per cent of persons with severe disabilities report a lack of family support for their efforts to work. Once again, there are significant differences by gender, as women with disabilities reported more negative attitudes.

Data such as these can pinpoint areas that policies can address to close existing gaps. Thus, the MDS, similar surveys and modules focusing on the environment have started to move data collection beyond disability identification and disaggregation to identifying potential policy levers to address barriers undermining participation.

Administrative data

Data on disability also come from administrative sources. Among national statistics offices responding to the WG survey of their members, 39 out of 56 collect disability data in administrative records, mostly through disability registries, or as part of mainstream administrative data collection such as health, education or social protection Management Information Systems.[m] The expansion of routine data collection and the use of disability markers in these systems support the rapid and efficient growth of information on access of persons with disabilities to services and programmes. However, such data are often focused on specific programmatic needs.

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[m] Argentina, Austria, Belarus, Botswana, Brazil, Burkina Faso, Canada, China, Colombia, Costa Rica, Czechia, Denmark, Finland, Georgia, Germany, Hong Kong, Hungary, Italy, Kenya, Latvia, Lithuania, Maldives, Mali, Mauritius, Mexico, Myanmar, Nepal, New Zealand, Panama, Peru, Poland, Russian Federation, Saint Lucia, Senegal, South Africa, Sweden, Thailand, Türkiye, United States.

Some administrative data systems have begun collecting data that can be used for multiple purposes. For example, disability registries in several contexts are evolving towards Disability Management Information Systems (DMIS) which now collect data on diverse support needs instead of only information required for determining eligibility for existing programmes. These data can inform policy planning and service development. Such DMIS exist or are in development with a varied scope of data collected in Armenia, Cambodia, Chile, Djibouti, Mauritania, Myanmar, Rwanda, Senegal, Sierra Leone and the United Republic of Tanzania, among others (*see Chapter 4*, section on social protection).

Another prime example is the Fijian Education Management Information System (EMIS).[109] The Fijian Ministry of Education implemented a method for disaggregating the country's EMIS (FEMIS) by disability, based on the CFM, for collecting data on child functioning within a student learning profile form that also collects information on assistive technology, learning support needs, capabilities and access to referral services. Since the development of the FEMIS, UNICEF and WG have created a similar tool for use globally in EMIS, known as the CFM-Teacher Version.[110] A second form in the FEMIS – the school accessibility and inclusion form – gathers information on school infrastructure, transport, materials and efforts towards inclusion, and information about the qualifications and professional development of school staff with regard to inclusion. Importantly, for any element that is inaccessible the school must record plans to increase accessibility. The FEMIS is therefore used for a range of purposes: monitoring the number of children with disabilities in school, monitoring their outcome gaps, identifying their needs, referring them to services, identifying opportunities to become more inclusive, support planning and budgeting, and monitoring the impacts of those efforts on children's outcomes.[111]

Administrative data offer a powerful resource for providing information on disability, but currently many sources do not yet collect information on disability, or disability measures are non-standardized or complexly calculated. Electronic health records are a key example, as they are becoming widely used to identify inequalities and predictors of health conditions. In the United Kingdom, studies using electronic health records frequently include 30 million or more participants, and they were key to identifying predictors of adverse outcomes from COVID-19. However, these records do not include simple markers for disability and so are limited to disaggregating by learning disability (as a learning disability register exists within these records)[112] or by linking to external markers of disability (e.g., from the census).[113]

Disability data harmonization

The policy interventions required for disability inclusion cut across all sectors, and data are being collected from multiple sources. With greater availability of disability data from censuses, surveys and administrative sources, and growing capabilities and interoperability of management information systems across sectors, **there is a potential for harmonization of different data sources pertaining to disability**. This would limit the confusion that can arise when different data sources report seemingly contrasting information, which can undermine confidence in data and thus their usefulness. Harmonization can also help leverage the power of collected data to reach a more comprehensive understanding of situations of persons with disabilities and their families and the impact of policies.[114]

In Armenia, data on children with disabilities in the EMIS are connected to corresponding data in the social welfare system. This allows for the data collected by the two different administrative sources to be used together for a more complete understanding of a child's situation. For instance, if a child appears in the disability registry but not in the EMIS, authorities can identify them as out of school and provide appropriate support. Similarly, if a country integrates the WG-SS questions into the national census and surveys, while also tracking official disability certificates (as done in Georgia), the combined data of surveys and disability certification mechanisms can offer information on who accesses formal disability support in relation to age, type of functional limitation and location, and on the broader disability support needs at population level.

Data harmonization has no effect on eligibility criteria for programmes, nor does it limit the type and depth of data to be collected for different surveys, programmes or statutory requirements. The goal is to align disability data across sources while maintaining flexibility for sector-specific needs.

A World Bank study on disability data harmonization in South Africa[115] **recommended using a 'crosswalk' approach, integrating common disability-identifying questions like the WG-SS to improve data comparability across systems**. However, the study identified challenges, such as the feasibility of applying a standard set of questions across all data tools. For example, the Department of Labor considered that including the WG-SS in its form to monitor employment quotas was too burdensome and preferred to continue using a single question asking for disability self-identification. The study recommended asking the WG-SS questions to those who first self-identified as having a disability to understand the distribution of functional difficulties among those being counted towards the employment quota compared with the distribution in the general population.

Citizen-generated data

Citizen-generated data (CGD) are increasingly being recognized by governments as a complement to official statistics, especially for marginalized groups. Data collected by civil society organizations, including OPDs, can be generated in real time and so respond to events like natural disasters more quickly. The collection of data generated by OPDs can also ensure that the type of data deemed most important or relevant to them is being collected. Crowdsourcing data are sometimes shown to spur innovation.[116]

As examples, the Ghana Statistical Service has carried out citizen data projects to improve the generation, timeliness and utilization of statistics at the subnational level by engaging citizens in the data supply process. One project used technology and innovation to assess the effectiveness of the District Assembly Common Fund for persons with disabilities.[117] Another example is an OPD-led CGD project, in collaboration with local authorities, to update databases of persons with disabilities in the Philippines.[118]

CGD raises challenges of data quality, reliability and inclusivity. A key concern is whether the findings are generalizable to all persons with disabilities, as respondents are likely to be a selected sample. Citizen organizations and governments must work together to develop practices to validate data-collection processes. There are also privacy and ethical concerns, especially when it comes to big data.[119] Governments and research institutes tend to have systems in place to address privacy and ethical concerns that citizen organizations may not have.

Considerations in the analysis of data

Progress in data collection has been substantial, which has revealed the inequalities experienced by persons with disabilities. **These data can also be used to take policy and programmatic actions.** For instance, studies on disability-related costs demonstrate the wide range of goods and services required for equal participation, and how they vary across types of disabilities and levels of support needs. The variance in needs clearly demonstrates the inadequacy and inefficiency of a social protection programme that is based solely on cash benefits.[120] A recent study in Georgia, for example, is serving as the basis for the development of a social package that can address the specific needs of children with disabilities.[121] A similar study of adults in Indonesia is the basis for the development of national regulations on concessions for persons with disabilities.

Another example of how data can drive policy in crisis response comes from the United Kingdom. When data analysis found that persons with learning disabilities were eight times more likely to die from COVID-19,[122] they were given priority in vaccinations.

In South Africa, studies conducted as part of the Forgotten Agenda research programme[123] led to the development of a national strategy on combating HIV.[124] And in Cambodia, the analysis of Cambodian DHS informed the drafting of national guidelines on disability inclusion in national social protection and the launching of the *Universal Healthcare Roadmap 2024–2035*,[125] the drafting of the National Action Plan to Prevent Violence Against Women and the National Action Plan on Inclusive Education, 2024–2028, in May 2024.

As in the FEMIS, administrative data on disability are also being used for the design and implementation of programmes in a growing number of countries, as demonstrated by the increased collection of data on children with disabilities and the school environment in EMIS. In 2022, 85.7 per cent of Global Partnership on Education countries were able to disaggregate education data by disability, up from 50 per cent in 2021.[126]

However, a lack of adequate data analysis often limits the utilization of these new data for policy design, planning, resourcing and monitoring. There are also challenges to the analysis and interpretation of disability data.

First, **sufficient information needs to be collected on the outcomes for disaggregation by disability** to allow relevant programme and policy inferences to be made. For example, many countries disaggregate school attendance rates but lack data on variables such as whether children are in the correct grade for age, educational attainment or place of education. For example, in 2016 over 40 per cent of students with disabilities in 30 education systems in Europe were in special schools. However, there are wide variations: in Belgium and Germany, it was 80 per cent, compared with almost zero in Italy and Norway.[127] Similarly, persons with disabilities are more likely to be self-employed, so simply disaggregating employment-population ratios may hide the lack of access to formal labour markets.[128]

Second, **household-level indicators may not be adequate for describing the experience of persons with disabilities**. A household having access to a service or feature does not necessarily imply that persons with disabilities living in that household also have access. For example, a study in Tajikistan showed that 24 per cent of households with a water source reported that persons with disabilities in their household could not access it without assistance. Over 60 per cent of households with a member with a disability had not made adaptations to their sanitation facility to meet the needs of their household members.[129] Person-level indicators may therefore be more important than the typically used household markers in understanding the experience of persons with disabilities.

Third, **additional or adapted indicators may need to be collected to describe the experience of persons with disabilities**. For instance, the disability-related costs incurred by persons with disabilities are a key issue. Due to barriers in the environment and support needs, persons with disabilities and their families face additional costs, which they may or may not be able to afford, for a variety of general (e.g., transportation) and disability-specific items (e.g., assistive technology) to meet their basic needs and participate equally.[130] Without adjusting the poverty measurement to account for the costs of those goods and services, disaggregating poverty rates by disability will undercount persons who are effectively living below the well-being levels associated with the standard poverty rate.

Some lessons learned are summarized in *Box 2.8.*

Box 2.8 Lessons learned

The following lessons learned are drawn from the actions already being undertaken in various contexts and are aimed at improving the quality and availability of data pertaining to disability and inclusion.

All standard indicators, including those used to track progress on the SDGs, should be routinely disaggregated by disability. This disaggregation provides a clearer understanding of the relative well-being of persons with disabilities and helps highlight gaps that need to be addressed. To do so, countries should integrate validated and internationally tested questions into censuses and all major household surveys used to generate those standard indicators.

Alongside demographic data, countries should also collect environmental data related to inclusion, capturing both barriers and facilitators, as well as information on specific support needs through both surveys and administrative data.

Given the complexity of disability and the diversity of persons with disabilities, dedicated disability surveys should be conducted regularly – ideally every five years – to gather more detailed and nuanced data on diverse groups' barriers, support needs and participation. Countries are also encouraged to make use of citizen-generated data, working closely with civil society to validate and integrate this information into official data systems where appropriate.

Finally, building harmonized and integrated disability data systems across all data sources is essential. By aligning census, survey, administrative and citizen-generated data, countries can ensure a comprehensive and coordinated approach to tracking and advancing disability inclusion.

Domestic and international public expenditures

Adequate financing and optimum use of maximum available resources is critical to translate harmonization of legislation and policies with the CRPD into concrete and positive change in the life of persons with disabilities.

This chapter provides initial information on the scale of government resources and official development assistance (ODA) dedicated to disability in a selection of low- and middle-income countries (see *Chapter 5* for an exploration of the considerations and pathways to finance acceleration of inclusion). While limited in scope, the diversity of low- and middle-income countries covered provides an overview of trends in efforts to resource the realization of rights of persons with disabilities in those locations.

Domestic public expenditures

Ideally, **a comprehensive and CRPD-compliant approach to public budget analysis would consider both disability-specific budget allocations and allocations that seek to mainstream disability** into the wider array of government activities. It would also assess to what extent programmes and services funded are aligned with CRPD provisions.[131] In practice, however, the way in which budget documents are structured and presented in countries across the globe does not allow a meaningful analysis of financial resources allocated to mainstream disability inclusion. Additionally, empirical evidence from several countries where such budget analyses have been carried out by different stakeholders in the past 10 years (Fiji, Georgia, India, Kenya) show limited mainstreaming of expenditures.[132] This was often due to lag in implementation on policy, limited development and enforcement of accessibility and non-discrimination measures, lack of sufficient training of relevant personnel and development of disability inclusion plans in different sectors.

In this context, the budget analysis presented here focuses on disability-specific expenditures that are clearly presented in national budget documents. The analysis draws from a variety of sources: new national budget analysis linked to the development of this report (Cambodia, India, Mauritania, Peru, Sierra Leone and Thailand); disability budget briefs developed by UNICEF (Malawi, Namibia and Zambia);[133,134] previous analysis undertaken by OPDs in collaboration with the Centre for Inclusive Policy (Fiji, India, Kenya, the Philippines and Uganda)[135] as well as by Development Initiatives;[136] and published government analysis of disability-related public expenditure (Argentina).[137] The primary source of information was published budget documents which, in some cases, was supplemented by access to more detailed expenditure data from line Ministries or implementing agencies. There are a number of important caveats worth highlighting on the approach taken to the budget analysis:

- Focusing on published national budgets means data availability depends on how each government structures and documents its budget, affecting comparability between countries.
- Some budget lines included in the analysis may provide support beyond persons with disabilities, for example, in the case of rehabilitation services and mental health services. The greatest effort possible has been made to include expenditure that primarily supports persons with disabilities.
- The analysis primarily focuses on budgeted expenditure, with a few exceptional cases where actual expenditure is included.[n]
- The focus on national budgets means that the analysis does not include expenditure by contributory social insurance schemes.

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[n] This relates, for example, to where disaggregated data on different kinds of social protection payments have been provided by implementing agencies.

- For some countries, a brief analysis of subnational budgets is included; however, it should be noted that these expenditures are typically less well documented, especially at local level.
- While the analysis focuses on disability-specific expenditures, it does not include an assessment of the extent to which they are in line with CRPD provisions.

Key trends in disability-specific government expenditure

Disability-specific expenditure in the countries analysed ranges from below 0.02 per cent of gross domestic product (GDP) towards 1 per cent of GDP (*see Figure 2.4*). Considering the share of the population experiencing disability and the diversity of barriers and support needs they face, most of the countries considered have limited expenditure. 0.1 per cent of GDP seems to emerge as a threshold in the financing effort between a set of countries with an initial level of identified spending between 0.01 and 0.07 per cent of GDP and more significant levels of expenditure between 0.14 and 0.8 per cent of GDP found in Argentina, Fiji, Namibia, Thailand and Zambia.

Comparison with government expenditure (*see Figure 2.5*) can shed light on the expenditure effort relative to the size of government expenditure in each country, which can vary substantially. However, the basic pattern relative to this measure is similar to when compared to GDP, with most countries allocating less than 0.5 per cent of government expenditure on disability-specific activities, apart from the five higher-spending countries (between 0.5 and 2.1 per cent).

Figure 2.4. Disability-specific government expenditure as a percentage of gross domestic product (GDP), latest year

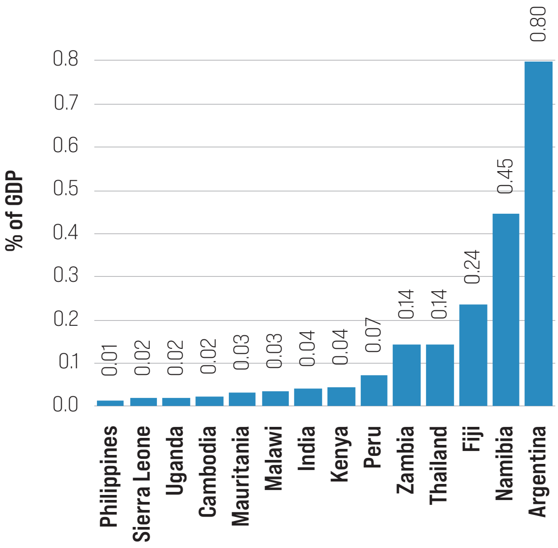
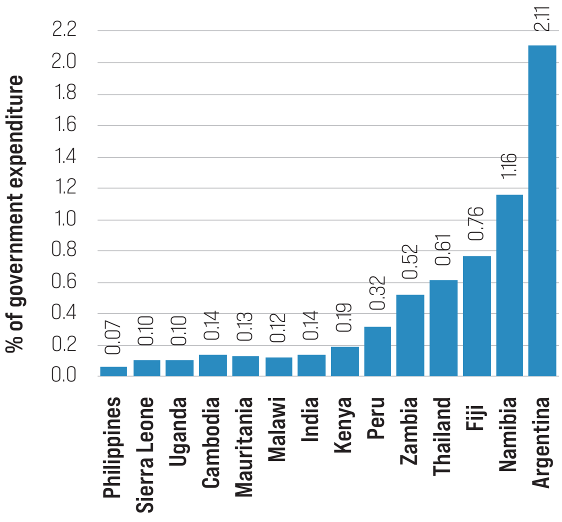


Figure 2.5. Disability-specific government expenditure as a percentage of government expenditure, latest year

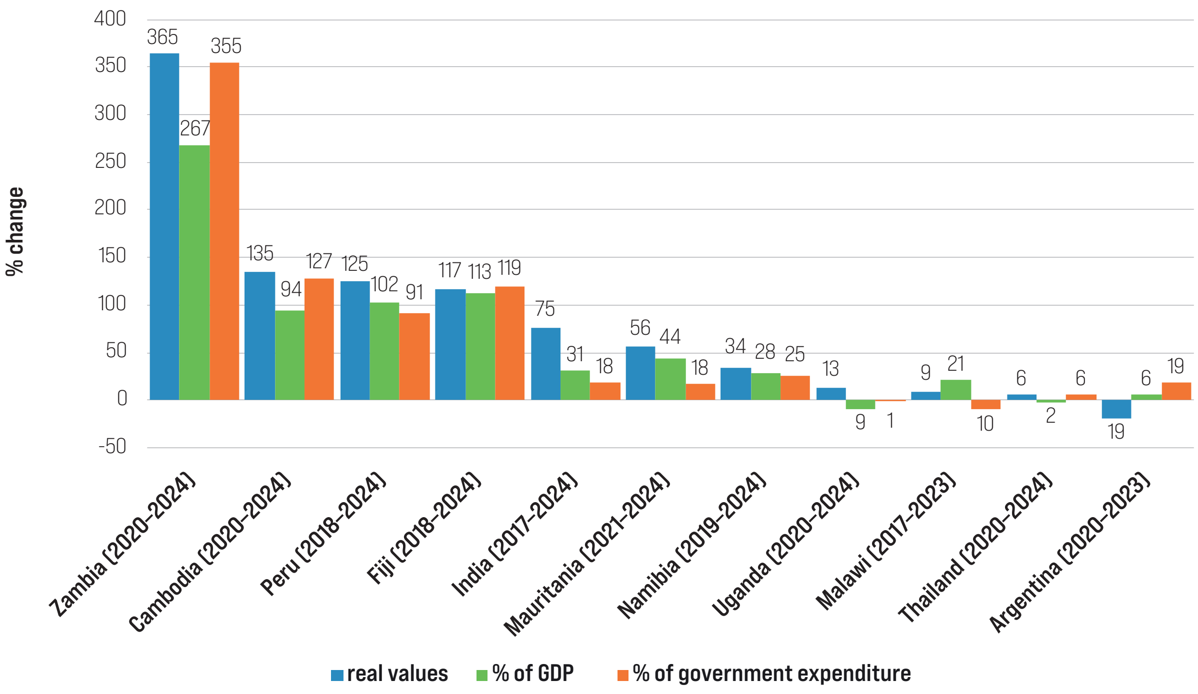


Source: Consolidated budget analysis undertaken for this report (Author's calculations).

Note: Latest year is 2024 for Cambodia, Fiji, India, Kenya, Mauritania, Namibia, Peru, Thailand, Uganda and Zambia; 2023 for Argentina, Malawi and Sierra Leone; and 2019 for the Philippines.

Most of the countries in this analysis saw increased or stable levels of expenditure over the period analysed. *Figure 2.6* shows the percentage change in the level of disability-specific expenditure in real (constant) prices, as a percentage of GDP and as a percentage of government expenditure. The analysis covers different periods of time between 2017 and 2024, from four years (in Argentina) to eight years (in India), depending on availability of data and scope of the country study. Cambodia, Fiji, Peru and Zambia saw expenditure more than double by at least two of the measures, while India, Mauritania and Namibia also saw increases of around 20 per cent or more. However, in other countries the picture was more mixed. In countries including Uganda, Malawi and Thailand, a slight increase in real value was accompanied by a decrease in either share of GDP or public expenditures, while in Argentina a decrease in real value was accompanied by an increase as a share of GDP and government expenditures, reflecting the scale of the economic crisis that struck the country. It should be underscored that – given the low levels of expenditure in some of these countries – the percentage changes in values may represent very small expenditure items in absolute terms. It should also be noted that COVID-19 and subsequent crises have had a significant economic and fiscal impact, which may have affected the evolution of disability expenditures.

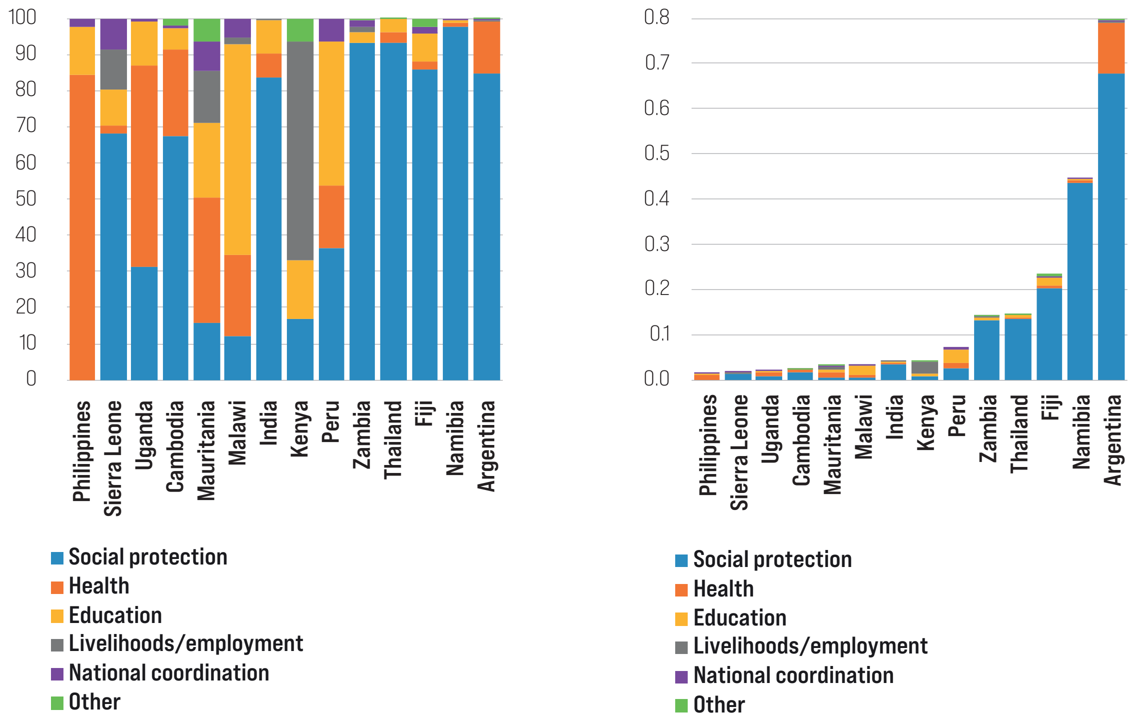
Figure 2.6. Percentage change in level of disability-specific expenditure over time in real values, as a percentage of GDP and as a percentage of total government expenditures (time period varies)



Source: Consolidated budget analysis undertaken for this report (Author's calculations).

While the disability-specific expenditure may focus on a range of different sectors, social protection tends to dominate in higher-spending countries. *Figure 2.7a* shows the proportion of disability-specific expenditure by sector, indicating that expenditures are commonly concentrated in four sectors – social protection, health, education and livelihoods/employment – but with different distributions. For example, in Cambodia, Fiji, Thailand and Zambia, the biggest share of disability-specific expenditures is social protection; in the Philippines and Uganda there is greater weight on health expenditures; while Peru puts greater focus on education; and Kenya puts greater emphasis on livelihoods and employment-related activities. When presented relative to GDP (*Figure 2.7b*), a notable trend is that expenditure in higher-spending countries tends to be dominated by social protection, in particular disability cash benefits; but that does not mean that they spend less than other countries in real value on disability in sectors such as education or health. Nevertheless, these data need to be interpreted keeping in mind that disability-related spending in sectors such as education and health may be less clearly disaggregated in national budget documents.

Figure 2.7. Disability-specific expenditure by sector, latest year



a. Per cent of total

b. Per cent of GDP

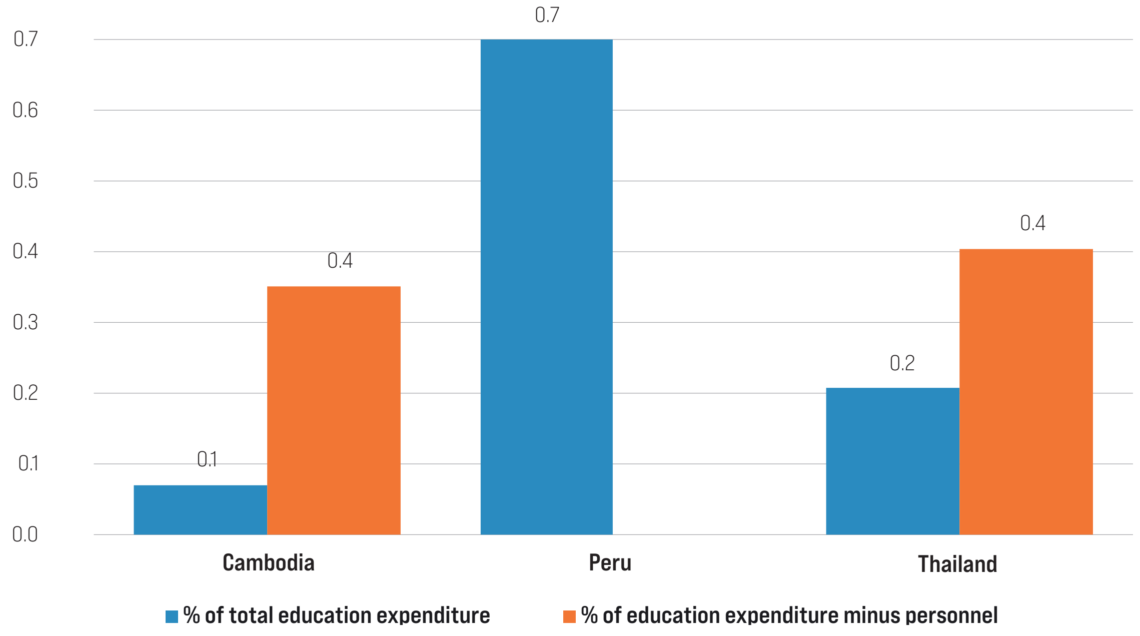
Source: Consolidated budget analysis undertaken for this report (Author's calculations).

Note: Latest year is 2024 for Cambodia, Fiji, India, Kenya, Mauritania, Namibia, Peru, Thailand, Uganda and Zambia; 2023 for Argentina, Malawi and Sierra Leone; and 2019 for the Philippines.

Disability often constitutes a small share of sector-level budgets, as illustrated by the example of education. Assessing the scale of disability-focused expenditure within total sector expenditure requires care, given that countries vary in terms of what they include at the disability-specific and sector levels. For example, while some disability-specific education budgets may include personnel costs such as teacher and support staff salaries, others may be limited to supplementary activities such as training and curriculum development. Nevertheless, the budget analysis here provides some tentative findings. *Figure 2.8* shows that – across three countries – disability-focused education expenditure ranges from less than 0.1 to 0.7 per cent of total education expenditure. Even when measuring against the education budget but minus personnel costs, only around 0.4 per cent of education expenditure is allocated to disability in Cambodia and Thailand.[o]

A similar picture was found in a separate analysis in Ghana, which showed expenditure on children with disabilities at 0.6 per cent of total recurrent education expenditure.[138] It is notable that these levels of expenditure fall well below those defined in a 2023 International Disability Alliance, International Disability and Development Consortium and Global Campaign for Education 'Call to Action to Ensure Inclusive and Equitable Quality Education', which called governments to commit to progressively increase budgetary allocations for disability-inclusive education towards being at least 5 per cent of education budgets by 2030.[139]

Figure 2.8. Disability-focused education expenditure as a percentage of total education expenditure, 2024



Source: Consolidated budget analysis undertaken for this report (Author's calculations).

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[o] This measure is not used in Peru as available data show that the vast majority of disability-focused education expenditure is allocated to personnel.

Deep dive on social protection

An analysis of disability-specific social protection expenditure provides another perspective on budget allocations to disability inclusion across the world. As illustrated in the analysis above, social protection commonly makes up the majority of disability-specific expenditure in countries with higher levels of expenditure overall. One driver of this dynamic is that support for persons with disabilities via the social protection system is more likely to manifest in the form of disability-specific programmes. This is in contrast to sectors such as health and education, where provision of services to persons with disabilities is more likely to be nested within broader service provision, thus making it less visible as discrete budget lines. Another factor is that social protection, and particularly cash benefits, may play a multifunctional role in covering costs associated with a range of sectors. Analysis of disability-specific social protection is supported by greater availability of cross-country comparative data on this topic.

In high-income countries, expenditure on disability-specific social protection benefits averages 1.5 per cent of GDP. The OECD Social Expenditure Database (SOCX) collects and classifies detailed information on social protection expenditure, including with a dedicated category of incapacity-related social expenditure. This includes a variety of both cash and in-kind benefits, the latter including home-based or residential care and rehabilitation services, among others. OECD countries spend an average of 1.5 per cent of GDP on incapacity-related social expenditure (excluding sickness),[p] although this ranges from below 0.5 per cent (in Chile, Türkiye and Costa Rica) to over 3.5 per cent of GDP in Denmark (*Figure 2.9*). Data collated by the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) – following the same methodology – show that most countries in this region, with the exception of Brazil, have incapacity-related social expenditures towards the lower end of this range. It should be noted that this expenditure category is focused on benefits for persons of working age, and generally excludes benefits provided to older persons and children, even where disability specific.[140] It should also be noted that this indicator includes contributory benefits, which have not been included in the analysis of disability-specific expenditure above. In terms of language, the description of ‘incapacity-related’ is not well aligned with concepts of inclusive social protection, although the analysis presented here does not presume the extent to which expenditure is, or is not, inclusive.

In low- and middle-income countries, existing data suggest that countries with higher coverage and adequacy of social protection support for persons with disabilities are spending in the range of 0.5 per cent of GDP on non-contributory cash benefits. Detailed cross-country comparable data of the kind collected in the OECD SOCX only exist for a small number of low- and middle-income countries. Nevertheless, a valuable indicator is the level of expenditure on non-contributory cash benefits for persons with disabilities, for which data are more readily available.[141,142,143] As with the analysis above, these data suggest that low- and middle-income countries with higher investments spend around 0.5 per cent of GDP (*Figure 2.10*). While this indicator only captures one aspect of social protection provision, other components such as in-kind social protection benefits and contributory cash benefits tend to be much less developed (with lower coverage) in low- and middle-income countries.

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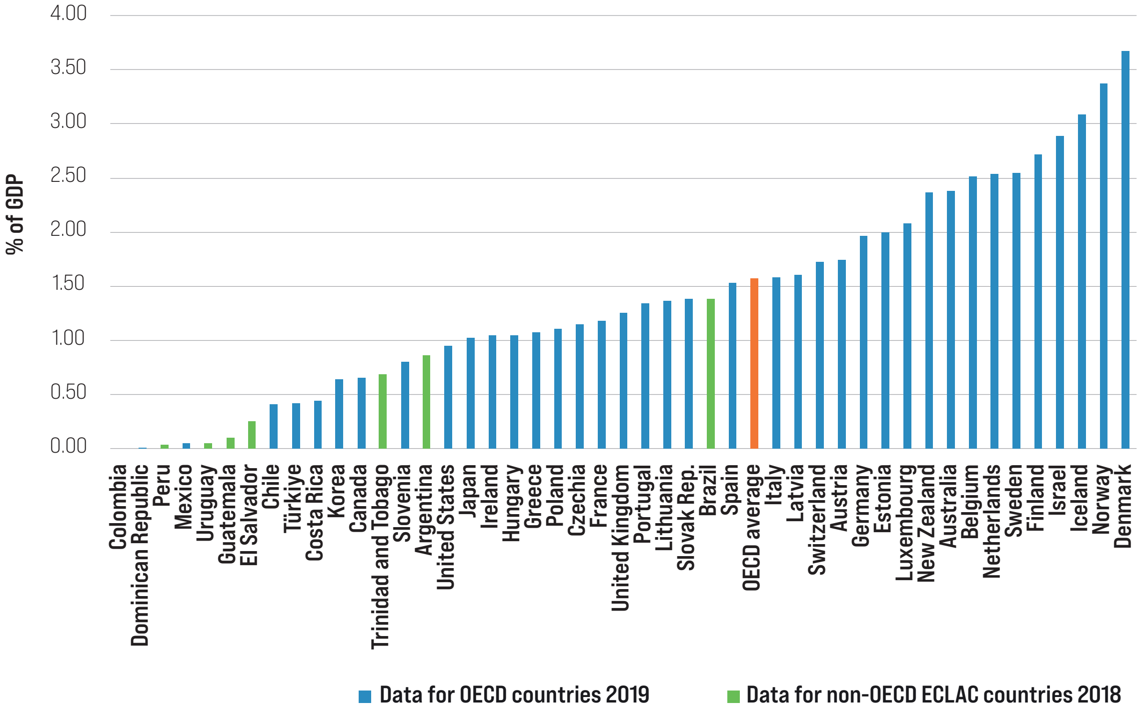
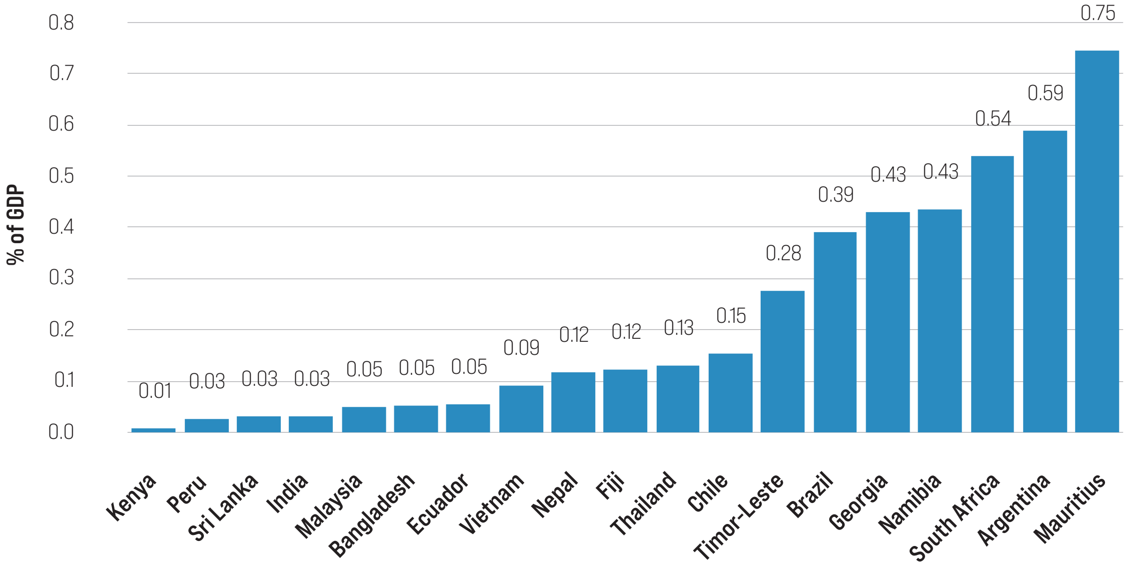
[p] The broader classification within the OECD Social Expenditure Database includes sickness benefits, which are excluded for the purpose of this analysis.

Figure 2.9. Incapacity-related public social expenditure (minus sickness) according to SOCX classification, per cent of GDP, 2018–2019



Sources: OECDStat and CEPALSTAT.

Figure 2.10. Expenditure on non-contributory disability benefits, per cent of GDP, latest year



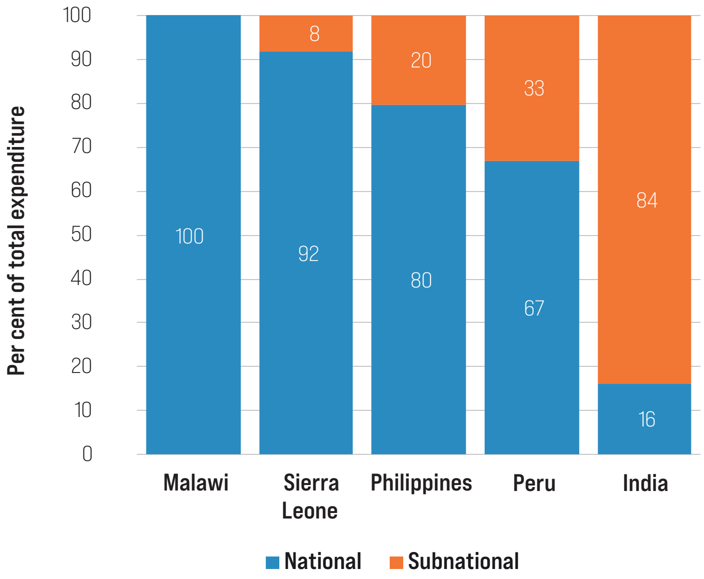
Source: Development Pathways, Disability Benefits Database – April 2023, 2023;[144] Partnerships for Social Protection. Database of Social Protection Expenditure in Pacific Island Countries and Timor-Leste – August 2024 Edition, 2024.[145] Consolidated budget analysis undertaken for this report.

National and subnational level

The extent to which resources for disability are spent at national or subnational level largely follows broader patterns of fiscal decentralization. *Figure 2.11* shows the proportion of disability-specific expenditure according to whether it is allocated to national (central) level or subnational level. Subnational expenditure may include various sublayers depending on the country (regional, provincial, district, state, municipal, local, county etc.). These data are only shown for countries where both national and subnational expenditure data were more readily available. The share of expenditure at subnational level ranges from 84 per cent in India to very low levels (below 1 per cent in Malawi). This distribution reflects the situation across the government as a whole in terms of fiscal decentralization. For example, total subnational expenditure as a share of total government expenditure is 63 per cent in India, 33 per cent in Peru, 16 per cent in the Philippines, 14 per cent in Malawi and 2 per cent in Sierra Leone.[146] It should, however, be noted that these data generally do not capture local-level expenditure, but rather focus on intermediate levels such as state and regional government. Data on local-level expenditure tend to be the least well evidenced in published budget documents.

In some cases, actual expenditure falls below budget allocations. The budget analysis here primarily focuses on budget allocations, but actual expenditure can sometimes fall below these allocations. This is captured in the concept of budget execution, which measures the percentage of a given budget allocation that is actually spent on its intended purpose. Data on budget execution are relatively limited across the countries analysed here, but one recurring issue – highlighted by the case of Kenya in *Box 2.9* – is of generally lower levels of budget execution at subnational levels. Similar issues have been found in Sierra Leone.[147] This is linked to weaknesses in local government capacity that go beyond the disability sector, but also a specific lack of knowledge and systems for implementing disability-inclusive programmes and services. Nevertheless, some countries have achieved high levels of budget execution; for example in Peru, budget execution exceeded 97 per cent across all disability-focused budget lines or programmes in 2024.

Figure 2.11. Disability-specific expenditure by level of government (per cent of total expenditure)



Source: Consolidated budget analysis undertaken for this report (Author's calculations).

Box 2.9 Budget execution for disability-focused expenditure in Kenya

Ongoing processes of decentralization, and the relatively good availability of data, make Kenya a noteworthy case for exploring budget execution at different levels. This was explored by an in-depth study of budget execution by Inclusive Futures[148] for the period 2016/17 to 2020/21. The analysis found that levels of budget execution for disability-focused expenditure at national level were relatively high, averaging 94 per cent for special needs education at primary, secondary and technical/vocational levels. Similarly, execution for the social development and children's services subprogramme and National Safety Net Programme subprogramme were 98 per cent and 94 per cent, respectively.

Budget execution at county level was, however, much lower. Notable dedicated programmes often had lower levels of execution than national programmes; for example, 70 per cent for the Persons with Disability Fund Account in Bungoma county. In some cases, the budget execution rate for disability-focused programmes was 0 per cent (no budget was spent).

This trend is reflected in more recent analysis of the county-level expenditure on protection, childcare and disability.[q] This is a dedicated budget programme that all counties are obliged to report on and – while its scope goes beyond disability – it provides some indication of the level of budget execution in relation to disability. Of the 21 counties for which data were available for the fiscal year 2022/23, budget execution averaged 74 per cent, again lower than at the national level.

Official development assistance

In the last decade there have been growing efforts to enhance disability inclusiveness within international cooperation. These have included the adoption of disability inclusion strategies by the United Nations, as well as other multilateral and bilateral donors, and the work of the Global Action on Disability Network (GLAD). While there are no data yet to assess adequately the value of ODA that is supporting disability inclusion globally or in different countries, progress has been made to monitor the level of disability inclusiveness of development cooperation activities. While development agencies may use different approaches, the main instrument available today is the disability marker[149] of the OECD Development Assistance Committee (DAC),[r] launched in 2018 and used by 23 donor countries and the European Union as of 2023.[150]

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[q] Detailed data collated as part of the Kenya country case study described in Chapter 5.

[r] The OECD Development Assistance Committee (DAC) is a forum of 32 major donor countries and organizations working to promote sustainable development and poverty reduction, particularly in low- and middle-income countries. Members, including the United States, Canada, the United Kingdom, Germany, France, Japan and the European Union, commit to providing aid based on internationally agreed principles and standards.

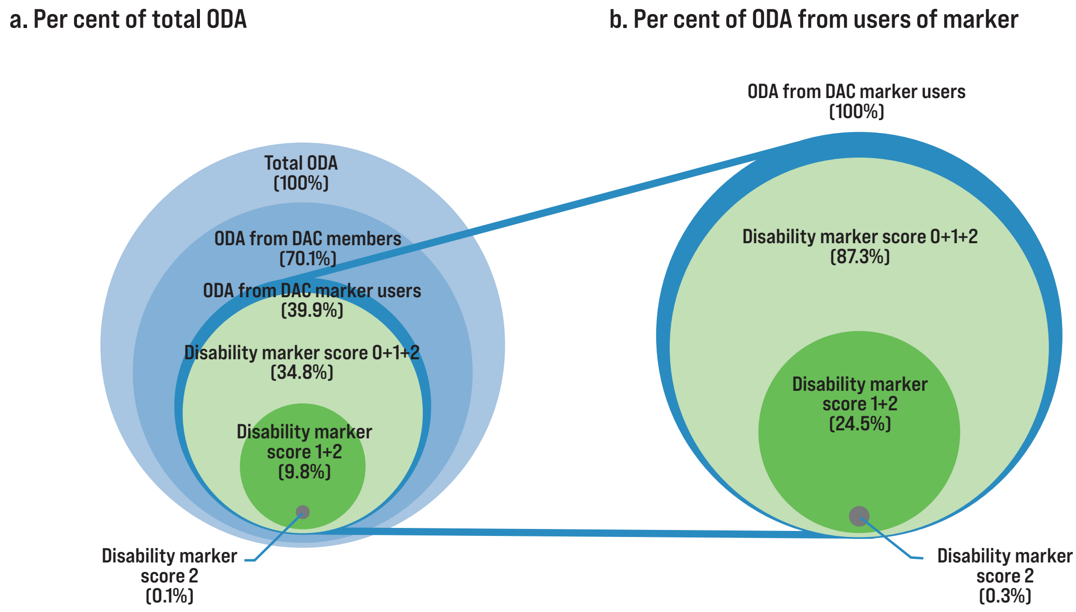
Like other OECD DAC markers, the disability marker includes three scores used by donors to assess their projects: '0' where disability inclusion is not an objective, '1' where disability inclusion is a significant objective and '2' where a project has disability inclusion as a principal objective.[151] When a donor scores a project as 0, there is still a requirement for the project to do no harm to persons with disabilities. It is important to note that the scoring represents the extent to which a given development cooperation activity targets disability inclusion as an objective and is not an exact quantification of the financial support to disability inclusion activities; therefore, the data should be read as indicating the share of ODA flows and activities with disability inclusion as a principal or significant objective, not the specific amount of financing. Also, the scoring is based on activity objectives and does not measure the actual impact on inclusion.[152]

This section provides a summary of evidence from use of the OECD DAC disability marker at both global and recipient country level.

Global-level indicators on ODA flows and disability

To fully understand the data generated by the disability marker, it is important to recognize that information on disability inclusion is still missing for the majority of ODA flows. As shown in *Figure 2.12a*, only 70 per cent of total allocable ODAs,[153] in 2023 came from OECD DACt members, for whom the marker was designed. Notably, except for the European Union, no multilateral donors use the marker. Moreover, not all OECD DAC members apply the marker, and only 40 per cent of all allocable ODA in 2023 was provided by donors that do. Even among those using the marker, it is not consistently applied across all projects. Some multilateral donors have developed their own internal disability markers, but data from these systems are often not publicly accessible.

Figure 2.12. Share of allocable ODA (US$ commitments) by disability marker score, 2023



a. Per cent of total ODA

b. Per cent of ODA from users of marker

Source: Authors' calculations based on OECD Creditor Reporting System.[154]

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s The focus on allocable ODA follows the OECD DAC preferred approach to analysis on marker data.

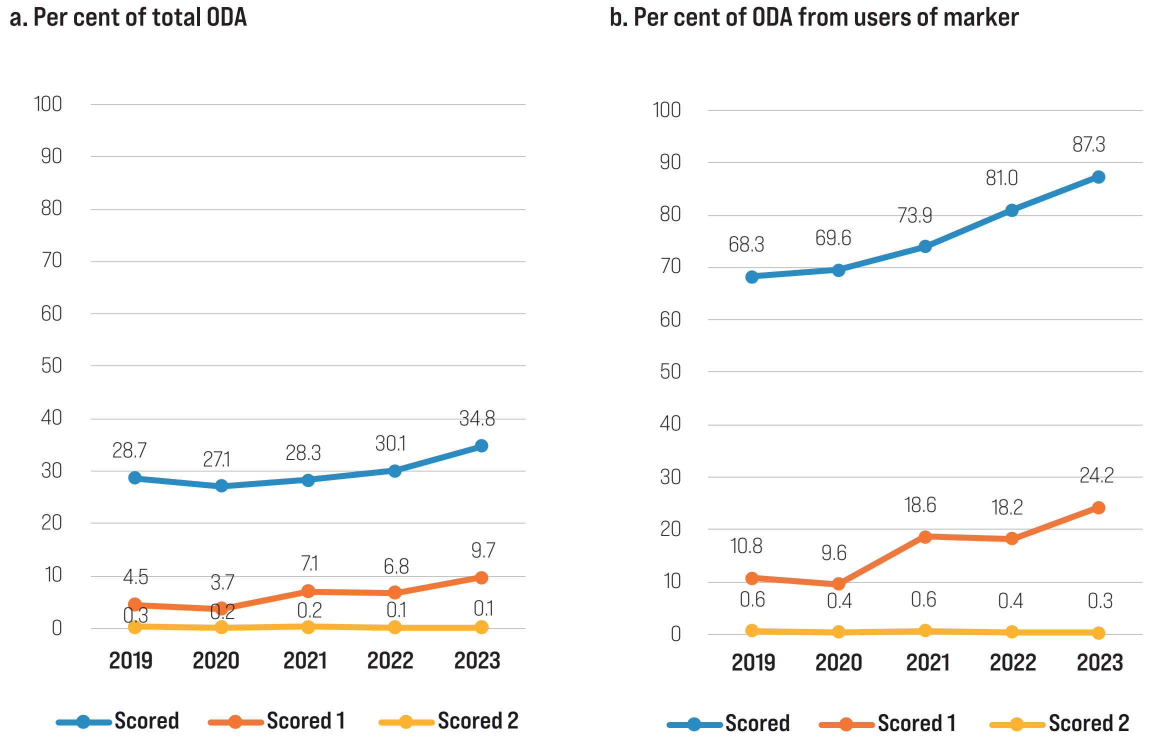
t This analysis covers ODA from the 32 DAC members as of 2023, which include 31 governments (bilateral donors) and the European Union.

Overall, less than 1 per cent of ODA flows have disability inclusion as a principal objective (score 2). *Figure 2.12a* shows that only 0.1 per cent of all allocable ODA has been scored 2. Given the major gaps in use of the marker by many donors, this will be an underestimate of the true value. However, even when focusing only on ODA from donors that use the marker, this number rises to only 0.3 per cent (*Figure 2.12b*). A much wider share of ODA is score 1, representing 24 per cent of ODA from donors using the marker in 2023.

The use of the disability marker has increased over time since its introduction. *Figure 2.13a* illustrates that, between 2019 and 2023, the share of all allocable ODA scored with the marker increased from 29 to 35 per cent. The share of scored ODA among the 23 donors that used the marker by 2023 increased from 68 to 87 per cent. This was due to both more donors using the marker (Denmark from 2020 and Belgium from 2023) and donors applying the marker to a greater share of their projects, which is a positive development. Germany, which is the second biggest bilateral donor globally, started to use the marker in 2024, which will bring insight on an even greater share of ODA. The greater use of the marker shows a steady increase in the share of ODA flows that are scored 1 but a stagnation below 1 per cent of the ODA score with disability as principal objective (score 2). This implies that most efforts on inclusion in development cooperation seem to be driven by mainstreaming in broader programmes.

While it is relatively straightforward to identify a project with a principal objective of disability inclusion (score 2), what constitutes a 'significant' objective (score 1) is more open to interpretation. It is possible that its use may range from projects with relatively significant components dedicated to disability inclusion, to those

Figure 2.13. Share of allocable ODA (US$ commitments) by disability marker score, 2019–2023



a. Per cent of total ODA

b. Per cent of ODA from users of marker

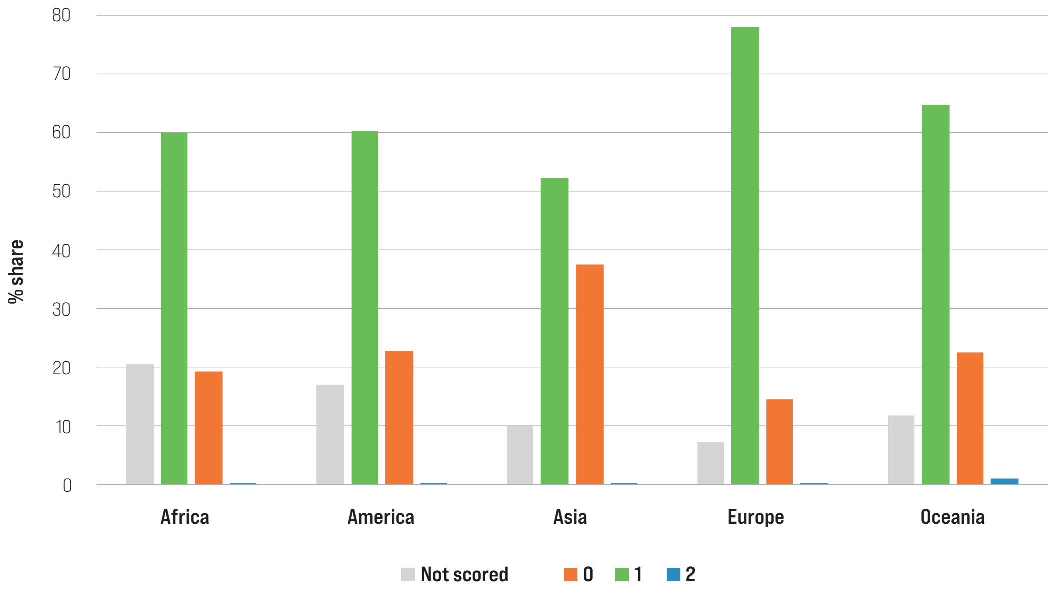
Source: Authors' calculations based on OECD Creditor Reporting System.[155]

which only include relatively marginal activities seeking to mainstream disability. Further analysis of data has shown that major infrastructure programmes have been scored 1 due to efforts to ensure accessibility. While this reflects important progress in building a barrier-free environment, it can also give an over-representation of the level of mainstreaming in development cooperation. For instance, a quarter of ODA flows scored 1 in 2023 were related specifically to a single loan commitment for a railway project in India. Recent research of the disability marker by CBM recommended strengthening guidelines for scoring by aligning with more detailed criteria established for the OECD Gender Equality Policy Marker.[156] There is also a need for greater analysis to understand how the marker is being used in practice by donors.

It is notable that the use of the disability marker lags behind the DAC gender equality marker. In 2023, the Gender equality marker was used to score 82 per cent of ODA (US$ value) against only 35 per cent for the disability marker. Contributing to these differences is that the gender equality marker is mandatory – unlike the disability marker, which is voluntary – as well as the fact the marker is used by multilaterals. The gender equality marker has also been in place for a significantly longer duration, having been introduced in 2008.

The use and scoring of the disability marker also vary between regions. *Figure 2.14* shows the distribution of disability marker scores according to the geographical region of recipients in 2023, focusing on ODA from donors that used the marker. The patterns across regions are likely to be influenced by the mix of donors and their respective priorities across countries and regions. Use of the marker is highest in Asia, Europe and Oceania (with between 7 and 12 per cent of ODA unmarked), and lower in Africa and America (21 and 17 per cent unmarked, respectively). The share of projects marked score 1 ranges from 15 per cent in Africa to 38 per cent in Asia, although the data from in Asia are highly influenced by a small number of significant Japan-funded infrastructure loans. The share of ODA scored 2 is below 0.3 per cent in all regions but Oceania.

Figure 2.14. Allocable ODA from donors using the marker (share of US$ commitments) by disability marker score and region, 2023



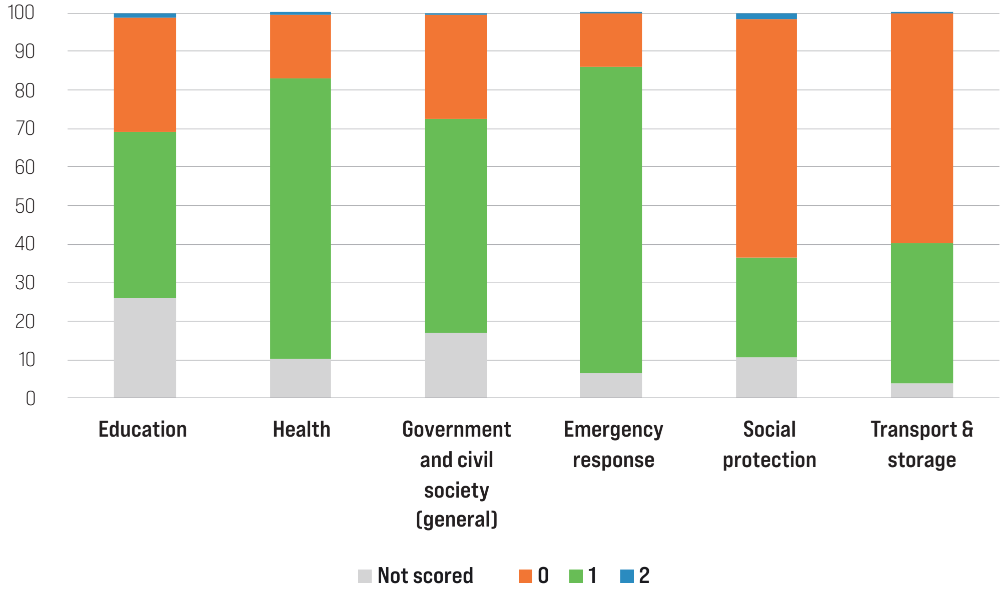
Source: Authors' calculations based on OECD Creditor Reporting System.[157]

The proportion of activities targeting disability inclusion also varies by sector. This is shown in *Figure 2.15* for donors that use the marker, for the six sectors of education, health, government and civil society, emergency response, social protection, and transport and storage, which are of particular relevance to persons with disabilities. The share of projects marked as targeting disability inclusion is highest for social protection and transport and storage. Education and government and civil society are found in the middle of the range. Health and emergency response are the least likely to be scored 1 or 2. As with the data presented above, these data point to a very small share of ODA being scored 2, even in priority sectors for persons with disabilities. The data also point to the need to scrutinize ODA scored 1 to assess the extent to which it is addressing disability inclusion in practice.

Country-level indicators on ODA activities and disability

In addition to global-level indicators, there is value in exploring how the marker is being used at a recipient country level. Such analysis can shed light on specific national-level dynamics and potentially inform dialogue between donors and country-level actors in order to increase disability inclusion within international development cooperation and support development of adequate national financing strategies.

Figure 2.15. Allocable ODA (US$ commitments) by disability marker score and selected sectors (users of the marker only), 2023



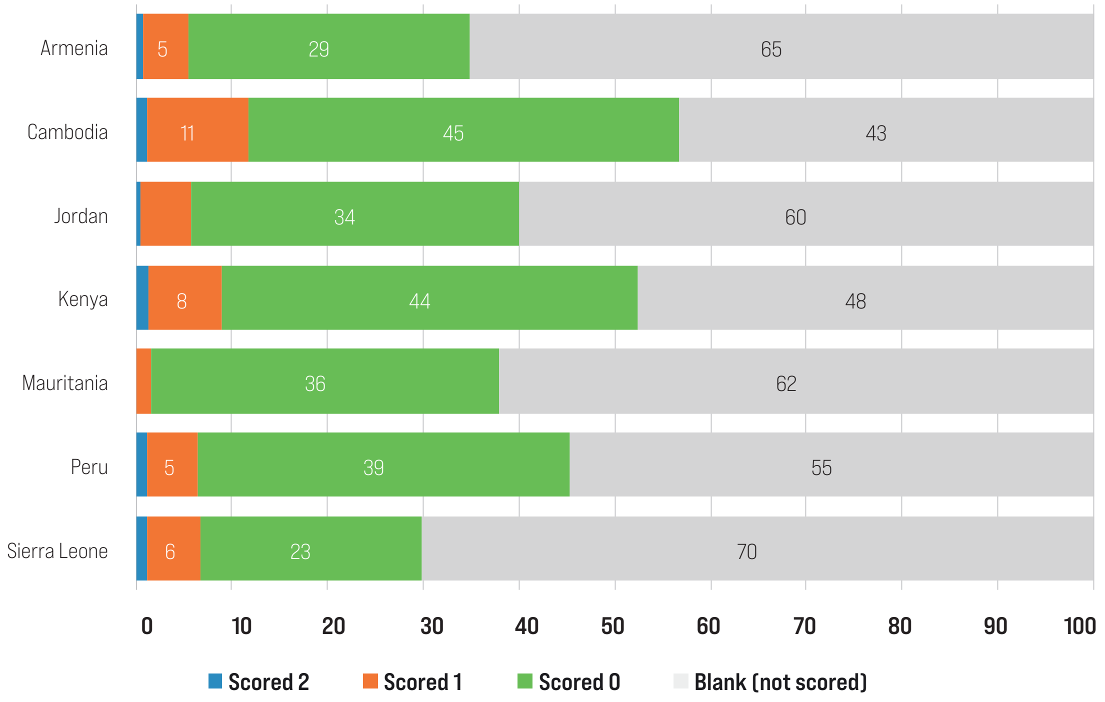
Source: Authors' calculations based on OECD Creditor Reporting System.[158]

Note: Education comprises the following four sectors: Education, Level Unspecified; Basic Education; Secondary Education; Post-Secondary Education. Health comprises the following three sectors: Health, General; Basic Health; Non-communicable diseases. Social protection projects have been identified using the purpose field in the CRS database, filtered for 'social protection' (i.e., corresponding to purpose code 16010).

At the global level, the share of allocable ODA expressed in US$ commitments has been used in line with the OECD DAC approach, as well as other reports such as the *Disability and Development Report*. However, for the purpose of the analysis of national-level trends for this report, the indicator used is the share of individual ODA activities,[u] rather than their monetary value. While this approach has some limitations,[v] it has the benefit of putting greater focus on the intentionality in terms of disability inclusion of smaller and larger donors in the development sector across all their programmes.

The share of ODA activities scored varies significantly between recipient countries. *Figure 2.16* shows data on the share of all ODA activities (from all donors) by marker score for seven countries where in-depth analysis was undertaken. In 2023, the proportion of activities not scored ranges from 43 per cent in Cambodia to 70 per cent in Sierra Leone, which significantly limits monitoring capacity of recipient countries. The share of activities scored 1 or 2 ranges from 2 per cent in Mauritania to 12 per cent in Cambodia. The extent to which the marker is used, and projects are targeting disability inclusion will be influenced by the role of different donors in each country, and their policy with regards to disability inclusion across their portfolios.

Figure 2.16. Allocable ODA activities (from all donors) by disability marker score, 2023, selected countries



Source: Authors' calculations based on OECD Creditor Reporting System.[159]

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[u] Activities are defined as each entry in the CRS database where a donor makes a commitment. Commitments may be made for a whole project or subcomponents of a project.

[v] Counting ODA activities will potentially give disproportionate weight to project commitments with a small monetary value. Donors also have different approaches to how they report ODA commitments, with some including only one commitment per project, and others dividing a given project into multiple commitments.

In 2023, on average 6.5 per cent of all allocable ODA activities were scored 1 or 2 across 141 recipient countries in the OECD CRS database, as shown in *Table 2.1*. Given the major gaps in reporting, this is likely an underestimate of the true proportion of activities potentially scored 1 or 2. When considering only those donors that use the marker, the share scored 1 or 2 only increases to 11.4 per cent on average. However, as for the global indicator, activities scored 2 are a very small share of ODA.

Table 2.1. Allocable ODA activities by disability marker score, average for 141 recipient countries, 2023

	Not scored	0	1	2	1+2
All allocable ODA	61.3%	32.2%	5.6%	0.9%	6.5%
Allocable ODA among donors using the disability marker	27.4%	61.2%	9.7%	1.7%	11.4%

Source: Authors' calculations based on OECD Creditor Reporting System.[160]

As more donors move to adopt the OECD-DAC disability marker, these data can provide a rich source of information for countries. Some notable dimensions of ODA flows and activities which can be explored using the data (explored in a background paper to this report) include:

- The level of focus on disability inclusion of the different donors supporting the country and the sector they support
- The scale of disability-related ODA to public expenditures: in some countries, such as Cambodia and Sierra Leone, the value of ODA principally targeting disability inclusion (score 2) is found to be comparable to disability-focused public domestic expenditures, while in other countries such as Kenya it represents a fraction.
- Channels for disability-related ODA: Analysis in Chapter 5 indicates that ODA specifically targeting disability inclusion (score 2) is less likely to be channelled via national governments – and more likely to be channelled via NGOs – than ODA in general.
- Sectoral distribution of expenditure: National-level analysis allows more granular exploration of the extent to which ODA is being channelled to different sectors.

This highlights the importance for greater and better use of the OECD DAC disability marker, as well as increased availability of data from multilateral donors and development agencies that use alternative approaches, to strengthen capacities of recipient countries to track the level of disability inclusiveness of the support that donors provide, alongside their own efforts to monitor domestic disability-related public expenditure.

Appendix 1. Legal harmonization review methodology

This appendix details the methodology used to inform the Legal Harmonization section of Chapter 2, using three distinct steps.

Step 1: Review of CRPD reports

The most recent reports submitted by 147 countries to the CRPD Committee were reviewed. However, to ensure methodological consistency, the analysis of legislative changes was limited to the 114 countries that had received concluding observations from the CRPD Committee. Within this group, it was determined that 53 countries had enacted or amended specific disability legislation after December 2006, the date of the CRPD's adoption.

Step 2: Analysis of concluding observations

The concluding observations of these 114 countries were analysed to assess compliance with key legal standards, focusing on the definition of disability and the recognition of disability-based discrimination. The first part of this review examined whether domestic legal definitions of 'disability' aligned with the CRPD's understanding. The analysis revealed that 94 of the 114 countries had definitions of 'disability' or 'persons with disabilities' that conflicted with the CRPD's conceptual framework. The concluding observations were then analysed to determine whether national legislation had adopted the CRPD's definition of disability-based discrimination, including the denial of reasonable accommodation as a form of discrimination.

Step 3: Detailed legislative analysis

An assessment was carried out for the 53 countries that had enacted or amended stand-alone disability laws following the CRPD's adoption, to verify the availability of the legal texts online and assess their alignment with the Convention. A more detailed analysis was conducted for 42 countries whose legislation was available online, including: Bangladesh, Bolivia, Brazil, Burkina Faso, Chile, China, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Eswatini, Germany, Iceland, India, Iraq, Jamaica, Malawi, Malta, Mauritius, Mexico, the Maldives, Marshall Islands, Monaco, Myanmar, Nicaragua, Nigeria, Panama, Palau, Peru, Pakistan, Republic of Korea, Senegal, Sierra Leone, Spain, Slovenia, Thailand, Türkiye, United Arab Emirates, Uruguay, Venezuela, and Vietnam. The analysis focused on identifying which rights areas were addressed in the legislation – without assessing compliance – to determine which disability rights issues were prioritized by States. The laws were reviewed for references to the following rights: independent living, inclusive education, social protection, legal capacity, political participation, and participation in culture and sports.

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Chapter 3

The impact of global trends on the inclusion of persons with disabilities

The world today is shaped by evolving and accelerating global trends, including climate change, advances in technology, urbanization, migration and displacement, humanitarian crises and emergencies, and a care economy in transition. Many of these trends are interlinked. For example, urbanization is a driver of climate change, while many humanitarian crises are caused or exacerbated by extreme weather events (e.g., hurricanes, droughts) linked to climate change. Meanwhile, climate change, humanitarian crises, participation in the care and support economy and urbanization are all causes of increased migration and displacement. At the same time, technological solutions can be harnessed to create more sustainable and climate-smart cities, strategies to provide care and support, and effective humanitarian action and migration policy.

These global trends are driving societal change and will continue to have wide-reaching impacts in the decades to come. Their impacts – and policy and programmatic responses to them – carry implications for the inclusion of persons with disabilities. Some trends, such as technological advances and urbanization, bring opportunities to enhance participation and well-being. All, however, will lead to widening inequalities unless there is a focus on developing and implementing inclusive strategies. Tailored and intersectional approaches will be needed to address differences across contexts and considering the diversity of persons with disabilities (e.g., by gender, age, impairment type and other characteristics).

This chapter will discuss the impact of several global trends on persons with disabilities. For each global trend, it will also explore how policies and programmes can mitigate negative impacts and optimize opportunities to build more resilient, inclusive communities and societies.

Technology

We live in an era of rapidly expanding digitization and major technological advancements. Some forms of technology, such as the internet, have been present for decades. The reach and potential uses of technology including mobile phones and computers are rapidly expanding globally, alongside emerging technologies, such as artificial intelligence (AI), robotics and virtual and augmented reality. Importantly, assistive technology is increasingly being integrated into mainstream products (e.g. smartphones), which can be instrumental in overcoming typical barriers to information, communication and participation for persons with disabilities.

These technological advances present both opportunities and risks for persons with disabilities. On the one hand, technology provides vast potential to improve persons with disabilities' health and well-being, and opportunities for work, education and social engagement. However, there are also challenges, including with accessibility and affordability, as well as safeguarding and ethical use, that risk widening existing inequalities.

The impacts of technological advances for persons with disabilities

How can technological advances accelerate inclusion?

Health and access to health care

The rise of eHealth services, such as telehealth, mobile health applications (mHealth) and electronic health information systems, is transforming the health sector. These technologies can address traditional barriers to health-care access for persons with disabilities, and improve the supply and affordability of critical health-care products and services. **Remote consultations through telemedicine** can avoid transport barriers to seeking care, which particularly affect persons with mobility limitations and those living in remote areas or in areas with few service providers.[1] Technology can also link persons with disabilities to health information, including through increasingly sophisticated AI-driven platforms that can summarize and respond to user questions.

Many technological innovations have the potential to **increase access to rehabilitation, assistive technology and screening for impairments**. Mobile-based applications have also been used for screening for vision, hearing and other impairments and linking users to needed services and products (*Box 3.1*).[2,3] Apps have been proliferating for delivery of rehabilitation and mental health services, including for stroke, musculoskeletal impairment, Parkinson's disease, and anxiety and depression, with some demonstrating effectiveness similar to standard care.[4,5,6] Meanwhile, 3D printing can create personalized and low-cost prosthetics or orthotics,[7] while rehabilitation robots provide repetitive, high-intensity motor tasks that enhance outcomes through consistency and precision.[8]

Technology can also **improve efficiency and quality of health care**. For example, electronic medical records promote integration of care – if there is interoperability between systems used by different providers – which can be particularly important for persons with disabilities with complex health-care needs. They can also be used for large-scale data analytics to identify ways to optimize health-care delivery for persons with disabilities.

Box 3.1 Health tools for impairment screening and services

Peek Acuity is a mobile application for vision screening. It has supported screening of 10 million people in low- and middle-income countries for vision impairment.[9] Peek offers many benefits, particularly in rural and remote settings with few eye health specialists. Importantly, it can be implemented by non-medical staff, is easily portable and can be used without an internet connection. Peek is estimated to cost six times less per completed referral compared with standard care.

Apple AirPods for hearing: Apple's AirPods 2 contain a clinical-grade hearing aid for persons with mild to moderate hearing loss. Users can take a short hearing test on their smartphone or upload an audiogram, and AirPods will calibrate according to this information.[10] Although still costly (approximately US$259 in 2024), they are significantly cheaper than many prescription hearing aids, which can be thousands of dollars.[11]

Work and education

The **availability and affordability of technology that can support inclusion in work and school is improving.** Accessibility features such as screen readers, speech recognition, alternative input devices and real-time captioning are increasingly built in to laptops, smartphones and many online applications and software. Their spread can enable the provision of workplace accommodations or supports for inclusive education. In Kenya, for example, university students who are blind or partially sighted were provided with tablets with VoiceOver screen readers enabling them to independently access course materials.[12] Online meeting platforms such as Zoom, Microsoft Teams, Google Meet and others allow for auto-captioning, providing low-cost and immediate transcription of discussions in real time. There are also newer innovations that can enhance learning or work outcomes for persons with disabilities: for instance, virtual and augmented reality technologies have been shown to improve reading, letter and number recognition among students with learning disabilities,[13] while virtual reality applications such as AllyChat use AI-driven conversation to help persons with intellectual disabilities practise and prepare for job interviews.[14]

The rapidly growing digital economy is leading to an expansion of jobs in this area (including entry level and those requiring more advanced digital skills, e.g., AI specialists and web design).[15] It also has the potential to enhance entrepreneurship, including in self-employment – a particularly dominant form of work among persons with disabilities.[16] For example, online platforms present opportunities for selling goods and services online to a wider pool of clients, purchasing business inputs at competitive prices and better managing business finances.[17] Online banking and mobile money can improve control over personal and business finances: in Ghana, persons with disabilities were less likely to have traditional bank accounts but more likely to use mobile money compared with persons without disabilities.[18]

Remote and hybrid work and online education opportunities – which, particularly after the COVID-19 pandemic, are now more common and acceptable – can help overcome geographic, transport, financial and other barriers to studying as well as seeking, performing and advancing at work.[19] Flexibility in hours can also enable greater engagement in work and school for many people, particularly women and others with and without disabilities who have care and support responsibilities.

Social participation and well-being

Technology is changing the way we interact with others. Importantly, **social media** can be a space for developing and maintaining friendships, sharing critical information and mobilizing for political activism, including for persons with disabilities.[20,21,22] Persons with disabilities in the United Kingdom, for example, used social media to protest austerity measures,[23] while WhatsApp, Facebook and other apps have been used to form self-help, peer support and collective action groups for persons with disabilities and caregivers of children with disabilities in settings such as Brazil, Kuwait and South Africa.[24,25,26] Social media is also used to disseminate critical information in accessible formats (e.g., during COVID-19, natural disasters and in other emergencies),[27] as well as to share lived experiences and stories, increasing representation and understanding of disability to a wider audience.

Technology can **support independent living** and well-being for persons with disabilities. For example, smart home devices allow persons with disabilities to adapt the lighting, temperature and other features of their living spaces through voice control, while wearable devices can call for assistance in the event of falls or other emergencies. Technology can also support personal organization, including through automated reminders to take medication, plan for appointments and other key daily life tasks. Further, AI and other innovations can improve access to information through helping to explain and break down complex information. There is also increasing focus on the accessibility of online gaming platforms, which can have a positive impact on the mental health and social inclusion of persons with disabilities.[28] Finally, accessible e-governance, such as 'one-stop' digital platforms for government services, can improve efficiency, governance and access to information and services for people with disabilities. For example, an eGovernment portal in the United Kingdom consolidates information about disability services, social protection and links to advisory services, in one place.

> **“I see many of my peers using AI like ChatGPT for translation and obtaining information.”**
>
> – Self-advocate with intellectual disability from United Arab Emirates

How can technology magnify exclusion?

Widening digital divide: unequal access to technology

Despite the vast potential of technology, there are challenges to equitable access for persons with disabilities (*Box 3.2*). Part of this gap is due to **poor availability and affordability** of needed technology. Persons with disabilities tend to have lower disposable incomes,[29] resulting in reduced capacity to pay for digital devices (e.g. mobile phones, computers) and supporting infrastructure (e.g., phone contracts, electricity, broadband, repairs), limiting digital access and use. For example, young persons with disabilities in Kenya reported that cost of data packages and lack of internet were the biggest barriers to using digital platforms for income generation.[30] Affordability also limits the widespread use of emerging technologies that could benefit persons with disabilities (e.g., robotics, virtual and augmented reality) in health, education and other sectors, particularly in lower-resource settings where core technological infrastructure can be lacking or unreliable, and new innovations are prohibitively expensive.[31,32] Further, although coverage is expanding rapidly, some areas still lack access to reliable electricity and network coverage.

Box 3.2 Who has access to technology? Recent use of the internet and mobile phones ownership

Persons with disabilities often have lower access to mobile phones, the internet and other critical technologies that can enhance inclusion. For example, persons with disabilities aged 15–74 years in the European Union were 15 per cent less likely to have used the internet in the last week compared to persons without disabilities (77 per cent vs 91 per cent).[33] In 36 low- and middle-income countries, persons with disabilities aged 15–49 years were 20 per cent less likely to own a mobile phone and 37 per cent less likely to have used the internet in the last week compared with persons without disabilities.

There are also differences in access among persons with disabilities. Women, persons in rural areas, older adults, and those with lower education and living in poverty tend to have lower digital inclusion. For example, 94 per cent of young persons with disabilities (aged 16–24 years) in the European Union used the internet, compared to 67 per cent of adults aged 55–74. Meanwhile, among persons with disabilities in 36 low- and middle-income countries:

- People in urban areas were 60 per cent more likely to own a mobile phone and three times more likely to use the internet than people in rural areas.
- People were more than twice as likely to have a phone and more than 11 times more likely to use the internet if they had at least secondary education compared with no education.
- People living in the poorest two wealth quintiles were half as likely to own a phone and three times less likely to use the internet compared with people in the richest quintile.
- Women with disabilities were 20 per cent less likely to own a phone compared to men with disabilities, but their use of the internet was similar.
- Access to the internet and mobile phone ownership increased by country income level: 8 per cent of persons with disabilities used the internet in low-income countries compared to 13 per cent in lower-middle- and 42 per cent in upper-middle-income countries; ownership of a mobile phone was 41 per cent in low-income, 63 per cent in lower-middle-income and 78 per cent in upper-middle-income countries.
- Persons with higher support needs were less likely to use the internet or own a mobile phone. Persons who are deaf or have significant difficulties communicating and/or with self-care were least likely to own a mobile phone, while internet usage was lowest for persons with significant difficulties in self-care.[a]

Source: Author's calculations.[b]

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[a] Reported 'cannot do' on Washington Group domains of hearing (deaf) or communicating, self-care.

[b] Data were analysed from 36 Multiple Indicator Cluster Surveys (MICS). Prevalence ratios were generated using a modified Poisson regression with robust error variance, adjusting for age and sex. Recent internet use was defined as the respondent having used the internet in the last week, and phone ownership was defined as the respondent owning a mobile phone themselves.

Inequalities in digital skills development pose a challenge. Barriers to accessing training for, and practice using, digital technology limits opportunities to build digital skills and confidence. Digital literacy is becoming increasingly essential for inclusion. As an illustration, it is estimated that 92 per cent of jobs in the United States of America require digital skills,[34] while 35–45 per cent of jobs in Côte d'Ivoire, Nigeria and Rwanda are expected to need digital skills by 2030.[35] Persons with intellectual disabilities, women and girls, older adults, persons with limited formal education and living in rural areas may particularly lack digital skills. For example, not knowing how to use a mobile phone was reported by more than half of women with disabilities in Pakistan as their reason for non-mobile phone use.[36] In Iceland, 25 per cent of persons with intellectual disabilities surveyed rarely or never used digital technology during the COVID-19 pandemic, compared to 9 per cent of persons with other disabilities.[37] This gap was linked to barriers such as limited digital skills training, and imposed internet use restrictions driven by safeguarding concerns or ableist assumptions about their abilities.[38]

Insufficient accessibility

Digital devices, platforms, content and services are often inaccessible for persons with disabilities. For example, many websites are difficult to use for persons who are blind or partially sighted due to insufficient colour contrast or font size, missing alternative text for images, or incompatibility with screen readers. Meanwhile, lack of captioning, transcripts and volume control for audio content can limit access for persons who are deaf or hard of hearing. An analysis of the top 1 million websites in 2024 found that 96 per cent had at least one accessibility failure.[39] Further, as companies rush products to market to gain an advantage over their competitors, accessibility features are often overlooked. The innovation approach which is driven by a minimum-viable product mentality – i.e., the least number of features needed to launch a product – often excludes the needs of persons with disabilities. For example, when Instagram and the more recent Threads were first launched, they lacked features such as alternative text for images.[40]

Disproportionate impact of technology disruptions

Technology is creating disruptions in many areas of life. While some of these changes are positive, others can have negative impacts. For example, **automation and AI are replacing many jobs and reducing wages especially for lower qualification jobs**, a trend which is expected to continue into the future.[41] Persons with disabilities are more likely to be in lower qualification jobs,[42] meaning they can be particularly affected by rising wage inequalities. They also may struggle to find work if their jobs become obsolete, due to discrimination in the job market and lack of inclusive (re)training programmes. For those in work, employers may pressure persons with disabilities to work remotely rather than provide accessible workplaces, leading to exclusion from workplace opportunities, isolation and perpetuation of disability stigma.[43] Inequalities are further exacerbated if adjustments for accessible remote working are not provided.

Automation is rapidly replacing human support in many sectors, yet these systems often fall short in terms of accessibility or providing the quality of personalized support needed for persons with disabilities. For instance, signing avatars can fail to capture the nuances of human sign-language (e.g. use of facial expressions) or take into account context-specific socio-cultural factors needed to accurately convey meaning.[44] Automated systems, increasingly used for resource allocation – such as determining eligibility for social services and social protection – may not adequately consider the complex social, relational and environmental factors that shape the lived realities of disability, as they typically rely on numerical indicators of functioning.[45,46] Thus, while automated systems can play an important role in accessibility and inclusion, they should be used in combination with, and not universally replace, personalized human support.

Additional safety and privacy concerns

The rise of technology presents new challenges related to **safety and privacy**. Worryingly, nearly one in four children with disabilities experience cyberbullying, higher than for children without disabilities.[47] The risk of technology-facilitated abuse can differ based on intersecting identities: for example, in Israel, a study found that, among young persons with learning disabilities, women and those with higher support needs were particularly vulnerable to online victimization and cyberbullying, including disability-focused abuse.[48] Risks of device theft, cybercrime and other harms may also be heightened for persons with disabilities. For example, persons with intellectual and other disabilities can be targeted by online scammers; they may also face increased difficulty identifying phishing scams and predatory online behaviour, as well as protecting their personal information.[49,50] Cybersecurity protections can also be inaccessible.[51,52]

Technology is also leading to the collection, processing and sharing of significant amounts of personal data, which poses privacy concerns for all. However, persons with disabilities may face additional risks. For example, their disability status and sensitive health information can be collected (e.g., by direct disclosure or inferred through use of accessibility features and assistive technology, as well as through social media and other big data) and shared with third parties. There are concerns that sharing this information could lead to discrimination: for example, in the United States, students with disabilities sued standardized test providers for disclosing information about their disability to prospective universities, potentially affecting admissions decisions.[53]

Perpetrating and worsening bias

The rise of AI technologies presents significant challenges related to **bias, representation and transparency**. The underrepresentation of disability in datasets that are used to train AI can lead to discrimination, exclusion and reinforce stereotypes. For instance, most language models have not been trained with non-standard speech.[54] This means that the technologies using these data sets, such as speech-to-text applications, are excluding persons who could most benefit from them – for example, persons with communication disabilities such as slurred speech – as the error rate in voice recognition makes the results uninterpretable. One notable exception is Google's Project Relate, a communication app for persons with non-standard speech whereby users train models specifically on their own speech patterns.[55] However, as with many apps, Google Relate is tailored to American or British English, creating barriers for speakers of other dialects or languages.[56]

Similarly, AI technologies are increasingly utilized in hiring processes. However, their algorithms can result in discrimination in recruitment when they reflect and exacerbate existing biases.[57,58] For example, AI algorithms for reviewing résumés can fail to factor in career or education breaks due to disability, or that previous discrimination in employment has affected an applicant's career progression.[59] Meanwhile, video interviews using AI algorithms to analyse eye contact, speech and facial expressions (e.g., for suitability in customer-facing roles) can discriminate against persons who are blind or partially sighted, persons with communication disabilities and persons with autism.[60, 61] There is also evidence of sexism and racism resulting from AI-processes,[62,63,64] meaning women with disabilities and persons with disabilities from minority racial or ethnic groups are especially vulnerable to compounded intersecting forms of discrimination.[65]

Recommendations for more inclusive approaches

Promoting access to available technology

The benefits of technology will only be realized for persons with disabilities through ensuring equitable access to needed technology. Reducing the digital divide can be achieved through **expanding the access to critical products (e.g., internet, computers, mobile phones, data packages, assistive technology) and enhancing digital skills**, particularly for groups at higher risk of exclusion (e.g., older adults, persons with intellectual disabilities, persons in rural areas, low-income countries or living in poverty). Social protection and other policies can reduce financial barriers to access, while digital skills courses must be accessible and inclusive (*Box 3.3*). Peer-support groups can also provide training and continual knowledge enhancement as well as confidence-building.

Awareness campaigns, training and peer-support can improve awareness of the full range of technology and accessibility features that are available to support participation. Employers and health, education and other service providers should also be trained on technological solutions for enhancing their delivery of services for users with disabilities.

Box 3.3 Training in digital skills in Kenya

Many young persons with disabilities who complete schooling lack the opportunity to access further educational programmes and training, leading to gaps in the technical and soft skills required for employment.[66,67] In response to this gap, IT Bridge Academy in Nairobi prepares Kenyan young persons with disabilities for work in the IT sector. The Academy is hosted at the National Industrial Training Authority and provides accessible IT training.[68,69] The programme also includes soft skills training and mentorships to support young persons transitioning into employment.[70] The Academy also focuses on addressing the gender gap in IT, and half of all trainees are women.[71]

Inclusive co-created design of products, systems and services

The **specific needs and preferences of persons with disabilities should be identified through inclusive design in collaboration with diverse users with disabilities**. Diversity among persons with disabilities can include by impairment, gender, age, context and other factors. Involving a diversity of users with disabilities from the outset is essential, as an accessibility feature that is enabling for one person with a disability may be disabling for another if their different needs are not holistically considered from the outset. For example, products that can be used at low bandwidth or with minimal data are particularly important in many low- and middle-income countries, as are applications that can be used by non-English-speaking users.[72]

Focusing on accessibility and involving persons with disabilities in design and development of products, systems and services can also drive innovations and improved outcomes for all (*Box 3.4*). As early adopters and innovators of many of these technologies, persons with disabilities can be at the forefront of driving technological change.

Box 3.4 Examples of how accessibility can drive innovation in technology

Features and products that were originally created to support inclusion for persons with disabilities are increasingly showing mass appeal, such as:

- **Voice and speech recognition technology:** Initially designed to assist persons with disabilities who have difficulty using traditional input devices such as keyboards, voice and speech recognition technology has now become mainstream. For example, it is used to power virtual assistants such as Siri, Alexa and Google Assistant, for transcription services that auto-generate captions and summaries of meetings, for customer service and as part of security authentication. The global market for voice and speech recognition was valued at US$14.8 billion in 2024 and is expected to grow to US$61.3 billion by 2033.[73]
- **Audiobooks:** Audio recordings of books were originally developed for persons who are blind or partially sighted and have also been widely used for persons with other disabilities (e.g., learning disabilities, certain physical disabilities).[74] Now, audiobooks are an increasingly popular means to access information and entertainment. In the United States, close to 40 per cent of the population had listened to an audiobook in the last year, and sales of audiobooks generated over US$2 billion in revenues in 2023.[75]

Evaluating and addressing potential harms of technology for persons with disabilities

New uses for technology are constantly emerging. It is important that **products, systems and services are assessed for their effectiveness, safety and other concerns** among persons with disabilities (e.g., impact of automation of key services, cybersecurity, data protection, bias, digital accessibility, child safeguarding). For example, one study found 144 apps for musculoskeletal rehabilitation on Google Play and Apple app stores.[76] However, three-quarters of these did not indicate any evidence testing their effectiveness. Meanwhile, expanding uses of AI in employment, health care, social interactions, social protection, care and support, and other areas can lead to discrimination, safeguarding and privacy concerns. Datasets used to train AI must include persons with disabilities to mitigate bias, and improve the usability, accuracy and fairness of AI systems. Persons with disabilities and Organizations of Persons with Disabilities (OPDs) must be actively included in these discourses on ethical and safe use of emerging technologies, and in developing strategies to monitor, evaluate and address arising issues.

Developing, adapting and enforcing inclusive policies

Globally, laws, policies and regulatory frameworks are struggling to keep pace with technological advances, including AI. As national legislative and regulatory frameworks are developed and adapted, it is essential that they reflect the abovementioned concerns for persons with disabilities. For example, nearly a third of countries worldwide do not have regulatory frameworks on accessibility of information and communication technology (ICT), ranging from 15 per cent of European countries to 55 per cent of countries in Africa.[77] Similarly, cybersecurity measures, privacy policies and user consent procedures often require adaptations to be accessible and inclusive for persons with disabilities.[78]

Urbanization

More than half of the world's population currently lives in cities, and this number is expected to rise to 70 per cent by 2050,[79] with the majority of growth occurring in Africa and Asia.[80] Urbanization can bring investments in infrastructure and services and, when accessibility and inclusion is prioritized, can be a powerful tool for sustainable and inclusive development.[81] However, growing urbanization also brings challenges, including high demands on infrastructure and services, overcrowding, congestion, pollution, crime, and rising inequalities and urban poverty. This section discusses the potential benefits and challenges of urbanization for persons with disabilities.

How does urbanization impact persons with disabilities?

Access to services

Cities typically have greater availability, and higher quality of services compared with rural areas (*Box 3.5*), including services that are critical for many persons with disabilities (e.g., rehabilitation and other health care, vocational training, inclusive education, accessible transport, formal care and support). Urbanization drives an increasing concentration of these services in cities, which can further increase disparities between rural and urban residents. Access to these services can be a particularly important driver of rural to urban migration for persons with disabilities.

Box 3.5 Rural-urban differences in access to key services

- **Health care:** Many health services, particularly specialist services, are concentrated in urban areas.[82] For example, across the United States, urban and suburban areas were three times more likely to have a community-based mental health treatment service compared with rural areas.[83] In Canada, 90 per cent of physiotherapists are located in urban areas.[84] Across 15 Latin American countries, the ratio of ear, nose and throat (ENT) specialists in the capital compared with other areas reached as high as 36:1: for example, in Paraguay, 75 per cent of ENT specialists are in the capital, where only 8 per cent of the population lives.[85]
- **Assistive technology:** Across 29 countries, access to assistive technology was higher in urban in almost all countries – with ratios of urban to rural access reaching up to 4.65.[86]
- **Education:** Across 43 low- and middle-income countries, children with disabilities in urban areas were twice as likely to attend primary school as children with disabilities in rural areas.[87] Inclusive education services also tend to be concentrated in urban areas.[88,89]
- **Housing:** Some indicators of housing quality, such as access to safe water and sanitation, connection to electricity and durability of materials used for construction, tend to be better in urban areas. For example, persons with disabilities in urban areas in Cambodia, Nigeria and Uganda were more than twice as likely to have electricity compared with people in rural areas.[90]

- **Awareness-raising and information on disability:** The CRPD Committee's concluding observations on Article 8 note that in several countries stigma and discrimination are heightened in rural areas (e.g., Ghana 2024, Djibouti 2021) and that awareness-raising activities on disability are more concentrated in urban areas (e.g., Saudi Arabia 2019, Burkina Faso 2024, Mauritania 2023, the Lao People's Democratic Republic 2022).[91]

Accessibility and inclusivity of urban environments

Creating accessible and inclusive urban environments (e.g., buildings, housing, transport, roads) has the potential to accelerate the inclusion and well-being of persons with disabilities by promoting better access to services, as well as social and economic participation.[92] Still, accessible and inclusive infrastructure, services and systems are often lacking due to the absence of mandated accessibility standards, low prioritization by decision-makers and lack of training of city planners and other stakeholders on inclusive design.[93] Implementation can also be inconsistent within urban settings, as greater attention is typically paid to making infrastructure accessible in wealthier areas.[94,95]

Transport

Investing in public transportation can create more sustainable cities by easing road congestion, providing low-cost transit, and reducing emissions that drive climate change and worsen air quality. As cities expand and upgrade their transport systems, there are critical opportunities to also make these systems more accessible (e.g., audio and visual announcements, step-free access) (*Box 3.6*). However, **many cities or areas of cities currently lack accessible public transportation options**. There can also be gaps in what accessibility features are provided:[96] for example, in Solo, Indonesia, there has been progress in growing the availability of physically accessible bus stops; however, communication accessibility (e.g., of stop announcements) is limited.[97]

Persons with disabilities are often restricted to private transport or experience longer journey times for some routes: for example, in London, United Kingdom, all bus routes are fully accessible for wheelchair users, but only a third of London Underground (metro) stations are.[98] As such, journeys can take up to five times longer.[99] Further, congestion, overcrowding and discrimination by transport operators can limit use of public transportation by persons with disabilities. For example, in Kiev, Ukraine, some bus drivers refused to stop for persons who are entitled to subsidized transport (e.g., older people, persons with disabilities), while in Nairobi, Kenya, persons with disabilities who were perceived to require longer boarding times were charged higher fares.[100,101] Improving accessibility of transport, however, can have significant impacts: in the United Kingdom, enhancing the accessibility of transport systems was estimated to generate £72.4 billion (US$89.3 billion) annually through increased well-being and access to employment and education for persons with and without disabilities.[102]

Box 3.6 Examples of improvements to accessible transport

- In Medellin, Colombia, advocacy by persons with disabilities has led to accessibility improvements within the Metropolitan Transport System. For example, most stations now have ramps, sloped walkways and elevators; Metro staff receive 'Cultura Metro' (Metro Culture) training which covers disability-inclusive service provision.[103]
- In reaction to exclusion and discrimination on transport in Ukraine, an age-related civil society organization, Turbota pro Litnih v Ukraini, initiated a system for transport users to report concerns to bus operators. They also provided trainings with transport operators on accessibility. Other improvements included longer green lights to allow more time to cross roads, and extension of bus services in underserved areas.[104]
- In Delhi, India, the metro has included easy-to-read signage using symbols and pictorial representation and navigational strips enabling better access for persons with intellectual and learning disabilities.[105]

Housing and informal settlements

Globally, 96,000 new affordable housing units would need to be built every day to meet the current demand posed by urbanization.[106] Access to suitable housing can be particularly challenging for persons with disabilities due to lower incomes, **lack of accessible housing options** and discriminatory housing practices.[107,108,109] For example, across the United States, 40 per cent of persons with accessibility needs did not have housing with accessibility features, with gaps larger in urban areas.[110] Meanwhile, across six cities (Freetown, Medellín, Nairobi, Surakarta, Ulaanbaatar and Varanasi), persons with disabilities reported housing issues such as the lack of lifts or ramps in buildings and difficulties using toilets due to overcrowding, inaccessible facilities and narrow doorways.[111]

Informal settlements in cities are growing rapidly, particularly in low- and middle-income countries, housing more than 1 billion people worldwide.[112] Persons with disabilities may be more likely to live in these environments due to higher levels of poverty and lack of affordable housing elsewhere.[113] Informal settlements are challenging environments for anybody to live in, but for persons with disabilities they are much more difficult because of heightened inaccessibility stemming from the difficulty of regulating construction standards.[114] Additionally, informal settlements are often situated in areas that are prone to air pollution and extreme weather events (e.g., landslides and floods) and characterized by less resilient infrastructure.[115,116,117] As discussed in the section on climate change, below, persons with disabilities can experience disproportionate impacts when exposed to these conditions.

Homelessness, including street homelessness, is increasing in many cities. Persons with disabilities, particularly persons with psychosocial disability, are overrepresented among homeless populations: for example, in a review across multiple countries, 7 per cent of homeless people were reported to have schizophrenia,[118] almost 17 times higher than the prevalence in the total population.[119] In Nagoya, Japan, one third of homeless people had an intellectual disability.[120] Migrants and displaced persons with disabilities can be particularly at risk: in Addis Ababa, Ethiopia, close to two thirds of homeless people – of whom most had a disability – were migrants and displaced persons.[121]

Pedestrian areas

Pedestrian infrastructure remains inaccessible and risky in many cities (e.g., congested footpaths, lack of pavements, kerbs or crossing lights), particularly in poorer areas.[122,123,124,125] For instance, a study in an urban area of Ghana found that none of the 79 pedestrian crosswalks assessed were accessible.[126] Informal settlements can have particularly difficult pedestrian areas, with narrow, uneven and crowded walkways, open sewers, potholes and other barriers – making it challenging for many people with mobility limitations to move around independently and safely.[127] Inaccessible pedestrian infrastructure remains a challenge even in high-income contexts: for example, in Northern Ireland, more than 74 per cent of persons who are blind or partially sighted were afraid or anxious about going out alone, with street clutter, parked cars on pavements and poor lighting as key issues.[128] There can also be tensions between efforts to address other urban infrastructure concerns (e.g., sustainable transport) and accessibility of pedestrian areas: for example, bike lanes and the presence of e-scooters can create additional obstacles to navigate around,[129,130] as can construction work for infrastructural developments (e.g., lack of fencing, signage).

Digital infrastructure

The rise of smart cities, where technology can help create more efficient services and optimize resource use, has great potential to address key urbanization challenges and accelerate inclusion for persons with disabilities.[131] For example, innovations such as automated door openers or voice- and movement-activated systems can improve accessibility. Similarly, mobile applications can provide information on accessible routes and enable greater citizen participation in urban planning and decision-making. However, persons with disabilities risk being left out of these benefits, due to barriers such as the digital divide, lack of ICT accessibility standards and failure to consider disability when planning smart solutions (*see section on technology, above*).[132] More than half (60 per cent) of 250 global experts surveyed in 2016 considered smart cities to be failing persons with disabilities.[133]

Health and well-being

Urban environments often have better availability of health services, which can improve the health and well-being of persons with disabilities. However, there are also **heightened health concerns associated with urbanization**. Cities, particularly where expansion is occurring rapidly, and in poorer areas of those cities, are prone to overcrowding, pollution, congestion and inadequate housing, water and sanitation. These conditions increase the risk of many health problems, including infectious diseases, respiratory disease, obesity, sedentary lifestyles, accidents and poor mental health.[134,135] Persons with disabilities can face a disproportionate impact from these health risks. For example, high levels of traffic and congestion coupled with inaccessible pedestrian infrastructure can increase the risk of accidents and injuries for persons with disabilities:[136] in the United States, Sweden and the United Kingdom, pedestrians with disabilities were up to five times more likely to be injured by road traffic,[137,138,139,140] while wheelchair users were 36 per cent more likely to die from road traffic accidents in the United States.[141] Road traffic injuries can also be a cause of disability, with 39 per cent of survivors in Nepal, Rwanda, Sierra Leone and Uganda experiencing long-term disabilities.[142] Meanwhile, persons with disabilities are often more exposed to and have worse health outcomes from pollution and climate hazards associated with climate change (*see section on climate change, below*).

Livelihoods

Urbanization is associated with economic growth, and **greater opportunities for work and higher wages** are a common driver of rural to urban migration.[143,144] Persons with disabilities can also benefit from these opportunities: in Burkina Faso and Bangladesh, employment rates were higher among persons with disabilities in urban compared with rural areas.[145] In Viet Nam, the difference in the poverty rate between persons with and without disabilities was lower in areas that had better roads and access to health care – which tend to be better in urban areas.[146] Still, persons with disabilities have more limited access to opportunities even in urban areas due to inaccessible infrastructure, discrimination among employers and lack of required skills due to earlier exclusion from education and training.[147,148]

Improved earnings may not always offset the **higher cost of living in cities**. The cost of living can be particularly high for persons with disabilities due to disability-related extra costs.[149,150] While some disability-related costs may be reduced in cities (e.g., transport, if accessible public transport is available, costs of seeking health, education and other services), others may be higher (e.g., care and support, accessible housing).[151,152] In Cambodia and China, urban households spent more than rural households on disability-related costs, which may reflect both higher purchasing power and higher costs of required goods and services.[153]

Social inclusion and well-being

Cities can serve as vital **hubs for social movements and collective action**.[154,155,156] OPDs are often based in cities, and in settings such as Botswana, Malawi, Nepal and Zimbabwe, persons with disabilities were much more likely to belong to an OPD if they lived in an urban area.[157] Meanwhile, in Northern Ireland, unpaid providers of care and support in urban areas were able to access support groups that were not available in rural settings.[158] However, persons with disabilities can be excluded from participating in mainstream social movements, such as urban anti-poverty organizations or unions, meaning their perspectives can be overlooked.[159]

Urbanization can present **additional risks for social isolation, loneliness and poorer mental health** due to factors such as stressful living conditions (e.g., congestion, inadequate housing, high costs of living) and weakening of community structures.[160,161] In Scotland, for instance, persons with intellectual disabilities reported much greater community engagement if they lived in rural rather than urban areas.[162] Still, social participation and well-being are also affected by environmental accessibility and access to required services, which are often but not always greater in urban areas.[163] Urbanization can also affect the availability of care and support for both persons with disabilities in cities – where family and community networks can be more limited – and in rural areas, where support may lessen due to family and community members moving to cities (*see section on migration and displacement, below*).

Finally, urbanization can present **additional risks of violence and exploitation for persons with disabilities**. For example, poverty, limited employment prospects and lack of social support can lead persons with disabilities to resort to or be coerced into begging.[164,165] Begging, particularly forced begging, can in turn expose them to exploitation, discrimination and unsafe conditions.[166] Persons who are homeless can experience high levels of violence, including sexual violence, with the latter particularly high for women and LGBTQIA+ communities.[167]

Recommendations for ensuring inclusive urbanization processes

Many policy and programmatic responses to urbanization can be important entry points to accelerate inclusion of persons with disabilities. There has been progress with international commitments, frameworks and toolkits to support inclusive urban development (*Box 3.7*). In addition to these initiatives for cities, it is critical that investments are also made to improve accessibility and inclusion in rural areas, particularly considering the increasing centralization of services driven by rapid urbanization.

Box 3.7 International commitments, frameworks and toolkits to support urban inclusion

- **Sustainable Development Goal 11** aims to "make cities and human settlements inclusive, safe, resilient and sustainable".[168] Persons with disabilities are explicitly mentioned in several targets, including on affordable and sustainable transport (target 11.2) and safe and inclusive green and public spaces (target 11.7).
- The **New Urban Agenda**, adopted by the United Nations General Assembly in 2016, is an action-oriented roadmap for decision-makers to promote sustainable, inclusive, and resilient cities.[169] It includes a focus on inclusive growth, including accessible and equal access to housing, transport, buildings and services. It also calls for equitable participation in urban planning and other decision-making processes.
- **Cities for all (C4All)**, also known as the Global Compact on Inclusive and Accessible Cities, more explicitly aligns the New Urban Agenda with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), as well as other commitments such as the SDGs and the WHO's Age Friendly Cities Initiative.[170] It emphasizes accessibility, universal design, inclusive programming, participation of persons with disabilities in decision-making and collection of data on disability to inform city planning.
- **Smart cities for all** focuses on how technological solutions in urban development can foster the inclusion of persons with disabilities and older adults.[171] It is led by the Global Initiative on Inclusive ICTs, in partnership with World Enabled, leading tech companies (e.g., Microsoft) and civil society organizations. It has produced a toolkit with resources on ICT accessibility and digital inclusion to support different stakeholders involved in creating Smart Cities.
- **Global Action Report: Delivering Inclusive Design in Cities** aims to equip cities with practical actions necessary to accelerate accessibility and disability inclusion.[172] Informed by research in six countries, it sets out 10 principles and 16 priority action areas covering infrastructure, services and operations.

Across these frameworks and commitments, key strategies include:

Ensuring accessibility and inclusive design throughout all processes

Urban planning must consider accessibility and inclusive design across all activities, systems and projects (e.g., buildings, transport, affordable housing, technology, service provision, public spaces). Importantly, there is an urgent need for wider legislative commitments and mandated, contextually appropriate accessibility standards with regular monitoring of compliance and accountability mechanisms (*for overarching principles of accessibility, see Chapter 4*). These standards and policies need adaption for contextual relevance in different cities and areas of cities. For example, many accessibility standards and building regulations are less suitable and difficult to enforce in informal settlements.[173,174,175] Dedicated focal points on accessibility and inclusion across urbanization processes can raise the political will and streamline coordination.

Diverse accessibility needs and other barriers to inclusion must be addressed during urban planning.[176] For example, accessibility standards and design guidelines often have greater focus on addressing physical barriers, with less attention to communication, digital and other accessibility concerns. Further, an intersectional approach is needed to identify and address diverse concerns among persons with disabilities. As an illustration, women and girls with disabilities may be less able to benefit from accessibility improvements if they are not coupled with improvements to safety and other gender-related concerns (e.g., well-lit public spaces; toilets that are accessible, private and equipped for menstrual hygiene management; efforts to reduce harassment on streets, transport).

Training on accessibility and inclusive design for stakeholders is also essential, across public and private sectors (e.g., city officials, development actors, local authorities, built environment planners and architects, digital sectors) and types of programmes (e.g., housing, employment, health care, policing). The current training gap has led to poor implementation such as tactile pavements being incorrectly installed.

Enabling meaningful engagement of persons with disabilities and OPDs

Persons with disabilities must be included in processes that shape the cities in which they live. Intentional and robust mechanisms are therefore needed to improve the meaningful participation of persons with disabilities and OPDs across all elements of urban planning and governance (*Box 3.8*).[177] The participation of persons with disabilities in urban governance structures must be resourced and regularly evaluated to ensure meaningful engagement. Consideration of specific issues faced by women and children with disabilities, persons with disabilities who are homeless or are in informal settlements and migrants and displaced persons with disabilities is critical, as they are often disproportionately excluded.

Collecting and disseminating data to monitor and inform accessibility and inclusion

Globally, better data are needed to monitor progress on making inclusive cities and to inform future planning. The Global Urban Monitoring Framework is a reporting system to monitor the New Urban Agenda commitments and SDG 11 objectives. However, only 25 countries provided reports between 2018 and 2022, and disability-disaggregated data were identified as 'lacking'.[178] Information is also needed on the impacts, costs, strengths and challenges of implementation processes for different strategies for inclusive urban development. Widespread sharing of these examples, such as through a single, open-sourced resource and creating a network of experts on inclusive urbanization (e.g., OPDs, policymakers, private sector innovators), can help inform other cities as they develop their own inclusive solutions.

Box 3.8 Engagement of persons with disabilities and OPDs in urban planning and governance

- In Banjarmasin, Indonesia, community members co-designed an accessible urban community space, which is used for integrated health services, volunteer activism and teaching children.[179] Collaboration between community members and OPDs, alongside the use of co-design tools (including Lego model making), were important for identifying and designing a building to meet the collective needs of the community.
- In Bristol, United Kingdom, a climate and disability programme launched "the UK's first community action plan made with, by and for" a local community of persons with disabilities. Regular meetings and strategic events are held to develop local climate- and disability-related policy and planning across different areas of the city.
- In Addis Ababa, Ethiopia, residents with disabilities were hired and trained to conduct surveys and accessibility audits of 600 selected buildings (e.g., hotels, hospitals, shopping centres and banks). Informed by the findings, the government implemented directives to reinforce the Ethiopian Building Proclamation No. 624, mandating physical accessibility, and many building owners made adjustments to comply with accessibility standards.

Mainstreaming disability within other sustainable development initiatives in cities

Cities are at the forefront of other global trends. For example, cities contribute to 70 per cent of global carbon emissions, and urban residents are among the most vulnerable to the effects of climate change.[180] Meanwhile, cities are host to many migrants and displaced persons, and technological innovations are increasingly being integrated into urban processes. Inclusive urban development must therefore also promote, invest in and monitor disability-inclusion across diverse mainstream initiatives (e.g., Smart Cities, C40 initiatives for climate change in cities). For example, programmes to make housing affordable and resilient in the context of the growing climate crisis must also consider accessibility and other barriers preventing equitable access for persons with disabilities.

Migration and forced displacement

Migration and displacement is a dominant social and political issue. Migration is the temporary or permanent movement of people from one location to another, either within the same country or across national borders.[181] Migration can be voluntary, such as to seek better opportunities for school or work, or to be reunited with family. It can also be forced, as people flee from persecution and humanitarian crises. Migration and displacement[c] – including of persons with disabilities – is likely to continue to increase in many contexts, especially with growing influences of climate change, conflict, urbanization and globalization.[182]

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[c] There are many different terms to describe persons who migrate voluntarily or forcibly. Persons forced to flee their home country due to threats of persecution or violence are called refugees or asylum seekers, while persons who are forced from their homes but remain in the same country are internally displaced persons. We use migrants and displaced persons to capture all these groups.

Persons with disabilities have the right to movement on an equal basis as others under Article 18 of the CRPD, and to protections and safety when fleeing situations of risk (Article 11). Recognition of the needs of migrants and displaced persons with disabilities has been growing among governments, development agencies, OPDs and other stakeholders.[183,184] However, in the absence of inclusive migration and displacement policies and practices, persons with disabilities will continue to encounter additional barriers that restrict their ability to move freely and safely, obtain legal status and integrate into new communities.

What are the experiences of migrants and displaced persons with disabilities throughout the migration cycle?

Reasons for movement

Persons with disabilities' **options for moving can be more limited**: they may lack the financial means due to higher levels of poverty, lack adequate and accessible information, face more difficult journeys or have reduced autonomy in making decisions to move. Moreover, non-inclusive evacuation procedures can prevent persons with disabilities from escaping dangerous situations (*see section on humanitarian crises, below*), while discriminatory and non-accessible migration policies and procedures can limit legal routes of migration.

Persons with disabilities have many of the same motivations for movement as others, including for economic opportunities, escaping conflict or due to the growing impacts of climate change. However, some push and pull factors are heightened or unique for persons with disabilities. For example, many services required by persons with disabilities – such as rehabilitation and other health care, inclusive education, accessible transport and vocational training programmes – are in scarce supply in some countries or heavily concentrated in cities,[185,186,187] driving rural–urban (*see section on urbanization, above*) or international migration. Some persons with disabilities may move to be closer to extended family for informal care and support.[188] **Seeking better access to these services and supports can be a driver of migration.**[189,190] Across five countries in Latin America, 80 per cent of older adults with disabilities cited lack of access to needed health care as a reason for migrating within and between countries, compared to 68 per cent of older adults without disabilities.[191]

Escaping **discrimination or persecution on the basis of disability** can be another reason for persons with disabilities to migrate.[192,193,194] For instance, Zimbabwean mothers of children with disabilities reported that beliefs about disability and discrimination led them to migrate to South Africa.[195] Stigma and discrimination against persons with disabilities can in some cases be grounds for seeking refugee status.[196] The 1951 Refugee Convention defines refugees as those "unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion".[197] While disability is not explicitly listed as a basis for persecution in the 1951 Convention, some national laws, such as South Africa's 1998 Refugee Act, do include disability under the category 'social group'.[198] Other countries have granted refugee status on a case-by-case basis, recognizing that persons with albinism or psychosocial, intellectual and other disabilities can be subject to harmful and exploitative practices such as ritual killings, exorcisms, shackling and forced begging in their country of origin.[199,200]

Difficult journeys

Migrants and displaced persons, particularly those fleeing humanitarian crises and persecution, do not always have access to legal and safe routes. They often take inordinate risks to seek security and a better life in another area, especially given the proliferation of policies and practices aimed at controlling and restricting population movement. Navigating these conditions can cause new or worsening disability, for example due to psychosocial distress and trauma, violence and abuse, malnutrition and lack of health care.[201] **Journeys can be particularly risky and gruelling for persons with disabilities**, and even more so for children, women and girls, and older adults with disabilities. In settings such as Darfur, Ukraine and Venezuela, persons with disabilities explained how journeys could take longer, due to mobility difficulties, inaccessible transport and lack of support.[202,203,204] Longer journeys prolong exposure to dangers: for example, women and girls with disabilities from Venezuela reported high exposure to violence, including sexual violence, while transiting.[205] Meanwhile, fleeing at short notice and challenging transit conditions can result in loss of assistive products and medications and separation from family members and others who provide care and support.[206,207,208]

Obtaining legal status

Legal status can affect persons with disabilities' ability to migrate and their rights on arrival. Legal status can change at multiple points throughout migration and displacement journeys: as an illustration, a person can enter as an asylum seeker, be granted refugee status, and later become a citizen. Yet persons with disabilities face multiple barriers to obtaining legal status at different stages: in Colombia, Ecuador, El Salvador, Honduras and Peru, older migrants and displaced persons with disabilities were almost twice as likely to be undocumented compared with their counterparts without disabilities.[209]

Many factors can prevent persons with disabilities from obtaining different forms of legal status. Importantly, **disability remains one of the most common forms of discrimination in migration and naturalization laws and policies**.[210] For instance, medical inadmissibility in national immigration laws prevents some persons with disabilities from emigrating. Canada's 2001 Immigration and Refugee Protection Act and Australia's Migration Regulations have clauses that restrict migration for persons who are deemed to present excessive demands on health, social care or social protection systems,[d] while the United States' Immigration and Nationality Act weighs whether disability affects an applicant's ability to live independently, work or attend school.[211,212,213] Once settled, migrants and displaced persons with disabilities face barriers to becoming citizens. Some countries – such as Cameroon and Panama – explicitly prohibit persons with disabilities from obtaining citizenship.[214] Many more have policies or vague language that can lead to discrimination, such as requiring applicants be of 'sound mind' or 'full capacity'. Similarly, language proficiency or knowledge tests and oaths of allegiance can be barriers, particularly for persons with intellectual disabilities or persons who use sign language.

Other elements of application procedures can disproportionately exclude persons with disabilities. For instance, discrimination in employment makes meeting minimum earning thresholds more difficult for persons with disabilities, as is obtaining sponsorships from potential employers for work visas. Meanwhile, lack of documents, such as birth certificates, is more common among persons with disabilities.[215] Other barriers during application procedures are commonly reported, such as inaccessible information and application points, failure to provide accommodations and discrimination from staff.[216,217]

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[d] Some exemptions apply – importantly, medical inadmissibility criteria do not apply to refugees. To note, Canada recently increased the threshold of what was considered 'excessive demands' on the health system.

Asylum seekers with disabilities encounter additional difficulties during refugee status determinations (*Box 3.9*). For example, asylum seekers who are deaf, hard of hearing or deafblind can have difficulties explaining their experiences during interviews, especially if they do not know a formal sign language or if there is a mismatch between sign languages used by applicants and that of available interpreters.[218,219] Meanwhile, persons with intellectual and psychosocial disabilities can have challenges recalling or disclosing events to support their applications, due to difficulties understanding, remembering and communicating or from trauma and fear of reprisals.[220,221,222,223] Lack of consistency in recollections can in turn negatively influence the credibility of an applicant's claims during assessment.

Box 3.9 Improving inclusion in refugee status determination

UNHCR Procedural Standards for Refugee Status Determinations has guidance for claims involving persons with intellectual and psychosocial disabilities.[224] Protocols include provision of accommodations to support direct participation as much as possible, such as through shorter or multiple interviews, provision of accessible information and communication (e.g., easy-to-read, simplified formats), referrals for counselling, and assistance from a support person. Staff involved in determination procedures should be trained in disability, including on how to factor in an applicant's disability when making credibility assessments. In instances where an asylum seeker is deemed not to have capacity to represent themselves even with these adjustments, their case should be assessed through other sources (e.g., testimony of family members, witnesses).

For persons who are deaf, hard of hearing or deafblind, lack of appropriate sign language, its adaptations and deafblindness-specific communication methods are increasingly recognized.[225] While sign language interpretation in International Sign Language or the reception country's sign language may be available, asylum seekers are often unfamiliar with these or any other formal sign language.[226] Various strategies are being used to address these challenges. For example, in Sweden, some deaf asylum seekers with no or non-Swedish sign language knowledge were given free classes for several months prior to their interview to allow for self-representation.[227]

Experiences at destination

Moving to a new area may result in improved or worsened inclusion for both migrants and displaced persons with disabilities compared with their community of origin.[228,229,230] Many migrants and displaced persons with disabilities have reported improvements to their quality of life and access to key services in a new host community, although not without navigating challenging integration and resettlement processes, and often a combination of ableism, racism and colonialism.[231,232] Others, particularly those in camp or detention centre settings, may experience decreased inclusion and access to key services. Resettlement can be a complex process, particularly for forcibly displaced persons' involving adaptation to multiple societies and systems (e.g., refugee or internally displaced persons camp, detention centre, multiple host communities, return to origin). Migrants and displaced persons with disabilities are recognized as a vulnerable group at the international level, meaning some, often limited, additional support can be offered from States through resettlement schemes.[233] However, this support is often inconsistent and inadequate.

Some common challenges migrants and displaced persons with disabilities encounter that affect their access to needed services and supports to live with dignity and integrate into new communities, whether abroad or within the same country, are discussed below (*see also section on humanitarian crises for further discussion on camp settings*).

Health and access to health care

Migrants and particularly displaced persons with disabilities often face difficulties **accessing needed health care**, including rehabilitation, impairment-related services and assistive products, due to barriers such as cost, long wait times, lack of insurance (*Box 3.10*), poor accessibility of services, communication challenges and difficulties navigating unfamiliar health systems.[234,235,236,237,238] For example, Venezuelan refugees and immigrants in Peru were 78 per cent less likely to seek needed health care than their counterparts without disabilities.[239] Persons with disabilities can experience interruptions in continuity of care due to the loss of medical documentation in transit, its incompatibility within a new health system or reluctance to disclose disabilities and health conditions for fear of affecting their immigration status.[240,241]

Box 3.10 Coverage of health-care costs for migrants

- In Germany, recognized refugees are entitled to health insurance, which covers rehabilitation, assistive products and specialist services.[242] However, some refugees with disabilities reported long processing times, leading to significant periods without needed health care.[243,244] Asylum seekers are not covered by health insurance and are only entitled to some basic health-care services, mainly for acute illness. However, the Social Welfare Office can make discretionary judgements to grant them access to rehabilitation, assistive products and other medical supports.[245]
- Migrant workers in Gulf Cooperation Council countries have varying levels of health-care coverage.[246] Across all countries, migrant workers are legally entitled to emergency medical care in public health systems. Access to non-emergency health care and health care for dependents is more mixed, with some countries and schemes providing no or limited coverage. There is also an increasing shift towards private health system models for migrants, leading to concerns of a two-tiered system, lower quality of care for migrants and higher costs to individuals and systems.

Migrants and particularly displaced persons can have **additional health-care needs**. For example, stress and uncertainty throughout the migration process and the loss of support networks can worsen mental health.[247,248] Persons who are forcibly displaced have often experienced traumatic events: nearly one third of refugees and asylum seekers across 15 countries had post-traumatic stress disorder (PTSD).[249] Time spent in detention centres can further worsen mental health: in Nauru and Australia, reported self-harm was more than 12 times higher among detained asylum seekers compared with community-based asylum seekers.[250] Persons with disabilities are more at risk of poorer mental health outcomes, given their increased isolation, stress of navigating frequently inaccessible systems and lack of inclusive mental health and psychosocial support (MHPSS) services: among Syrian refugees in Türkiye, nearly half of children with disabilities had symptoms of anxiety, depression or PTSD, twice as frequent as for children without disabilities.[e] Escaping humanitarian crises, dangerous transits and engagement in precarious employment in the new host community increases the risk of injuries, including new or worsening disability.[251,252]

Education

Migrant and displaced children with disabilities and their families can face challenges **navigating new education systems**.[253,254] For example, parents can be reluctant to disclose their child's disability to school systems, due to past experiences of discrimination or fear of losing their immigration status.[255] They may also be unfamiliar with the concept of inclusive education or specific services offered in their new context, and could face difficulties communicating with school staff about their child's schooling due to language barriers.[256,257] Moreover, teachers and school staff can lack training in inclusive as well as culturally sensitive instruction.[258] Migrant and displaced children with disabilities can be behind in their schooling, due to periods of exclusion from school in their area of origin, during transits or while in camps, detention centres and other holding sites.[259]

Proper assessment of migrant children for disabilities and special education needs can be complicated by illiteracy, lack of knowledge of the language of instruction or unfamiliarity with standardized testing procedures.[260] It can also be difficult to disentangle the effect of trauma and psychological distress on learning and academic performance.[261] As such, there are concerns that migrant and displaced children are more likely to be misdiagnosed as having learning disabilities, which can affect their education trajectories.[262] Meanwhile, migrant and displaced children with genuine needs that are not identified lack access to required inclusive education supports.

Employment and livelihoods

Migration, including labour migration, and displacement can bring new economic opportunities for persons with disabilities. However, migrants and displaced persons with and without disabilities may **have limited options for work**, particularly if they are without legal status, do not speak the local language or lack training and education.[263,264] They also contend with disability-related barriers to employment (e.g., discrimination, lack of reasonable accommodations).[265] Among Syrian refugees in Türkiye, men with disabilities were almost half as likely to be working compared with men without disabilities.[266] Women with disabilities face additional employment challenges due to gender-related barriers. For example, social norms in either their new setting or from their culture of origin can restrict workforce participation.[267] Female labour migrants – including women with disabilities – have widely reported violence and exploitation, including sexual abuse, from employers.[268,269,270]

Lack of options for safe, secure work means many migrants and displaced persons either have **long periods of unemployment or enter precarious, low-paid or dangerous work**. This situation can lead to poverty and lower standards of living, particularly for persons with disabilities: for instance, Venezuelan refugees and immigrants

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[e] Analysis by authors based on data from Polack, S., et al., 2020. 'Disability and mental health among Syrian refugees in Sultanbeyli, Istanbul', Research Report, 2020, London, International Centre for Evidence in Disability, London School of Hygiene & Tropical Medicine..

with disabilities in Peru were 25 per cent more likely to have unmet food needs compared with their counterparts without disabilities;[271] in the United States, 49 per cent of working-age immigrants with disabilities[f] had low incomes (< 200 per cent of the federal poverty line), compared to 26 per cent of non-immigrants with disabilities and 36 per cent of all immigrants.[272] Moreover, many jobs done by migrants and displaced persons can worsen physical and mental health, and carry an increased risk of disabling or fatal injuries.[273,274] In a review across 13 countries, 22 per cent of immigrant workers in agriculture, domestic work and other mainly low-paid work had had at least one occupational accident or injury, and 47 per cent had an occupational health problem.[275] Depending on context and legal status, many migrants and displaced persons have limited access to social protection systems and other legal protections (e.g., workers' compensation, unemployment insurance, disability benefits).[276,277]

Social inclusion

Migration and displacement involve adapting to a new setting, where culture, customs, language and social norms can be different. Some migrants and displaced persons with disabilities have reported more accepting attitudes towards disability and other characteristics (e.g., race, gender, religion) in their new area, and that greater accessibility and access to inclusive services increased their social participation relative to their experience in their area of origin.[278,279] However, some persons with disabilities encounter challenges adapting to new environments and cultures.

Migrants and displaced persons with disabilities may have additional challenges receiving **accessible and adapted language services** (e.g., translation and language courses).[280] Migrants and displaced persons who require alternative communication formats can struggle to find information and instruction that is both accessible and caters to persons who do not speak the local language.[281,282] For persons who are deaf, hard of hearing or deafblind, access to sign language, its adaptations and deafblindness-specific communication methods in non-local sign and other languages can be particularly difficult.[283,284] Some programmes have sought to address these gaps: UNHCR has run pilot Rwandan sign language courses for refugees who are deaf and their family members.[285]

Appropriate and accessible housing is also important for promoting social participation of migrants and displaced persons with disabilities.[286] However, the supply of accessible housing is limited in many contexts.[287] Further, accessibility concerns and proximity of housing to required services, transport and support networks are often not considered during placements.[288,289]

Finally, **social attitudes about disability and migration** affect inclusion of migrants and displaced persons with disabilities.[290,291] Discrimination against migrants and displaced persons is increasing in many settings, particularly with the rise of nationalism, worsening economic conditions and austerity measures.[292] A common discriminatory attitude views migrants and displaced persons as 'drains' on host communities' resources, a sentiment that can be compounded for persons with disabilities given the common stigma surrounding disability.[293] Women and girls, and ethnic, racial or religious minorities with disabilities often experience additional attitudinal barriers, due to sexism, racism and other forms of discrimination.

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[f] 58 per cent for non-citizen immigrants with disabilities and 43 per cent for naturalized immigrants with disabilities.

Return and reintegration

Migrants and displaced persons with disabilities can encounter challenges with reintegration upon return to their community of origin. Migrants and displaced persons returning with disabilities acquired across different stages of migration and displacement – including the return process – must navigate new realities and systems in their place of origin (e.g., former housing may no longer be accessible, adaptations to work may be required).[294] In Nepal, 7–11 per cent of returning migrant workers cited sickness, injury or disability as their reason for return.[295] They and other returnees can struggle to receive social protection, health care and other services: for example, there can be gaps in accountability between destination and origin countries (e.g., who pays workers' compensation). Similarly, benefits received abroad or in another administrative zone in the same country may not transfer or may require re-registration.[296]

Other challenges can include poor accessibility of return and reintegration services (e.g., repatriation services, programmes for re-training or to recognize skills and education received abroad). Returnees can also experience discrimination and social isolation, particularly if their journeys are viewed as 'unsuccessful' (e.g., did not earn sufficient money, forced to return).[297] Women, particularly migrant workers, can experience added stigma and discrimination upon return, particularly in cultures and contexts where women working and travelling alone breaks social norms.[298,299] Further, children may have no memory of or connection to their or their families' place of origin, which can create social isolation and challenging re-entry processes.[300]

Implications of migration and displacement for persons with disabilities remaining in their communities of origin

Global migration patterns can impact persons with disabilities even if they themselves are not moving. Importantly, **other family members may migrate, particularly to earn higher incomes that can be sent back as remittances**.[301,302] Remittances can help cover disability-related costs and loss of wages due to the exclusion of persons with disabilities from work. In Indonesia, onset of a physical disability resulted in a reduction in income from work, which was partially compensated by an increase in remittances.[303] In some cases, families may have to balance the potential for higher earnings with the loss of unpaid care and support.[304,305,306]

Many people are **migrating to take part in the care economy**.[307] Most countries have severe shortages of care and support workers and are increasingly turning to migrants to fill these roles. For example, in Taiwan, families with members who need regular assistance can hire a live-in migrant care and support worker: as a result, the number of people migrating to Taiwan annually to become care and support workers increased exponentially, from 306 in 1995 to 210,215 in 2013.[308] The impacts of such migration patterns are complex, as although they can provide critical support to persons with disabilities – often in wealthier countries – they may in turn worsen shortages of these key staff in the typically poorer countries of migrants' origin.

Recommendations for creating more inclusive migration processes

Identifying persons with disabilities and their support needs

Identifying migrants and displaced persons with disabilities and their support needs can help to ensure they are provided with access to required services and supports (e.g., accessible housing, accommodations during migration procedures, inclusive education and medical care, care and support) and provide data to inform the planning of inclusive services.[309,310] However, disability status is often not captured: in Lebanon, it was estimated that 22 per cent of Syrian refugees had a disability, but only 1.4 per cent of all refugees were officially designated as having a disability.[311] Similarly, most European Union Member States do not have systematic processes for identifying disabilities among asylum seekers and refugees.

As in other situations (*see section on humanitarian crises, below*), the Washington Group Questions can be a helpful tool to identify persons with disabilities, although additional questions may be needed to identify specific support needs of individuals.[312] Identification should avoid using the term 'disability', as it can be understood differently by different groups, and migrants and displaced persons can be reluctant to disclose disability for fear it may affect their migration status.

Improving access to inclusive, accessible services

Migrants and displaced persons with disabilities require inclusive and accessible services across the migration process (e.g., visa applications, refugee status determinations; health care, education, legal aid, language services, social protection in communities, camps and detention centres, reintegration services) (*Box 3.11*).[313] Services must therefore be physically accessible, provide information in both alternative communication formats (e.g., sign language, Deafblind interpretation, Braille) and non-local languages, and address specific needs of persons with disabilities (e.g., accessible housing and transport, coverage for disability-related costs, access to care and support).[314] Further, service providers require training on both disability and cultural competency. Importantly, service providers should recognize that migrants and displaced persons with disabilities and their families can have different conceptualizations of disability, familiarity with services for persons with disabilities (e.g., inclusive education, rehabilitation, vocational training) and trust in institutions compared to non-migrants.[315,316]

Box 3.11 Strategies to create more inclusive services

- In Italy and Slovakia, refugees and asylum seekers with disabilities are provided with information about their rights and how to access different services (e.g., health care, assistive products, inclusive education) as part of their welcome pack.[317]
- In refugee camps in Türkiye, persons with mobility limitations were prioritized for housing with private internal bathrooms (as opposed to shared facilities).[318]
- UNHCR assisted an estimated 480,000 refugees with disabilities in 2023, including through social assistance, assistive technology and rehabilitation.[319]
- Income support for refugees and internally displaced people in countries such as Ethiopia, Germany and Ukraine provides top-ups for persons with disabilities to help cover disability-related extra costs.[320,321,322]

Protecting the right to movement of persons with disabilities

Migration policies and practices must align with the CRPD, including Articles 11 and 18.[323] Enforcing this right requires reforming discriminatory immigration and nationality laws,[324] as well as addressing other barriers that limit legal movement and settlement (e.g., inaccessible application procedures). Some countries have made strides in reform: for example, Italy has deemed that denying citizenship to persons who are unable to swear oaths of allegiance due to their disability is unconstitutional.[325]

Engagement of persons with disabilities and OPDs

Migrants and displaced persons with disabilities can be invisible within both migrant and displaced persons groups and OPDs.[326] This exclusion can mean their experiences, concerns, skills and input are often not represented in programmes and policies for migrants and displaced people and/or persons with disabilities. However, there are positive examples of more inclusive practices (*Box 3.12*).

Box 3.12 Engagement of persons with disabilities and OPDs

- In Sweden, the Mutual Integration and Right to Work aims to help refugees with disabilities overcome barriers to employment, including supporting their understanding of Swedish society and the labour market.
- The Centre for Disability in Development and CBM helped establish disability committees in Rohingya refugee camps in Bangladesh.[327] These committees were led by refugees with disabilities, who voiced the concerns of refugees with disabilities and helped develop strategies to enhance their inclusion within the camp.
- The International Labour Organization (ILO) TRIANGLE programme has organized trainings in Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam with migrant and disability rights groups to address issues facing persons with disabilities in labour migration.[328]

Climate change

Human-induced climate change is "a change of climate which is attributed directly or indirectly to human activity that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time periods".[329] Climate change and its drivers are increasing the severity and frequency of climate hazards, which can be gradual (e.g., changes in temperature, rainfall patterns and sea-level rise), as well as sudden onset (e.g., extreme weather events such as heatwaves, hurricanes, drought, floods).[g] Climate hazards have far-reaching consequences, including through threats to health, disruption of livelihoods, diminished well-being and mortality.[330] The impacts of climate change disproportionately affect marginalized groups and exacerbate existing inequalities, including for persons with disabilities (*Box 3.13*).[331,332] As such, climate action must be shaped by equity and inclusion of persons with disabilities.[333]

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[g] This chapter will also talk about air pollution as a climate hazard. Many air pollutants are worsened by human activities that drive climate change (e.g., burning of fossil fuels, deforestation, certain agricultural practices). Extreme weather events, such as wildfires or dust storms in drought conditions, can also increase some forms of air pollution. Some forms of air pollution can also accelerate climate change (e.g., by trapping heat).

What are the key impacts of climate change for persons with disabilities?

Box 3.13 What factors affect persons with disabilities' risks from climate change?

Persons with disabilities are disproportionately affected by climate change because of the interplay of several factors:

- **Greater exposure to climate hazards:** Persons with disabilities are more likely to live in poverty, which can increase exposure, and limit their capacity to prepare and adapt to, climate hazards (e.g., air pollution, extreme temperatures and floods).[334,335,336,337,338] Their exposure is also affected by inadequate housing and barriers to accessing protective measures (e.g., air conditioning).[339]
- **Heightened vulnerability when exposed to climate hazards:** The nature of some impairments and health conditions increases the risk of adverse outcomes when exposed to different climate hazards. For example, some persons with disabilities have difficulties with thermoregulation due to their impairment (e.g., spinal cord injuries, multiple sclerosis) or medications (e.g., many psychotropic drugs), increasing sensitivity to heat;[340,341] persons with autism, attention deficit hyperactivity disorder (ADHD), epilepsy and Parkinson's disease are more susceptible to some immune system responses triggered by air pollution.[342,343,344,345,346] Further, climate hazards can disrupt health, transport and other services.[347,348] As persons with disabilities are more likely to require these services, they are more affected by disruptions.[349]
- **Exclusion from climate change responses:** Persons with disabilities are routinely left out of climate adaptation, mitigation and response processes (*see below*).[350,351] This not only means they miss out on the benefits of these actions, but response strategies that do not consider disability can create even more disabling environments.

Worsening health and rising health-care needs

Climate change is **worsening physical health** due to the increasing spread of infectious diseases, heat-related illness, injuries, malnutrition and non-communicable diseases such as cancers and cardiovascular and respiratory conditions.[352,353,354,355] There is increasing evidence that persons with disabilities are disproportionately impacted. For example:

- Estimates from activists suggest that 90 per cent of persons with albinism in Africa die before the age of 30 due to skin cancer,[356] with risks increasing with more frequent exposure to high temperatures.[357]
- Persons with disabilities in Bangladesh were more likely to experience negative health outcomes (e.g., infectious disease, malnutrition) during and in the aftermath of extreme weather events than persons without disabilities.[358]
- In Kiribati, Solomon Islands and Tuvalu, persons with disabilities reported that they were deprioritized in the division of food within the household during food shortages triggered by climate change.[359]
- In urban areas of South Korea, persons with disabilities were five times more likely to seek medical care for heat-related illness during heatwaves than persons without disabilities.[360]

Mental health outcomes are also worsening due to climate change for many reasons, including discomfort from higher temperatures and air pollution, trauma caused by extreme weather events and the stress from disruptions to livelihoods, food security and access to needed services.[361,362,363] Persons with disabilities, particularly persons with pre-existing psychosocial disabilities and those facing intersectional discrimination (e.g., based on gender, race, ethnicity, Indigeneity), can be particularly at risk.[364,365] For example, Indigenous persons with disabilities' connection to ancestral land and water is significantly threatened by climate change – which, on top of disability discrimination and intergenerational trauma, affects their mental well-being.[366] One study found that Black and Hispanic persons with disabilities were more likely to have symptoms of anxiety and depression compared to white persons with and without disabilities following winter storm Uri in the United States.[367]

Climate change is a **driver of new or worsening disability**. For instance, long-term or in-utero exposure to air pollutants has been tied to the development of dementia, cognitive impairment, ADHD, psychosocial disability and autism,[368,369,370,371,372,373,374] while extreme weather events cause injuries that can impact people's levels of functioning and participation in society.[375] Shorter-term exposure to climate hazards can also worsen functioning. For example, heightened exposure to air pollution increased hospital admissions for multiple sclerosis in Italy by up to 42 per cent,[376] for autism and ADHD in South Korea by 3–17 per cent and 12– 68 per cent, respectively,[377,378] and the incidence of epileptic seizures by 4 per cent in Australia.[379] The negative effects of air pollution, heat and other climate hazards on persons with psychosocial disabilities have been extensively documented in many settings: it is estimated that every 1° C increase in temperature raises mental health-related morbidity (e.g., hospital admissions) by 0.9 per cent and mortality (e.g., suicides, overdoses) by 2.2 per cent.[380]

Climate hazards are also creating **disruptions to health, water and sanitation, transport, care and support and other systems**, which affect health and health-care access, particularly for persons with disabilities (see *Box 3.14*).[381] As an illustration, persons with disabilities in the United States had three times the likelihood of experiencing constrained access to health care post-Hurricane Harvey.[382] Similarly, people living in areas of Japan affected by serious flooding were twice as likely to have long-term care and support discontinued compared with people in non-affected regions.[383] These disruptions can have dire consequences: mortality among persons in nursing homes in the United States increased during Hurricane Irma,[384] particularly for facilities with power outages.[385]

Livelihoods

The livelihoods of persons with disabilities **are often at high risk from the effects of climate change**. Rural livelihoods, such as agriculture, fishing and animal husbandry, are among those most at risk to climate hazards.[386] An analysis across 10 countries found that among young persons who were working, persons with disabilities were 27 per cent more likely to be in the agricultural sector than their peers without disabilities.[387] Adaptation responses, such as migrating to a new area, can be more difficult for persons with disabilities (*see section on migration and displacement, above*).[388]

Box 3.14 Access to safe water and sanitation in Bangladesh[h]

In flood- and cyclone-prone areas of Bangladesh, 13 per cent of people reported damage to their latrines as a result of these weather events. Nearly half of persons with disabilities whose latrines were damaged were unable to use an alternative source, due to distance, inaccessibility, fear of abuse and other concerns. As such, many reduced toilet use or had to follow toileting practices that were less safe and hygienic. One man who is partially sighted and deaf explained how he had to use the household's overflowing latrine, leading to his clothes "...getting ruined with faecal waste" and dirty water and faeces "splashing on me while defecating". Another man with a mobility limitation described how he had sustained injuries navigating muddy paths post-cyclone: "While going to the latrine with my crutch, I slipped and fell in the mud. My amputated leg hit a brick on the ground. I cut the upper part of the amputated leg, and blood came out. I used a plastic pot for my toileting at that time, and my mother or wife cleaned it..."

Restricted access to water sources forced many to wash in polluted floodwater, increasing health risks. The situation was even more complex for women with disabilities who menstruate and persons with disabilities who experience incontinence. Disruptions of water, sanitation and hygiene services led to a reduction in changing, washing and drying incontinence and menstrual materials. A mother explained: "I changed [my daughter's menstrual] cloths less frequently at that time... Due to remaining in an unclean condition for a long time, she faced allergies and rashes in her private parts due to [faecal] waste and menstruation."

Climate hazards can affect work productivity by making it unsafe or more difficult for people to work – especially those with jobs in outdoor settings or in environments without adequate climate regulation.[389,390,391,392] For example, it is estimated that people will lose the equivalent of 9 days of work in high-income and 19 days in low- and middle-income countries per year, if global surface temperatures increase by 1.5 ° C.[393] As described above, many persons with disabilities are more sensitive to the health effects of air pollution, heat and other climate hazards, meaning they may have even more lost workdays and earnings. In India, the gap in earnings between households with and without members with disabilities was highest in areas with the lowest quartile of rainfall and the highest quartile of annual temperature.[394]

Household members providing care and support can have reduced engagement in livelihood activities due to the additional care and support needs linked to climate change. For example, they may need to spend time ensuring persons with disabilities are protected from climate hazards (e.g., providing adequate hydration and cooling during hot temperatures), seeking health care and other services for climate-related health impacts, and navigating and rebuilding environments made inaccessible by climate hazards. In Vanuatu, family providers of care and support described how time spent on hygiene-related needs after cyclones damaged water and sanitation facilities reduced their engagement in income-generating activities.[395]

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[h] Source (unpublished): Inclusive Pathways to Climate-Resilient WASH in Bangladesh. Funded by the Australian Government Department of Foreign Affairs and Trade's Water for Women Fund.

Finally, persons with disabilities face additional **barriers to adapting their livelihoods** so that they are more resilient to the effects of climate change. They are more likely to live in poverty, and so many cannot afford the initial investment required to undertake adaptations, even if, in the long term, they lead to more sustainable livelihoods. They may also face barriers to accessing information about adaptation strategies linked to higher levels of illiteracy and lack of adapted forms of communication (*Box 3.15*), and exclusion from livelihood programmes (including for climate adaptation).

Box 3.15 Importance of accessible communication on climate change: experiences of deaf farmers in Zimbabwe[396]

Farmers who are deaf in Mashonaland, Zimbabwe, described difficulties getting information about climate change in sign language. Lack of information about how to protect crops and livestock in the face of climate hazards, in turn, led to economic losses. One man described the impact on his cattle business: "…I did not know anything about climate change and its impact…My cattle's health was deteriorating, there was a decrease in milk and meat production. I suffered a massive loss. When I consulted this friend of mine, he then explained [in sign language] that all this was happening because my animals were experiencing heat stress which was a result of climate change. And I cannot believe that all along I knew nothing about it."

Some efforts are being made to provide accessible information about climate change. For example, the Zimbabwe Sunshine Group, with funding from the Global Greengrants Fund, has been using theatre programmes with sign language to explain the implications of climate change for livelihoods.[397]

Education

Children with disabilities' access to **quality, inclusive education risks being further delayed** by climate change. For example, children with disabilities may be more likely to miss school due to their increased risk of illness and poor health from climate hazards; heightened negative impacts from lack of preparedness of schools (e.g., hot classrooms, no evacuation plans for students with disabilities); or challenges getting to and moving around school because of reduced accessibility. Further, school systems can be disrupted by extreme weather events and other climate hazards, with inclusive education services particularly impacted: in Puerto Rico, 1 in 10 students with disabilities were still not receiving special education services a year after Hurricanes Maria and Irma.[398]

Participation and well-being

Climate change can reduce persons with disabilities' **engagement in daily life activities**. For example, worsening health brought on by climate change can restrict participation, as can loss of or reduced access to assistive products and personal assistance (e.g., batteries draining more quickly on electric wheelchairs in the heat). Increased rainfall and flooding can amplify transportation and environmental barriers, making commuting and movement more difficult, particularly for persons with mobility limitations.[399] Additionally, pre-existing social exclusion – which is more common among persons with disabilities[400] – can increase the risk of poor outcomes during climate hazards: for instance, people living in socially isolated conditions with limited access to health care and health information are most likely to be affected by heatwaves.[401]

Stress and strain caused by climate change and hazards have been **linked to increasing violence**, including gender-based violence.[402,403,404] Persons with disabilities are already more likely to be the targets of violence and discrimination, which can be exacerbated with rising tensions in the community. For example, persons with disabilities face additional water insecurity due to climate change: in Bangladesh, Malawi and Vanuatu, this limited access to water for bathing hindered personal hygiene, intensifying stigma and isolation.[405,406] Water scarcity, which often necessitates longer travel distances to more remote areas, may place women and girls with disabilities at greater risk of gender-based violence.[407]

Poverty

Climate change is predicted to increase the number of people living in extreme poverty by 68–132 million by 2030.[408] Persons with disabilities are likely to be overrepresented in these numbers. Poverty increases underlying vulnerability to the negative impacts of climate change (e.g., worsening health, deteriorating livelihoods), and persons with disabilities are more likely to be poor.[409] Climate change will then further exacerbate poverty and inequality, particularly for people with disabilities, given the disproportionate negative impacts on livelihoods, health, education and other areas described above. As such, climate change will lead to new or deepening poverty for many persons with disabilities. It also **limits strategies to escape poverty** by eroding the resources needed to strengthen livelihoods, protect health and ensure access to services.

Climate change **brings additional costs that push people into poverty**, including rising food and energy prices and expenses to offset livelihood, health and other impacts of climate change (e.g., repairing damage from extreme weather events, undertaking climate adaptations, paying for additional health care). Many persons with disabilities are already living in poverty and face disability-related costs, so have a lower capacity to pay for these additional climate change-related expenses. They may also be more likely to incur these expenses. For example, persons with disabilities in the United States were more likely to have their houses condemned after a hurricane, and they spent a higher proportion of their income covering repairs.[410] Meanwhile, energy insecurity is a critical concern for persons with disabilities, particularly those who rely on electricity-powered medical and assistive products or who have difficulties with thermoregulation without cooling and heating.[411] Yet studies from multiple settings, including South Africa, Nigeria, Guatemala and Mauritania, have found that persons with disabilities have lower access to electricity and other forms of essential energy[412,413,414] and have more difficulties paying: across the European Union, persons with disabilities were more at risk of energy poverty.[i,415] In Australia, persons with disabilities faced a heightened risk of eviction and homelessness, driven in part by rising fuel costs.[416]

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[i] More than 10 per cent of household income spent on energy costs.

Recommendations for more inclusive climate responses

A 'just transition' emphasizes that climate action must be inclusive and fair for all, and avoid widening inequalities.[417] To achieve this, disability inclusion across climate mitigation and adaptation responses, and to respond to climate-related loss and damage (e.g., of property, infrastructure, income, cultural heritage), is essential. Climate mitigation focuses on decreasing the magnitude of climate change, such as by reducing greenhouse gas emissions. Climate adaptation involves actions to help individuals and communities cope with the current and future impacts of climate change. Some actions combine mitigation and adaptation (e.g., green economy jobs can reduce greenhouse gas emissions and create more resilient livelihoods to withstand the impact of climate change).

Disability-inclusive climate responses generate greater benefits, given the disproportionate impacts of climate change on persons with disabilities. Inclusive responses can also be an opportunity to address wider barriers to participation and inclusion that persons with disabilities face. Further, inclusive responses harness the knowledge and skills of persons with disabilities as agents of change in tackling the climate crisis.[418]

A twin-track approach will be needed. Disability must be mainstreamed across existing and upcoming climate change response and policies (e.g., through training on disability for practitioners involved in mitigation and adaptation planning, budgeting for accessibility, evaluating potential impacts on persons with disabilities). Targeted programmes and policies are also necessary to address climate change impacts that are more relevant to persons with disabilities (e.g., maintaining continuous access to health and community services, accessible housing, electricity, care and support and other services).

Create inclusive climate change policies and governance

The needs and views of persons with disabilities are rarely considered when designing climate change policies and programmes. For example, a systematic review of over 1,680 articles on climate adaptation responses reported that only 1 per cent considered persons with disabilities, the least of any of the other marginalized groups assessed (e.g., ethnic minorities, migrants, young people).[419] Moreover, 81 per cent of States Parties to the Paris Agreement on Climate Change did not reference disability at all in their Nationally Determined Contributions (NDCs), and most of those that did had few meaningful provisions.[420]

It is essential that persons with disabilities and OPDs – representing persons with diverse backgrounds (e.g., young people, women and girls, Indigenous people) – are actively involved in designing, implementing, monitoring and negotiating on climate change policies and programmes.[421,422,423] One way to achieve this is the recognition of a disability constituency, similar to the constituencies formed by other groups, in the United Nations Framework Convention on Climate Change (UNFCCC) Conference of the Parties (COP) mechanism.[424] Budgeting for accessibility and reasonable accommodations must be included across consultation processes, including for NDCs.[425] Similarly, disability inclusion must be embedded across NDCs and National Adaptation Plans. Disability inclusion metrics must also be integrated into results frameworks, monitoring systems and evaluation of programmes.

Ensure climate adaptation and mitigation responses are disability-inclusive and address heightened risks among persons with disabilities

In line with the Paris Agreement, countries across the world are implementing a range of actions at local and national levels to protect against the risks of climate change and to reduce and reverse the magnitude of climate change. For these strategies to be effective, equitable and in line with the principles of climate justice, it is essential that they are inclusive of marginalized and vulnerable populations and groups, including people with disabilities. There are opportunities to redress existing barriers to inclusion within many climate actions. Strategies for more inclusive responses include, but are not limited to:

Enhance participation in the green economy

Participation of persons with disabilities in the green economy can accelerate climate mitigation efforts and generate more sustainable, climate-resilient livelihoods (*Box 3.16*). The shift to a green economy is creating new job opportunities across sectors (e.g., climate-smart agriculture, waste management, recycling and eco-industries). Accessible, inclusive workplaces and training are vital to ensure inclusion of persons with disabilities in the growing green economy.[426,427,428] These opportunities can also contribute to closing the disability employment gap and harness the experiences and expertise of persons with disabilities across the sector.

Box 3.16 Examples of inclusion of persons with disabilities in the green economy

India: Disability-inclusive climate-smart agriculture[429]
CBM India trained farmers in organic practices to improve soil resiliency and reduce the need for polluting agrochemicals. The programme promoted inclusion of persons with disabilities through accessible trainings and increased leadership of persons with disabilities.

Canada: Energy Advisor Recruitment, Training and Mentorship Campaign[430]
The campaign aims to increase workforce diversity, with a focus on Indigenous peoples and persons with disabilities. The programme offers training, mentorship and exam preparation to help candidates become certified energy advisors.

Ensure access to social protection and reduce costs of climate change

Many actions that individuals and households take in response to climate change require resources (e.g., investing in climate-resilient housing, migrating to areas less affected by climate hazards, adapting livelihoods, seeking additional health-care services and products in relation to health-related impacts from climate change). However, as described above, many persons with disabilities have both heightened costs and lower capacity to pay.

Social protection, including cash transfers, public works programmes and social insurance, has a key role to play in inclusive climate action.[431,432] It can help households to maintain basic needs in the face of climate change-related shocks and pressures, and put in place protections to minimize future impacts (*Box 3.17*).[433,434] For example, social insurance, including for climate-related risks such as flood, crop and livestock insurance, can help individuals and households cope when their health, livelihoods and well-being are affected by climate hazards. Meanwhile, cash and in-kind transfers can provide persons with disabilities with key resources (e.g., food aid, provision of health products). Further, public works programmes and cash-plus programmes with livelihoods components can both strengthen livelihoods and enhance climate mitigation and adaptation (e.g., support climate-resilient agricultural practices).[435,436] However, without adequate attention to inclusive and participatory design and implementation, people with disabilities are likely to be excluded from these programmes (*see Chapter 4*).

Persons with disabilities may require exemptions from certain policies designed to combat climate change (*Box 3.17*). For example, taxes and charges for private transportation, single-use plastics and energy use can disproportionately affect persons with disabilities if sustainable options are not inclusive or suitable (e.g., lack of accessible public transport).

Box 3.17 Examples of social protection and other strategies

Indonesia: Expanding social protection[437]
Modelling estimations found existing social protection programmes were insufficient to protect many people, but particularly persons with disabilities, from income shocks related to extreme weather events. However, proposed reforms, such as a top-up cash transfer delivered to affected households, provided enhanced protection from poverty.

Kenya: Albinism Sunscreen and Support Programme[438]
Sun exposure is a particular risk for persons with albinism due to their lack of melanin, putting them at increased risk of skin cancer. The National Council for Persons with Disabilities in Kenya provides one bottle of sunscreen monthly and protective clothing to the over 3,000 persons who are registered as having albinism.

Milan, Italy: Exemptions from congestion pricing[439]
Persons with disabilities can be disadvantaged by efforts to reduce use of private transport, as public transportation systems may be inaccessible or unfeasible for them to use. In an area of Milan's historic city centre known as Area C, a road pricing measure has been implemented to reduce vehicle congestion and pollution. However, the city exempts cars transporting persons with disabilities from these charges.

Mainstream accessibility in sustainable infrastructural development

Buildings, systems and spaces are being developed, upgraded or rebuilt in response to climate change. Examples include: expanding sustainable transportation options to reduce greenhouse gas emissions and improve air quality; creating urban green spaces and other green infrastructure to dissipate heat and promote biodiversity; reconstruction of buildings after extreme weather events; or renovating infrastructure to increase energy-efficiency and climate resilience. However, these initiatives can create additional barriers to inclusion if they do not consider the needs and potential impacts on persons with disabilities. For example, elevating buildings to reduce exposure to floods worsens access for persons with disabilities unless paired with accessibility measures (e.g., adding ramps and lifts). Meanwhile, urban green spaces and sustainable transportation often do not consider accessibility and may be less available in poorer neighbourhoods.[440,441,442]

Instead, with proper planning and financing, these initiatives can be opportunities for accelerating accessibility (*Box 3.18*). For example, accessibility standards should be adhered to when building or adapting infrastructure.[443] They can also promote better participation of persons with disabilities in these efforts (e.g., adding Braille signage and adjusting heights of recycling bins enables persons with disabilities to recycle; accessible public transportation reduces private transportation use for some persons with disabilities).

Box 3.18 Examples of mainstreaming accessibility in green infrastructure

Mexico City, Mexico[444]
In Mexico City, improper parking of bikes and scooters on sidewalks led to complaints of restricted access to buildings and reduced mobility and safety for persons with disabilities. As such, the city initiated a data-gathering exercise to guide the establishment of designated parking zones to ensure sidewalks and crosswalks are kept clear and available for use by persons with disabilities.

European Union[445]
The Renovation Wave is a strategy to improve energy efficiency in 35 million buildings across the European Union by 2030. Ensuring equal access to renovated buildings for persons with disabilities through a focus on accessibility is part of the action plan, as is using renovations as mechanisms to address energy poverty, including for persons with disabilities.

Improve access to information and education on climate change

Accessible climate change education and information are essential to inform children, young persons and adults with disabilities about the risks of climate change, potential mitigation and adaptation strategies and to alert them in the event of emergencies.[446,447] Yet many persons with disabilities lack access to this critical information: for example, in India, many websites with information about community-level air and water pollution exposure were deemed not accessible.[448] Producing information in accessible formats is essential, as is addressing barriers to participation in awareness-raising and skills development activities (e.g., youth-led climate action groups, trainings in greening skills).

Establish inclusive disaster risk reduction policies and practices

Inclusive Disaster Risk Reduction (DRR) ensures that persons with disabilities are protected during extreme weather events. It includes measures such as vulnerability, needs and risk assessments to identify persons with disabilities who would need support in an emergency, accessible early warning signs, inclusive evacuation procedures and improving resiliency to climate hazards (*see section on humanitarian crises and emergencies, below, for more details*).[449,450,451]

Humanitarian crises and emergencies

Humanitarian crises and emergencies are on the rise globally and are becoming increasingly complex and protracted.[452,453] Humanitarian crises and emergencies include:[454]

- **War and conflict:** It is estimated that 1 in 4 people globally are impacted by conflicts.[455]
- **Natural hazards**, including floods, earthquakes, hurricanes, tsunamis and wildfires: These crises are becoming more common due to climate change.[456]
- **Health emergencies** such as the COVID-19 pandemic, Zika virus epidemic and outbreaks of diseases such as Ebola, cholera and dengue: Health emergencies can be triggered by conflicts and natural hazards (e.g., outbreaks of polio, cholera, malnutrition and other diseases can be caused by disruptions to food systems, water, sanitation and hygiene (WASH), and health infrastructure).

States are obligated under Article 11 of the CRPD to ensure the protection and safety of persons with disabilities during humanitarian crises and emergencies. Yet persons with disabilities are often excluded from prevention and preparedness planning, national emergency and humanitarian responses, and recovery processes.[457,458,459,460,461] This exclusion risks being magnified with rising funding shortfalls for humanitarian action, as persons with disabilities and inclusive measures are de-prioritized.

What are the impacts of humanitarian crises on persons with disabilities?

Survival, health and access to health services

Persons with disabilities face a heightened **risk of dying** during humanitarian crises and emergencies, as they encounter additional difficulties evacuating, fleeing and staying safe (*Box 3.19*). For example, persons with disabilities were two to four times more likely to die in the 2011 Great East Japan Earthquake compared to persons without disabilities,[462] while, globally, persons with disabilities were almost three times more likely to die from COVID-19.[463] Violence directed at persons with disabilities can escalate during conflicts, including targeted killings, being used as suicide bombers, and as human shields.[464,465] Further, they often miss out on life-saving health and emergency services due to discrimination and lack of disability-inclusive protocols in evacuation and responses.[466,467] There are also disproportionate impacts of loss of essential services, such as electricity, for some:[468] a study in the United States found only half of surveyed families with a child who required an electricity-powered device for survival had a backup source.[469]

Crises increase the number of persons acquiring new disabilities and result in worsening health for persons with disabilities.[470,471,472] For instance, 23–25 per cent of Syrian refugees in Jordan, Lebanon and Türkiye have disabilities,[473,474] while in Libya, there were over 14,000 officially reported disabilities from conflict-related injuries from 2012 to 2017..[475] Further, many survivors of disease outbreaks, including COVID-19, Ebola, poliomyelitis and Zika, develop long-term disabilities.[476,477,478] Disability and worsening health can be caused directly by crises (e.g., injuries, exposure to trauma). They can also result from worsening access to health care and other essentials, including WASH, housing, food, care and support, assistive products and medications.[479] Persons with disabilities have a higher need for these goods and services to support health and well-being,[480] and so are disproportionately impacted by their disruption.[481] Further, transitional and emergency services – when available – are often inaccessible.

Box 3.19 Difficulties accessing protective measures in crises for persons with disabilities

During **COVID-19**, key information was often not provided in accessible formats (e.g., sign language, Deafblind interpretation, Braille, screen-reader compatible, easy-to-read). A man who is deaf in Thailand explained how sign language interpreters on TV often wore masks, but he and other persons who are deaf "need to see facial expressions to better understand sign language". Avoiding physical contact was often not possible for persons who are blind and needed to touch surfaces to move around. Persons with psychosocial and intellectual disabilities did not always understand guidance or faced increased distress following protocols. A non-binary person with autism in Peru described: "They wouldn't let me in [the health centre] with any companion…it makes me very anxious to be alone in places I don't know."

During an **earthquake in Türkiye** a woman with physical disabilities described how she was left behind: "My family members dashed out. My daughter was at work, and they dashed out, leaving me behind. I couldn't go downstairs."[482] In the aftermath of the earthquake a man who is blind described the inaccessibility of safety instructions: "They show on television what we can do visually, but we can't see them. I mean, we can't even see how to do the 'drop, cover and hold on' movement, for instance."[483]

When **conflict escalated in the Central African Republic**, persons with disabilities faced challenges fleeing violence, with many abandoned and left behind.[484] Those reaching camps experienced barriers to basic needs, including sanitation and health care. A man with physical disabilities living in a camp reported: "My tricycle doesn't fit inside the toilet so I have to get down on all fours and crawl. Initially I had gloves for my hands so I didn't get any [faeces] on them, but now I have to use leaves."

Importantly, **heightened exposure to trauma and distress – combined with non-inclusive MHPSS – increases the risk of poor mental health outcomes for persons with disabilities** (*Box 3.20*).[485,486,487,488] After a flooding event in Australia, persons with disabilities were more likely to report that their homes had been flooded, evacuation was inaccessible, their access to health and social care was disrupted, and housing was unsafe: as such, they had over three times the likelihood of PTSD compared with persons without disabilities.[489] Similarly, children with disabilities in Darfur, Sudan, and adults with disabilities in Ukraine reported poor mental health outcomes more often compared with their counterparts without disabilities.[490,491] Women and girls, including those with disabilities, have additional risks for poor mental health outcomes in crises, driven in part by violence and abuse (*see below*).[492,493,494,495] For persons with psychosocial and intellectual disabilities, distress is exacerbated by disruption to routines and care and support, as well as failure to provide easy-to-understand explanations of events.[496]

Box 3.20 Disability-inclusive mental health and psychosocial support

Limited disability inclusion in humanitarian contexts contributes to stress, social exclusion and isolation. Prior to the 2023 escalation of conflict, services for children who are deaf and hard of hearing in the Gaza Strip were already lacking.[497] Few were given the opportunity to learn sign language or access assistive products, such as a hearing aid, limiting communication, increasing isolation and worsening mental health. Additionally, children who are deaf and hard of hearing in this setting experienced disability-related discrimination, causing psychological distress. A child who is deaf reported, "They whisper and point at me that I'm dumb." Researchers and a local NGO, in partnership with CBM, OPDs, caregivers, teachers, MHPSS professionals and policymakers, and with input from adults and children who are deaf and hard of hearing, developed guidelines on inclusive school-based MHPSS for children who are deaf and hard of hearing in the Gaza Strip. The guidelines included actions such as improving teachers' abilities to recognize signs of distress and knowledge of inclusion, inclusive MHPSS activities, and promoting deaf culture within schools.[498]

Education

Children with disabilities **face additional challenges attending schools during crises**. In the aftermath of the 2010 earthquake in Haiti, children with disabilities were more than twice as likely to be out of school compared with children without disabilities.[499] Schools and travel to school can become more inaccessible, inclusive education services may stop, or alternative options (e.g., remote teaching) may not be inclusive.[500,501,502] There are reports of children with disabilities being turned away from education services during emergencies, for example if humanitarian organizations do not feel equipped to educate them or teachers fear that they would not be able to evacuate them safely.[503,504] These barriers not only impact academic development, but also deprive children with disabilities of critical humanitarian assistance and child protection interventions delivered through schools (e.g., school feeding programmes, mine-risk education).[505] For example, children with disabilities in Turkana, Kenya, a complex humanitarian setting, were more likely to be malnourished than their siblings or neighbours without disabilities due in part to exclusion from schools, where feeding programmes were delivered.[506] However, there are examples of steps taken to provide inclusive education during crises (*Box 3.21*).

Box 3.21 Examples of supporting access to education for children with disabilities

- To improve access to education in the Central African Republic, a conflict-affected context, UNICEF expanded an existing cash transfer to reach children with disabilities.[507] Receiving the cash transfer was conditional on children having an 80 per cent school attendance rate, motivating parents to send their children to school. School accessibility was improved, alongside other initiatives, such as assistance reaching school. Within two years, attendance rates improved, so that nearly all children with disabilities in the programme were attending.
- *Ahlan Simsim* is an Arabic version of Sesame Street, combining a TV show with in-person and online programmes to help young children to learn and process emotions related to crises, and to support caregivers to help their children learn. It features characters with disabilities, trains staff and caregivers on disability inclusion, and provides inclusive activities and materials. It is considered the largest early childhood development initiative in a humanitarian setting, reaching over 3.5 million children and caregivers across the Middle East and North Africa.[508]

Livelihoods and poverty

Humanitarian crises and emergencies can **exacerbate existing challenges to maintaining decent livelihoods** for persons with disabilities and their households.[509] Persons with disabilities often have less stable livelihoods pre-crisis (e.g., lower earnings, fewer protections) (*see Chapters 1 and 4*), and barriers can become heightened (e.g., increasingly inaccessible environments, loss of required care and support). For example, in Viet Nam during COVID-19, persons with disabilities were two to three times more likely than persons without disabilities to to report that they stopped working, and that the pandemic had caused a large negative impact on household finances and their ability to get food.[510] In Afghanistan and western Darfur, households with members with disabilities had some of the highest levels of multidimensional poverty, with women and girls at an even higher risk.[511,512] In conflict settings, persons with newly acquired disabilities are often men – in northwest Syria, 83 per cent of people with conflict-acquired disabilities were men of working age.[513] In contexts where men are the primary or sole breadwinner, time out of work due to recovery or newfound disability discrimination in employment can have profound impacts on household poverty.

Humanitarian assistance (e.g., public works programmes, food aid and cash and voucher assistance) is essential for many to meet basic needs, reduce poverty and protect livelihoods during a crisis (*Box 3.22*). Yet persons with disabilities can encounter difficulties accessing many programmes. For example, food aid can be unsuitable for persons requiring a special diet (e.g., persons with difficulties swallowing or chewing, or persons with autism with specific food preferences), and distribution points can be inaccessible.[514,515] Cash for work programmes may offer only a limited range of jobs, and may not provide reasonable accommodations, and staff may have biases about the ability of persons with disabilities to work.[516]

Persons with disabilities can also face disrupted access to existing social protection benefits. In Ukraine, persons with disabilities in areas annexed by Russia in 2014 had to cross into government-controlled territories to receive their disability benefits, a difficult and dangerous journey over conflict front lines.[517] Benefits, which are already often insufficient to cover both basic needs and disability-related costs, often become even more stretched with rising inflation and other costs triggered by crises.[518,519,520]

Box 3.22 Examples of programmes to improve livelihoods and financial security

Humanity & Inclusion and the World Food Programme (WFP) launched a pilot programme in South Sudan to improve livelihood opportunities and food security for persons with disabilities.[521] The project included a situational analysis with OPDs to identify barriers and enablers to inclusion across programmes, training over 200 staff and mainstreaming inclusion across WFP and partner activities.

In Syria, UNICEF, in partnership with the Ministry of Social Affairs and Labour and NGOs, has run an integrated social protection programme since 2016, reaching over 30,000 children with disabilities. The programme provides a monthly cash transfer combined with case management services. A programme evaluation found households were better able to meet their food needs, and increased their spending on health care and education for children by 112 per cent and 124 per cent, respectively. Additionally, over 25 per cent of children began receiving needed health care and 9 per cent gained access to education services.

Violence and abuse

Persons with disabilities are more vulnerable to violence, abuse, neglect and exploitation in humanitarian crises.[522,523] Importantly, crises can worsen stigma and discrimination against disability, particularly when resources are scarce.[524,525] Elevated stress and burn-out in persons providing care and support, and the loss of trusted care and support networks due to disruption or displacement, increase the risk of neglect and violence.[526,527]

Persons with disabilities living in institutions often face abandonment and dangerous conditions. For example, at the start of the war in Ukraine, at least 42,000 children with disabilities were rapidly discharged from institutions – often to families who had previously claimed they were unable to care for them – without any follow-up or assessment.[528] Meanwhile, children and adults remaining in institutions have faced worsening conditions as staff flee, medical and food supplies dwindle, and spaces become overcrowded.[529] The lack of accessible shelters and other protections can also lead to institutionalization of persons with disabilities who had previously been living independently, which can continue even after crises resolve.[530]

Gender-based violence (GBV) is a serious concern during humanitarian crises (*Box 3.23*). Women and girls with disabilities already have a heightened risk of many forms of violence,[531,532] which is further elevated in a crisis. For example, women and girls with disabilities in Nepal reported increased psychological, physical and sexual violence after the 2015 earthquake, especially around temporary shelters.[533] Inaccessible WASH facilities in shelters pose particular concerns, as GBV can increase if there are no private and safe facilities for women and girls with disabilities to use, or if loss of trusted support networks means they have to rely on others for access.[534,535] In one GBV response centre in a refugee camp, 44 per cent of Somali women accessing services had disabilities:[536] these numbers likely underestimate the true risk of GBV during crises among women and girls with disabilities, as they can face additional difficulties reporting violence, being believed and using often inaccessible protection services.[537,538] In Ukraine, there are reports of fake and potentially forced marriages of women with disabilities, to allow men to avoid military service by gaining the legal right to leave the country for treatment.[539,540]

Box 3.23 Inclusion of women and girls with disabilities in GBV response[541]

The Women's Refugee Commission and the International Rescue Committee worked together to change knowledge and attitudes on disabilities among humanitarian actors working on GBV. Many actors felt ill-equipped to provide GBV services to persons with disabilities, resulting in restricted access to services and reduced opportunities for women and girls with disabilities to participate in planning and programming. Involving women and girls with disabilities during training of GBV practitioners increased their confidence in disability-inclusion. Further, women and girls with disabilities became more active in GBV responses, hosting community discussions, becoming members of refugee committees, and working with NGOs as community volunteers.

Recommendations for more inclusive humanitarian actions and emergency responses

Article 11 of the CRPD has spearheaded critical progress in protecting persons with disabilities during crises and making humanitarian action more inclusive.[542] The Inter-Agency Standing Committee (IASC)[j] Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action provides detailed recommendations, developed in partnership with persons with disabilities and OPDs through an extensive global and regional consultation process.[543] Additionally, United Nations Security Council Resolution 2475 focuses on the protection of persons with disabilities in armed conflict,[544] and the Sendai Framework for Disaster Risk Reduction (2015–2030) includes persons with disabilities as stakeholders in disaster preparedness.[545,546]

The IASC guidelines define four 'must-do' actions for disability-inclusion across humanitarian activities: **(1) meaningful participation; (2) removal of barriers; (3) empowerment and capacity-building; and (4) the collection, use and analysis of disaggregated data for monitoring inclusion**. These actions must be integrated across the humanitarian programme cycle (e.g., needs assessments, strategic response plans, monitoring) and across different phases of crises and emergencies (i.e., preparedness, response and recovery).[547,548]

Promote meaningful participation and enhance capacities of persons with disabilities

Men and women with different types of impairments and intersecting marginalized identities (e.g. based on race, sexuality, religion) and OPDs must be engaged in **global and local humanitarian decision-making processes, coordination forums, implementation and monitoring**.[549] OPDs often play critical roles in humanitarian action, connecting persons with disabilities to information, humanitarian assistance, key services (e.g., education, assistive technology) and advocating for more inclusive responses (*Box 3.24*). However, persons with disabilities and OPDs frequently report ongoing barriers to participating in humanitarian policies and programming or feel their roles are tokenistic.[550,551] They are also often underfunded by donors despite the critical roles they play.[552,553] Support and capacity-building, including dedicated and sustainable funding, for persons with disabilities and OPDs are key to enable meaningful participation.[554]

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[j] The Inter-Agency Standing Committee is the United Nations system's highest-level humanitarian coordination forum.

An important advancement in meaningful participation is the formation of the IASC Disability Reference Group, a platform for cooperation for inclusive humanitarian action between OPDs, governments, development agencies and civil society. It facilitates collective action and shared learning and assists in operationalizing IASC policy, guidance and tools.[555,556]

Box 3.24 Critical importance of OPDs in humanitarian action

Persons with disabilities and OPDs have been active in preparing for and responding to crises in different settings, holding humanitarian systems to account, and filling gaps when government or other official responses inadequately include persons with disabilities.[557,558,559,560,561,562] Examples include:

- **Nicaragua:** OPDs contributed to the National System for Disaster Prevention, Mitigation and Attention, resulting in disability-inclusive state programmes and plans for responding to disasters or emergency situations.[563]
- **Ukraine:** OPDs have led war response and recovery efforts, providing key services to persons with disabilities (e.g., assistive technologies, MHPSS, transport), collaborating with government bodies and international partners on disability inclusion, modelling deinstitutionalization projects, and providing leadership training of women and girls with disabilities.[564,565,566]
- **Philippines:** An OPD, the Deaf Disaster Assistance Team-Disaster Risk Reduction, worked with the Philippines Red Cross and the Cebu government to conduct regional trainings on providing accessible communication during a crisis. These trainings improved the capacity of community leaders who are deaf and sign language interpreters to act as first responders in the event of a crisis.[567]

Remove barriers to inclusion across humanitarian action

Disability-inclusion must be at the forefront of planning and action across the humanitarian programme cycle, including preparedness, needs analysis, response and monitoring (*Box 3.25*). Ensuring inclusive policies and programming requires the **removal of attitudinal, environmental, communication and institutional barriers**, including through training and confidence-building for humanitarian actors, adequate financing for inclusion, meaningful participation of persons with disabilities and OPDs, and implementation of accessibility standards.[568,569,570,571] Donors also play an important role in pushing for inclusion: for example, World Bank-funded projects in India and Bangladesh required that all shelters comply with universal design principles.[572]

Box 3.25 Examples of inclusive planning and response

- **Vulnerability, needs and risk assessments:** Assessments should focus on the specific needs of individuals with disabilities during a crisis (e.g., continued access to medications, assistive technology, care and support; accessible shelters and information) and how they are being impacted by the crisis. This information is used to develop personal preparedness plans and inclusive local as well as national preparedness and response actions (e.g., stockpiling of assistive technology, training of humanitarian response teams, establishing partnerships with OPDs, preparation for inclusive services).[573]
- **Inclusive preparedness plans:** Inclusive preparedness planning is critical to ensure support to individuals can be quickly deployed, and that local and national evacuation routes and procedures are accessible.[574] Humanitarian actors, rescue and emergency response teams, persons with disabilities and providers of care and support must be trained on inclusive evacuation and other emergency protocols (e.g., bringing medications and assistive products when evacuating).[575] Specific procedures for schools and residential facilities (e.g., assisted living, long-term care homes) and for persons with special health-care needs are crucial. Additionally, individual preparedness plans are important for some persons with disabilities. Globally, 39 per cent of persons with disabilities reported that they would have difficulties evacuating without assistance – but one in four people did not have someone who could assist them in the event of an emergency and 84 per cent did not have a personal preparedness plan.[576,577]
- **Accessible early warning systems:** Ensuring timely evacuation and other actions can be bolstered through early warning systems and communications.[578] However, often this information is not disseminated through accessible formats to reach persons with different communication requirements (e.g., sign language, Deafblind interpretation, visual and audio information, easy-to-read formats). Early warnings systems should also consider that some persons with disabilities will need additional time to prepare or may begin facing harms at an earlier stage in a crisis. Early Warnings for All, launched in 2022, seeks to provide more inclusive disaster communication, including through co-production of messaging with OPDs.[579]
- **Coordinated assistive technology provision:** WHO Europe and Ukraine's Ministry of Health, with support from ATscale, have spearheaded efforts to enhance access to assistive technology for civilians affected by the war in Ukraine. Through this partnership, the WHO AT10 kits – comprising essential items such as wheelchairs, crutches and walking aids – have been distributed alongside integrated services, including fitting, training on use and maintenance. These efforts, implemented through 'Assistive Technology Clusters' within Ukraine's health-care system, have provided 2,458 assistive products across five oblasts, benefitting nearly 1,500 individuals.

Applying a **twin-track approach** makes actions more disability-inclusive.[580,581] Targeted programmes are essential, such as ensuring continual access to assistive products, medications and care and support during a crisis, and assistance in evacuating.[582,583,584] At the same time, inclusion should be mainstreamed across all programmes. Examples include establishing accessible shelters, information and evacuation routes, and creating inclusive programmes such as for GBV, MHPSS, health care, education and other forms of humanitarian assistance (*Boxes 3.20–3.26*). Failure to remove barriers to services increases the vulnerability of persons with disabilities before, during and after crises. For instance, inaccessible shelters, including in camps for refugees and internally displaced persons and evacuation centres, mean that persons with disabilities are forced to stay at home or experience discomfort, reduced autonomy and loss of dignity while using available facilities.[585,586]

Collect data to inform planning and monitor inclusion

Data collection is essential for identifying persons with disabilities, the barriers they face, their support needs, how they are impacted by crises and the extent to which current planning and programming is inclusive.[587,588] This information can support preparedness planning, as well as monitor inclusion in responses and recovery. Examples of data collection activities in which disaggregation by disability is important include vulnerability, needs and risk assessments (*Box 3.25, 3.26*), enrolment for refugees, displaced persons and migrants, registration for access to services and assistance, feedback and complaint mechanisms, and surveys of crisis-affected groups.[589] Data collection should explore differences amongst persons with disabilities as much as possible (e.g., by impairment type, gender and age). The Washington Group Questions is a common tool to disaggregate data by disability, particularly in surveys. However, depending on the intended purpose, collection of additional data on barriers and support needs is also often required.[590]

Box 3.26 Humanitarian Needs Overviews and Response Plans

Humanitarian Needs Overviews (HNOs) are comprehensive assessments conducted by humanitarian organizations, typically coordinated by the United Nations Office for the Coordination of Humanitarian Affairs. Their information is used to inform Humanitarian Response Plans (HRPs), which are crucial to delivering effective, coordinated humanitarian responses across actors and agencies. Annual reviews of HNOs and HRPs highlight that significant progress has been made, particularly on the collection of data on persons with disabilities. They also point to a need to strengthen translation of these data towards inclusive response planning.[591] For example, while many HNOs present disaggregated data on how persons with disabilities are impacted by a crisis, this information may not be reflected in how HRPs describe the ways in which barriers will be addressed.

Centre inclusion in recovery efforts

The wake of crises are an opportunity to 'build back better', centring disability-inclusion into new systems, infrastructure and norms that will shape the future of a society.[592] For example, infrastructure destroyed by conflict and natural hazards can be rebuilt in line with accessibility standards. Moreover, crises often increase the number of persons with disabilities, which highlight the need for more inclusive services, systems and societies. In many settings – such as El Salvador, Mozambique, Palestine and the United States – veterans with disabilities have used their political traction to push for disability rights.[593]

Persons with disabilities must be included in recovery processes, including peace-building, transitional justice and reconstruction (*Box 3.27*).[594,595] They must have equitable access to individual-level redress and support (e.g., reparations, access to justice) and to participation in society-wide processes (e.g., truth commissions, peace treaties, recovery plans). Greater inclusion can produce better outcomes for all: for example, more inclusive peace processes have been shown to be more durable.[596]

Persons with disabilities and OPDs have been critical in creating more inclusive recovery efforts. In Ukraine, OPDs have led recovery efforts such as training municipalities on how to improve physical, informational and digital accessibility in reconstruction projects, supporting access to rehabilitation and assistive technology for soldiers and others with conflict-acquired disabilities and building momentum for deinstitutionalization.[597,598,599]

Box 3.27 Women with disabilities in peace-building processes[600]

Women are often left out of peace processes – for example, only 6 per cent of peace treaty signatories between 1992 and 2019 were women. The inclusion of women with disabilities in peace-building is not tracked, but the combination of sexism, ableism and lack of accessible processes presents significant barriers to participation. As such, women with disabilities are frequently invisible in resulting policies and programmes. For example, many recent National Action Plans on women, peace and security are silent on intersections with disability. One exception is South Sudan's 2015–2020 National Action Plan, which has frequent references to women and girls with disabilities as a result of consultations with women with disabilities and OPDs.

An evolving care and support economy

The care and support economy refers to care and support work – both paid and unpaid, by persons inside and outside the household – and the persons who provide and require it.[601] Care and support work is essential for sustaining life and promoting the participation and well-being of all persons across the life-course, including children, working-age adults and older persons with disabilities.

The current care and support economy disproportionately impacts women and girls, who are overwhelmingly the primary providers of care and support – often in unpaid or underpaid work. This situation reinforces gender inequalities and limits their opportunities for school, work and social participation. The status quo also is inadequate in meeting the requirements of children and adults with disabilities: they frequently lack access to adequate care and support, and available services are often limited, unaffordable and rely on institutionalized provision. This hinders autonomy and inclusion and is in violation of the CRPD, including Article 19 (living independently and being included in the community).[602]

The care and support economy is in transition, shaped by a shifting demographic and socio-political landscape (*Box 3.28*). **The evolution of the care and support economy has profound implications for persons with disabilities**, as persons both providing and requiring care and support. There is an opportunity to develop disability-inclusive, age-sensitive and gender-responsive care and support systems that address the needs, rights and agency of those requiring and those providing care and support, and advance deinstitutionalization.[603] However, without appropriate policy and programmatic responses, persons with disabilities and their families are at risk of rising unmet needs for care and support, denial of rights and worsening poverty, participation and well-being. Importantly, there is a danger that strategies to address growing care and support gaps will reverse progress on deinstitutionalization.

Box 3.28 What drives the evolution of the care and support economy?

A combination of forces is creating **a growing gap in appropriate, CRPD-compliant care and support**.

The number of persons requiring care and support is rapidly rising, driven primarily by increased life expectancy and ageing populations.[604,605] By 2050, the global population of persons aged 60 years and above is projected to double, reaching 2.1 billion – with two thirds living in low- and middle-income countries.[606] Many older adults have functional limitations that generate care and support needs, including for the 34 per cent of adults in this age group with disabilities.[607] Alongside this rising prevalence of disability, the failure of many countries to make environments, systems and services accessible and inclusive for persons with disabilities amplifies the demand for care and support to overcome these barriers. For example, failure to invest in inclusive education increases the need for childcare for children with disabilities who are out-of-school, while adults with disabilities without access to assistive technology or who must navigate inaccessible environments will need additional human assistance.

The current structure of care and support – provided predominantly through unpaid work by women and girls – is unsustainable. As women increasingly participate in the labour market, the demand for care and support services outside the home is rising, including for childcare and support for older adults. Yet services, such as personal assistance or communication support, are limited, particularly in low- and middle-income countries. Low pay, poor working conditions and lack of training in turn restrict the development of a skilled care and support workforce. Additionally, many care and support services globally rely heavily on institutionalization. As demand for services outside the home increases, there is a serious risk that these models will become even more deeply rooted rather than shifting to less established, but rights-based approaches.

Persons with disabilities, as both persons requiring and providing care and support, must have equal standing in shaping the care and support agenda. They too are advocating for changes – for services that promote independent living, autonomy and community inclusion and for deinstitutionalization. Alongside women and other providers of care and support, they must be equally involved in co-design, co-advocacy and co-monitoring of care and support agendas.

A note on the terminology of 'care and support'

'Care' has been used to refer to a wide range of activities to support the life and well-being of others across the life-course. Over the past decades, the care economy has gained significant attention as feminist movements call for policies to reduce and redistribute unpaid work, promoting shared responsibility across genders and society.

However, 'care' has traditionally been associated with paternalistic approaches that position persons with disabilities as 'burdens' or 'dependents', leading to a history of medicalizing, segregating and disempowering them.[608,609,610] As such, the disability community uses the term 'support' when referring to adults with disabilities, to emphasize agency, autonomy and alignment with the principles of the CRPD. 'Care' is typically reserved for referring to children, including children with disabilities.

Increasingly, international frameworks and discourse have embraced the term 'care and support' – acknowledging both the necessary aspects of care and the importance of support systems that enable autonomy and participation for persons with disabilities.

What are the implications of an evolving care and support economy for persons with disabilities and their families?

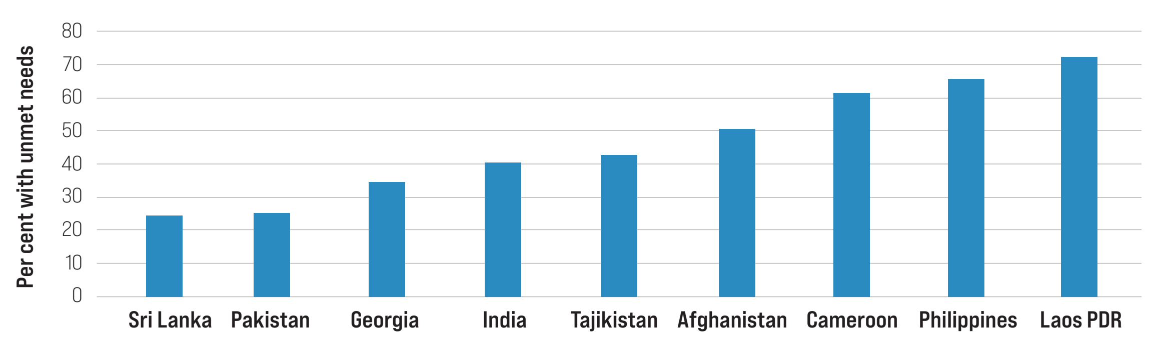
Unmet needs for care and support

Currently and historically, care and support for persons with disabilities has been provided predominantly by families – particularly by female family members, including mothers, daughters, wives, sisters and aunts. For example, in Chile, 94 per cent of human support provided to persons with disabilities was from family members, of whom 74 per cent were women.[611]

Despite efforts from families and communities, **persons with disabilities face a significant shortfall in accessing the care and support they require** (*Box 3.29*).[612,613,614] These gaps in care and support are at risk of widening as the unpaid support provided by families and communities becomes more stretched. For example, particularly in rural settings, working-age members are migrating to seek better opportunities for school and work (*see section on migration and displacement, above*). Meanwhile, societal norms are evolving, encouraging – and necessitating – the participation of women and girls in school and work.

Box 3.29 Unmet need for personal assistance amongst adults with disabilities

Across nine low- and middle-income countries, self-reported unmet needs for personal assistance among adults with disabilities were high. They ranged from 25 per cent in Pakistan and Sri Lanka, up to 72 per cent in the Lao People's Democratic Republic.



Source: Authors' calculations.[k]

Gaps will widen further without investment in services, including community-driven solutions. Formal care and support services remain severely limited or unaffordable in many regions, especially in low- and middle-income countries. Hiring and retention of care and support workers is hampered by poor compensation and unsafe, precarious working conditions. Further, there are rising global inequalities, as care and support workers from predominantly low- and middle-income countries migrate to high-income countries to fill gaps in those settings. For instance, in Organisation for Economic Co-operation and Development (OECD) countries, over a quarter of workers in the long-term care sector are foreign-born, while in the Arab States, 83 per cent of domestic workers are migrants.[615,616] At the same time, support provided by families and communities requires mechanisms and investment to alleviate and redistribute responsibilities.

Quality of care and support

Low pay, poor working conditions and job insecurity contribute to a high turnover of paid care and support workers, which not only affects the availability of services but its quality. Similarly, family and other unpaid providers of care and support face stress and burnout,[617] impacting how they provide assistance.

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[k] Based on Model Disability Surveys (Afghanistan 2019; Cameroon 2016; Georgia 2021; Pakistan 2015, Sri Lanka 2015), Brief Model Disability Surveys (Tajikistan, India and Lao PDR – all 2018), and the National Disability Prevalence Survey of the Philippines (2016). Unmet need defined as not having but requiring assistance, or having but requiring more assistance.

Further, both paid and unpaid providers **frequently have insufficient training and resources to deliver effective care and support** for persons with disabilities.[618] For example, childcare workers often do not receive training on working with children with disabilities, which can lead to the exclusion of children with disabilities from nurseries, daycare centres, formal education and other services. Parents and other caregivers of children with disabilities can lack information about disability and how to best support their child, which can lead to parental stress and poor child outcomes (*Box 3.30*).[619,620]

Qualifications and training for personal assistants, long-term care workers and other forms of human support can be inconsistent, inadequate or even non-existent in some settings. Existing training can lack evidence of effectiveness and fail to align to the needs of the user.[621,622] Addressing these gaps through **evidence-based, user-guided training and better support for both paid and unpaid providers** is essential for improving the quality of care and support delivered to persons with disabilities.

Box 3.30 Increasing skills of caregivers of children with disabilities[623,624]

Early care and support for children with disabilities is important to reduce mortality and improve child health, development, social inclusion and quality of life. The Ubuntu Hub brings together groups of children with disabilities and their caregivers to take part in participatory, group-based interventions that aim to help caregivers improve skills in caring for their child. Sessions are co-facilitated by 'Expert Parents', themselves caregivers of children with disabilities, alongside health-care professionals. Ubuntu programmes have been implemented in 40 countries, and studies have demonstrated improvements in child development and well-being, caregiver knowledge, confidence and quality of life.

Autonomy and participation

Inadequate access to quality care and support leaves persons with disabilities without the resources needed for autonomy and to participate equally in their communities. It can result in denial of many rights, including accessing health care and education, engaging in work and social life, and making decisions about one's own life.

Critically, conventional approaches to paid care and support services frequently **rely on institutional models that perpetuate segregation and disempowerment** (*Box 3.31*). These models include large-scale care homes, small group homes, nursing facilities and day services that isolate persons with disabilities from their communities. While long-term care and support services can be delivered in a variety of settings, investments in this sector have historically prioritized residential facilities.[625] This approach is contrary to the principles of the CRPD and restricts the agency and autonomy of persons with disabilities. Moreover, lack of choice, power imbalances between staff and residents, and insufficient oversight raises the risk of violence, abuse and neglect.[626] Recent events, including the COVID-19 pandemic and humanitarian crises in Ukraine and other settings (*see section on humanitarian crises and emergencies, above*), have further highlighted these dangers.[627,628]

Rising care and support gaps risk stalling and reversing progress on deinstitutionalization in many countries.[629] Many countries continue to invest in institutional models: for example, the population of older adults (aged 65+) in residential institutions has increased in 19 of 26 European Union Member States in the last 10 years.[630] To counter this trend, **investments in the care and support economy should focus on independent living. Deinstitutionalization efforts must continue to be accelerated**, with funds moving away from institutionalizing practices towards individualized and inclusive support services.[631] This includes personal assistance that provides one-on-one human support to persons with disabilities, granting them control on hiring, funding and service delivery.

Box 3.31 Children and institutional provision of care

Estimates suggest that 5–6 million children globally were in institutions in 2015, though actual figures may be higher due to unregistered facilities.[632] Children with disabilities face a significantly higher risk of institutionalization: in Europe and Central Asia, children with disabilities are between 6 and 30 times more likely to live in institutions than their peers.[633] In the European Union, around 171,000 children with disabilities lived in residential care between 2010 and 2016, with some countries reporting that up to 30 per cent of institutionalized children have disabilities.[634] Institutionalization of children has increased in some countries in recent years.[635] Factors driving institutionalization of children with disabilities include poverty, discrimination, lack of caregiver knowledge on disability, and insufficient community-based support.

Institutionalization carries many harms for children, including children with disabilities. Investigations have uncovered serious cases of abuse and neglect, including use of physical restraints in Russia, sexual violence against girls with disabilities in India, the use of caged beds in Greece, inappropriate use of psychotropic medication in Serbia, and the shackling of children with disabilities in Ghana and Indonesia.[636,637,638,639]

Economic empowerment and well-being

The evolving care and support economy carries short- and long-term implications for the economic empowerment and well-being of persons with disabilities and their families, as well as others in the care and support economy and societies at large.

Providers of both paid and unpaid care and support face barriers to decent work.[640] Family members, particularly women, frequently reduce their paid working hours or leave employment altogether to provide care and support.[641] This contributes to lower labour force participation among households with members with disabilities.[642] For example, in Norway, mothers of school-age children with disabilities had fewer working hours, lower earnings and reduced labour force participation compared with mothers with children without disabilities.[643] Children can also be providers of care and support, affecting their future opportunities for work: in Viet Nam and Tanzania, children with parents with disabilities were less likely to attend and progress in school.[644,645] Meanwhile, paid care workers – particularly migrant workers – experience precarious livelihoods, including low pay, unsafe working conditions, lack of access to social protection and denial of labour rights.[646]

Women and girls – including those with disabilities – are the main workers in the care and support economy, in both paid and unpaid roles. They are then most impacted by these barriers to decent work. This dynamic reinforces gender inequalities, limits women's opportunities for education, employment and financial independence, and places significant physical, emotional and financial strain on them.[647,648,649] Women with disabilities' roles as providers of care and support are often invisible, even though their contributions are significant:[650] a 2024 survey in the United Kingdom found that 70 per cent of people providing care and support had a long-term health condition, illness or disability themselves.[651] Persons with disabilities who provide care and support face additional barriers to decent work, including limited support services, increased physical and mental strain, and a lack of resources that address their dual role as a provider and recipient.

Receiving adequate care and support is also essential for persons with disabilities to build sustainable livelihoods. For example, communication support – including sign language and Deafblind interpretation – enables persons who are deaf, hard of hearing or deafblind to participate in school and work. Unmet needs, including services that do not support autonomy, in turn can constrain opportunities: in Bulgaria, use of personal assistance services is confined to one's home municipality, restricting work options.[652]

Reduced labour force participation and earnings of persons both providing and requiring care and support then lowers households' income and resources, heightening the risk of poverty. Persons with disabilities and their households also **face extra costs for paying out-of-pocket for care and support**, further straining their financial security (*Box 3.32*).

Box 3.32 Costs to families for required personal assistance

Personal assistance is essential for many persons with disabilities for supporting autonomy and independent living. Yet many do not have access to this critical support due to cost and other barriers. Costs vary significantly by type and level of support needed and other factors (e.g., age, gender, daily life activities). To afford all required personal assistance, studies have estimated that households would need to pay the following amounts[l] annually:

- In Ireland, families with adolescents with intellectual disabilities would require US$4,002.[653]
- In Barcelona, Spain, required costs ranged from US$3,804 for persons who are partially sighted up to US$39,910 per year for persons with intellectual disability and high support needs.[654]
- In Georgia, costs among children with high support needs ranged from US$6,588 for children who are deaf to US$23,783 for children with physical disabilities.[655]

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[l] All costs are converted in to US dollars with 2017 Purchasing Power Parity.

Investing in inclusive care and support systems holds enormous potential for sustainable and inclusive economic growth and development. An inclusive care and support economy has the potential to create stable jobs that foster the economic participation of women, persons with disabilities and other often marginalized groups. Implementing comprehensive care and support policies can generate significant socioeconomic returns, including job creation and increased earnings, tax revenues and consumption.[656]

Recommendations for shaping a more inclusive care and support economy

Enhancing the voice of persons with disabilities in the care and support economy agenda and building alliances with other social movements

Ensuring that the evolution of the care and support economy benefits and upholds the rights of all persons who provide and who require care and support will require collaboration with multiple stakeholders – feminist movements, migrant worker groups, labour unions, children's rights advocates, older persons' collectives and disability rights groups – each with distinct but interconnected priorities. Feminist movements, grounded in addressing gender inequality and acknowledging the value of care, have focused on recognizing, reducing and redistributing unpaid work. Persons with disabilities call for support systems that empower individuals, foster dignity and agency, enable full participation in society and accelerate deinstitutionalization efforts. Workers' unions, often in coalition with feminist groups and migrants groups, strive to ensure decent work for care and support workers. Children's rights advocates emphasize the importance of caring and nurturing environments for child development, while older persons' collectives focus on preserving dignity, autonomy and quality of life as people age.

Children, working-age and older adults with disabilities and OPDs must be actively included in care and support economy debates and governance. Their voices are essential to ensure policies and programmes shaping care and support systems are disability-inclusive and rights-based (*Box 3.33*). So far, discussions have focused primarily on providers of care and support, with less attention paid to the voices and concerns of those requiring support or to the dynamic and reciprocal nature of care and support relationships. The voices of persons with disabilities who provide care and support to others have also been excluded. When disability perspectives are not meaningfully included, there is a risk of rising unmet needs, decreased quality of care and support and denial of rights. Importantly, exclusion can result in perpetuating care and support systems that do not respect the autonomy of persons with disabilities and their right to live in the community, including through institutionalization.

There are, however, increasing opportunities for collaboration between these diverse stakeholders at local, national and international levels. For example, the Post–2030 Agenda presents a strategic moment to embed care and support within global development frameworks. Additionally, the Global Alliance for Care has created a valuable platform for fostering intersectoral dialogues, driving coordination and mobilizing joint efforts.

Box 3.33 Voices of persons with disabilities in shaping the care and support economy agenda

"Today, as a woman with visual impairment raising a child with disabilities, I am both a care and support provider and receiver. I understand how deeply essential these systems are – not only to survive but to thrive, and to live lives of dignity and purpose. In my case, support takes many forms. It might be access to accessible childcare, services for my son, or simply the understanding of colleagues and the broader community who recognize the unique challenges I face as both a mother and an advocate…I strongly believe that care and support should never be carried alone. We need systems, services and social protection mechanisms in place to ensure that we, as women with disabilities, can balance our many roles." – **Rina Prasarani, single mother from Indonesia who is blind and the carer of a son with multiple disabilities**[657]

"I spent 25 years in different institutions and from 2012 I have lived in the community. For me, the community is important because it is my right and every person with a disability has the right to live in the community…I work, I am paid…I have the freedom which I didn't have in institutions." **Anonymous self-advocate with intellectual disabilities from Romania**

Collecting data to understand the nature of care work and care and support needs

Additional data and research are needed to advance effective design of policies and programmes for a disability-inclusive care and support economy and care and support systems. Importantly, data are needed on met and unmet needs for care and support among persons with disabilities (*Box 3.34*),[658] including on why needs are unmet (e.g., cost, availability) and satisfaction with existing support. This information can be used to enhance service delivery, including identifying policies and programmes to reduce unmet needs and improve the quality of paid and unpaid care and support. Meanwhile, time-use and care surveys should include questions on the disability status of persons providing and receiving care and support, including on self-care.[659,660] They should also focus on any remuneration received by providers and the extent to which costs are covered out-of-pocket by recipients. These data can illustrate the economic and social impact of both unpaid and paid care and support on individuals and households, including on time poverty.

All data should be disaggregated by at least gender, as well as age, geographic location, ethnicity and other characteristics. Disaggregation can highlight equity gaps – including gender differences in the provision of unpaid care and support and remuneration and working conditions for paid care work – that can then inform policy adjustments. Data are also needed at a systems level: for example, governments should develop and report on standardized indicators relating to public expenditures on care and support.[661]

Box 3.34 Kenya survey on support needs

The Kenya Ministry of Labour and Social Protection, in collaboration with OPDs, conducted a survey in 2022 on the support needs of persons with disabilities and family providers of care and support. This survey was commissioned as part of the Kenyan Government's commitments made during the 2018 Global Disability Summit. The survey sought to provide information on met and unmet support needs among persons with disabilities and family providers of care and support.

The survey found that 78 per cent of the primary adult providers of care and support were women. Among persons with disabilities, 34–43 per cent could not access workplaces, schools or shops, more than 60 per cent reported that household toilets, bedrooms and living spaces were inaccessible, and the majority required assistance with household and community activities. Support needs among family providers of care and support were identified; for example, 90 per cent reported needing financial support to enable their work, 48 per cent needed skills development, and 44 per cent wanted support networks.

Instituting policies and programmes for a more inclusive care and support economy and care and support systems

Policies and programmes shaping the care and support economy and care and support systems must be grounded in five key principles: a human rights approach, state accountability, universality, transformative policies, and leaving no one behind.[662] This approach requires a shift from conventional models – characterized by low expectations of autonomy for persons with disabilities, family-only responsibility and gendered caregiving roles – toward systems that prioritize equality, autonomy and empowerment for those both requiring and providing care.

Key policy and programmatic priorities for shaping inclusive care and support systems will be discussed in Chapter 4. In brief, they include policies to: compensate, redistribute and alleviate pressures associated with unpaid care and support (e.g., care leave policies, flexible working arrangements, social protection for income security); enhance access to required care and support services for independent living in the community (e.g., investing in community-based care and support services, reducing financial and other barriers to access); improve working conditions and skills of providers (e.g., regulations on safe work environments, pay, training); make infrastructure and mainstream services (e.g., health, education, transport) accessible and inclusive to reduce the need for care and support; and accelerate deinstitutionalization efforts.

These policies and programmes require sustainable and adequate financing and must be shaped through the meaningful participation of diverse persons with disabilities and OPDs, with particular attention to women with disabilities and persons with high support needs. They also require coordination across multiple sectors (e.g., health, education, social protection) and actors (e.g., governments, civil society, OPDs). Poor coordination both decreases access and increases monetary and time costs for persons with disabilities and their families, as well as governments. Digital technologies can be used to improve governance and streamline service delivery.[663]

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Chapter 4

Accelerating inclusion

Creating inclusive societies, which ensure the rights of persons with disabilities as guaranteed by the Convention on the Rights of Persons with Disabilities (CRPD), will require comprehensive, cross-sectoral, multi-actor approaches to remove barriers and promote full and equal participation.

While there has been progress in some sectors and systems in many countries, there are still systemic roadblocks to inclusion. These challenges vary by context and sector, but often include insufficient human and technical resources, inconsistent and inadequate financing and investment, lack of political will to make required changes, and poor coordination between sectors and actors. Progress has also been unequal across and within countries and among persons with disabilities. Importantly, many low-income and fragile contexts – including humanitarian settings – have particularly limited resources for inclusion. Underlying systems, such as health, education and social protection, are also often developing and fragmented. Yet even many high-income countries are still far from meeting their commitments to the CRPD, despite greater availability of resources and maturity of systems. Meanwhile, certain groups face additional barriers to inclusion. These include women and girls, persons with high support needs, persons living in poverty and in rural areas, and groups that face overlapping forms of marginalization (e.g., racial and ethnic minorities; LGBTIQA+ persons).

Accelerating inclusion requires concerted efforts that bring together a wide range of stakeholders, including governments, civil society, development agencies and – critically – persons with disabilities and Organizations of Persons with Disabilities (OPDs). Strategies for inclusion will require adaptations to be contextually relevant and appropriate for meeting the diverse needs of persons with disabilities. Coordinated, multisectoral efforts to simultaneously and holistically tackle barriers across sectors and systems will be more effective than siloed approaches. For example, strategies to increase access to inclusive education for children with disabilities will be most effective if there are concurrent efforts to provide access to timely early intervention and other health-care services to enhance functioning and well-being, appropriate assistive technology to support learning and mobility, and accessible transport to and from school.

This chapter offers priority actions that all countries can tailor to accelerate inclusion of persons with disabilities across sectors and systems. It begins with an overview of **cross-cutting enablers** that are the backbone for inclusion. These include improving accessibility of environments, services and systems; fighting stigma and discrimination related to disability; increasing access to assistive technology; creating inclusive care and support systems; and enhancing participation of persons with disabilities and OPDs in decision-making. It then discusses progressive steps that health, education, employment and social protection sectors can take to accelerate inclusion.

Cross-cutting enablers

Improving accessibility

Ensuring accessibility is part of States' commitments under Article 9 of the CRPD,[1] which mandates that they "...must take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas".[2]

Accessibility requirements differ among persons with disabilities, depending on the type and the level of support they require, as well as their daily activities and the contexts in which they live. Applying principles of universal design can help ensure products, environments, programmes and services are usable to as many people as possible without the need for adaptation. As such, **societies as a whole benefit from the creation of more accessible and well-designed environments, products and services** (*see Box 4.1*).

Box 4.1 The wide-ranging benefits of improving accessibility

Accessibility is critical for the participation and inclusion of persons with disabilities. It also carries many benefits for societies as a whole.

- **Improving physical access:** Elevators and ramps in buildings and even pavement with curb cuts make navigation easier not only for persons with disabilities but also for children, older adults, people with strollers, luggage and heavy items, and people experiencing illness or injury.
- **Enhanced user experience:** Forty per cent of Netflix users globally use subtitles all the time, and 80 per cent use them at least once a month, with use even higher among young people.[3]
- **Economic returns:** One estimate found that companies see an average revenue return of more than US$9 for US$1 spent on accessibility features and inclusive design.[4]

Globally, there has been progress in improving accessibility, with most countries enacting at least some standards and legislative frameworks. For example, 69 per cent of countries have accessibility frameworks for information and communications technology,[5] and 59 per cent of countries have policies that require employers to provide reasonable accommodations.[6] Further, some governments, international organizations and donor agencies are embedding accessibility requirements into new and ongoing projects.[7] Technological advances have also brought opportunities for improving accessibility (*see Chapter 3*).

However, **roadblocks remain**. For example, standards and legislative frameworks often do not cover the full range of accessibility requirements for all persons with disabilities. Meanwhile, there is a lack of implementation of existing legislation and standards in many settings due to factors such as inadequate monitoring and enforcement, insufficient human and financial resources (e.g., budget constraints; availability of key professionals, such as sign language interpreters and contractors, architects, product developers and others with expertise in implementing accessibility measures) and lack of leadership and coordination.[8,9,10,11] There can also be significant inconsistencies in implementation within countries, with rural and poorer areas often facing additional constraints.[12]

Strategies for improving accessibility for all persons with disabilities will vary between and within countries. This will depend on factors such as the human, financial and other resources available to make changes, the existing level of accessibility, and the needs of the population. It will also depend on the context, as strategies may need adaptation to be relevant to diverse settings (e.g., rural versus urban, informal settlements, humanitarian contexts). Across contexts, it is important to avoid siloed approaches, so that multiple government departments and a range of stakeholders, including persons with disabilities and OPDs, are coordinating on the following steps, aimed at improving accessibility. Below are key priorities, although other steps will be needed in different contexts.

1. Establish legislative frameworks, standards and guidelines that are contextually relevant and incorporate diverse accessibility requirements

Accessibility standards and legislative frameworks are important for setting requirements that governments, businesses, service providers, developers and other stakeholders must meet across infrastructure, products, services and systems (*see Box 4.2*). There are international standards that can guide the development of national standards, such as Web Content Accessibility Guidelines (WCAG) 2.0 or European standard EN 301,549 for digital accessibility, as well as ISO 21,542:2021 on Accessibility and Usability of the Built Environment. To be effective, standards must become requirements in different processes such as public procurement, building permits, accreditation of services for the public as well as in training of all relevant professionals.

Applying these standards and frameworks to different contexts may require adaptations, particularly for settings such as remote areas or informal settlements. There are helpful guidelines that have been produced to assist implementers in applying standards, such as *Listen, Include, Respect* from Inclusion International and Down Syndrome International and *Accessibility Go! A Guide to Action* from CBM Global Disability Inclusion and the World Blind Union.

Box 4.2 European Accessibility Act 2019

The European Accessibility Act (EAA) came into force in 2019: from 2022, European Union Member States had to publish national laws, regulations and administrative procedures to comply with the Act, and by 2025 their measures must be applied.[13] The Act aims to ensure equal access to many products and services (e.g., computers, smartphones, telecommunications, media) by standardizing accessibility requirements across all Member States. It contains strong enforcement mechanisms, requiring providers to document how their products meet accessibility standards and Member States to designate a body to monitor compliance, review complaints and take corrective actions. The effects of the EEA are likely to be seen beyond the borders of the European Union, as international businesses will be forced to adapt their products and services – which are delivered in other countries as well – to comply with this legislation. Still, it does not cover accessibility in all domains, with the built environment being a major omission.

2. Instituting road maps for implementation

National, regional and local governments, as well as the private sector, service providers, development agencies and other stakeholders, must have comprehensive road maps with specific targets and action plans for enhancing accessibility across systems, products, services and environments. These road maps must:

- Be designed, implemented and monitored in partnership with OPDs and persons with disabilities with diverse accessibility requirements
- Be in line with established frameworks, standards and legal obligations
- Reflect diverse accessibility requirements (e.g., physical accessibility, Braille, sign language and Deafblind interpretation, Easy-to-Read and other alternative communication formats) and different contexts (e.g., rural/urban, informal settlements)
- Define realistic time frames and milestones for achievement
- Earmark adequate and sustainable human and financial resources for implementation
- Establish clear responsibilities and coordination mechanisms.

Road maps should be informed by assessments to identify current gaps. Key stakeholders – including persons with disabilities – can then agree on priority actions, given the available financial and human resources and the most urgent barriers.[14] Short-term solutions, such as providing reasonable accommodations to individuals with limited access, may be required while progressively working towards whole-system change. Further, in some contexts, efforts may be needed to increase the supply of professionals (e.g., sign language interpreters and guides; product developers, contractors and others trained on accessibility) and other inputs (e.g., producers of Braille signage, tactile paving).

There are also **levers for all countries to accelerate implementation**. Importantly, incorporating accessibility considerations at the outset of projects is significantly less costly than later adaptation.[15] There are also opportunities to embed accessibility improvements within other initiatives, such as reconstruction efforts after a humanitarian crisis, within smart city and other urban development projects or as part of climate change adaptation strategies for energy-efficient and climate-resilient infrastructure (*see Box 4.3*). Public procurement – the process through which governments purchase goods and services – is also a critical mechanism for accelerating implementation, representing on average 13 per cent of a country's gross domestic product (GDP).[16]

Box 4.3 Zu Peshawar bus rapid transport system, Pakistan

For decades, the city of Peshawar experienced war and acts of terrorism that disrupted public safety and made it difficult to plan the city's growth. Public transport was limited to a patchwork of hundreds of small, privately operated buses, trucks and taxis that were unreliable and unsafe. This system was particularly unusable for women and persons with disabilities. In 2013, the government of Khyber Pakhtunkhwa province committed to revamping the transport system. Jointly financed by the Asian Development Bank, Agence Française de Développement and the government of Khyber Pakhtunkhwa, Zu Peshawar launched the bus rapid transport (BRT) system in 2020. Accessibility is at the core of the design of BRT. For example, the entire line is step-free, and information is available through Braille signage, Easy-to-Read format, audio descriptions and sign language. Staff members receive regular training on accessibility and how to provide support to users with disabilities. Planning and implementation of these measures were undertaken in collaboration with a local disability rights organization.

3. Monitoring and enforcement

Effective monitoring and enforcement mechanisms are vital for achieving progress on accessibility. Persons with disabilities with diverse accessibility requirements should be actively involved to identify areas of non-compliance and for further improvement. Monitoring requires resources from governments and other stakeholders, but enforcement can then generate revenues through fines and other penalties for non-compliance. Across countries, there are opportunities to engrain monitoring and enforcement of accessibility standards into existing processes, which can be cost-effective and expand the reach of monitoring efforts. For example, accessibility audits can be built into other auditing processes, such as for health and safety. Further, building permissions and procurement contracts can mandate compliance with accessibility standards. Particularly in least-developed countries and fragile contexts, development agencies and civil society must also play a central role in enforcement by ensuring compliance with accessibility standards across their projects and contracts.

Combating stigma and discrimination related to disability

Countering stigma and discrimination related to disability is the focus of Articles 5 and 8 of the CRPD, and is central to achieving many of its other rights.[17] Disability stigma refers to negative beliefs and attitudes directed towards persons with disabilities because of their disability. It includes destructive misconceptions, such as the belief that persons with disabilities are incapable or unable to learn and work.[18] Stigma can result in different forms of discrimination, such as situations where persons with disabilities are treated unfairly (direct discrimination), denied reasonable accommodations to fully participate in society, or subjected to harmful actions (harassment) such as name-calling, bullying and violence.[19]

Indirect or structural discrimination occurs when societies are organized in ways that prohibit persons with disabilities from having the same opportunities as everyone else. This form of discrimination happens when buildings, transportation, information, services communication and public spaces are not accessible or when policies and laws do not provide equal opportunities and rights for persons with disabilities. Structural discrimination is an important cause and consequence of the stigmatizing beliefs and discriminatory actions that individuals display towards persons with disabilities. Countering structural discrimination requires actions covered elsewhere in this chapter (e.g., making environments accessible, increasing access to assistive technology and care and support, ensuring autonomy in decision-making and making health, education, social protection and employment systems and services inclusive).

Stigma and discrimination can harm persons with disabilities in multiple ways (*see Box 4.4*). They reduce participation in school, work and community life, and lead to poor health and well-being, social exclusion and poverty. Additionally, many persons with disabilities (as well as other marginalized groups) who have had experiences of stigma and discrimination avoid future situations in which they may be likely to be discriminated against. This anticipated stigma can significantly limit their opportunities.[20] Effective strategies for reducing stigma and discrimination should therefore aim to eliminate not only actual discrimination but also the underlying expectation of it.

Box 4.4 How stigma and discrimination harm persons with disabilities

- In 28 low- and middle-income countries, 26 per cent of adolescents aged 15–17 years who are deaf or hard of hearing have experienced discrimination or harassment because of their disability.[21]
- Across 32 European countries, disability discrimination was associated with poorer health and lower levels of well-being; this effect was larger compared to being discriminated against on other grounds (e.g., ageism, sexism, racism).[22]

Effectively eliminating disability stigma and the resulting discrimination will require different strategies for different contexts and groups of persons with disabilities. Cultural context affects beliefs about disability and acceptability of certain forms of discrimination. Similarly, visibility of impairments influences attitudes and treatment. Impairments that can easily be seen, like a missing limb, often attract stigma and discrimination, as does an associated mark of having a disability (e.g., using an assistive product). But even persons whose disabilities cannot be seen, such as certain health conditions, still experience discrimination. For instance, someone might be questioned for using an accessible bathroom because others wrongly assume they do not need it. Persons with intellectual or psychosocial disabilities often experience more stigma and discrimination than others, as do individuals with higher support needs or multiple disabilities. Finally, persons with disabilities may face stigma and discrimination not only because of their disability but also for other reasons (e.g., gender, gender identity or sexual orientation; racial, ethnic, religious or linguistic minority groups).

The approaches described below are context-dependent and need adaptation to be relevant to diverse settings and cultural contexts and for different persons with disabilities (e.g., women and men, across the life-course, by impairment). They require coordination between diverse actors, including governments, OPDs, civil society, development agencies, service providers and others. Other steps are also likely needed depending on context.

1. Ensure institutions and authorities actively support efforts to stop stigma and discrimination against persons with disabilities

Support for the prevention of stigma and discrimination by institutions and authorities (e.g., through anti-discrimination laws, policies and reporting mechanisms) is critical. It also helps persons with disabilities regain confidence and trust in participating in society by encouraging the view that disability stigma and discrimination are unacceptable. Most countries have some form of anti-disability discrimination legislation, but these laws are generally not comprehensive. For example, 62 per cent of United Nations Member States broadly prohibit disability-based employment discrimination, but only 30 per cent prohibit workplace harassment.[23] Governments must enact strong anti-discrimination legislation that prohibits all forms of discriminatory actions against persons with disabilities, such as hate crime, harassment and violence, and protects rights to equal participation without discrimination on the basis of disability (e.g., in work, education, society), including through provision of reasonable accommodations. This can be done as part of implementing comprehensive anti-discrimination legislation protecting the rights of all groups (e.g., women and girls, LGBTIQ+ persons).

These measures should be combined with awareness-raising training about the rights of persons with disabilities. These activities should be part of formal education, as well as trainings for policymakers, the judiciary, law enforcement, educators and professionals working with and for persons with disabilities, as well as for persons with disabilities and their families.[24] Finally, national, regional and local political leadership and governance structures must champion the representation of persons with disabilities within political systems and leadership (*see Box 4.5*).

Box 4.5 Political leaders with disabilities

Despite comprising 16 per cent of the global population, persons with disabilities are often not represented among national, regional and local political leadership.

Political leaders with disabilities are vital to represent the interests of persons with disabilities. Examples of political leaders with disabilities include Lenín Boltaire Moreno Garcés, President of Educador (2017–2021), who is a wheelchair user, and Spanish Parliamentarian María del Mar Galcerán Gadea (2023–present), who has Down syndrome.

2. Creating opportunities for friendship and positive interactions

Increasing opportunities for positive interactions between persons with and without disabilities is one of the most effective ways to counter stigma.[25] These interactions can correct misperceptions and negative attitudes about disability. However, contact between persons with and without disabilities is prevented by structural barriers, such as inaccessible environments and segregation or exclusion in schooling and work. Ensuring that persons with disabilities have access and can equally participate in places that offer opportunities for repeated interactions (schools, religious institutions, community groups) is a critical strategy for tackling disability stigma.

Contact is most effective at countering stigma when paired with other measures, including institutional support against stigma and discrimination (*see point 1*) and where individuals perceive themselves as having equal status and working towards common goals, on a cooperative basis. For example, simply placing students with disabilities in a mainstream classroom will not be as effective at countering stigma and discrimination unless it is combined with other measures to support equal participation, such as teacher training, provision of assistive technology and adapted curricula. Additional interventions are likely to be most important for tackling stigma against more heavily stigmatized groups of persons with disabilities, such as persons with intellectual or psychosocial impairments (*see Box 4.6*).

Box 4.6 Special Olympics Unified Champions Schools®

The Special Olympics Unified Champions Schools® (SOUCS) programme has been implemented in over 32,000 mainstream schools across 150 countries. The programme aims to foster social inclusion in schools to counter stigma and discrimination of persons with intellectual disability and build a positive school climate for all students. It includes several components: Unified Sports, where young people with and without intellectual disabilities train and compete together; inclusive youth leadership, in which students with and without intellectual disabilities take on leadership roles to positively impact their schools and communities; and whole-school engagement focused on awareness-raising activities related to respect and acceptance. Through comprehensive evaluations in multiple settings including China, Greece, India, Kenya and the United States of America, SOUCS has shown many benefits, including improving attitudes and interactions between students with and without intellectual disabilities and increasing high school graduation rates for children with and without disabilities.[26,27]

3. Shifting culturally embedded beliefs about disability

Mass-media and awareness-raising campaigns must combat stigmatizing attitudes, draw attention to the capabilities and contributions of persons with disabilities and promote their inherent value.[28] Strategies include positive representations of persons with disabilities in books, TV shows, radio dramas and other forms of media that span the full range of identities that persons with disabilities possess (e.g., genders, ages, ethnicities) (*see Box 4.7*). Portrayals of persons with disabilities that reinforce negative stereotypes (e.g., as incapable or in need of pity) must be eliminated.

Box 4.7 Persons with disabilities in the media

Story Story was a radio drama in Nigeria produced by BBC Media Action to address disability stigma and discrimination. As a disability-themed drama, *Story Story* featured characters both with and without disabilities, and each episode followed one character's experiences in everyday life. *Story Story* was an example of how media can change attitudes by getting viewers to identify with relatable characters. It can also promote knowledge and awareness of the lives of different groups of people while simultaneously providing engaging entertainment.

Enhancing care and support systems

As discussed in Chapter 3, the care economy is in transition, with challenges to the status quo of overreliance on unpaid family care done disproportionately by women and girls, and inadequate support for children and adults with disabilities, including older persons. In response, there is a need to develop care and support systems that are disability-inclusive, gender-responsive and age-sensitive.[29] Such systems provide the services, products and human assistance to allow persons with disabilities to live independently in the community, with autonomy, choice and control.[30] In particular, they support children to grow and learn, young persons to gain independence and self-confidence, adults to participate in the workforce and live independently, and older persons to remain included and active members of society. Rights-based systems also reduce gender inequalities by appropriately valuing and redistributing unpaid care and support work. The societal and economic value of inclusive care and support systems is undeniable, as they foster equity, drive economic growth, reduce poverty and promote social cohesion.[31]

The **care and support needs of persons with disabilities are diverse, reflecting the intersection of factors such as age, gender, functional difficulties, culture and environment** (*see Box 4.8*).[32] Yet, many of these needs remain unmet (*see Chapter 3*). In most contexts, unpaid care and support provided by families, neighbours and communities are the core of care and support systems. However, these arrangements can be unstructured, unpredictable and vulnerable to shocks. They can also reinforce gender inequalities, increase economic vulnerability of households and lack safeguards to ensure quality of support and autonomy. Meanwhile, in many contexts – particularly in low- and middle-income countries – care and support outside the family are scarce. Paid services that are available can be unaffordable to many, of poor quality and delivered primarily in segregated institutional settings – which constitutes a denial of the rights of persons with disabilities. The additional dangers and precarity of institutionalized care have been highlighted by the COVID-19 pandemic as well as in recent humanitarian crises and emergencies (*see Chapter 3*).

Box 4.8 The diversity of disability-related care and support

Persons with disabilities and their families have a wide diversity of care and support needs, which can also vary greatly across the life cycle. They include but are not limited to the following.

- **Support for daily living activities**, such as assistance with mobility, self-care, household management and participation in the community; and adapted housing and accessible transport
- **Communication support**, including sign-language interpretation, Deafblind interpretation, screen-readers and other assistive technology
- **Decision-making support**, such as supported decision-making and self-advocacy support
- **Family support**, including respite care, flexible working hours and carers leave for parents, family and other unpaid providers of care and support.

Global efforts have **increased collaboration between OPDs, feminist movements, care advocacy networks and other stakeholders**. These include the recent United Nations Human Rights Council Resolution 54/6 on care and support from a human rights perspective and 55/8 on support systems to ensure community inclusion of person with disabilities.[33,34] However, while persons with disabilities have clear perspectives on the support they need (*see Box 4.9*), they remain underrepresented in care and support policies and debates at both the international and national levels. This exclusion leads to a lack of alignment with the CRPD and amplifies the danger that institutional approaches will be used to meet care and support shortfalls.

To ensure children and adults with disabilities receive appropriate, rights-based care and support, solutions must be community-driven, unpaid care and support must be recognized and redistributed, and there must be investment and coordination of key services, workforce and products. Developing inclusive and sustainable care and support systems requires a diversity of schemes and services, including social protection, human assistance, assistive technologies and accessible transport, housing and digital infrastructure. Coordinated efforts across sectors and stakeholders are essential, fostering partnerships among governments, civil society, community-based organizations, OPDs and persons with disabilities and their families. Additionally, they must consider gender, personal and cultural differences in the acceptability of various care and support models (e.g., family versus non-family provision).

Box 4.9 Care and support systems from the perspective of self-advocates with intellectual disabilities

For the elaboration of this report, Inclusion International held consultations with self-advocates, which included discussions on care and support systems. They emphasized that they want support that respects their independence. As a self-advocate from Colombia explained: "We are not sick, nor are we eternal children, and we do not want charity. We want to be given the necessary support in all spaces to participate freely and for our voices to be heard."

They highlighted how care and support gaps affect their freedoms both in the community and in care institutions. According to a self-advocate from the United Republic of Tanzania: “Families lock away their children for many reasons … we can address these barriers so people with intellectual disabilities can be free.” A self-advocate from Hong Kong Special Administrative Region, China, said: “I cannot have the key to the main door. I cannot shower anytime I like. I cannot sleep or wake up at the time of my choice...”

They also underscored the importance of support to their families. A self-advocate from Brazil said: “If we don’t have a family that is well-prepared, that is well-informed, life for us is difficult. If we have a family that can support us, we are able to go out into the world and live actively in society.” They further recognized the challenges faced by support workers: “It’s a very hard job and it’s hard to get a good support worker … Staff don’t want to leave, but they have to leave if they can’t make a living,” according to a self-advocate from the United States.

Below are several key elements – with the recognition that others may be required – that need to be considered in developing care and support systems that are disability-inclusive, age-sensitive and gender-responsive, and progress efforts on deinstitutionalization.

1. Establish legislative and policy frameworks for inclusive care and support

An inclusive care and support system must be grounded in clear legislation and governed through multisectoral coordination.[35,36,37] Policies and programmes must be aligned across key sectors – including social protection, transportation, child protection, health and education. All approaches must adhere to the principles of the CRPD, and persons with disabilities and OPDs must be actively engaged in all stages of developing and implementing care and support systems. Coordination across actors and sectors, including through e-governance, will result in more efficient and effective systems.[38]

Key priorities for legislative action include provisions for:

- Prevention of family separation and placement in care institutions with clear provisions and timeframe for deinstitutionalization
- Person-centred, community-based care and support models that transition away from institutionalized approaches and guarantee agency, choice and control of persons with disabilities over the support they receive (including self-care)
- Case management systems, including through digital platforms, to identify support needs among persons with disabilities, streamline provision of services and products and enhance cross-sectoral coordination
- Development or expansion of key support services and products required by persons with disabilities (e.g., sign language and Deafblind interpretation, personal assistance, supported decision-making, assistive technology and accessible transport)

- Social protection programmes to ensure income security and coverage of extra costs for care and support (*see 'Social protection' later in this section, Box 4.10*)
- Zero-rejection and inclusive education policies to reduce the number of children with disabilities out of school and therefore the need for unpaid care at home
- Support for unpaid providers to continue engagement in work across the formal and informal economies (e.g., flexible working arrangements, extended parental leave for families of children with disabilities and leave for providers of care and support)
- Adoption of enabling regulatory and financing frameworks to enable effective and accountable partnerships with civil society and private providers
- Monitoring mechanisms to ensure the delivery of quality, safe care and support (e.g., protections against abuse, neglect and denial of rights; compulsory training and assessment of skills; and decent working conditions and pay for workers).

Box 4.10 Social protection programmes to increase access to care and support

Expansion of 'cash plus' programmes, such as in the Lao People's Democratic Republic, the Syrian Arab Republic and Yemen, combine a regular cash benefit with elements of care and support. In countries such as Rwanda and South Africa, basic care and support work has been included as part of public works programmes. These approaches contribute to recognizing and remunerating care and support, providing an income source for providers while also expanding access to required community-based care and support.

2. Develop, evaluate and scale innovative, sustainable approaches to care and support

Mapping exercises, including those in low- and middle-income countries, have identified promising community-led initiatives, such as peer support groups, local care networks, point to point transportation and independent living centres. However, these programmes remain largely isolated pilot projects rather than integrated, sustainable programmes.[39]

Given the often-severe public funding and human resources constraints, particularly in low- and middle-income countries, developing care and support systems will necessitate a combination of strengthening publicly funded formal services and scaling up of innovative community-based mechanisms, including those led by

OPDs and civil society (*see Boxes 4.11 and 4.12*). This process must evaluate the availability, strengths and weaknesses of different care and support arrangements. Particular attention should be given to how solutions promote the autonomy and rights of persons with disabilities (e.g., prevent substituted decision-making and institutionalization), ensure high-quality and comprehensive care and support, and impact providers of care and support (e.g., gender equality, wages and working conditions). For effective provision and scale-up, national and local governments must foster more intentional partnerships with development agencies, OPDs and civil society, including community-based groups.

Box 4.11 Circles of support

Circles of support have been used globally as informal community networks providing support for decision-making and other daily life activities, particularly for persons with intellectual and psychosocial disabilities.

The Kenya Association of the Intellectually Handicapped (KAIH) adapted the circle of support approach. KAIH organizes parent and self-advocate groups, which then provide guidance, training and access to public support schemes (e.g., disability card registration and cash transfer). These groups pool resources, offer mutual support and create buddy systems; for example, community members assist children with disabilities to attend school and engage socially. KAIH has initiated 135 circles of care and support across 15 counties. To sustain and scale these community-driven approaches, KAIHis participating in a pilot program together with with Kenya's Directorate for Social Development, UNICEF and the United Nations Global Disability Fund. This model highlights the potential of integrating informal and formal care networks in resource-constrained settings and ensuring sustainable, rights-based and community-driven systems.

Box 4.12 Fiji: Government–OPD partnership for a sign language interpreters system

In Fiji, sign language services are primarily coordinated by the Fiji Association of the Deaf (FAD). The government finances FAD to provide interpretation services in courts and police stations first and with ongoing work to expand to other public services. In schools, interpreters are directly paid by the Ministry of Education. While there are currently not enough interpreters to meet demand, the establishment of an association of sign language interpreters has brought formal recognition to this profession which will help its development. [40]

3. Enhancing the agency, autonomy and choice of persons with disabilities

Autonomy and choice for persons with disabilities must be at the centre of care and support policies and programmes. To this end, persons with disabilities must have input into the types of care and support they receive, how it is provided and who provides it (*see Box 4.13*). For example, technological solutions may be suitable and preferred by some persons with disabilities, while others will still require or favour human support (e.g., sign language interpretation versus auto-captioning).

Box 4.13 User-directed models of care and support: The emergence of personal assistance

In many high-income countries, personal assistance systems are well established and increasingly shifting toward user-directed models, such as direct payments and personal budgets, offering persons with disabilities greater flexibility and control. [41] However, challenges remain, including restrictive eligibility and limited funding along with concerns over equity, service quality and working conditions. [42] In contrast, in many low- and middle-income countries, available non-familial care and support is primarily from domestic workers who are paid for privately. Publicly funded personal assistance schemes have emerged more recently, and their reach is uneven. Countries such as Albania, Armenia, Costa Rica, Moldova, Serbia, Thailand and Uruguay are leading these efforts, though at varying scales and levels of integration.[43] Constrained service provision capacity, scarce funding and lack of awareness among authorities about the specific role of personal assistance in supporting independent living limit development of such services.

Increasing access to assistive technology

Assistive technology comprises digital and non-digital assistive products such as wheelchairs, walking sticks, hearing aids, prostheses, eyeglasses or digital devices (e.g., screen-readers, voice recognition software), and their related systems and services (e.g., health, rehabilitation and other services for fitting and repairing, information and communication technology systems that integrate products and training on their use).[44] Access to assistive technology is crucial for ensuring the rights of persons with disabilities and enabling participation in work, school and community life. It can also reduce the need for unpaid care and support work, including self-care. As such, access to assistive technology is prominent in the CRPD, including Articles 4 (General Obligations), 9 (Accessibility), 20 (Personal Mobility) and 26 (Habilitation and Rehabilitation).[45] States are required under the CRPD to enhance the availability, affordability and utility of assistive technology to ensure access for all who require it. Expanding access will also be necessary for achieving most of the Sustainable Development Goals (SDGs).[46]

The *2022 Global Report on Assistive Technology* estimates that **2.5 billion people require at least one assistive product**, a figure which will rise to 3.5 billion by 2050.[47] Despite this large and growing need, access to required assistive products stands at between 10 and 15 per cent globally. There are significant inequities, with access as low as 3 per cent in some low-income countries, but up to 90 per cent in some high-income settings. There are also disparities within countries. For example, persons living in rural areas tend to have worse access to assistive technology compared to persons in urban areas, as do women and persons with lower socioeconomic status.

Improving access to assistive technology brings many benefits for persons with disabilities and their families, communities and governments. For example, improving a child's access to assistive technology can generate US$100,000 in lifetime income.[48] Meanwhile, scaling up coverage of ear and hearing care – including hearing aids and other hearing assistive technology – to 90 per cent globally would bring a societal return of US$15 for every US$1 invested.[49]

There are persistent barriers to accessing assistive technology. For example, persons with disabilities often lack knowledge about assistive products that could benefit them and how to access them.[50,51] Costs of products and related services are prohibitive for many. There is also limited availability of quality products and service providers in many settings, and poor investment in assistive technology systems to support them. Further, available products, services and systems can require adaptation to meet the needs and preferences of diverse users, particularly in certain contexts (e.g., humanitarian settings and remote or rural locations).

There has been an **increase in global efforts to improve access to assistive technology**. The 2018 World Health Assembly Resolution WHA71.8 called on Member States to improve access to assistive technology, such as through its integration into universal health coverage (UHC) and national policies and programmes.[52] The Global Cooperation on Assistive Technology (GATE) is a WHO initiative that has brought together over 2,500 stakeholders from 135 countries. In alignment with GATE, the Global Partnership for Assistive Technology (ATscale) was created at the 2018 Global Disability Summit to extend assistive technology to an additional 500 million people in low- and middle-income countries by 2030.[53]

Countries can improve their assistive technology systems in line with recommendations from the Global Report on Assistive Technology and the WHA71.8 Resolution.[54] In developing national strategies, stakeholders must consider the resources that are available to make changes, as well as the current national and subnational availability, accessibility, quality and affordability of assistive products and services, and the personnel, systems and supply chains needed to deliver it. Policies and programmes must also be informed by the experiences, preferences and priorities of persons with disabilities with diverse assistive technology needs and from different backgrounds (e.g., by gender, across the life-course, impairment type). They must also consider which adaptations are needed to best meet the requirements of individuals across the country – including in remote and rural areas and humanitarian settings. In line with a people-centred approach, persons with disabilities and OPDs must be at the forefront of design, implementation and monitoring of strategies. Below are several essential steps that countries can take to improve access to assistive technology, with recognition that others are likely needed depending on context.

1. Developing national action plans and policies

To develop evidence-based legislation and strategies, and to plan, monitor and evaluate them, it is necessary to invest in, collect and analyse relevant data on the need for and use of assistive technology across the population, as well as system-level capacity for provision. The WHO Assistive Technology Toolbox (ATA) can support countries in these efforts (*see Box 4.14*).

Box 4.14 Assistive Technology Access (ATA) toolkit

The ATA toolkit can support countries to collect data on assistive technology to inform planning.[55] The toolkit includes the following components.

- **Assistive Technology Capacity Assessment (ATA-C):** A system-level tool to capture a country's capacity to finance, regulate, procure and provide assistive technology
- **Rapid Assistive Technology Assessment (rATA):** A survey tool to assess self-reported use, need and barriers to accessing assistive technology across the population.
- **Assistive Technology Impact Assessment Tool (ATA-I):** A survey tool that is being piloted to measure the impact of assistive technology (e.g., on participation, quality of life)
- **WHA71.8 Progress Indicators for Access to Assistive Technology:** Used to track and report progress towards implementation of the World Health Assembly Resolution.

Countries can then build policies and action plans, including for a list of priority assistive products (in line with the WHO Priority Assistive Products list).[56] As part of this planning, countries must establish a responsible line ministry, coordination mechanisms and sustainable financing, workforce and service delivery. Regulatory mechanisms are required to ensure minimum standards for assistive products and services, as are systems for monitoring and evaluation. Persons with disabilities and OPDs must be included across all these processes (e.g., within governance structures tasked with designing, implementing and monitoring policies and programmes).

2. Scaling up access to assistive technology through making, shaping and enabling markets

Limited local production, high import taxes, lack of coordination and fragmented supply chains limit access and drive up costs for assistive products.[57] Different interventions for shaping markets can address these barriers, including the following.

- Policies and incentives (e.g., tax breaks, grants) can promote local manufacturing, resulting in lower cost and contextually appropriate assistive products.
- The provision of assistive products and services can be integrated into health, social protection, education and other systems to streamline delivery and coordination.

- Purchasing strategies, such as centralized public procurement and bulk purchasing agreements, can connect users to approved products that meet quality standards while achieving economies of scale to reduce costs (*see Box 4.15*).
- International and regional cooperation can also improve markets. For example, South–South partnerships can establish regional production centres and reduce reliance on expensive imported products, while public–private partnerships can spur innovation and establish equitable pricing models (e.g., differential pricing agreements offering reduced prices for low-income countries).

Box 4.15 Pooled procurement of hearing aids through the UNICEF Supply Catalogue

In 2021, as part of the AT2030 programme – which was funded by UK Aid – UNICEF was able to add quality hearing aids to its Supply Catalogue for the first time. The catalogue enables governments around the world to access competitively priced and procured products, offering low-cost, high-quality solutions. In Rwanda, this led to a 94 per cent reduction in the price of like-for-like hearing aids: a hearing aid that cost as much as US$2,000 commercially in the country was only US$118 through the UNICEF Supply Catalogue.

At the same time, strategies are needed to stimulate demand for assistive technology, including by better informing stakeholders and training potential users. Further, diverse users of assistive technology must feed into processes for designing better products, services and service delivery. For example, IDA's Assistive Technology Users Community of Practice is a forum for sharing information about accessing and using assistive technology, and to collectively advocate for better products, services and policies.[58]

Technological advances (*see Chapter 3, the section on Technology*), including artificial intelligence (AI), are also increasing opportunities to scale up access to assistive technology, including innovations in products and services (e.g., integration of accessibility features on mobile devices), improving service delivery (e.g., digital case management) and enhancing user satisfaction (e.g., online mechanisms to share information and user experiences).

3. Enhancing the capacity of the assistive technology workforce

Many countries, particularly in low-income and humanitarian settings, have a limited workforce to assess assistive technology needs and provide, fit and repair products. Opportunities in this area include training primary health-care workers and other front-line staff to assess needs for and provide assistive technology, which can help shift tasks away from specialists (*see Box 4.16*). Further, technology can reduce costs and the need for specialists and expensive equipment. For example, digital screening tools can help identify persons who could benefit from assistive technology, while some products (e.g., certain hearing aids) can now be calibrated with mobile applications (*see Chapter 3, section on Technology*).[59,60] Persons with disabilities with diverse backgrounds and assistive technology needs can contribute to activities to enhance workforce capacity.

Box 4.16 WHO Training on Assistive Products[61]

The WHO Training on Assistive Products (TAP) is a free online training programme to support primary health workers in a range of contexts to identify persons with assistive technology needs, provide assistive technology where appropriate and to refer to other services as needed. It was developed to address the shortage of health personnel trained to provide assistive technology. The modules are available in multiple languages and are organized across the domains of cognition, communication, vision, hearing, self-care and mobility.

Enhancing the participation of persons with disabilities and OPDs

Participation is at the heart of democratic societies, representing not only a core democratic principle and a human right but also an essential mechanism for empowerment, accountability and social inclusion. For persons with disabilities, **participation is not only a vital tool for involvement in decision-making processes but also a transformative force** that ensures the protection of their rights and recognition of their leadership and expertise in relation to their own situations, and the elimination of systemic exclusion and marginalization. The CRPD acknowledges that OPDs are central to this endeavour. These representative bodies enable persons with disabilities to advocate for their rights, influence policy development and challenge systemic inequities. Through the leadership and involvement of OPDs, the CRPD's vision of inclusive equality becomes achievable.

The **significance of participation is underscored by the CRPD**, particularly Article 29, which highlights the obligation of States to ensure political rights for persons with disabilities on an equal basis with others. OPDs are crucial in bridging the gap between persons with disabilities and policymakers, fostering inclusive decision-making and advancing rights-based governance. These organizations act as catalysts for dismantling barriers, enhancing accessibility and fostering environments where persons with disabilities can participate fully in political and public life.

The transformative potential of participation was evident in the drafting of the CRPD itself, where the unprecedented involvement of OPDs shaped a treaty that prioritizes inclusion and equity. Recognizing persons with disabilities as active agents of change rather than passive recipients of aid, the CRPD integrates participation as a foundational principle across various articles. Notably, Articles 4(3), 29 and 33 emphasize the involvement of OPDs in policymaking, legislative development and monitoring. This holistic approach reflects the interconnected nature of participation with other rights, such as accessibility (Article 9), legal recognition (Article 12), freedom of expression (Article 21), and national monitoring mechanisms (Article 33).

However, despite this legal framework, systemic barriers persist (*see Box 4.17*). Structural and legislative obstacles, such as restrictive legal provisions and guardianship laws, often exclude persons with disabilities from voting or holding public office. Accessibility challenges further hinder participation, with inaccessible polling stations, voting materials and public forums creating significant hurdles. Representation remains limited, with women, children and persons with intellectual and/or psychosocial disabilities particularly under-represented. These issues are compounded by insufficient financial and institutional support for OPDs, along with gaps in awareness and advocacy among political parties and public institutions. Many governments have failed to put in place a system of structured dialogue and properly resourced, meaningful participation to ensure that persons with disabilities, through their representative organizations, can play their role in shaping implementation and actively monitoring implementation of the CRPD. These challenges collectively undermine the transformative potential of participation.

Box 4.17 Monitoring participation: The IDA Global Survey on OPD Participation

In 2018, IDA launched its inaugural Global Survey on OPD participation, aiming to evaluate the depth and breadth of their involvement in decision-making at local, national, regional and international levels.[62] This initiative served as a vital monitoring mechanism for the implementation of Articles 4(3) and 32 of the CRPD. The survey revealed a troubling paradox: although consultations with OPDs had become more frequent, these groups felt their engagement was often superficial, offering little real influence on outcomes.

Since then, the landscape of OPD participation has evolved amidst global challenges. The COVID-19 pandemic, environmental crises and humanitarian emergencies have further complicated the inclusion of OPDs, intensifying pre-existing barriers. At the same time, initiatives like the United Nations Disability Inclusion Strategy (UNDIS) and commitments from the Global Disability Summit have created new avenues for disability-inclusive development, offering opportunities to reframe participation in more meaningful ways.

In 2021, IDA conducted a second global survey, building on lessons learned to improve accessibility and expand outreach. It gathered input from 1,341 participants from 136 countries representing diverse disabilities and contexts. Key results included the following.

- Fifty-five per cent of respondents noted improvements in the influence of OPDs in international forums.
- Dissatisfaction with government engagement rose from 46 per cent in 2018 to 53 per cent in 2021; accessibility of consultations also decreased, with those citing inadequate funding for reasonable accommodations increasing from 14 per cent in 2018 to 41 per cent in 2021.
- Consultations on health and education became more common, but were often excluded from areas such as budgeting and monitoring.
- Persons with psychosocial and intellectual disabilities are still excluded.

OPDs distinguish themselves through their representative nature, being organizations led, governed by and comprised primarily of persons with disabilities. Organizations including family members and/or relatives of persons with disabilities are also among OPDs, as outlined in the General Comment 7 of the CRPD.[63] Their structured approach and collective advocacy amplify the voices of persons with disabilities, transforming personal experiences into systemic change. Unlike informal networks or individual participation, OPDs possess the organizational strength and legitimacy to sustain long-term advocacy and negotiate effectively for disability-inclusive policies. By bringing together diverse perspectives, OPDs present unified platforms that influence policymaking, address discriminatory practices and advocate for comprehensive accessibility.

Umbrella organizations further enhance this impact by uniting diverse disability-specific groups to advocate with a collective voice. These coalitions ensure that even the most marginalized groups are represented, promoting inclusivity and equity. At the national level, OPDs serve as watchdogs and advocates, lobbying for legislative reforms and mobilizing communities to demand equal opportunities. Regionally, they collaborate across borders to share best practices and develop coordinated advocacy strategies. Internationally, OPDs play a vital role in shaping global discourses on disability rights, participating in United Nations processes and monitoring compliance with the CRPD.

To strengthen the role of OPDs, States and stakeholders must prioritize meaningful participation at all levels of governance. This entails removing legal barriers, investing in capacity-building, ensuring accessibility and fostering inclusivity. By doing so, they can transform the aspirations of the CRPD into actionable outcomes, advancing the dignity and rights of all persons with disabilities. The future of inclusive societies depends on recognizing OPDs as partners, advocates and leaders in shaping equitable policies and practices. Through sustained commitment and collaboration, the transformative power of participation can be realized, creating a world where every person, regardless of ability, is an equal participant in shaping their future. Below are several key actions.

1. Strengthen mechanisms for OPD participation at all levels of governance, including through financial and institutional support

Governments and international partners must involve OPDs from the earliest stages of policy and programme design, ensuring their contributions lead to meaningful outcomes. Feedback mechanisms should validate the inputs of OPDs, fostering accountability and trust. Legal and policy reforms must prioritize the active involvement of OPDs in decision-making processes.

To ensure meaningful participation, consultation processes must be fully accessible, incorporating physical accommodations, diverse communication formats and adequate preparation time. Further, OPDs require sustainable funding, such as through proportional funding mechanisms and core operational support from governments, development agencies and civil society. Additionally, OPDs need support to develop expertise in emerging fields such as climate change and humanitarian response, and decision makers must recognize the technical knowledge OPDs have in rights-based, disability-inclusive approaches.

Other strategies should be closely monitored to ensure they do not marginalize OPDs. For example, there can be a tendency to consult with select persons with disabilities rather than the leaders of OPDs, as a short cut to inclusion. This does not comply with CRPD standards and is an inadequate form of representative participation. Similarly, structures such as national disability councils must not replace or crowd out the perspectives of

OPDs. There are examples of national councils marginalizing the capacity of OPDs to influence legal and policy decisions, or creating the perception that engagement with and financing of OPDs is not required because the views of the council are sufficient.

2. Increase political participation of persons with disabilities

Several barriers restrict persons with disabilities from participating in political life, including voting and standing for office. These barriers include:

- **Restrictive legal frameworks:** Many countries have constitutional or legislative provisions that restrict political participation for persons with disabilities, particularly those with intellectual or psychosocial disabilities (Azerbaijan, Belarus, Belgium, Burkina Faso, Ghana, Kazakhstan, Ukraine).[64] This includes full or partial deprivation of legal capacity under guardianship laws, which often excludes individuals from voting and standing for elections (Austria, Denmark, Malawi).[65]
- **Inaccessible voting procedures:** Physical inaccessibility of polling stations and lack of accessible electoral materials and information limit the participation of persons with disabilities in elections (Austria, Belgium, Burkina Faso, Ghana, Israel, Malawi).[66]
- **Lack of accessible information:** Electoral campaigns, materials and public debates are often unavailable in accessible formats such as Braille, sign language or Easy-Read formats (Belgium, Israel, Kazakhstan, Mauritius).[67]
- **Discrimination and limited awareness among political parties and public institutions:** Political parties and public institutions often lack awareness about the rights and contributions of persons with disabilities, leading to low levels of inclusion (e.g., in candidate lists) and advocacy for their rights (Ghana, Malawi).[68]

Strategies to reduce these barriers can include removing restrictive legal frameworks, increasing resources for supported decision-making and comprehensive accessibility across election procedures (e.g., voting procedures, information about candidates). They can also include actions to increase representation – including of women and other underrepresented groups – as public officials (e.g., quotas for candidates, leadership development programmes) (*see Box 4.18*).

Box 4.18 Examples of strategies to increase political participation

- In its 2018 municipal elections, Tunisia applied a disability quota to candidate lists, leading to the election of 144 people who identified as having a disability.[69]
- Electoral management bodies in the Philippines conducted accessibility audits of polling stations and transport links between the polling stations and surrounding areas.[70] The results were used to implement improvement plans.
- Spain amended its laws so that persons under guardianship can vote.[71]
- Twenty per cent of poll workers in Nepal's 2017 national election were persons with disabilities.

3. Collect data on the participation of persons with disabilities and organizations representing them
Improving data on the barriers and participation rates of persons with disabilities can support evidence-based policymaking and the development of targeted interventions. For example, Australia and Canada have developed indicators to monitor disability inclusion in political participation. IDA's Global Surveys on the participation of OPDs have served as a vital monitoring mechanism for the implementation of Articles 4(3) and 32 of the CRPD and have highlighted key barriers to meaningful participation (*see Box 4.17*).

4. Increase representation within OPDs
The meaningful participation of OPDs also requires proactive efforts to include underrepresented groups, such as women, young people, Indigenous persons with disabilities and those with less visible disabilities. By adopting intersectional approaches, OPDs and States can foster leadership that reflects the diversity within the disability community. Inclusive strategies should proactively involve under-represented groups, promoting unity while respecting diversity.

Sectors

For health, education, employment and social protection, priority actions are presented across a progressive arc to inclusion. This arc demonstrates initial steps that countries can take to improve inclusion of persons with disabilities in that sector, even when financial and technical resources are constrained and underlying systems are weak. It then describes how countries can progressively advance and build upon these initial efforts, as systems develop, political will strengthens and resources increase.

Health

Health is a fundamental right of all people, recognized internationally and in the laws of individual countries.[72] The CRPD provides an international framework that promotes and protects the right of persons with disabilities to enjoy their highest attainable standard of health. It asserts their right to make decisions about their own bodies and their own health care and access services without being discriminated against on the basis of their disability.

A health system encompasses all organizations, people and actions whose primary intent is to promote, restore or maintain health, and thereby to ensure the right to health.[73] The ultimate aim of a fully functioning health system is to achieve UHC for its population, so that all people have access to the full range of the high-quality health services they need, when and where they need them, without financial hardship.[74] UHC covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life-course. Health systems vary across countries in their structure, resources, level of maturity and focus.

There is clear evidence that health systems are not currently achieving equity for persons with disabilities, as they experience stark gaps in health outcomes as well as the quality and cost of care.[75,76] Persons with disabilities experience more than double the mortality rate of those without disabilities, which equates to an approximate 14-year gap in life expectancy.[77] Moreover, they are more likely to have a range of health conditions, including diabetes, HIV and cancer,[78,79] due to a combination of their underlying health condition/impairment, poorer social determinants of health (e.g., poverty, poor access to education, social exclusion) and worse access to health-care services. They also face a range of barriers to accessing health services, including financial, attitudinal, accessibility, informational and logistical barriers.[80]

Consequently, persons with disabilities on average have greater needs for health-care services but experience worse outcomes, including: poorer coverage (e.g., lower rates of cancer screening),[81] worse quality of care (e.g., inadequately skilled health-care workers),[82] including violations of fundamental rights (e.g., forced treatment),[83] and higher out-of-pocket costs.[84] Certain groups may face particularly large inequities, including women with disabilities, people with multiple disabilities and those living in humanitarian settings. Without including persons with disabilities, governments risk not achieving their health goals, the goals of the CRPD or UHC.

Overview of progress and persistent roadblocks

Historically, there has been a lack of focus on the health needs of persons with disabilities by the global health movement, for example because of a lack of awareness and prioritization, and by the disability movement, due to a reaction against the medical model of disability and the equating of disability with poor health. In recent years there has been progress in highlighting the need for a disability-inclusive health sector, though much work remains. An important step was the CRPD coming into force in 2008 and the recognition that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability" (Article 25).[85] Moreover, Article 26 of the CRPD recognizes the importance of rehabilitation. Next, WHO and the World Bank published the *World Report on Disability* (2011), which clearly explained the need for health services for persons with disabilities, including rehabilitation, and how they are left behind.[86] The 2019 United Nations General Assembly made a political declaration for the high-level meeting on UHC highlighting the importance of disability inclusion.[87]

In 2021, the World Health Assembly adopted a landmark resolution on "The highest attainable standard of health for persons with disabilities" (EB148.R6).[88] Following the resolution, WHO produced its 2022 *Global Report on Health Equity for Persons with Disabilities*, which included 40 recommended steps to strengthen the inclusion of persons with disabilities in the health sector.[89] In 2024, WHO launched the *Health Equity for Persons with Disabilities: Guide for Action*, which supports the implementation of these recommendations (*see Box 4.19*).[90] There has been a concurrent growth in attention to health equity for persons with disabilities during this period, reflected in increasing involvement of governments, non-governmental organizations (NGOs), academia, OPDs and other actors around this topic.

Nevertheless, there are persistent roadblocks to the inclusion of persons with disabilities in the health sector due to failures at the system and service delivery levels,[91,92,93] including the following:

- Lack of political commitment, leadership and governance on health equity for persons with disabilities
- Inadequate health financing to support the provision of reasonable accommodations or to mainstream disability inclusion and accessibility within health systems
- Gaps in service delivery in both mainstream services (e.g., cancer screening, immunization, rehabilitation services, early identification and support services for children) as well as specialist services required to identify and manage impairments
- Health and care workforce without the skills, training, resources and competencies to provide quality care for persons with disabilities
- Inaccessible health-care facilities, equipment, communication and digital technologies
- Lack of monitoring on equity in access to health information, services and outcomes for persons with disabilities
- Limited research and evidence on approaches to support disability inclusion and improve health access/outcomes for persons with disabilities.

These roadblocks create barriers to inclusive health and contribute to the inequities in health outcomes, quality and costs experienced by persons with disabilities.

Steps to accelerate inclusion

Box 4.19 WHO Guide for Action

- The WHO *Health Equity for Persons with Disabilities: Guide for Action* provides practical guidance to countries on how to develop a comprehensive and coherent plan to advance health equity for persons with disabilities through integration of disability into initiatives for strengthening health systems and primary health care.[94] It serves as a foundational resource supporting Member States to meet commitments to achieving the highest attainable standard of health for all people, as outlined in the SDGs, the CRPD and World Health Assembly Resolution 74.8.
- The *Guide for Action* is designed for use at national and subnational levels and is structured for greatest flexibility with options for tailoring to specific country situations and contexts. It supports countries through a four-phase process: (1) the planning phase to identify and engage with key stakeholders, including OPDs; (2) a situational assessment to identify gaps and opportunities for disability inclusion in the health sector; (3) design of an action plan with priority activities with costing, as well as a monitoring and evaluation framework; and (4) implementation of the action plan and building the capacity of stakeholders.
- The *Guide for Action* is implemented in countries through collaboration between WHO, ministries of health and relevant stakeholders, including persons with disabilities, OPDs and civil society.

There are multiple and complex reasons why people with disabilities frequently experience poorer health and higher mortality, including poverty, limited training of health-care workers on disability, inaccessible infrastructure and large gaps in care and support.[95,96,97] There is therefore no single solution to reduce these health inequities. Instead, a multisectoral, multi-level and system-wide approach is needed, as outlined in the 2022 WHO *Global Report on Health Equity for Persons with Disabilities.*[98]

Different countries are currently at different stages in the level of health equity for persons with disabilities, and so recommendations must be adapted and tailored for individual countries. Nevertheless, the process of setting actions must always be based on evidence and systematic (i.e., including a planning stage, situational analysis, priority action setting and monitoring and evaluation) and rooted in the principles outlined in the WHO *Guide for Action* (*see Box 4.19*). It is imperative that all actions are undertaken by working in partnership with persons with disabilities and OPDs, including at the planning, implementation and evaluation stages. Persons with disabilities are highly diverse and experience different health needs and barriers according to characteristics such as age, gender and impairment type. It is therefore important to consult widely to ensure intersectional and core concerns are considered.

The suggested actions to promote equity for persons with disabilities in the health sector, presented in the next section, were based on the 40 steps recommended in the 2022 WHO report.[99] The core actions were defined and prioritized through expert consultation with an advisory group, which included representatives of OPDs.

Key actions to promote equity for persons with disabilities in the health sector

1. Promote political commitment, leadership and governance for disability inclusion in the health sector

Initiating

- Raise awareness of health equity for persons with disabilities within the Ministry of Health (e.g., events, training) with the meaningful participation of persons with disabilities and OPDs.
- Establish a focal point or committee within the Ministry of Health with the responsibility for coordinating disability inclusion across the health system.

Progressing

- Integrate disability inclusion in national health strategies, policies and laws, in line with the CRPD and the WHO 2022 report, including establishing accountability mechanisms.
- Integrate health equity in disability strategies, policies and laws, in line with the CRPD and the WHO 2022 report, including establishing accountability mechanisms.

Maturing

- Health equity for persons with disabilities is a priority within the Ministry of Health, mainstreamed across all health programmes in the health system.
- The Ministry of Health has taken a stewardship role for disability inclusion through multisectoral engagement, ensuring that policies or public health interventions led by other sectors are disability-inclusive (e.g., health programmes delivered in schools, population-wide physical activity campaigns or water, sanitation and hygiene [WASH] policies).
- Disability inclusion is integrated in national health strategies and health equity in disability-related strategies in alignment with the CRPD.
- Legislation and policies are aligned with the CRPD and there is an established accountability mechanism to oversee implementation.
- Persons with disabilities and OPDs are actively and meaningfully engaged in all health sector processes.

Box 4.20 Mainstreaming disability using a human rights approach in Uruguay

In the past five years, the Government of Uruguay has been taking a human rights approach to mainstreaming disability in the health sector under an innovative nationwide project involving several government bodies, United Nations organizations, civil society and OPDs.[100] The strategy, entitled 'The right to equality and non-discrimination of persons with disabilities', includes activities such as:

- Improving access to health, with a focus on the sexual and reproductive health of young persons with disabilities
- Training health workers
- Providing accessible information
- Establishing care protocols based on human rights
- Preventing and highlighting gender-based violence and other forms of institutional violence by adapting protocols for accessible care
- Incorporating a disability component in administrative records and data sources, and by training state technicians, civil society organizations and academia on the methodologies to survey and assess disability.

Across the development and implementation of the strategy, persons with disabilities provide technical inputs and take part in exchange spaces or dialogue tables.

2. Establish inclusive health financing mechanisms to advance health equity for persons with disabilities

Initiating

- Work with the social protection sector to initiate strategies to progressively address certain health-related needs of persons with disabilities, such as cash transfers or transport subsidies to support access to health care for persons with disabilities.
- Collaborate with development agencies and other actors to increase funding to address health inequities for persons with disabilities in all their diversity, such as supporting the provision of reasonable accommodation and accessibility measures in health-care facilities.

Progressing

- Include funding for disability inclusion in the Ministry of Health budget and funding mechanisms to mainstream disability inclusion and accessibility within health systems; this can involve, for example, training health workers or the provision of accessible communication and facilities.
- Progressively allocate funding for improving and strengthening health services for specific impairments, rehabilitation and early childhood development services in packages of care for UHC.

Maturing

- Ensuring equity, as a core principle in health financing, includes targeted actions to address the needs of persons with disabilities.
- There are established cross-sectoral investments contributing to health equity for people with disabilities, going beyond the health system and looking at cross-sectoral public health interventions and addressing social determinants of health.
- Health services for specific impairments, as well as assistive products, are funded within packages of care for UHC.
- Existing social protection mechanisms to cover indirect costs of seeking health care are fully inclusive of persons with disabilities.
- National health budgets finance support persons, interpreters and assistants of persons with disabilities, and disability mainstreaming interventions.

3. Ensure access to inclusive, high-quality and comprehensive models of health care for persons with disabilities in all their diversity

Initiating

- Establish an agreed implementation plan on disability inclusion (e.g., a specified protocol/guidance/standards), to accompany the implementation plan for health services provided within the health system (e.g., HIV treatment, immunization, early screening and identification services for children, prevention of non-communicable diseases, sexual and reproductive health and rights).
- Pilot-test approaches to provide care to persons with disabilities in their communities, such as in local health-care facilities or home-based health settings, or in relation to strategies for deinstitutionalization.

Progressing

- Progressively integrate disability inclusion considerations into quality care mechanisms of the health system. This can include, for example: existing health safety protocols; feedback mechanisms at facility level, for instance an accessible complaints process to record barriers and/or quality concerns, or accessible safeguarding processes; or care pathways, for instance by establishing inclusive and accessible referral mechanisms.
- Progressively strengthen services such as rehabilitation, assistive technology and early identification and support for children with disabilities as part of health packages of care.

Maturing

- The full spectrum of health services, including mainstream services such as rehabilitation, as well as specialized services for specific impairments and early identification services, are fully integrated in the UHC packages of care and delivered in an inclusive way close to where people live.
- Disability inclusion is well integrated into existing health safety protocols, feedback mechanisms and care pathways.
- Governments fully implement person-centred, rights-based community services instead of long-term health and social care institutions.

Box 4.21 Early identification of children with hearing loss

Early detection of impairments in children is critical to support early intervention and to maximize their functional development. For instance, identifying hearing impairment in young children is vital for their language and communication development. Mobile technology is increasingly used to facilitate screening and early detection, especially in low- and middle-income countries. These approaches are often relatively low cost yet sufficiently accurate and reliable, and may be implemented by community health workers, other health-care workers at primary care level or teachers. For instance, smartphones can be used by non-specialists to screen for hearing (e.g., using hearTest) and vision impairment (e.g., using Peek vision).

A good-practice example comes from South Africa, where community health workers used mobile technology to identify young children with hearing and vision loss. They screened 10,390 preschool children (mean age 5.7 years) living in low-income communities. As a result, 254 children with potential hearing impairment and 317 with potential visual impairment were identified and referred for further testing and investigation at specialist clinics.[101] These technologies have also been used to screen schoolchildren for hearing and visual impairments across southern Africa and other countries.[102,103]

4. Build the capacity of the health and care workforce to deliver quality care to persons with disabilities in all their diversity

Initiating

- Provide in-service training on health equity for persons with disabilities, including the need for informed consent and elimination of forced treatment, for all existing health providers, including medical, nursing and allied staff.

Progressing

- Initiate adoption of competency-based training on health equity for persons with disabilities in the educational curricula of all health workers.
- Promote inclusion of persons with disabilities in the health workforce.

Maturing

- Competency-based training on health equity for persons with disabilities is integrated into the pre-service curriculum of all health workers.
- Existing medical, nursing and allied staff are well trained and supported to achieve health equity for persons with disabilities, for example through mentoring or evaluation of skills.
- Persons with disabilities, including women and gender-diverse people, have equal opportunities to participate in the health workforce.
- Persons with disabilities, including those with intellectual and psychosocial disabilities, are supported to provide informed consent for health-care treatment, and forced treatment does not occur.

Box 4.22 Oliver McGowan mandatory training on learning disability and autism in the United Kingdom

The Oliver McGowan training on learning disability and autism is mandatory for all health and care staff in the National Health Service in the United Kingdom.[104] This training is implemented to ensure that the health and social care workforce has the right skills and knowledge to provide safe, compassionate and informed care to persons with autism or learning disabilities. This requirement is set out in the Health and Care Act of 2022. The training includes components on communication skills, the importance of person-centred care, addressing barriers, and legal and ethical considerations. A core element of the training addresses informed consent, explaining its importance, teaching communication skills and emphasizing the need to respect the autonomy and decisions of the individual.

5. Ensure accessibility in all digital and physical communication materials and technologies and health infrastructure, including provision of reasonable accommodation

Initiating

- Establish national accessibility standards for physical and digital health infrastructure, building on available international standards.
- Undertake an accessibility audit of physical and digital health infrastructure.

Progressing

- Apply accessibility standards for physical and digital health infrastructure by undertaking audits and adapting key existing infrastructure to become accessible, and by ensuring new infrastructure is built to be accessible.
- Establish mechanisms to promote the improvement of accessibility, such as accountability or incentive schemes or procurement of accessible equipment at affordable prices.

Maturing

- Physical, communication and digital-health infrastructure is fully accessible for persons with disabilities in all their diversity, applying standards for accessibility and universal design, and including the provision of reasonable accommodation.

Box 4.23 Assessing accessibility in the health sector

The Accessibility Standards and Audit Pack launched by Sightsavers in 2018 was designed to support the development of national accessibility standards, assess existing health infrastructure and guide the development of new health-care facilities.[105] In 2022, the pack received a Zero Project Award as an innovative practice in the field of accessibility. So far, Sightsavers has used the Accessibility Standards and Audit Pack to train over 400 representatives of OPDs, governments and the private sector – who then conducted accessibility audits and coordinated priority renovations in over 80 health-care facilities across 9 countries (e.g., Bangladesh, Malawi, Mozambique, Nigeria and Pakistan).

6. Generate country-specific data and evidence on health equity for persons with disabilities

Initiating

- Undertake a mapping exercise to identify data collection and research activities on disability inclusion and health within the country.
- Analyse existing health data from national surveys, disaggregated by disability and other characteristics, for example, the national census or health or demographic surveys.

Progressing

- Create a monitoring and evaluation plan for disability inclusion within the health sector.
- Draft and pilot a plan for incorporating disability data in national and subnational health information systems.
- Collaborate with research institutions and OPDs to undertake research on disability inclusion at policy and systems levels, to inform improvements at national and subnational level.

Maturing

- There is an established and integrated monitoring and evaluation plan for disability inclusion within the health sector that is fully implemented and used to inform policy and resourcing.
- Indicators for disability inclusion are well integrated and disaggregated as part of the national health information systems, both at population and facility levels, including in electronic health records, and used to inform policy and resourcing.
- There is a national health policy and systems research agenda on health equity for persons with disabilities, executed in collaboration with research institutions and OPDs.

Box 4.24 Improving data and evidence on disability in the health sector in Australia

A good-practice example of embedding disability identifiers within health administration data comes from the state of Victoria in Australia.[106] Persons with disabilities, health workers and experts in disability and data partnered and co-designed, implemented and evaluated patient self-report 'Disability Identifier' questions, which can be integrated into hospital electronic medical record systems. As of March 2023, the Disability Identifier was made available in two different systems at five partnering Victorian health services. Their patients and carers now have the option to self-report whether they have a disability and detail their specific care preferences. The Disability Identifier can be completed via an online patient portal or with the assistance of health workers. The information provided is automatically displayed within patients' medical records to help health workers determine which adjustments and referrals may be required to improve hospital care for patients with disability. As of December 2024, more than 66,000 patients had completed the Disability Identifier questions.

Education

Article 24 of the CRPD stipulates that States must ensure all education systems are inclusive and that persons with disabilities have access to an inclusive, quality education on an equal basis with others.[107] Inclusive education is also embedded within the 2030 Sustainable Development Agenda, particularly Goal 4, which calls for "inclusive and equitable quality education" for all, with specific reference to persons with disabilities.[108]

Inclusive education seeks to transform school systems so that they cater to the needs of all students, including children with disabilities.[109,110] The General Comment 4 by the CRPD Committee is clear that inclusive education "requires an in-depth transformation of education systems in legislation, policy and the mechanisms for financing, administering, designing, delivering and monitoring education". To make education systems inclusive, persons with disabilities must not be segregated from mainstream schools and classrooms. Further, school environments, curricula, teaching practices and cultures must be accessible and consider the diverse learning and social needs of children with disabilities, including those with intellectual or psychosocial disabilities and those facing multiple forms of discrimination (e.g., due to gender, sexual orientation, race, ethnicity, religion, displacement or poverty).

Excluding persons with disabilities from education has an economic cost to individuals, their households and society due to lower participation in work, loss of taxes and earnings and decreased GDP.[111] Investing in inclusion, on the other hand, leads to economic gains. For example, in countries such as China, Nepal, the Philippines and the United States, each additional year of completed schooling by persons with disabilities yielded a wage return of between 6 and 26 per cent.[112,113,114,115,116] The benefits from inclusive education are more than just economic. They include improving attitudes on disability, self-sufficiency, confidence and physical and mental well-being.[117,118,119,120] These social and economic benefits to inclusive education are experienced by children with and without disabilities and their communities.[121,122]

Overview of progress and persistent roadblocks

School attendance in some countries has increased for both boys and girls with disabilities over recent decades;[123,124,125] however, due to challenges in how data are collected in different countries, it is unclear if these increases are seen in inclusive settings.

There is also growing focus in national policies and laws on the rights of children with disabilities to an education. As of 2021, 86 per cent of countries had laws and policies protecting the right of children with disabilities to education, although only 17 per cent of countries had guarantees of education in inclusive settings.[126] Further, there is an increasing amount of data on education and disability, including through the Washington Group-UNICEF Child Functioning Modules (*see Chapter 2*).

However, children with disabilities continue to experience inequalities in terms of attendance, progression, attainment, development of skills and social inclusion within schools.[127,128,129,130] For example, children with disabilities are more likely to be over-age for grade, leave school early, repeat a grade and experience bullying, and are substantially less likely to have foundational reading and numeracy skills than children without disabilities.[131] Additionally, overall trends tend to obscure significant discrepancies that exist in relation to gender, poverty, type of impairment, level of support needs and context.[132,133,134,135]

The following are key barriers to ensuring the rights of children with disabilities to inclusive education:

- Physically inaccessible schools (including WASH facilities) and journeys to school (e.g., lack of accessible transportation)
- Lack of adapted, flexible and accessible curricula, communication and learning materials
- Stigma and discrimination and low expectations of children with disabilities among school staff, peers and caregivers
- Inadequate classroom support and pre- and in-service training programmes for teachers, which are essential for equipping them to adopt Universal Design for Learning[a] in ways that are contextually appropriate and build on locally available resources
- Poor access to assistive technology, health care and other services required to support participation in education for children with disabilities
- Lack of data at national and school levels, including on type of educational setting (e.g., inclusive versus segregated classrooms or schools) and individual support needs for inclusion in education.

Further, the rise in humanitarian crises, climate change and other emergencies, which disrupt education and disproportionately affect persons with disabilities (*see Chapter 3*), complicates delivery of and access to inclusive education.[136]

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[a] Universal Design for Learning is a set of principles for ensuring schools and teaching and learning processes are universally accessible and meet the diverse needs of all learners – including students with disabilities.

Steps to accelerate inclusion

There is still much to be done to make inclusive education for children with disabilities a reality. It is important to recognize that development of an inclusive education system is highly contextualized. Countries differ in their current approaches to education broadly and for children with disabilities specifically. The availability of resources to invest in inclusive education also vary. Moreover, efforts to achieve inclusive education are significantly shaped by the larger socio-political and economic milieu. In light of these challenges, the next section defines priority actions that all countries can adapt to advance inclusive education for children with disabilities. They are informed by a workshop on disability-inclusive education which took place in preparation for the Global Disability Summit (2025) (*see Box 4.25*).

Box 4.25 Recommendations for making the Global Disability Summit 2025 count

In preparation for the Global Disability Summit (GDS) 2025, a workshop was held on disability-inclusive education at Hughes Hall College, University of Cambridge, 17–18 September 2024.[137] This participatory workshop was organized by the Cambridge Network for Disability and Education Research (CaNDER), IDA, CBM, UNICEF and the World Bank and involved 48 attendees from 31 organizations. It brought together international stakeholders, including representatives of the co-hosts of the GDS 2025 – IDA, the governments of Germany and Jordan – civil society organizations, policymakers and education experts.

Through a series of plenary sessions, presentation of new research evidence, small-group discussions and the generation of a 'living visual representation', the participants agreed on a series of priority actions entitled 'Making GDS 2025 Count'.[138]

Key actions to accelerate inclusion of children with disabilities in education

1. Promote political commitment, governance and increased visibility for inclusive education

Initiating

- Strengthen legislative frameworks by enacting and implementing legislation that enshrines the right to inclusive education for all children without discrimination on the basis of disability, in compliance with the CRPD, and ensuring accountability mechanisms for enforcement.
- Establish coordination mechanisms by designating a focal point within the Ministry of Education and/or the education cluster[b] who is responsible for coordinating disability-inclusive education, including with other relevant sectors (e.g., the Ministry of Health for early intervention services and health-related programmes delivered in schools).
- Raise awareness about disability-inclusive education by developing and implementing awareness and advocacy campaigns through traditional and social media, targeting policymakers, educators, persons with disabilities and their families, and the public. Messaging must emphasize the value of inclusive education and the rights to education of learners with disabilities and leverage the voices of young people with disabilities and OPDs.

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[b] An interagency coordination mechanism at country and global levels to respond to education needs during humanitarian emergencies.

Progressing

- Collaborate with OPDs and communities to identify and address the root causes of stigma and discrimination that prevent children with disabilities from attending schools or limit their social inclusion in schools, including through evidence-based social and behavioural change approaches and interventions to foster societal and institutional change.
- Develop implementation road maps in consultation with OPDs and families. This involves creating comprehensive policies and strategies for implementation of inclusive education that include activities, milestones, budget allocations, monitoring frameworks and accountability mechanisms.
- Ensure cross-sectoral coordination by appointing focal points for disability-inclusive education across relevant ministries (such as the ministries of infrastructure, and child and family issues) and establish coordination and financing mechanisms, monitoring and evaluation frameworks and a clear role for different stakeholders, including OPDs, families and communities.

Maturing

- Twin-track approaches to disability inclusion are institutionalized within education settings, This approach entails mainstreaming inclusion and providing targeted support to those at highest risk of exclusion. It includes strong school-based support systems which provide reasonable accommodations and support learners with a diverse range of learning needs.
- National and subnational intersectoral disability-inclusive education plans are in place, with dedicated budgets, clear responsibilities and strong accountability mechanisms. Coordination mechanisms between the education and other key sectors (e.g., health, social protection) ensure access to support services that promote inclusion in education (e.g., assistive technology, early intervention, rehabilitation and other health care, and financial support for families). OPDs and young persons with disabilities are consistently and meaningfully engaged in decision-making across the education sector.
- Disability-inclusive school-based water, sanitation, health (including sexual and reproductive health and rights and mental health and psychosocial support) and nutrition programmes are available. This includes school feeding programmes as well as universal school-based screening and early intervention services.

2. Increase investments in disability-inclusive education financing

Initiating

- Conduct a comprehensive baseline assessment of current national expenditures on education for children with disabilities, including budgets spent on mainstream versus segregated education.
- Develop a budgeting framework that aligns with the CRPD, for example by progressively transitioning resources from segregated to inclusive education.
- Plan for disability inclusion from the beginning. Costs will be cheaper if inclusion is budgeted for at the outset (e.g., building accessible schools rather than retrofitting). Embed principles of inclusive education pedagogy and Universal Design for Learning at the very start of new teacher education programmes.
- Mobilize resources for inclusive education, including through national budgeting (e.g., taxation and other measures), as well as through collaboration with civil society and development agencies.

Progressing

- Hardwire disability inclusion into mainstream education budgets, aligned with a twin-track approach and the CRPD, and progressively increase expenditures.
- Prioritize pro-equity spending to meet the needs of the most marginalized, including among persons with disabilities (e.g., scholarships and eliminating primary school fees; access to free transport; supporting out-of-school children with disabilities to return to school).
- Generate and channel the required resources for effective and ongoing implementation of inclusive education obligations and other commitments, led by government with collaboration from OPDs, development agencies and other civil society organizations.

Maturing

- All budgeting for disability inclusion is aligned with the CRPD, including through investing in the provision of mainstream rather than segregated education.
- Countries meet the universally agreed recommendations of allocating 4–6 per cent of GDP and/or at least 15–20 per cent of public expenditure to education, with equitable allocations for inclusion.
- Education policies and programmes are regularly monitored and evaluated to assess their impact and cost-efficiency to inform decision-making and refine strategies.

3. Ensure the inclusion of learners with disabilities in mainstream education systems and high-quality learning environments

Initiating

- Ensure that national legislation is aligned with the CRPD, including through prohibiting discrimination on the basis of disability in admissions and adopting clear policies for the enrolment of learners with disabilities in mainstream schools.
- Develop and implement national standards for accessible schools (e.g., for infrastructure and digital platforms).
- Undertake an audit of existing curricula to review and adapt for effective disability-inclusive education in line with the principles of Universal Design for Learning. Similarly, undertake an audit of existing assessment processes and systems and develop plans for accommodations for learners with diverse disabilities, ensuring equity in national assessments.

Progressing

- Conduct regular audits of infrastructure, curriculum, teaching practices and assessments. These audits are needed to ensure the continued provision of reasonable accommodations, and compliance with the CRPD, the principles of Universal Design for Learning and implementation of national standards.
- Provide school leaders and teachers with resources to develop and implement action plans for capacity development, social behaviour change, promoting social inclusion of children with disabilities, provision of individualized supports and reasonable accommodations, and school infrastructure.

Maturing

- Safe and inclusive learning environments for students with disabilities in all their diversity (e.g., considering gender, different impairments and support needs, migrants and displaced persons) are in place within all mainstream schools. To do so, schools must be aligned with the CRPD, including ensuring accessible school infrastructure, spaces for inclusive play, and delivery of inclusive nutrition and health programmes. Schools should respect and value diversity and have zero tolerance for bullying, stigma and discrimination.

- Accessible and inclusive teaching and learning materials – including in additional languages where relevant – as well as reasonable accommodations and individualized supports (e.g., Braille, co-teaching) are available.
- The education system supports the participation and empowerment of families who have children with disabilities in all activities carried out by the educational community. Families with children with disabilities should be visible and attend meetings with other families to allow them to build support networks and become an active part of the community.

Box 4.26 Sign bilingual education in Hong Kong Special Administrative Region, China

School environments must respect and foster the cultural and linguistic identities of children who are deaf and hard of hearing. Bilingual and multicultural environments allow children to be taught in sign language, interact with peers and teachers fluent in sign language and learn about deaf culture within mainstream schools.

The Sign Bilingualism and Co-Enrolment in Deaf Education (SLCO) programme in Hong Kong Special Administrative Region, China, enables children who are deaf and hard of hearing to learn together with hearing children in a bilingual, mainstream environment.[139] A hearing teacher and a deaf teacher work collaboratively, using sign and oral languages. Classrooms typically have ratios of one child who is deaf or hard of hearing for every three to four hearing children. SLCO programmes are available across kindergartens, primary and secondary schools, reaching more than 500 children. They are also being expanded to other areas, such as Singapore, Macao and Quzhou in mainland China.

4. Increase the capacity of the educational workforce for inclusive education

Initiating

- Promote the recruitment and retention of teachers, especially teachers from minority groups, female teachers, teachers with disabilities and teachers fluent in national sign languages or Deafblind interpretation.
- Train educators to use and integrate assistive technology and no-tech, low-tech and high-tech education technology into classrooms. Education technology should offer high-quality, accessible and affordable digital and remote learning tools.
- Build the capacity of school leaders to support inclusion, as they are central to the success of developing a whole-school approach to inclusive education.
- Provide pre-service and in-service teacher education to support identification and removal of barriers in the learning environment, identification and support of individual learning requirements and implementation of Universal Design for Learning.

Progressing

- Strengthen teacher training and support. Teachers need to be trained to effectively use assistive and educational technologies to support inclusive delivery of curricula. Teachers also need to be adequately supported through the recruitment and training of support staff, such as teaching assistants and interpreters, to support mainstream teachers.

- Develop teacher competency frameworks to guide capacity development, monitoring and accountability for inclusive practices.

Maturing

- A well-trained and diverse education workforce is in place, who are equipped to implement inclusive education practices effectively. Teacher shortages are avoided by appropriately incentivizing teaching and creating workplaces that foster inclusive practices (e.g., reasonably sized classes). Teachers with disabilities are part of a diverse workforce.
- School leaders, teachers, specialists, interpreters and support staff are part of multidisciplinary teams that are trained to work together and with children and their families to ensure that all children with disabilities can reach their full potential.

Box 4.27 Enhancing educational workforces

- **In Chad,** UNICEF, Humanity & Inclusion and a national NGO (APSELPA) aimed to enhance access to education and learning for children with disabilities as part of a humanitarian response.[140] They trained 110 trainers in inclusive education practices, including on the rationale for and steps involved in developing individualized learning plans (ILPs) for students with disabilities. These trainers then trained teachers and community educators. Through this programme, 1,253 children with disabilities were identified and supported with ILPs. A follow-on project has developed strategies for teachers to measure progress towards goals set in the ILPs.
- **In the United Republic of Tanzania**, Sense International piloted a programme in the Dar Es Salaam and Kilimanjaro regions to support the education of children with deafblindness in mainstream classrooms.[141] As part of this programme, teaching assistants provided learning and communication support, facilitated social interactions, and supplied mobility and orientation support. Teachers were trained to work with teaching assistants, and on inclusive pedagogical approaches to support the diverse needs of students with deafblindness.

5. Strengthen national education data systems, programme monitoring and use of contextually relevant research for decision-making

Initiating

- Develop and strengthen national data systems, surveys and administrative systems to collect data on children with disabilities. This can be done by employing standard tools, such as the Washington Group-UNICEF Child Functioning Module, to increase the availability, quality and comparability of data. Disaggregate data by sex, age, disability, geography and other intersecting dimensions.
- Assess and strengthen the efficiency of education management information systems to ensure they can collect programme and individual learner data that are timely and disaggregated for disability, among other factors of exclusion.

Progressing

- Use globally recommended tools, such as the Washington Group-UNICEF Child Functioning and Inclusive Education Modules, in programme-level data, including education monitoring information systems. Data are used to understand learner needs and environmental factors affecting school participation, identity gaps in provision and support inclusive education.
- Develop comprehensive monitoring and evaluation frameworks for disability inclusion in the education sector to evaluate the effectiveness of inclusive education programmes.
- Invest in contextually relevant research, including pilot-testing innovation in the development of inclusive systems, studies on effective teaching practices and evaluations of the impact of inclusive education on the overall quality of education.

Maturing

- Data on disability are regularly collected in national surveys and administrative systems to monitor inclusion of children with disabilities in education and inform decision-making. Information is collected on children who are both in and out of school, and is disaggregated by gender, age, migration/displacement status, geography and other characteristics.
- Data systems across health, education, social welfare and other systems are harmonized. These systems collect data on children with disabilities using globally recommended tools and are interoperable to ensure continuity of services and assistance across the life cycle and across sectors. This includes provision of early intervention to children with disabilities, or who are at risk of disability, and their families.
- Local research institutions and researchers, including researchers with disabilities, collaborate to establish and carry out a contextually relevant research agenda. Research includes a focus on learning outcomes for students with disabilities, costing and cost-effectiveness of programmes and policies, innovation in the development of inclusive systems and the scaling of successful implementation models.

Box 4.28 School information management systems in Lebanon

In 2024, the Ministry of Education and Higher Education in Lebanon partnered with UNICEF to enhance data collection on children with disabilities by piloting an amended disability module in the information management systems in public schools. Key changes included making the disability module mandatory rather than optional; capturing information on functioning (e.g., Washington Group) rather than only on impairments; and establishing linkages with the Ministry of Social Affairs database to capture information on whether children had a formal certification of disability (i.e., a disability card). The pilot-testing identified several areas for improvement before wider scale-up, including providing more training to teachers who would be making assessments, and resolving technical issues, such as poor connectivity in rural areas.

Work and employment

Under Article 27 of the CRPD, persons with disabilities have the right to decent work on an equal basis with others.[142] Decent work is defined by the International Labour Organization (ILO) as "productive work for women and men in conditions of freedom, equity, security and human dignity". Decent work must provide workers with secure employment, safe working conditions, fair wages, equal treatment, access to social protection and labour protections, and opportunities for personal development and social integration.[143] It must also be freely chosen and in work environments that are open, inclusive and accessible. The 2030 Sustainable Development Agenda calls for "full and productive employment and decent work for all", with specific reference to inclusion of persons with disabilities under Target 8.5.[144]

Yet, as described in Chapter 1, persons with disabilities remain excluded from decent work. Importantly, there is a significant and persistent gap (30–40 percentage points depending on country) in employment-to-population ratios between persons with and without disabilities.[145] Women with disabilities are more likely to be out of work than men with disabilities, as are persons with intellectual and psychosocial disabilities and high support needs. Young persons with disabilities are twice as likely to be neither in employment, education or training than young people without disabilities.

When employed, persons with disabilities earn on average 12 per cent less than persons without disabilities – and are overrepresented among people with low wages – which is only partially explained by differences in education.[146] Women with disabilities then experience an additional gender wage gap, earning 5–6 per cent less than men with disabilities. Other employment indicators highlight the precarity of work for persons with disabilities, including their higher likelihood of working in the informal sector and in self-employment, exclusion from leadership positions and greater risk of losing work.[147,148,149,150,151] They also face discriminatory practices, such as the legal use of sub-minimum wages and employment in sheltered workshops – with people with intellectual and psychosocial disabilities particularly affected by these measures.

Overview of progress and persistent roadblocks

There has been some progress in recent decades in promoting access to decent work of persons with disabilities, including in low- and middle-income countries. The rights of persons with disabilities in work and employment have been increasingly recognized in national laws and policies. For example, across 193 countries, 62 per cent have legislation broadly prohibiting discrimination on the basis of disability. However, only 30 per cent prohibit workplace harassment due to disability, 47 per cent outlaw discrimination in pay or promotions/demotions and 52 per cent require employers to provide reasonable accommodations.[152] There has been progress in establishing programmes and policies to improve opportunities for work, such as the expansion of business and disability networks in Africa, Asia and Latin America. These networks support companies by providing technical guidance and peer-to-peer exchange on how to become inclusive of persons with disabilities.[153] Some countries, such as Brazil, France and Kenya, have implemented disability employment quotas, although they are primarily restricted to the formal or public sectors, tend to favour persons requiring few adjustments and can be inadequately enforced.[154,155]

Despite this progress, **significant challenges remain, particularly in the informal economy**. Globally, more than 60 per cent of all jobs are in the informal economy,[c] exceeding 90 per cent in many low- and lower-middle-income countries.[156] Persons with disabilities are more likely to be employed in the informal economy than persons without disabilities, often in self-employment. As such, most persons with disabilities do not benefit from labour-market policies and employment-related social protection schemes (e.g., unemployment insurance, pensions, sick leave, workers' compensation, quotas), which are mainly associated with the formal sector. While there has been some progress in increasing access to formal sector employment for persons with disabilities, many governments, OPDs, civil society organizations and development agencies recognize the importance of strengthening the livelihoods of persons with disabilities in the informal economy, since it is the primary source of employment in low- and middle-income countries. Therefore, programmes and policies to support livelihood development and entrepreneurship for persons with disabilities in the informal economy (e.g., microfinance, livelihood or skills development programmes) are increasingly being implemented, but with limited evidence of impact.[157]

Another challenge is the design of **social protection policies, which historically consider disability mostly from the perspective of incapacity to work and compensation for loss of earning** (*see the next section, Social protection*). Indeed, many disability-targeted benefits (e.g., disability cash benefits) have had and still have, in many countries, stipulations that persons with disabilities cannot receive them if they work or if they earn above a certain (often low) threshold. Such policies may undermine participation in work for persons with disabilities who face significant challenges in finding and keeping work, and encounter additional costs when working (e.g., additional transport). In recognition of these challenges, several countries – such as Brazil, Fiji, Namibia and Thailand – have reformed or adopted disability-targeted schemes that are compatible with work, such as removing incapacity to work eligibility criteria from disability benefits. There are also increasing social protection programmes to strengthen entrepreneurship and work in the informal sector, including financial assistance to take part in programmes for skills development.

Beyond government policies related to the labour market and social protection, other persistent roadblocks have prevented persons with disabilities from engaging in work, receiving fair compensation and advancing in their careers, both in the formal and informal sectors. They include:

- Lack of skills due to earlier exclusion from education and training opportunities
- Inadequate access to assistive technology, health care and other goods and services needed to support engagement in work
- Discrimination on the basis of disability from employers, colleagues, suppliers and potential clients
- Inaccessibility of workplaces, transport systems and other places of business (e.g., online and in-person marketplaces to sell and purchase goods and services)
- Poor access to credit and financing to grow businesses due to poverty, discrimination and inaccessible banking systems; and exclusion from many mainstream work and employment programmes.

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[c] The informal economy refers to economic activity that is not covered, or not covered sufficiently, by formal arrangements. It is often not taxed or monitored by regulatory bodies.

Women with disabilities encounter additional barriers due to gender norms, gender-based violence and discrimination at places of work, and lack of legal protections, such as maternity or carers' leave. Inflexible working arrangements can limit engagement in work for providers of care and support, who are predominantly women.

Steps to accelerate inclusion

Importantly, national and subnational strategies must consider the **level of formality of the economy**. Efforts to promote inclusion in the formal sector and increase formalization of the informal sector (e.g., enforcing compliance with labour laws, increasing access to social protection programmes) must be inclusive of persons with disabilities. While these efforts are important, they must also be balanced with other actions to improve the working conditions, labour rights and opportunities for growth of persons with disabilities who remain in the informal economy, since it is likely to continue to be their dominant source of work for the foreseeable future. It is therefore important that countries create polices, programmes and conditions that are relevant to both formal and informal sectors, as well as in different parts of the country (e.g., rural and urban).

Strategies must also consider **dominant industries** in a given context. In many low- and lower-middle-income countries, and in rural areas within countries, agriculture is the main livelihood. For example, in Uganda 68 per cent of the working population works in agriculture, forestry and fishing; with women and people in rural areas particularly likely to work in this sector.[158] Strategies to promote access to and sustainability of work should consider the demands and opportunities of local markets, including through labour-market assessments.

Strategies must also prepare persons with disabilities for the **future of work**. There are new or growing risks of and opportunities for decent work for persons with disabilities, including from climate change and technological advances (*see Chapter 3*). For example, jobs in many markets are increasingly requiring digital skills, while farming and other industries require adaptation to practices to withstand the impacts of climate change. If the labour markets of the future are to be more inclusive than the current ones, persons with disabilities must be fully included in all initiatives to both mitigate negative impacts on work from these trends and maximize opportunities. Importantly, skills relevant to digital and green economies are very likely to be increasingly demanded in all economies, including in low- and middle-income countries.

Finally, although governments are essential for shaping work and employment opportunities, they alone cannot ensure access to decent work for persons with disabilities. The private sector, civil society organizations, development agencies, OPDs and others are critical stakeholders in creating the opportunities and conditions to accelerate inclusion in work and employment for persons with disabilities. Consequently, designing, implementing and monitoring comprehensive and effective work and employment strategies will require **partnerships between multiple sectors of governments – such as ministries of labour, social protection and education – persons with disabilities and OPDs, employers, civil society and other actors**.

Key actions to accelerate inclusion of persons with disabilities in work and employment

1. **Establish a legislative and regulatory environment to protect the rights of persons with disabilities to decent work**

Initiating

- Establish national minimum standards for accessibility in the workplace and for the provision of reasonable accommodations.
- Enact comprehensive anti-discrimination laws covering recruitment, hiring, fair pay, workplace harassment, promotions and terminations.
- Raise awareness, in partnership with persons with disabilities and OPDs and among key government stakeholders (e.g., ministries of labour), on the need for disability inclusion within employment laws, policies and programmes.
- Create a focal point or advisory group within ministries of labour, including persons with disabilities and OPDs, to mainstream inclusion across new employment laws and policies.
- Review the impact and possible improvements of existing mainstream and disability-targeted employment schemes, such as vocational training, job-matching, tax incentives and quotas. Focus on equity, including on whether certain groups remain excluded, such as women, persons with high support needs and young people.
- Develop preliminary enforcement mechanisms, such as complaints mechanisms.

Progressing

- Amend existing employment laws, policies and programmes to be inclusive, in line with the principles of the CRPD and in collaboration with persons with disabilities and OPDs.
- Develop contextually relevant policies and programmes to increase work opportunities for persons with disabilities, such as quotas and financial support for reasonable accommodations.
- Strengthen monitoring and enforcement systems, for instance through audits and active review of compliance, and extend this to the informal sector.

Maturing

- The rights of persons with disabilities to decent work is codified in employment laws and policies, such as anti-discrimination laws, workplace accessibility and reasonable accommodation laws and policies and social protection.
- Policies and programmes are in place to improve access to work for persons with disabilities in the formal and informal sectors. This differs depending on the context but can include quotas for persons with disabilities for public and private sector jobs and public procurement tenders; tax incentives or financial support to employers to cover reasonable accommodations; and financial support to persons with disabilities for work-related extra costs such as travel, human assistance and assistive technology.
- Disability inclusion is consistently and meaningfully integrated across national employment policies, programmes and action plans, in collaboration with persons with disabilities and OPDs.
- Robust monitoring and enforcement systems are in place to ensure adherence, for example through fines and sanctions for non-compliance, inspections, audits and complaints mechanisms.

2. Governments, OPDs, employers, civil society and others develop programmes to strengthen livelihoods in the informal sector

Initiating

- Conduct a situational analysis of available opportunities to enhance livelihoods, including in the informal sector (across public, private and non-governmental institutions), and assess the extent to which they are inclusive and accessed by men and women with disabilities. Increase access of men and women with disabilities to available livelihood opportunities (e.g., through awareness-raising, referrals, including through OPDs).
- Review the impact and possible improvement of existing livelihood development programmes for the informal sector.

Progressing

- Adapt existing livelihood development programmes, or create new ones, to be inclusive and widely accessed by persons with disabilities. Adaptations require consideration of additional barriers faced by women, persons with high support needs and others frequently excluded from livelihood programmes.

Maturing

- Men and women with disabilities in the informal economy, including in self-employment, have equitable access to opportunities to create more sustainable livelihoods. Examples include microfinance, village savings and loans groups, trade unions for workers in the informal sector, integration of small-scale producers into agricultural value chains (*see Box 4.29*), job-matching or microenterprise development programmes.

Box 4.29 Disability-inclusive value chains in Papua New Guinea[159]

The European Union-funded, United Nations Joint 'Support to Rural Entrepreneurship, Investment and Trade in Papua New Guinea' (EU-STREIT PNG) programme, led by the Food and Agriculture Organization of the United Nations (FAO), integrates smallholder producers into cocoa, vanilla and fishery value chains in the East and West Sepik provinces. It is implemented with four other United Nations agencies and the Government of Papua New Guinea, micro, small and medium enterprises, NGOs, Chambers of Commerce and academic institutions. Approximately 8 per cent of beneficiaries are persons with disabilities, and the programme collaborates with a national disability rights organization, Callan Services, to promote inclusion and accessibility. Beneficiaries are provided with inputs to strengthen their livelihoods (e.g., solar kits for drying vanilla and cocoa) and gain access to cocoa seedlings, cocoa farms and vanilla vines. The programme also enhances access to finance through community-based banking points called Mama Access Points and mobile banking, reducing long-distance travel – a major barrier for many persons with disabilities. The programme also improved transport infrastructure, resulting in greater road safety, market access and connectivity to community spaces, which enhanced economic development, entrepreneurship and participation opportunities for persons with disabilities. Additionally, renewable energy systems were installed in health centres and schools.

3. Enhance the skills of persons with disabilities, particularly young people, to meet the demands of local markets and adapt to trends affecting the future of work

Initiating

- Conduct a situational analysis of locally relevant, current and emerging industries, available opportunities for skills development in those fields (across public, private and non-governmental institutions) and the extent to which they are inclusive and accessed by people with disabilities, including men, women and young people. Increase access of men and women with disabilities to these available skills development opportunities (e.g., through awareness-raising, referrals, including through OPDs).
- Review the impact and possible improvement of strategies to improve the transition of young people with disabilities from learning to earning, with an emphasis on inclusive education and vocational training.

Progressing

- Adapt existing and new opportunities for skills development to be inclusive and widely accessed by persons with disabilities, including training of instructors; accessibility across curricula, facilities and communication; and financial support for participation. Adaptations require consideration of additional barriers faced by women, persons with high support needs and others frequently excluded from skills development opportunities.

Maturing

- Men and women with disabilities, including youth, have equitable access to inclusive, accessible and quality opportunities for skills development. This can include formal education, technical and vocational education and training, mentorship, apprenticeships and other workplace-based learning. These opportunities are aligned with the demands of local markets and the future of work, including, for example, digital skills and those related to the green economy. Self-employed persons and entrepreneurs with disabilities access additional skills trainings, such as book-keeping and compliance with local and national regulations.

Box 4.30 STAR+ programme for young persons with disabilities in Bangladesh

The NGO BRAC in Bangladesh has run the STAR programme for youth who are out of school and work.[160] STAR has reached more than 60,000 young people, including those with disabilities, which represents 11 per cent of graduates. The programme's implementers recognized that further adaptations to STAR could make the programme even more inclusive. They piloted an adaptation of the programme – STAR+ – in 2022 for young persons with disabilities, which was developed and implemented in close collaboration with OPDs, persons with disabilities and the Government of Bangladesh.

STAR+ involves multiple components, starting with participants choosing a preferred trade from a list that BRAC developed by assessing the labour market. Young people are then trained to develop skills in that trade over six months through a combination of classroom trainings (once a week) and on-the-job paid apprenticeships (five days a week). The classroom trainings and the apprenticeship workplaces were adapted to be accessible, and employers and trainers received sensitization on disability inclusion. Young people also received access to assistive devices and rehabilitation support to enhance their participation. After the six-month training period, participants were matched to a paid job in their trade.

4. Create social protection systems that enhance job security and employment opportunities for persons with disabilities

Initiating

- Adopt or reform disability-targeted benefits so they are compatible with work as well as with existing vocational training and livelihood schemes. They should also contribute to disability-related costs, including those related to work.
- Provide accommodations so that persons with disabilities can be included in public works programmes.
- Enhance access to existing social protection programmes (*see the next section on Social protection*).

Progressing

- Expand existing social protection programmes for decent work, for example by covering more people and increasing the range of benefits that are offered, with flexibility for exit and re-entry in income security schemes. Ensure meaningful engagement of persons with disabilities and OPDs in design and implementation, as well as monitoring and evaluating real and potential impacts, including among women and persons with high support needs.

Maturing

- All workers with disabilities are covered by a comprehensive range of social protection programmes to support engagement in decent work, including unemployment insurance, workers' compensation, sick leave, pensions, and parental and carers' leave. They are also covered by disability-targeted social protection benefits that are compatible with formal and informal work, to help address disability-related costs. Programmes consider and address additional risks faced by persons with disabilities, such as pension top-ups if barriers in the labour market and other factors have resulted in lower life-time contributions.

Box 4.31 Auxílio-Inclusão: The evolution of social protection support for economic inclusion in Brazil

The Benefício de Prestação Continuada (BPC) is a Brazilian social protection programme providing financial support to older persons and persons with disabilities living in poverty, defined as having per capita income of no more than one quarter of the minimum wage. Persons with disabilities must also demonstrate that they are unable to work.

Originally, beneficiaries who entered formal employment lost their BPC benefits entirely and would have to go through the entire eligibility determination process for BPC if they subsequently lost their employment. A 2011 reform sought to provide more flexible support by allowing the suspension rather than cancellation of BPC if beneficiaries started formal employment. Receipt of BPC could resume if they stopped working and receiving unemployment insurance.

An additional reform came in 2021, when Brazil introduced Auxílio-Inclusão (Inclusion Aid). Under this programme, persons with disabilities who enter into formal employment and cease to receive BPC can now receive some financial support for disability-related extra costs. Auxílio-Inclusão provides 50 per cent of the value of BPC and is provided to formal-sector workers earning less than twice the minimum wage. It is also provided for those who had previously received BPC within the last five years and are now working. If beneficiaries lose their jobs within five years, they are automatically reinstated into BPC.

5. Enhance the confidence of employers to include persons with disabilities, and provide relevant technical and financial assistance to employers

Initiating

- In collaboration with persons with disabilities and OPDs, raise awareness among employers about the employment-related rights of persons with disabilities and provide technical training on how to implement inclusive practices.

Progressing

- Governments, OPDs, civil society and other actors work in partnership with employers to identify, resource and monitor changes to employer practices to support inclusion. This can include accessibility audits; disability metrics in hiring and promotion decisions; financial support from governments for reasonable accommodations; and job-matching programmes.

Maturing

- Employers are aware of the employment-related rights of persons with disabilities and recognize the value of inclusive workplaces. They have the knowledge and resources to adapt work spaces, systems and processes to ensure men and women with disabilities are equitably included, for instance through accessible communication and infrastructure; inclusive recruitment, hiring, promotions and workplace culture; and by providing reasonable accommodations.

Box 4.32 Ethiopia Business and Disability Network

The Ethiopia Business and Disability Network has played an active role in engaging several actors in the employment ecosystem, including OPDs, universities, technical and vocational education training centres, the Ministry of Women and Social Affairs, NGOs and more than 80 Network member companies. By creating engagement between these actors, the Network increased awareness and confidence in relation to disability among member companies, which has then led to an increase in employment opportunities. One example is the special economic zone of the Bole Lemi Industrial Park, a textile manufacturing hub, which generates hundreds of jobs. Through the Network and its partners, the park has been able to provide internship and employment opportunities to persons with disabilities.

6. Collect and analyse data on decent work among persons with disabilities, and use it to inform action

Initiating

- Analyse available national surveys and other sources of data on disability and work. Analyses should include disaggregation by gender and other characteristics whenever possible, such as rural or urban residence, type of impairment and level of education.
- Map upcoming national data collection activities on employment, to embed additional questions on disability (e.g., Washington Group Short Set, Washington Group–ILO Labour Force Survey Module).[161]

Progressing

- Define national priorities for research on disability and work, in collaboration with research institutions and OPDs.
- Monitor and evaluate the impact of new employment policies and programmes – and emerging trends such as the growth of digital platforms, integration of AI and other technology in work – on men and women with disabilities.

Maturing

- National and subnational data on disability and work are regularly collected, analysed and disseminated. Disability indicators are routinely incorporated into population-based surveys (e.g., labour force surveys) and administrative data (e.g., recipients of government employment services; employer tracking of hiring and promotions) to monitor progress towards inclusion, including by gender.

Box 4.33 Washington Group–ILO Labour Force Survey Disability Module[162]

The Washington Group–ILO Labour Force Survey Disability Module (LFS-DM) was created by the Washington Group on Disability Statistics and the ILO for use in population-based surveys that collect data on employment, including labour force surveys. It includes questions on barriers to employment, accommodations that would support employment, attitudes of employers and other workers towards disability, and access to social protection.

Social protection

Across regions and countries, persons with disabilities are disproportionately affected by poverty, economic insecurity, lower education levels and catastrophic health expenditures compared to persons without disabilities.[163] As described above in *Work and employment*, they experience barriers to working and earning. Meanwhile, family members – often women and girls – who provide unpaid care and support also often have reduced opportunities for earning.

Children, working-age adults and older persons with disabilities and their families face significant disability-related extra costs, for example for health care, assistive technology and human assistance (*see Chapter 1*). The additional costs of goods and services required for survival and equal participation can reach several times the poverty line or even the minimum wage, and are unaffordable for most individuals and households. Extra costs, especially when unmet, exacerbate poverty and hinder inclusion. Crises such as the COVID-19 pandemic and climate change, conflict and economic shocks magnify barriers that create costs, and limit the ability of individuals and their households to pay for goods and services.

The CRPD, in addition to ILO conventions and recommendation 202 on social protection floors, stipulates the right of persons with disabilities to access all social protection programmes without discrimination. States also have an obligation to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs (Article 28), free or affordable health care (Article 24), and support services to live independently and be included in the community (Article 19).[164] The CRPD further specifies the duty to provide support to children with disabilities and their families (Articles 16 and 23). It also mandates meaningful participation of persons with disabilities in the design, implementation and monitoring of social protection policies and programmes. Disability-inclusive social protection is also critical to meeting many of the SDGs, including SDG 1 on ending poverty, among others.[165]

The momentum of the CRPD implementation and the SDGs, combined with the emergence and development of social protection systems in low- and middle-income countries, has created a growing consensus globally and at national level on the critical role of social protection. It is key to addressing poverty, facilitating socioeconomic participation and inclusion of persons with disabilities, and responding effectively during crisis and shocks.

Overview of progress and persistent roadblocks

Historically, social protection policies viewed disability through the lens of incapacity to work, leading most countries to adopt disability-targeted income replacement contributory schemes.[166] While this approach has provided essential income security to workers in the formal economy, it entrenched a dichotomy in disability-related social protection programmes between persons deemed able or unable to work. In most low- and middle-income countries, this approach translated into systems combining contributory schemes covering the small share of the population in the formal economy, with often low-coverage, non-contributory, poverty-targeted schemes – both of which are related to incapacity to work. This has left many persons with disabilities without any disability-related support.[167]

The paradigm shift brought about by the CRPD, together with evidence that the lack of support to address disability-related costs undermined socioeconomic participation, has contributed to reforms, mostly in high-income countries. There has been an evolution from a sole focus on incapacity to work, towards a combination of benefits for income security and schemes to cover disability-related costs.[168] In low- and middle-income countries there has also been increasing acknowledgement of the importance of disability-related costs, with some countries adopting universal disability cash benefit schemes (e.g., Fiji, Namibia, Nepal, Thailand) or disability top-ups for existing household social safety nets (e.g., Indonesia, Zambia). Also, more and more countries are adopting measures to cover health-care costs and to a lesser degree assistive technology, as well as other concessions to offset disability-related costs.

Significant progress has been made in data collection to support the design and delivery of social protection (*see Chapter 2*), leading to more inclusive social registries[169] and better understanding of disability-related costs (*see Chapter 1*). There has also been progress in the development or reform of disability assessments and certification mechanisms required for eligibility determination. This has made them more accessible, comprehensive and reliable, in part thanks to digitization. These changes have contributed, in a few countries, to the development of Disability Management Information Systems (DMIS). The potential interoperability of DMIS with other management information systems can pave the way for more effective case management, such as is being done in Armenia, Cambodia and Rwanda (*see Box 4.34*).[170]

Box 4.34 DMIS in Cambodia

In Cambodia, the government introduced a cash transfer programme for persons with disabilities in 2011, initially relying on medical criteria to determine eligibility, which excluded many people and was difficult for community workers to implement. To address this challenge, a new system focusing on functional assessments was developed, with UNICEF support. Age-appropriate questionnaires were created to evaluate functional difficulties and basic support required for daily activities, minimizing the need for medical referrals. A standardized identification tool and disability database were introduced, issuing disability identification cards with three categories, to facilitate benefit access.

A major innovation was the digitization of assessments via smartphone apps, improving data flow and reducing delays in certification. Launched during the COVID-19 pandemic, the system now operates nationwide, with over 4,600 commune workers trained and 342,000 persons with disabilities registered as of May 2024. This digitization also aided COVID-19 vaccination prioritization.

Globally, between 2015 and 2023, coverage of statutory disability cash benefits for persons with significant disabilities rose from 32 to 38 per cent. Progress has varied by region, with increasing coverage in Asia and the Pacific (from 19 to 31 per cent), but more limited coverage in many lower-middle-income countries (from 11 per cent in 2015 to 19 per cent in 2023) and very minimal in low-income countries (3.3 to 3.5 per cent).[171]

Several elements limit the expansion, access and effectiveness of disability-inclusive social protection. These include:

- Persistent focus on incapacity to work in many countries rather than on support requirements for inclusion. This leads to an emphasis on working-age adults and poverty-targeting of disability support, and less consideration for disability-related needs in old age and during childhood. Only 7 per cent of all statutory disability cash benefits are applicable to children with disabilities.[172]
- Disability certification mechanisms rely mostly on medical assessment and criteria. These assessments are complex to administer, can be costly for both applicants and health systems, and are difficult to access particularly in settings where few specialists are available. As such, this process excludes many children and adults with disabilities who could benefit from programmes.
- Many countries provide support to households rather than to individuals with disabilities, undermining their choice and agency in relation to the support received.
- There is very limited investment in support services that would effectively complement cash benefits, such as inclusive health, education, care and support systems.
- Access to available social protection programmes is limited by a lack of awareness and poor accessibility of systems, including inaccessible application and pay points, information about programmes and how to apply.

Steps to accelerate inclusion

Building on the 2019 Joint Statement on Inclusive Social Protection Systems,[173] a group of development agencies, civil society organizations, OPDs and others organized a series of webinars, published background papers, ran a global online training course and – finally in 2024 – adopt a joint guidance document. This document, entitled *Towards Inclusive Social Protection Systems Enabling Participation and Inclusion of Persons with Disabilities*,[174] was the basis for most of the information in this section.

An inclusive social protection system provides all persons with disabilities, across the life cycle, basic income security and coverage of health-care and disability-related costs, and facilitates access to essential services (*see Figure 4.1*). To achieve these aims, systems must include comprehensive data collection; meaningful engagement with persons with disabilities and OPDs; and inclusive and coordinated delivery mechanisms. They must also include a blend of cash benefits, in-kind support and concessions supported by a reliable and accessible mechanism to identify children and adults with disabilities and their support needs. OPDs and civil society organizations play a critical role in helping persons with disabilities and their families access social protection schemes, by providing outreach and information and facilitating administrative procedures.

Figure 4.1. Inclusive social protection systems across the life cycle

<table>
<tr><th rowspan="2">Categories of instruments</th><th colspan="3">Examples of types schemes across the life cycle</th><th rowspan="2">Function</th></tr>
<tr><th>Childhood</th><th>Working age</th><th>Old age</th></tr>
<tr><td rowspan="5">Cash benefits</td><td colspan="3">Poverty assistance cash transfer, cash for work</td><td rowspan="3">Income security</td></tr>
<tr><td>Child grant/ family benefits</td><td>Unemployment, maternity, sickness, parental leave benefits</td><td rowspan="2">Old age pensions</td></tr>
<tr><td>Caregiver benefits</td><td>Disability-related income replacement benefits</td></tr>
<tr><td rowspan="2">Child disability benefits</td><td colspan="2">Disability costs basic allowance/top-up schemes</td><td rowspan="4">Coverage of health care and disability-related costs</td></tr>
<tr><td colspan="2">Third-person support/caregiver benefits</td></tr>
<tr><td rowspan="2">In-kind benefits</td><td colspan="3">Concessions
Free or discounted public transport, subsidized utilities, insurance or services, tax exemptions</td></tr>
<tr><td colspan="3">Services
Health insurance/free, early intervention, rehabilitation, assistive technology, community care and support, case management, personal assistance schemes, interpreters, counselling, point-to-point transport, respite care</td></tr>
<tr><td>Interlinkage</td><td>Early childhood development, childcare, education</td><td colspan="2">Economic empowerment programmes, return to work programmes, women's empowerment, protection services, financial inclusion services</td><td>Connection to other services</td></tr>
</table>

Source: Cote, Knox-Vydmanov and Lippi (2024).[175]

The pathways that countries choose to develop inclusive social protection systems are highly dependent on many parameters. For instance, they depend on the existing schemes and legal frameworks; prevailing norms and the societal and political consensus regarding social protection and disability inclusion; the fiscal space for social protection; institutional capacities; advocacy from OPDs; support from donors; and informal social support mechanisms. However, the review of the evolution of systems and policies in many countries which took place in relation to the development of the joint guidance document[176] led to the identification of milestones on the path to developing such systems. These can be clustered broadly around the key actions described below.

The contribution of social protection to inclusive education, health care, work and employment, and care and support, was discussed in more detail in respective sections in this chapter.

Key actions for disability-inclusive social protection

1. Generate evidence to support the design and delivery of inclusive social protection

To design and implement effective disability support schemes, it is essential to understand the diverse needs of children, working-age adults and older persons with disabilities and their families, and the extent to which current social protection systems meet those needs (*see Box 4.35 for an example*). This process requires reliable data on disability prevalence, barriers to participation, support needs, socioeconomic status and current strengths and challenges to the design and delivery of social protection.

Initiating

- Analyse data from recent household income and expenditure surveys as well as administrative data from existing sources, such as social registries. Use these analyses to inform inclusive social protection planning (e.g., prevalence of disability, poverty and its predictors among people with disabilities, and sources and scale of spending on disability-related goods and services). Add disability questions (e.g., Washington Group Short Set) to upcoming national surveys and social registries if they are not already included.
- Conduct an in-depth study to understand the scope, diversity and magnitude of disability-related costs, in collaboration with OPDs, persons with disabilities and family providers of care and support.

Progressing

- Develop a monitoring and evaluation plan for disability inclusion in social protection, with input from research institutions and OPDs.
- Evaluate access to and the impact of existing social protection programmes (cash and in-kind), as well as informal social support, on children, working adults and older persons with disabilities, to identify major gaps and opportunities to strengthen the social protection system.

Maturing

- There is regular monitoring and evaluation of social protection programmes and systems (e.g., to identify strengths and challenges in inclusive design and delivery, and the effectiveness and cost-effectiveness of programmes). This is done in collaboration with OPDs, combining data from household surveys and disability and social protection management information systems. Equity among persons with disabilities is a key focus.
- Household income and expenditure surveys and labour force surveys are systematically disaggregated by disability and periodically include specific modules on disability-related goods and services and time use.

Box 4.35 The cost of raising children with disabilities in the Philippines[177]

The Department of Social Welfare and Development in the Philippines, with the support of UNICEF and the Australian Government, conducted a nationally representative study on the cost of raising children with disabilities. The study revealed that families have to spend 40–80 per cent more to care for children with disabilities compared to those without disabilities. Disability-related expenditures contribute to poverty rates that are 50 per cent higher among families with children with disabilities. The study highlighted multiple unmet needs, suggesting that costs would be even higher to ensure equal participation of children with disabilities. It also found that government subsidies linked to disability cards disproportionately benefit wealthier households. The study's findings and recommendations have informed policy discussions and congressional debates on introduction of a disability allowance in the Philippines.

2. Identify children, working-age adults and older persons with disabilities and their specific support needs

Strategies are needed to increase enrolment of eligible children and working-age and older adults with disabilities across an increasing range of social protection benefits. In doing so, there must be greater identification of households likely to have members with disabilities, and greater access to individual disability assessments and certification mechanisms. These mechanisms must be aligned with CRPD standards and be accessible at local level. They should also move away from solely medical assessments of impairment, to focus on identification of the diverse support needs of individuals. An effective DMIS, connected with social protection management information systems, can promote linkages between social protection programmes and other services, reduce costs to individuals and systems, support effective case management and enable planning.

Initiating

- Eligibility criteria for disability certification required to access disability-targeted benefits reflect the human rights model of disability, as per CRPD standards.
- Initiate formal identification of children and adults with disabilities through several entry-points.
    - Enable inclusive targeting by including disability-related questions, such as the Washington Group Short Set, in data collection for social registries and mainstream social protection programmes to identify vulnerable households that are highly likely to have members with disabilities. For example, this is being done in the Dominican Republic.
    - Use a multi-stakeholder participatory process to design and pilot procedures for accessible, digitized disability assessment and certification at local level, using the available local workforce (i.e., health, social welfare, education, local government and OPDs). Do this with a focus on accessibility, identification of basic support needs and reliability, and with attention to differentiated instruments for children and adults. An example of this approach is taking place in Sierra Leone.
    - Establish connections with the health and education sectors for early identification of children with developmental delays and disabilities, as demonstrated in Uganda.

Progressing

- Scale up accessible and reliable individual disability assessment and certification procedures, supported by a DMIS, for children and adults with disabilities. Focus on identifying individuals' support needs.
- Establish a DMIS (stand-alone or integrated with other management information systems) that includes disability assessment and certification information. Begin to enable interoperability with civil registration and vital statistics systems, social registries or social protection management information systems (currently in progress in Cambodia [*see Box 4.35*] and Rwanda).
- Establish initial case management that focuses on facilitating access to existing benefits and referrals to available services provided by governments and civil society.

Maturing

- The criteria for disability certification procedures required to access disability-targeted programmes reflects the human rights model of disability, based on CRPD standards.
- Disability assessments and certification procedures are easily accessible and affordable to all people everywhere in the country. They consistently gather comprehensive information on persons with disabilities and their support needs with differentiated approaches for children and adults. They are consistent and reliable, and their outcomes are trusted by stakeholders.
- Individual support plans are developed, and enhanced case management supports access to the diversity of support and services required by the individual.
- A DMIS is in place (stand-alone or integrated into other mainstream management information systems). It is interoperable with civil registration and vital statistics, information systems for social protection and other sectors (e.g., health and education), and it supports disability assessment and certification as well as case management by improving access to diverse social protection benefits and coordination with other local services. Examples of such interoperability can be found in Armenia and Chile.

3. Ensure that contributory and non-contributory cash benefits provide income security and cover some disability-related costs for persons with disabilities

Cash benefits, including non-contributory and contributory schemes, have two main functions in inclusive social protection: providing income security, and coverage of some disability-related costs. Individual disability benefits, paid directly to adults with disabilities rather than households, enhance autonomy and agency.

Initiating

- Ensure that persons with disabilities have equitable access to existing mainstream cash benefits for income security, for example through poverty-targeted programmes.
- Establish new or adapt existing cash benefits (mainstream or disability-targeted) to enhance income security and begin to cover disability-related costs. Options include:
  - Prioritizing persons with disabilities in the targeting of mainstream poverty assistance cash benefits (e.g., as in Ethiopia and Ghana), increasing the means-testing threshold for households with members with disabilities (such as in Pakistan), and/or adding a disability top-up (as in Indonesia and Zambia)
  - Establishing disability-targeted cash benefits for specific age groups or persons with high support needs (as demonstrated in Egypt, Kenya, Lebanon and Peru) with or without means-testing. Ideally, these benefits must be compatible with work from the start and should be targeted to individuals, in case of adults with disabilities, rather than households (as demonstrated in Nepal).

  - Establishing contributory schemes such as disability pensions and work injury compensation, in line with relevant ILO conventions, wherever these schemes do not currently exist.

Progressing

- Countries progressively increase income security and coverage of extra costs, including through:
  - New or adapted disability-targeted non-contributory cash benefits that cover more persons with disabilities and increase the level of coverage (such as in Brazil, Fiji, Namibia, Thailand and Viet Nam). A key area for expansion is a basic third-person support or caregiver allowance for persons in need of intensive human assistance (as demonstrated in South Africa and Viet Nam). All benefits are compatible with work and other benefits.
  - Contributory cash benefits are expanded to recognize additional income security risks faced by persons with disabilities and their households; for example, top-ups to pensions for persons with disabilities and family providers of care and support, due to lower earnings throughout their working years; or expansion of parental and carer leave for providers of care and support.

Maturing

- **Coverage of some disability related costs:** All persons with disabilities in need of support have access to a universal disability cash benefit that is compatible with work and other benefits, with varied amounts reflecting the costs of disabilities. Persons with disabilities requiring care and support have access to a third-person allowance (such as in Mauritius).
- **Income security:** Persons with disabilities, as well as family members providing care and support, have equitable access to all contributory and non-contributory mainstream income security cash benefits (e.g., unemployment insurance, old-age pensions, workers' compensation, sick leave and maternity leave) and/or disability-specific income security schemes (e.g., disability pension). Income security cash benefits are compatible with benefits covering disability extra costs, and their means-testing excludes income from benefits covering disability-related costs (as demonstrated in North Macedonia).

Box 4.36 Disability cash benefits in Pacific Island countries

Since 2015, six Pacific Island countries have introduced non-contributory disability cash benefit schemes, reflecting progress in tax-financed social protection and the implementation of the CRPD. Most schemes are universal, cover all age groups, and some are compatible with informal work (Kiribati) or even formal work (Fiji), promoting labour participation. As a result, Pacific countries have some of the highest disability-benefit coverage in the East Asia–Pacific region. Such programmes have also proven to be effective in providing rapid relief to persons with disabilities and their families in response to natural disasters, for example in Fiji and Tonga.

However, most programmes are not yet enshrined in law, and adequacy of cash benefits could be improved. There is also a need for more comprehensive complementary support for persons with disabilities, including coverage of health-care costs and assistive technology, and development of community care and support services.[178]

4. Implement in-kind support and concessions to cover health-care and disability-related costs

While cash benefits provide much-needed flexibility, they are not the most appropriate instrument for covering the costs of health care and some disability-related goods and services, which may be quite costly and are highly variable among persons with disabilities (e.g., health care, assistive products, care and support). As such, most countries' social protection systems will combine cash benefits with in-kind support and concessions (e.g., UHC, tax exemptions, direct provision, cash-plus programmes). Effective concessions require strategic planning to maximize impact and equity. For example, free public transportation may be more beneficial for persons with disabilities in urban areas than in rural areas but will also benefit those living in poverty, while tax exemptions may disproportionately favour higher-income groups.

Initiating

- Ensure that persons with disabilities are prioritized within mainstream in-kind support programmes (e.g., energy subsidies, food aid, transport discounts).
- Initiate coverage of health costs through priority access to existing UHC subsidies schemes (e.g., social health insurance), and coverage of a basic set of health services and products (e.g., rehabilitation, early intervention, assistive technology) through vouchers and/or direct provision, including through partnerships with NGOs and donors.
- Establish other programmes and policies to offset disability-related costs (e.g., transport, discounts; community-based care and support initiatives; livelihood support and financial inclusion initiatives).
- Align all programmes with the principles of the CRPD (e.g., avoid financing institutionalized care, initiate deinstitutionalization).

Progressing

- Progressively enhance coverage of early intervention, assistive technology, rehabilitation and other health services and products required by persons with disabilities in UHC packages of care (as in the Philippines and Georgia).
- Progressively expand coverage of other disability-related extra costs. For example, this may include development of schemes for point-to-point accessible transportation, respite services for family providers of care and support, support to modify housing for accessibility, formal personal assistance, and diverse forms of human assistance as demonstrated in Thailand (*see Box 4.13*).

Maturing

- Health-care costs are covered, including health services and products particularly required by persons with disabilities, as part of comprehensive UHC packages (e.g., early intervention, assistive products, rehabilitation, specialist services for impairments). Non-discrimination on the grounds of disability is enforced across public and private health insurance schemes.
- Disability-related costs are covered through comprehensive packages of in-kind support and concessions including: formal personal assistance and diverse forms of human assistance (e.g., interpretation, circle of support), accessible transportation (e.g., discounts on public transport and point-to-point transport), and housing (e.g., priority access to accessible housing, provision of land and materials to build a home). Programmes are in line with CRPD principles and the rights of persons with disabilities to live in their communities and contribute to achieving deinstitutionalization.

5. Create inclusive and coordinated social protection delivery mechanisms

Barriers such as administrative complexity, inaccessible facilities and communication, inadequate outreach and other exclusionary design features must be addressed to promote access to social protection for persons with disabilities.

Initiating

- In consultation with OPDs, review existing processes across social protection programmes to identify barriers to persons with disabilities (e.g., school attendance requirements for conditional cash transfers when schools are not inclusive; inaccessible facilities and communication). Create and begin to implement an action plan to address identified barriers.
- Train social protection staff on disability inclusion.
- Include disability indicators in routine data collection, monitoring and evaluation.
- Develop minimum standards for accessibility, non-discrimination and provision of reasonable accommodation, which apply across the design and implementation of all social protection schemes.
- Partner with OPDs and civil society to support the sharing of information, outreach and application assistance, to facilitate access to existing programmes.

Progressing

- Routinely monitor inclusion and accessibility across procedures (e.g., accessibility audits of social protection websites, payment mechanisms, forms, information and facilities).
- Progressively initiate strategies to enhance inclusion across design and delivery (e.g., address geographical barriers to enrolment through mobile registration and home visits), and provide reasonable accommodation in public works programmes.

Maturing

- There is comprehensive accessibility and inclusive practices across social protection systems, including websites, communication materials, payment and application points, and registration, outreach, delivery and complaints/appeals mechanisms.

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Chapter 5

Financing acceleration of disability inclusion

Introduction

Achieving disability inclusion at scale requires a whole-of-society approach grounded in government-led strategic vision, robust policy frameworks and the effective implementation of well-designed programmes and services. Crucially, this must be underpinned by adequate and sustainable resourcing aimed at achieving the full and effective participation and inclusion of persons with disabilities.

Inclusion involves the transformation of communities and societies; therefore, resourcing it necessitates contributions from a broad range of stakeholders, including individuals, families, communities, civil society organizations, the private sector, local and national governments, and international actors. The nature and scale of these contributions will vary significantly depending on the stakeholder and context, yet their collective impact will be substantial. For example, in Europe and the United States of America – contexts with relatively well-developed publicly funded care systems – an estimated 70–90 per cent of care and support across the life cycle is provided to persons with disabilities by unpaid caregivers – primarily family members, especially women. This demonstrates that even in high-income contexts with significant public investment, families and civil society provide considerable time and financial resources. The reliance on these contributions is even greater in low- and middle-income countries, where governments face fiscal constraints and competing priorities.

As signatories to the Convention on the Rights of Persons with Disabilities (CRPD), governments are required to mobilize maximum available resources to ensure the promotion, protection and realization of all human rights for persons with disabilities. Similarly, the role of government financing is key in achieving the Sustainable Development Goals, with a focus on "leaving no one behind". While governments are central to financing inclusion, their capacities vary significantly by context and sector.

While governments have the obligation to mobilize maximum available resources, domestic public resources alone are unlikely to cover the full cost of all necessary interventions required for inclusion. Therefore, governments must use their resources as efficiently as possible and leverage a combination of public and private, local, national and international resources to enable effective and equitable implementation at scale of required national policies and programmes. In many low- and lower-middle-income countries, international cooperation continues to play an essential role in supplementing domestic efforts, with, in some instances, Official Development Assistance (ODA) spending on disability-specific programmes comparable to domestic resource allocations (*see Chapter 2*). In any case, government investments should not only contribute directly but also catalyse and support contributions from other stakeholders in ways that maximize efficiency and equity.

As outlined in previous chapters, notable progress has been made in strengthening legal and policy frameworks, enhancing national coordination and monitoring mechanisms, and improving data collection. However, these advancements have not yet translated into widespread and sustained improvements in the lives of persons with disabilities. Too often, public resources remain insufficient to deliver meaningful changes at scale.

Several factors explain the current state of disability inclusion in financing and development planning. They include the following.

- In many countries, the ratification of the CRPD provided the first framework for considering disability inclusion across sectors at scale. However, there is often an inevitable time lag between initiating significant legal and policy changes and achieving tangible improvements in resource allocation. This delay reflects the complexity of translating commitments into actionable change.
- A significant gap persists between the scope of provisions and priorities of disability rights legislation and national strategies, and their integration into national development plans and financing strategies, Integrated National Financing Frameworks (INFFs), or large-scale, domestically or internationally financed development programmes. This gap is partly due to the limited visibility of disability issues within broader policy areas, such as infrastructure, economic development, employment and gender-responsive budgeting, and partly due to the lack of relevant data.
- The lack of systematic tracking of disability-related expenditures makes it difficult to assess progress and identify gaps. While progress has been made in tracking relevant ODA spending – most notably with the adoption of a voluntary disability marker by the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC) – similar tracking mechanisms have yet to be implemented in national budgeting and relevant fiscal processes.
- There is a dearth of research and evidence on the costs of interventions required to achieve disability inclusion across sectors. Also, while there has been an increase in the number of studies on disability-related costs faced by persons with disabilities and their households in recent years, data collection is not yet systematic, which prevents governments from gaining the necessary understanding of their actual standard of living and poverty level. Combined with the lack of data on current spending – domestic and international, public and private – this prevents a collective understanding of the financing gaps that need to be addressed across sectors.
- National disability coordination mechanisms or government focal points (*see Chapter 2*) often lack the influence and convening power necessary to provide substantial input into national development plans, financing strategies or annual budget processes. This undermines the integration of disability inclusion into broader national financing strategies.

- Despite growing interest and involvement in many countries recently, Organizations of Persons with Disabilities (OPDs) – which played a critical role in the ratification of the CRPD and the adoption of new legislation – often lack the capacity to engage meaningfully in the development of national plans, financing strategies and the annual budget cycle.
- Development agencies that support governments and civil society in the area of financing have only recently begun incorporating disability inclusion in their work. This is in contrast to the more established efforts in areas such as gender equality or child rights.

In recent years, low- and middle-income countries have faced growing challenges that complicate efforts to finance disability inclusion. The cumulative impacts of the COVID-19 pandemic, climate change, conflict, inflation, debt servicing and demographic shifts – such as a youth bulge or an ageing population – have intensified competing priorities for public resources. These pressures highlight the urgency of identifying innovative, efficient and equitable financing mechanisms to protect and expand the fiscal space needed to accelerate disability inclusion.

Countries have nevertheless employed various approaches to resource disability inclusion, including costing national strategies, earmarking funds for disability across government entities and creating dedicated disability funds. However, there is still limited evidence on the effectiveness of existing financing mechanisms, and there have been few initiatives to support governments of low- and middle-income countries to mobilize maximum available resources to implement the CRPD and inclusive development.

This chapter explores the critical issues regarding the scale-up and acceleration of disability inclusion, and options for national governments in low- and middle-income countries to finance it. The chapter begins by examining the overall implications for public finance of the CRPD's provisions and standards and the "leave no one behind" approach (*see Box 5.1*). It then addresses the challenges of assessing financing gaps across sectors, with a focus on specific sectors and certain countries – Cambodia, Kenya, Mauritania, Peru and Sierra Leone – representing a diversity of contexts. It then explores strategies and options for governments to make the most of their available resources. The chapter concludes by presenting recommendations for advancing evidence generation, guidance and innovation to strengthen the resourcing of disability inclusion and advance the realization of the CRPD in low- and middle-income countries.

Box 5.1 Investment case: The gain of inclusion and the cost of exclusion of persons with disabilities

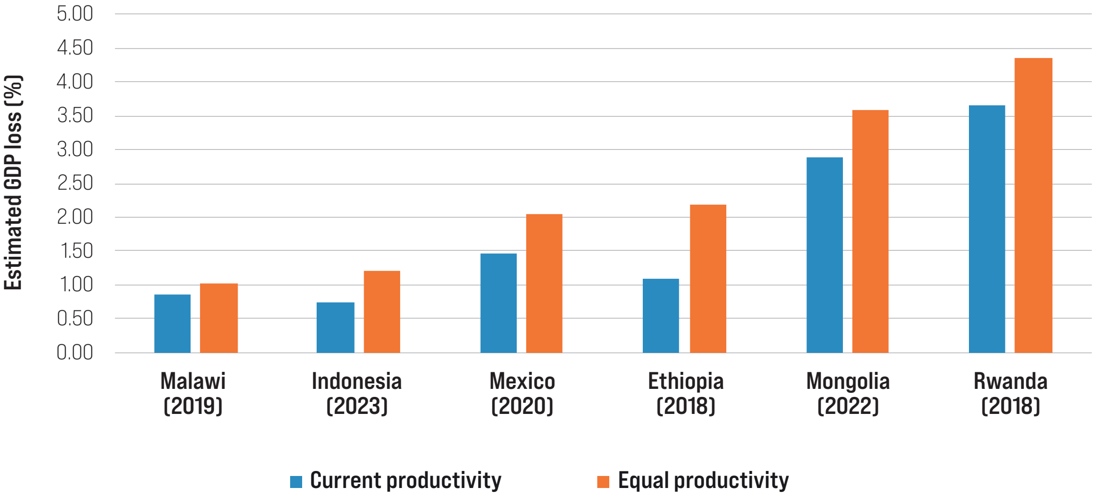
Persons with disabilities not only face barriers to employment; when employed, they often earn less than their peers without disabilities. This may result from inaccessible employment or barriers to education and training that reduce their earning capacity. This affects not only individual livelihoods but the size of the macroeconomy, as well as government coffers. One study estimated that equalizing employment between persons with and without disabilities in Spain would generate US$1.5 billion in social contributions annually.[1]

In 2009, a widely quoted study by the International Labour Organization (ILO) estimated the loss in gross domestic product (GDP) in low- and middle-income countries due to higher rates of unemployment and lower earnings among persons with disabilities as ranging between 3 and 7 per cent.[2] However, due to a lack of reliable data on earnings of persons with disabilities at the time, these estimates relied on assumptions about their productivity.

Since then, data on persons with disabilities have improved significantly, with more recent data on actual wages of persons with and without disabilities, and greater cross-country consistency in how persons with disabilities are identified.

A study carried out for this report using the same methodology but with actual wage data and a dataset all using the Washington Group questions, results from six countries – Ethiopia, Indonesia, Malawi, Mexico, Mongolia and Rwanda – reveals estimated losses in GDP ranging between 0.73 per cent and 4.36 per cent, confirming the relevance and findings of the 2009 ILO study. In *Figure 5.1*, the blue bars show the increase in GDP that would result if persons with disabilities were employed at the same rate as those without disabilities, but with their current median wages. The orange bar shows the potential increase if persons with disabilities had both the same employment and wage rates as those without disabilities.

Figure 5.1. Estimated percentage GDP loss from disability employment and earnings gaps



Source: Mont et al. (2025, pending).[3]

In other words, in Rwanda, if persons with disabilities had the same employment rate as persons without disabilities, but at their current median wages, GDP would rise by about 3.66 per cent. If their wages also rose to match those of persons without disabilities, the increase in GDP would be 4.3 per cent.

It is important to note that these countries were selected based on the availability of comparable data, not to be globally representative. As more data become available, estimates will vary by country, reflecting the diverse experiences of persons with disabilities, the structure of each country's labour market and economy, and the measure of employment in dataset. The most reliable and consistent estimates of GDP loss would come from widespread use of the ILO/Washington Group disability employment module, enabling the collection of high-quality, comparable data on employment, wages, and disability identification.

Improving access to quality education is a critical way to improve the employability and earnings of adults with disabilities. Studies in a wide range of countries found that each additional year of schooling yielded a wage return of between 6.4 and 25.6 per cent.[4,5,6,7,8] Completing at least primary school versus never attending school in Burkina Faso, the Gambia, Rwanda and Senegal was associated with wage gains of 56 per cent for adults with disabilities; completing secondary education achieved gains of 161 per cent.[9]

Moreover, the economic returns to education are enhanced by investing in an inclusive education system that eliminates costs associated with a parallel segregated school system.[10] For example, in OECD countries, the cost of segregated education was found to be 2.5 times higher per capita than the cost of mainstreaming.[11] In Pakistan, a study reported that per capita costs of education in a segregated school costs were 15 times higher than education in a mainstream school.[12] In contrast, a study in South Africa found that making physical structure and amenities of an existing mainstream school more disability inclusive amounted to only 4 per cent of the project budget for building a new segregated school.[13]

Making education systems more inclusive is not the only way to offset these GDP losses. The provision of assistive technology is also a key enabler of socioeconomic participation of persons with disabilities, with a return on investment of US$9 for every US$1 invested.[14] Increased accessibility also generates returns. Improving the accessibility of transport systems in the United Kingdom could yield an estimated socioeconomic benefit of US$89.3 billion.[15]

Addressing the barriers to livelihood generation – such as access to education and support or an inaccessible environment – requires investment, but it can generate significant macroeconomic gains, in addition to ensuring the rights of persons with disabilities.

Public finance and inclusion of persons with disabilities

While achieving disability inclusion requires contributions from all stakeholders, governments, as duty-bearers, are accountable for accelerating progress through effective financing. Beyond the obligations set by the CRPD, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the United Nations Convention on the Rights of the Child (CRC) and other relevant treaties, achieving universal coverage for necessary support and systematically removing barriers across sectors can only be accomplished with significant government resources. No other stakeholder can catalyse and sustain the realization of rights for persons with disabilities across their life cycle at the scale and consistency required.

Although civil society and communities are essential for resourcing social innovation and fostering inclusion, their contributions are often limited in scale and sustainability. Private sector actions, such as promoting accessibility or developing community support services, are also more effective when supported by regulatory frameworks, government incentives or co-financing. Programmes and services financed solely by civil society or private actors can unintentionally create or reinforce inequalities among persons with disabilities, as these efforts often reflect the priorities of specific groups, geographic areas or issues.

A key challenge for governments, especially in low- and middle-income countries, is how to effectively, efficiently, and equitably catalyse and leverage public and private, domestic and international resources to implement disability inclusion at scale. This section examines the implications of CRPD standards and the 'leave no one behind' approach for public financing. Drawing on insights from the CRPD Committee and publications by UNICEF, the United Nations Development Programme (UNDP), UN Women and the Center for Inclusive Policy, it outlines principles to guide public financing for CRPD implementation.

Principles guiding public finance for CRPD implementation

At the core of the relationship between the CRPD and public finance are the obligations for States to mobilize maximum available resources and ensure immediate and progressive realization of rights according to human rights standards. This duty underscores the need to align financial and policy decisions with human rights principles, such as prioritizing disability inclusion as an essential component of equitable and sustainable development and use of public resources. It extends beyond mere resource allocation, encompassing governance reforms, fiscal strategies, international cooperation, and mechanisms for transparency and accountability.

Do no harm: The principle of 'do no harm' is essential to ensure that public finance does not contribute to policies, programmes or financial decisions that would disadvantage persons with disabilities or exacerbate inequalities. Public budgets should not finance programmes or services that are harmful to persons with disabilities, such as by actively contributing to discrimination, segregation or deprivation of liberty. Public finance must also prevent the creation of new barriers to inclusion. Investments in inaccessible infrastructure, facilities and services result in avoidable barriers that restrict participation of persons with disabilities on an equal basis with others.

More broadly, this principle also requires better coherence and alignment of public finance policies to create an enabling environment that will do no harm with regards, for instance, to tax policies, debt instruments or investment strategies.

Progressive realization and avoiding retrogression: The CRPD acknowledges resource limitations but requires States to progressively realize economic, social and cultural rights while ensuring immediate action in areas such as non-discrimination and equal access. For example, while it may take a decade to achieve fully inclusive education, States must provide reasonable accommodations in schools to prevent discrimination without delay. Progressive realization demands deliberate and continuous improvements, with maximum resources mobilized to expand disability-inclusive measures over time.

States must also avoid retrogressive measures – actions that roll back existing rights or reduce funding for critical programmes supporting persons with disabilities. Even during economic crises, cuts to disability programmes are only permissible if accompanied by mitigating measures, grounded in strong justifications and without disproportionate impact on persons with disabilities, among other rights-holders.

Mobilizing maximum available resources: Under the CRPD, States are required to mobilize maximum available resources to fulfil their commitments to persons with disabilities. This includes leveraging domestic revenues, reallocating resources and seeking international cooperation where necessary. The principle emphasizes that disability inclusion must be a priority within national and subnational budgets, as well as within medium-term expenditure frameworks (MTEFs), ensuring sufficient appropriate financial planning and investment in programmes and services that meet the needs of persons with disabilities. It also requires all ministries and public entities to finance disability inclusion within their respective sectors while contributing to the development of essential support services, such as sign language interpretation, to ensure accessibility across sectors.

States must adopt equitable fiscal policies, including progressive taxation, that expand the fiscal space for disability-inclusive initiatives in an equitable manner by addressing tax avoidance, reallocating spending from non-essential areas and eliminating inefficiencies. In resource-constrained settings, States are encouraged to seek international assistance, including ODA, and may consider borrowing, provided the human rights, social and economic impacts of debt repayment are carefully assessed.

Despite these obligations, underspending on disability inclusion is a common issue in many countries. Limited government capacity often slows or prevents programme implementation, and additional funding received late in the fiscal year may remain unspent due to lengthy procurement processes. Poorly designed programmes or inaccessible information, facilities or services can create barriers for eligible beneficiaries. Furthermore, a lack of human resources or institutional capacity at the local level can delay or prevent the disbursement of funds. Donor funding may also fail to materialize as promised, further compounding the issue of underspending. It is important to assess the level of utilization of funds and identify the extent to which existing bottlenecks and issues are disability-specific or common to other sectors, so as to be able to tackle them adequately.

Equity: Resource allocation must recognize and address the disproportionate exclusion and marginalization faced by persons with disabilities. This often requires States to ensure that adequate resources are available to ensure equal access to mainstream programmes such as inclusive education, health care and employment initiatives, but also to (re)allocate funds to programmes that specifically address the needs of persons with disabilities with regards to social protection, care and support systems or assistive technology, for instance.

An important element is ensuring that equity is not only considered in a duality between persons with disabilities and persons without disabilities, but also among persons with disabilities. The incremental nature of budget processes often leads to progressive increases in resources for existing publicly funded services that may benefit some persons with disabilities but not others. For example, there may be consistent increases in funding for mobility devices and hearing aids, which are already budgeted items, while no funding is allocated for sign language interpretation, which may not yet be publicly funded. This does not imply that spending on existing items should be reduced, but rather that future budget increases should ensure all groups benefit, with particular attention paid to those who have previously been left behind.

Additionally, intersectionality should be carefully considered, such as how resource allocation and utilization address the specific issues of women and girls with disabilities,[16] children with disabilities,[17] or persons with disabilities living in remote areas, Indigenous communities, informal settlements or impoverished areas, among others.

Efficiency and effectiveness: Governments must spend as efficiently and effectively as possible to maximize the impact of resources and achieve policy outcomes – specifically, the inclusion of persons with disabilities in the most equitable way (*see Figure 5.2*). This requires avoiding overpayment for goods and services, acquiring unnecessary or low-quality items, relying on inappropriate solutions despite available research, or engaging in hasty spending due to late funding disbursement.

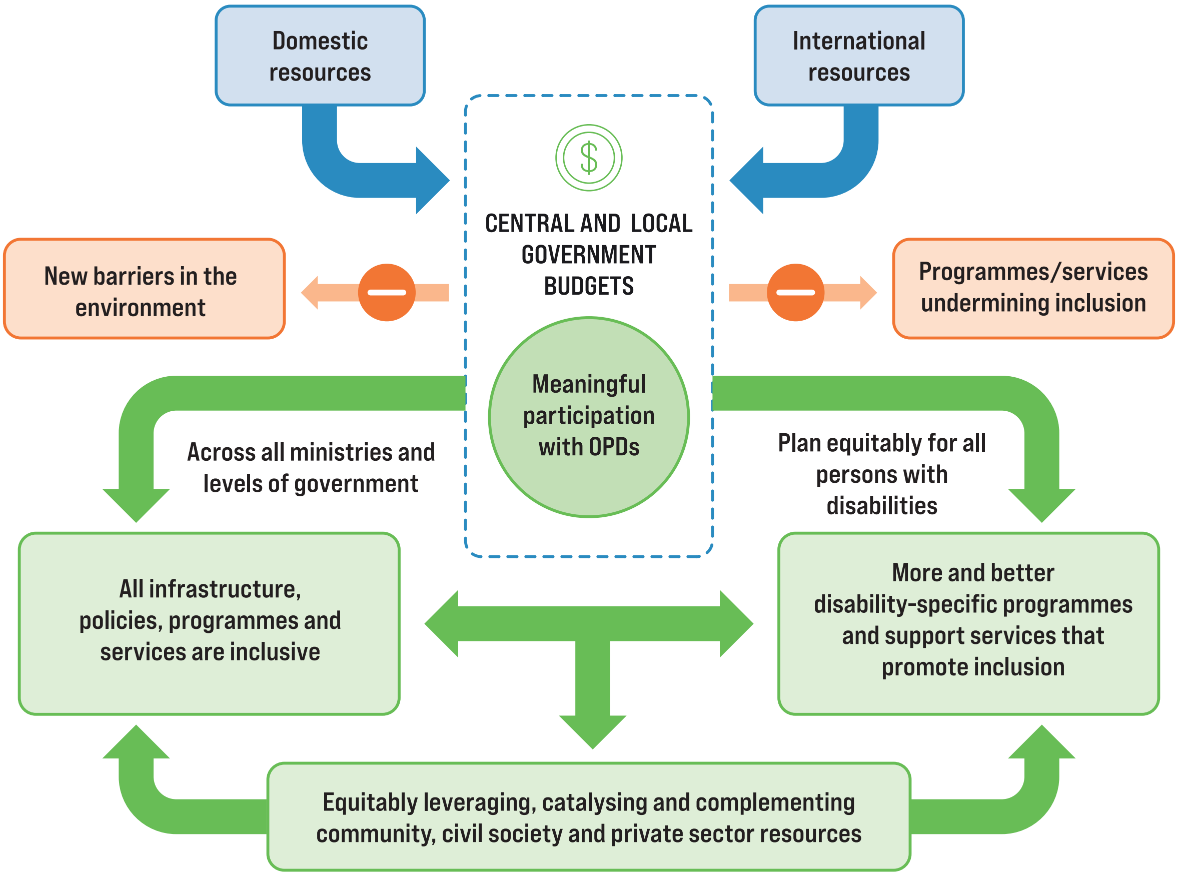
Efficiency also entails avoiding unnecessary transition costs, such as building inaccessible schools or procuring inaccessible buses, only to incur additional expenses later to retrofit them. Similarly, investing in segregated education or care facilities instead of inclusive education and community support systems can lead to significant future costs during the deinstitutionalization process. Inclusive planning and financial decisions that prioritize accessibility and universal design can avoid these unnecessary transition costs.

A critical consideration is that while efficiency or 'value for money' might suggest prioritizing expenditures that benefit larger populations, it is essential to account for equity.[18,19] Spending decisions must ensure that the rights of marginalized groups are not undermined. For instance, resourcing public services for people living in remote areas often entails higher unit costs than in urban areas due to challenges in achieving economies of scale. Likewise, providing adequate support for children with significant functional difficulties in remote educational settings or personal assistance for working adults or older persons to live independently may incur high individual costs. However, these investments yield significant benefits, enhancing socioeconomic participation and reducing the demands of unpaid care and support on families.

Transparency and accountability: Transparency and accountability are fundamental to mobilizing and using resources effectively. States must ensure accessible, timely information on budgeting and expenditures, enabling public understanding of disability inclusion efforts. This implies increasing their ability to identify and track disability-related expenditures. Accountability mechanisms, including audits, parliamentary oversight and civil society engagement, are essential for monitoring progress and addressing inefficiencies. Meaningful involvement of persons with disabilities and their organizations throughout these processes fosters trust and enhances the effectiveness of policies.

In a landscape of competing priorities, the obligation to mobilize maximum available resources is crucial for achieving equity and inclusion for persons with disabilities. By adhering to CRPD principles, governments can ensure that public financing advances rights-based policies, fulfilling their legal commitments while upholding the broader human rights imperative of creating inclusive societies. This requires deliberate planning, sustained investment and active engagement with all stakeholders to leave no one behind.

Figure 5.2. Pathway to effective and efficient use of public resources for inclusion



Source: Adapted from Cote and Balsubramanian (2020).[20]

Estimating the financing gap to accelerate inclusion of persons with disabilities

Estimating the financing gap for disability inclusion presents significant challenges. These relate to a variety of issues, including the following.

- **A lack of reliable data:** Data on the diversity of persons with disabilities and the barriers they face are often limited. There is a lack of systematic and documented evidence on the costs of providing disability-specific support and making public services and infrastructure accessible and inclusive across sectors such as education, health, justice and employment. Data are also typically fragmented, making it difficult to reach a comprehensive understanding.
- **Methodological challenges:** The diversity of persons with disabilities and their support needs in relation to factors such as age, gender, socioeconomic status, barriers in the environment, types and level of impairments and functional difficulties adds a significant layer of complexity, as inclusion costs vary widely. This is compounded by the dynamic nature of needs, which evolve with technological advancements, demographic shifts and urbanization, and vary due to factors such as geography. In many cases, there are few readily available methodologies and tools available for application at a national level.

- **Institutional challenges:** Overlapping interventions, such as accessible transportation, support services such as sign language interpretation systems, point to point transportation, personal assistance or access to assistive technology, that benefit multiple sectors make it challenging to accurately estimate costs of ensuring inclusion in some specific sectors. There are also additional issues in converting the estimated costs of interventions for the purpose of budget planning, as most countries lack comprehensive policies or plans that outline the financial requirements for disability inclusion. Responsibilities are often fragmented across different government departments, with cross-cutting investment missing.
- **Conceptual challenges:** A key conceptual challenge relates to defining the level of ambition for a programme to support disability inclusion. One approach could be to undertake a fixed normative benchmark for aspects such as the population reached and the benefits or services provided. However, given the significant economic, fiscal, political and other constraints faced in low- and middle-income countries there is also a case for setting out pathways to make gradual progress towards disability inclusion over time. Another conceptual challenge is how to define what should be considered within the boundaries of the financing gap of disability inclusion, given that many relevant services also provide significant support to persons without disabilities.

The analysis here focuses on a limited number of priority actions to accelerate inclusion to 2030. This approach seeks to understand the potential cost of key policies and programmes that might be achieved in the next five years (to 2030) based on national priorities and circumstances. This is done through a focus on five case study countries: Cambodia, Kenya, Mauritania, Peru and Sierra Leone. While the process to measure the financing gap varied by country, each case study included a review of key national priorities with respect to disability inclusion, identification of existing gaps, and costing of key policies and programmes that could seek to fill these gaps. In all cases, the analysis was undertaken with the involvement of actors closely connected to national policy debates on disability inclusion. More detailed information can be found in the country background papers produced to this report.[21]

The costing exercise focuses primarily on disability cash benefits and subsidized health insurance but also seeks to bring in lessons from efforts focused on other types of programmes and services. *Box 5.2* summarizes the methodology and data sources used for these costings. In general, cash benefits are comparatively more straightforward to cost because they are more likely to be delivered as distinct disability-specific programmes, and both the unit costs and target population are simpler to define. By contrast, services such as health care, inclusive education and care and support services are more complex because they are often delivered as part of population-based services also benefiting people without disabilities, and defining the unit cost requires much more granular information. In many cases, costing these services requires in-depth and dedicated studies that go beyond the scope of the case studies in this report. Despite these challenges, the focus on more disability-specific benefits and services is still seen to provide a relevant indicator of the financing gap, given that – as discussed in *Chapter 2* – they tend to constitute the main component of disability-related expenditure. Examples of global experience in quantifying financing gaps for other sectors are also included in the discussion.

Box 5.2 Key data sources for national costings

The costing of cash benefits and subsidized health insurance was undertaken using a costing model developed by UNICEF for costing cash and in-kind benefits supporting disability inclusion. The model draws on background population data from the United Nations Population Division[22] and economic data from the International Monetary Fund (IMF).[23] The model is then calibrated by entering key national information relating to disability prevalence and/or certification, poverty lines and exchange rates.[a] Costings are undertaken by entering relevant nationally defined parameters such as scheme coverage and the unit cost of different benefits. For cash benefits, administration costs are assumed to equal 10 per cent of the total cost of transfers, while for social health insurance they are assumed to be encompassed within the unit cost to cover an individual person with disabilities.

Social protection

The five case study countries vary considerably in terms of their existing social protection for persons with disabilities. Kenya and Peru have stand-alone disability cash benefits, while in Cambodia and Sierra Leone support is limited to a household social safety net that considers disability one of the eligibility criteria and provides a disability top-up (*Table 5.1*). Mauritania can be considered somewhere between these two scenarios. One notable observation is that all of these measures have been introduced over the last 15 years, and some much more recently. This reflects the global picture in the growing use of cash benefits for persons with disabilities in ow- and middle-income countries. These cash benefits often exist alongside cash benefits for other groups, such as older people, children, and households living in poverty. All countries also have forms of disability benefits in place via contributory social insurance schemes for public sector workers and/or schemes for public servants or veterans. The nature of these arrangements varies, but the overarching picture is that contributory schemes in these countries cover a relatively small proportion of the labour force.

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[a] The exchange rates for 1 US$ for the five case studies are: Cambodia - KHR4,017, Kenya - KES129, Mauritania - MRU40, Peru - PEN3.8 and Sierra Leone – SLE22.7. This is based on exchange rate data from www.xe.com, accessed on 18 December 2024.

Table 5.1. Characteristics of main existing cash benefits in case study countries

Country (scheme)	Description	Monthly benefit level	Recipients	
			Number	% of total population
Cambodia (Family Package)	Cambodia has had allowances in place for persons with disabilities living in poverty since 2011, although the design of these benefits is undergoing change. As of 2024, households assessed as living in poverty by the country's Identification of Poor Households (IDPoor) system receive cash benefits under the recently launched social assistance Family Package. Households that include a person with disability receive a top-up of KHR 28,000 per month.[24] The coverage of the scheme is expected to increase significantly in 2025 to 113,447 recipients (from 35,937 in 2024), with greater linkage to the country's recently expanded disability registry.	**KHR 28,000** (US$7)	**113,447** (2025)[b]	**0.6**
Kenya (PWSD CT)	The Persons with Severe Disabilities Cash Transfer (PWSD CT) was launched in 2011 and targets extremely poor households with a person with severe disability. The household must have been resident in a particular location for at least a year and should not be receiving any other cash benefit. The person with disability must be a Kenyan citizen. Kenya also has other non-contributory cash benefits in place, including for older persons, and orphans and vulnerable children.[25]	**KES 2,000** (US$15.50)	**62,315** (2024)	**0.1**

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[b] Based on the budgeted coverage in 2025, according to correspondence with the Ministry of Economy and Finance.

Country (scheme)	Description	Monthly benefit level	Recipients	
			Number	% of total population
Mauritania	Mauritania has one disability-specific cash transfer programme for families of children with multiple disabilities, paying MRU 2,000/month and benefiting about 1,000 children in 2024. In the Nouakchott region, UNICEF has also been funding a cash transfer targeting 10,000 households of persons with disabilities. There are plans to integrate this within the Takavoul social protection programme. The Takavoul programme targets low-income households identified through the Social Registry, but it does not yet operate in Nouakchott. Persons with disabilities living in poverty may benefit from the programme which has integrated the Washington Group questions since 2024.	Child disability benefit: **MRU 2,000** (US$50) Households with disabilities in Nouakchott: **MRU 1,000** (US$25)	Child disability benefit: **1,100** (2024) Households with disabilities in Nouakchott: **10,000**	Child disability benefit: **0.02**
Peru (Contigo)	Peru's Contigo programme (introduced in 2015)[26] provides a non-contributory benefit to persons with severe disabilities living in poverty or extreme poverty.[27] Persons with disabilities are ineligible if they receive any income or pension that comes from the public or private sphere, including from employment, or financial benefits from the country's social health security scheme (EsSalud).	**PEN 150** (US$39)	**142,771** (2024)[28]	**0.4**
Sierra Leone (Social Safety Net Programme)	Sierra Leone does not have a dedicated disability cash benefit; however, disability-specific elements have been included in the country's Social Safety Net Programme. This programme – which is primarily financed by World Bank International Development Association grant-financed projects – provides top-up benefits to households that include a person with disability and uses disability as an eligibility criterion in urban areas.[c]	N/A	N/A	N/A

Source: Country background papers.[29]

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[c] It remains unclear whether the specific eligibility criteria for persons with disabilities in urban areas will continue under the current round of the project.

Cash benefits across the five countries have a variety of shortcomings in the extent to which they can support disability inclusion. These relate to a number of factors which apply to varying extents in each country, as follows.

- **Low coverage:** As shown in *Figure 5.3*, the proportion of the total population covered by non-contributory disability cash benefits in low- and middle-income countries ranges from almost zero to around 3 per cent. Coverage is higher in more economically developed countries, with an average of 6 per cent of the working-age population in OECD countries receiving disability cash benefits.[30] In the four countries where data are available (Cambodia, Kenya, Mauritania and Peru), less than 0.6 per cent of the population receives such benefits. A key factor limiting coverage in all five countries is the fact that benefits target people living in poverty, and often those in extreme poverty. Other factors such as challenges related to disability assessment and determination mechanisms can also play a role.
- **Low benefit adequacy:** The average benefit level for non-contributory disability benefits found in countries across the globe is around 15 per cent of gross national income (GNI) per capita. This provides a measure of the benefit adequacy relative to the country's level of economic development. Benefit levels in the case study countries fall well below this average in most cases, at between 3 per cent of GNI per capita in Cambodia and 9 per cent in Kenya (*see Figure 5.4*). In all countries, the benefit levels fall below relevant international poverty lines. These indicators suggest these benefits will be insufficient to meaningfully cover the extra costs associated with disability. Mauritania is an outlier among the case study countries, with a benefit at 31 per cent of GNI per capita – more than double the global average – although this is the scheme with the lowest coverage.
- **Reliance on household benefits:** In all countries except Peru, benefits are provided at the household level (typically to a household head), meaning that persons with disabilities will often not be the primary recipient.[d] This can significantly limit their control over the use of this money, with potentially significant implications for their autonomy.
- **Reliance on external financing:** The cash transfer systems in place in Mauritania and Sierra Leone are primarily reliant on financing from external sources. While this can be an important way to fill financing gaps and support development of the social protection system, the long-term sustainability of disability cash benefits will rely on a greater contribution from domestic financing.
- **Incompatibility of the disability cash benefit with other benefits:** In Kenya, a household cannot receive both a benefit for a person with disability in the household and the country's older persons cash transfer for an older person in the household.
- **Incompatibility with work** is a common barrier to inclusion of persons with disabilities in social protection schemes. Peru's Contigo is incompatible with both work and various other social protection benefits. The eligibility criteria exclude individuals who receive any income or pension from the public or private sphere, including from employment, or financial benefits from the country's social health security scheme (EsSalud).[e]

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[d] In Sierra Leone, for the specific quota for persons with disabilities in urban areas, the person with a disability would be the main recipient.

[e] Financial benefits from EsSalud include breastfeeding, maternity, funeral and temporary disability allowances. See Ministerio de Trabajo y Promoción del Empleo, 'Prestaciones económicas', MTPE, Lima, <www.gob.pe/institucion/essalud/tema/prestaciones-economicas>; Ministerio de Desarrollo e Inclusión Social, 'Afiliarme como beneficiario del programa Contigo', MIDIS, Lima, <www.gob.pe/13922-conocer-los-requisitos-para-afiliarme-al-programa-contigo?token=hB6I1de0QiTUtJ7ExkPgdnqeiWRzzfMCianp13YIJyE>.

Figure 5.3. Coverage of non-contributory disability cash benefits as a percentage of total population, selected countries (latest year)

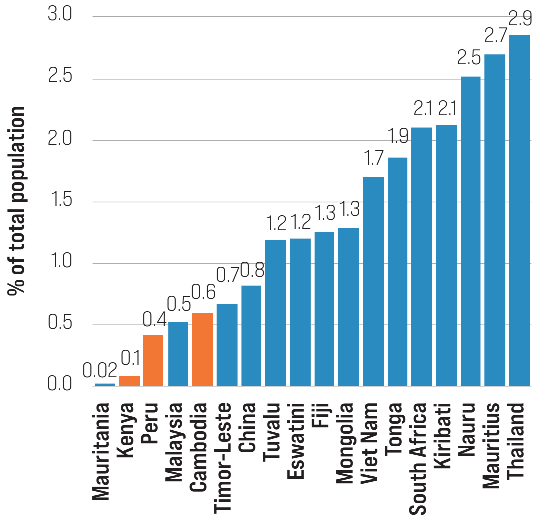
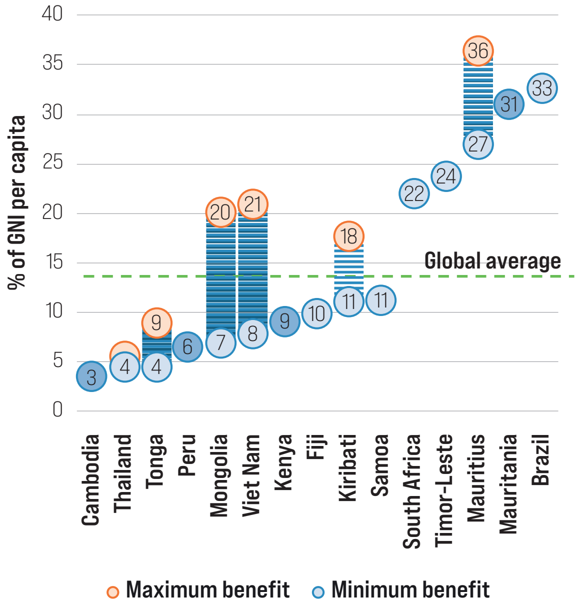


Figure 5.4. Benefit level of disability cash benefits as a percentage of GNI per capita, selected countries (latest year)



Source: Statistical annexes to this report.

Two different approaches are taken to cost non-contributory disability cash benefits that can better support disability inclusion:

- **Standard parameters** seek to provide an understanding of the range of costs when using parameters which follow the same basic logic. These parameters are based on work by the ILO to calculate the financing gap for universal social protection and are rooted in human rights and labour standards.[31] The ILO approach draws on the concept of a social protection floor to cost a set of cash benefits addressing a range of life-cycle risks, including disability. This provides a set of costing parameters which are more consistent across the case study countries. Specifically, the approach costs a cash benefit for all persons with severe disabilities, set at the national poverty line. Some adjustments are made here, including drawing on international rather than national poverty lines, and applying a uniform figure for the share of theoretically eligible persons with high support needs at 2 per cent of the total population.[f]

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[f] The costing uses international poverty lines according to the country income group, as defined by Jolliffe, D., et al., 'Assessing the Impact of the 2017 PPPs on the International Poverty Line and Global Poverty', Policy Research Working Paper No. 9941, World Bank, Washington, D.C., 2022. This is due to the greater availability of up-to-date data than for national poverty lines. Unlike the ILO, which draws on WHO estimates, the costing here assumes severe disability prevalence of 2 per cent of the total population because this reflects the experience of low- and middle-income countries that have successfully implemented such benefits. By contrast, indicators of severe disability used in the ILO analysis (which are generally around 3 per cent of the population) reflect only the highest coverage found in low- and middle-income countries (*see Figure 5.3*).

- **Parameters based on national discussion** draw on consultations with national stakeholders and deeper analysis undertaken in the five countries, seeking to account for a wider array of fiscal, economic and political factors. While the scenarios proposed do not constitute an agreed set of parameters for cash benefits among all national stakeholders, they seek to reflect more closely the direction of travel at a national level. These nationally defined parameters (summarized in *Table 5.2*) vary substantially between countries.

Table 5.2. Costing parameters for cash benefits

Country (scheme)	Direction of reform	Monthly benefit level	Recipients	
			Number	% of total population
Cambodia (Severe disability benefit)	The introduction of a dedicated benefit for all persons with severe disabilities, as assessed by the country's disability registry, with no means testing. This would complement the Family Package benefit that would still target all poor households with a person with disability (regardless or severity/support needs). The benefit level would remain low by international standards but would represent a significant increase from the current top-up paid under the Family Package.	**KHR 100,000** (US$25)	**94,524**	**0.5**
Kenya (PWSD CT)	An expansion of coverage to all persons with severe disabilities – removing the means-testing criterion. In the absence of reliable measures of severe disability, this assumes an increase in the number of recipients to 500,000 (0.9 per cent of the population) in the medium term, in line with experience of similar schemes in low- and middle-income countries. The benefit level would also be doubled to KES 4,000, reaching the global average for non-contributory disability benefits (15 per cent of GNI per capita), or around 80 per cent of relevant national and international poverty lines.[g]	**KES 4,000** (US$31) *Increased from KES 2,000 (US$15.50)*	**500,000** *Increased from 62,315 in 2024*	**0.9**

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[g] The rural poverty line is estimated at KES 5,057 in 2025, based on the value of KES 3,947 defined in the 2021 Kenya Continuous Household Survey, adjusted for inflation. See Kenya National Bureau of Statistics, 'The Kenya Poverty Report', KNBS, Nairobi, 2023, <www.knbs.or.ke/wp-content/uploads/2023/09/The-Kenya-Poverty-Report-2021.pdf>.

Country (scheme)	Direction of reform	Monthly benefit level	Recipients	
			Number	% of total population
Mauritania (Child disability benefit)	The expansion of the existing cash transfer for children with disabilities to all children with severe disabilities up to the age of 18. This also entails a shift from a focus on children with multiple disabilities to children with high support needs (not necessarily multiple disabilities). The benefit level would remain the same.	**MRU 2,000** (US$50)	**10,228**[h] *Increased from 1,000 in 2024*	**0.2**
Peru (Contigo)	An increase of the benefit level for the Contigo scheme from PEN 150 to PEN 250 per month based on a 2024 government analysis and proposal.[i] The scheme's eligibility criteria would remain the same, but coverage would increase to cover the programme's entire target population.[j]	**PEN 250** (US$66) *Increased from PEN 150 (US$39)*	**395,128** *Increased from 142,771 in the current programme*	**1.1**
Sierra Leone (Child disability benefit)	The introduction of a child disability benefit for children with severe disabilities up to the age of 18, which was a recommendation from technical discussions undertaken in 2024. The proposed scheme is limited to children due to the particular fiscal constraints in Sierra Leone, and the fact that a national disability registry is in the process of development. The benefit level is set at SLE 270 (US$12), based on the proposed level of a disability benefit in the National Social Protection Strategy (2022–2026). This is around two thirds of the relevant international poverty line.	**SLE 270** (US$12)	**40,913**[k]	**0.4**

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[h] Calculated from a survey-based measure in the Demographic and Health Survey (Enquête Démographique et de Santé – EDS) 2021: Office National de la Statistique, Ministère de la Santé and ICF, 'Enquête Démographique et de Santé 2019-2021', Nouakchott, Mauritania and Rockville, Maryland, USA, 2022, <https://dhsprogram.com/pubs/pdf/FR373/FR373.pdf>, accessed 25 March 2025.

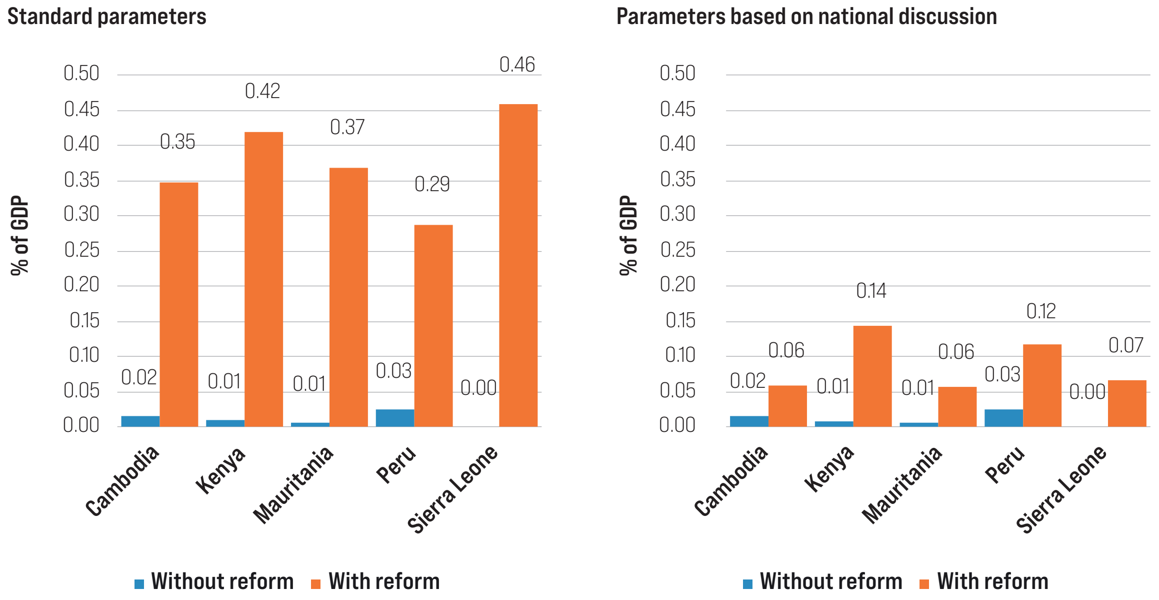
[i] The proposed benefit level was based on unpublished analysis undertaken by the Contigo programme, taking account of the monthly basic goods basket, the consumer price index and analysis of the extra costs associated with the presence of a person with disabilities in the household.

[j] The programme's target population is an estimate of the full population meeting the eligibility criteria. It was established based on a number of sources, including a 2012 national survey of persons with disabilities (Encuesta Nacional Especializada Sobre Discapacidad – ENEDIS), the national system for household targeting (Sistema de Focalización de Hogares – SISFOH), and the list of persons with severe disabilities provided by Peru's Ministry of Health.

[k] Based on UNICEF analysis of disability prevalence using the dataset of the Sierra Leone Integrated Household Survey (SLIHS) 2018: Statistics Sierra Leone, 'Sierra Leone Integrated Household Survey (SLIHS)', <www.statistics.sl/index.php/sierra-leone-integrated-household-survey-slihs.html>, accessed 25 March 2025.

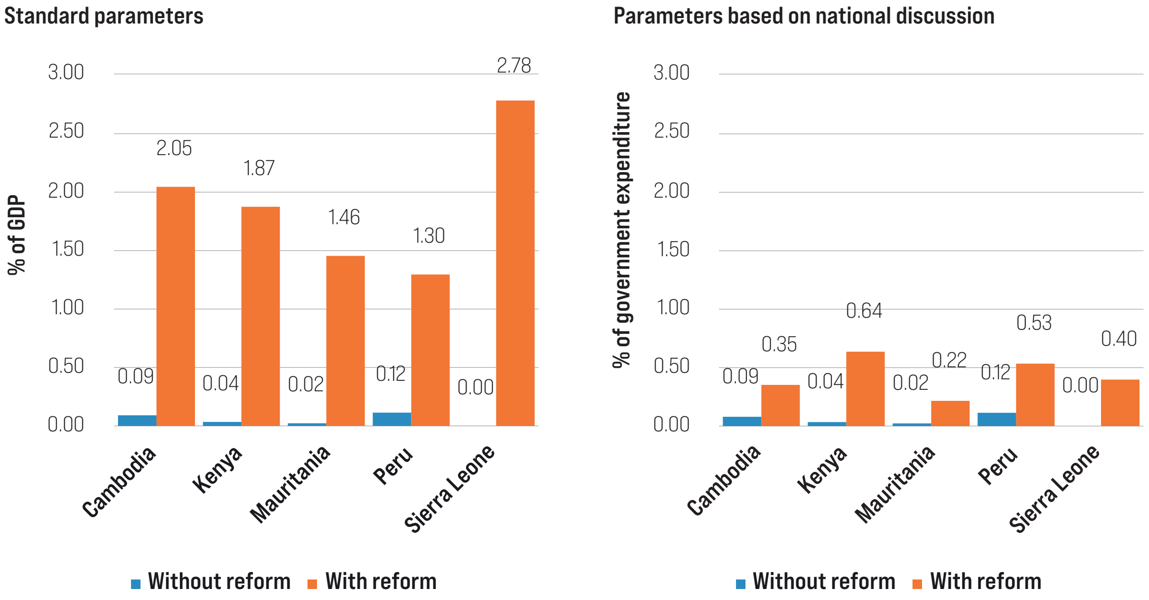
The costs of extending cash benefits to accelerate inclusion vary between 0.06 and 0.5 per cent of GDP depending on the country and scenario (*see Figure 5.5*). Costing according to standard parameters results in expenditure of between 0.3 and 0.5 per cent of GDP, which is closer to the level of low- and middle-income countries that have more established non-contributory disability benefits with high coverage and moderate to high adequacy. This would represent between 1.3 and 2.8 per cent of government expenditure. The scenarios adapted to the national context range from between 0.06 and 0.14 per cent of GDP, with the lower expenditure linked to the fact these schemes would remain more limited in benefit adequacy and coverage. These scenarios would require around 0.6 per cent of government expenditure or less (*see Figure 5.6*).

Figure 5.5. Cost of expansion of cash transfers for persons with disabilities in Cambodia, Kenya, Mauritania, Peru and Sierra Leone (percentage of GDP), 2025



Source: Authors' calculations.

Figure 5.6. Cost of expansion of cash transfers for persons with disabilities in Cambodia, Kenya, Mauritania, Peru and Sierra Leone (percentage of government expenditure), 2025



Source: Authors' calculations

Evidence on the financing gap of other forms of social protection remains much more limited. There have been some initiatives to undertake costing of care and support services; however, they have generally focused on the cost of long-term care services, often with an emphasis on older persons. These initiatives include global-level analysis conducted by the ILO on the cost of long-term care, and a review of approaches to model the cost of long-term care by the Asian Development Bank.[32,33] There appear to be very few examples of costing of concessions for areas such as transport and utilities. In both of these areas, more evidence of country experience of costing is needed, along with tools and methods that can be used by governments seeking to quantify financing gaps.

Health care

The cost of disability-inclusive health care is difficult to disentangle from financing of health systems as a whole. While persons with disabilities may in average have higher health care needs, they mostly access promotive, preventive, rehabilitative, curative and palliative health services through the same channels as people without disabilities.

A key step to accelerating disability inclusion across all health care services is to develop costed strategies to address disability in mainstream health actions. The World Health Organization (WHO) has developed guidance for the development of action plans for achieving health equity for persons with disabilities. The guidance, which focuses on strengthening health systems using a primary health care approach, includes four stages: preparation, assessment of disability inclusion across the health system, design of disability-inclusive actions, and implementation and monitoring.[34] *Box 5.3* describes the development of an action plan in Montenegro, which included a costing of the plan. A caveat on this costing is that it relates mainly to policy development processes, rather than some of the more significant costs associated with delivering health care in a way that promotes equity.

Box 5.3 Costing an action plan for health equity in Montenegro

Montenegro was the first country in the European region to implement the WHO's Disability inclusion guide for action, which culminated in the development of the Action Plan on Health Equity for Persons with Disabilities 2024–2027. The Action Plan was developed in consultation with a working group comprising representatives of the Montenegrin Ministry of Health, other Montenegrin government ministries, United Nations agencies and civil society organizations (including OPDs). Key action areas defined in the plan were:

- Political commitment, leadership and governance focused on revision of legislation and creation of a working group to oversee delivery of the Action Plan
- Health financing, focused on revising a rulebook to extend technical aids covered by Montenegro's Health Insurance Fund
- Engaging stakeholders and private sector providers, focused on raising awareness at facility level about disability inclusion
- Models of care, relating to service planning guidelines, and strengthening early childhood development and early intervention services for children
- Health and care workforce, focused on delivery of disability inclusion training to medical and non-medical staff
- Physical infrastructure and communication, involving auditing accessibility of health-care facilities, and standards for accessible health information
- Digital technologies for health, relating to health sector digitization plans and accessibility of Montenegro's eHealth portal
- Quality of care, relating to strengthening the role of Defenders of Patients' Rights and strengthening protocols for care of persons with disabilities
- Data collection for monitoring and evaluation, involving the development of data indicators, and integration of disability into population-level health research
- Health systems and policy research, involving creating a national research agenda on health equity and a protocol for disability research.

The development of the Action Plan was accompanied by a costing exercise, which calculated a cost of €120,000. The biggest single cost related to the establishment of three new centres for early childhood development in health centres, with the remaining costs mainly relating to staff and consultants' time, workshops and training. It should be noted that the actions within the plan – and their associated costs – are generally policy process-oriented and do not reflect the eventual cost of putting certain elements of the plan into practice (for example, costs of making health-care facilities more accessible or financing provision of technical aids under health insurance).

In many countries, there are specific interventions to improve coverage of some of the additional health care costs that persons with disabilities may face that can be costed. Two key examples are: (1) subsidized social health insurance for persons with disabilities; and (2) the costing of sets of goods and services that are of particular relevance to persons with disabilities, most notably rehabilitation and assistive technology.

Subsidized health insurance

Subsidized social health insurance can make an important contribution to increasing health coverage for persons with disabilities. Many countries around the world are undertaking efforts to achieve universal health coverage by addressing gaps in population coverage, service coverage and financial protection. In some countries, a core component of these efforts is the extension of coverage of social health insurance schemes. Typically, these countries seek to extend coverage through a mix of approaches, including mandated contributions from workers in the formal economy, partly subsidized contributions for groups of informal workers, and fully tax-financed coverage subsidies for certain population groups. Defined categories of persons with disabilities are often included as a fully subsidized group, alongside other groups such as poor households, older persons, young children and students. Countries pursuing such an approach include the Philippines and Viet Nam.[35] The impact of such initiatives on persons with disabilities will depend significantly on the design and implementation of social health insurance schemes (including the comprehensiveness of benefit packages and the extent of financial protection), and how they fit within the wider heath financing system. Nevertheless, even where gaps exist, this approach can contribute to better health protection for persons with disabilities.

Three of the case study countries (Cambodia, Mauritania and Sierra Leone) are using social health insurance arrangements as part of a strategy to achieve universal health coverage. In Cambodia, this process has involved a combination of its contributory National Social Security Fund and a non-contributory Health Equity Fund. The Health Equity Fund has mainly focused to date on supporting people in poverty , at-risk and informal workers, without a dedicated focus on disability.[36] Mauritania is also seeking to expand health insurance coverage through a combination of its long-standing compulsory health insurance fund (Caisse Nationale d'Assurance Maladie – CNAM) and a newly established voluntary health insurance fund (Caisse Nationale d'Assurance Santé – CNASS). Sierra Leone is in the process of establishing the Sierra Leone Social Health Insurance (SLeSHI) fund, which will combine mandatory and voluntary contributions, alongside fully non-contributory coverage for poor households.

The cost of extending social health insurance arrangements to persons with disabilities is assessed in the three countries. *Table 5.3* outlines the parameters for extending coverage of social health insurance to persons with disabilities, which have been adapted according to national-level discussions. The varying scale of the population to be covered relates to differences in coverage gaps and policy ambitions. The unit cost also varies significantly, mainly due to the varying design of health systems (including the relative weight put on social health insurance within health financing) and the different methods for determining the unit cost.

Table 5.3. Costing parameters for subsidized health insurance for persons with disabilities

Country (scheme)	Direction of reform	Unit cost (contribution rate), monthly	Number of recipients	% of total population
Cambodia (Health Equity Fund)	Inclusion of all persons with a disability card in the Health Equity Fund scheme. This would be in addition to the estimated 136,176 persons with disabilities already covered as living in poor or 'at-risk' households. The unit cost is based on the Health Equity Fund's current per capita expenditure on persons with disabilities.[l]	**KHR 9,000** (US$2.20)	222,182	1.2
Mauritania (Caisse Nationale d'Assurance Maladie – CNAM)	Inclusion of the poorest 60 per cent of persons with moderate or severe disabilities in the national health insurance fund (CNAM). The unit cost for inclusion of persons with disabilities is based on the current amount negotiated between the Ministry of Social Action, Childhood and Family (MASEF), which leads on disability-related issues, and the Ministry of Health.[m]	**MRU 350** (US$8.80)	94,047[n]	1.8

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[l] The unit cost is calculated using data shared by the National Payment Certification Agency, which is responsible for verifying and processing claims for health services under the Health Equity Fund. The per capita cost of expenditures for persons with disabilities in 2024 was KHR 8,999 per month; however, this related to only 2,295 persons with disabilities identified in the database – significantly fewer than the estimated 136,176 currently covered by the Health Equity Fund. It is therefore likely that this per capita expenditure overestimates the unit cost for a person with disability. The per capita expenditure for all those covered by the scheme was significantly lower (KHR 2,506 per month).

[m] This arrangement already benefited 4,000 persons with disabilities in 2024.

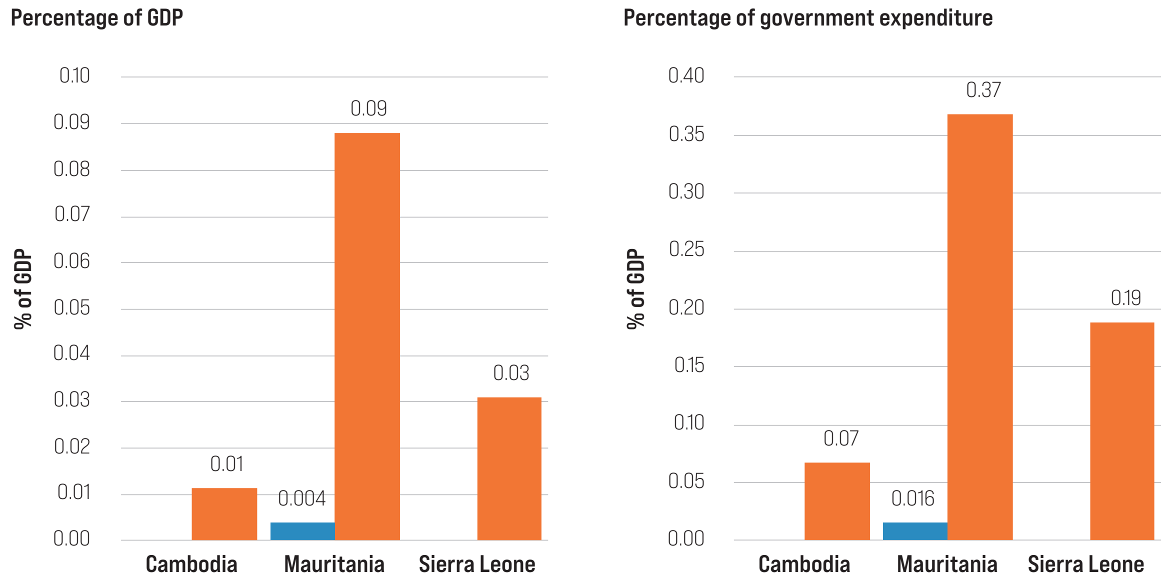
[n] Based on a survey-based measure in the Demographic and Health Survey (Enquête Démographique et de Santé – EDS) 2021.

Country (scheme)	Direction of reform	Unit cost (contribution rate), monthly	Number of recipients	% of total population
Sierra Leone (SLeSHI)	Inclusion of all persons with moderate and severe disabilities in the SLeSHI. The unit cost for inclusion of persons with disabilities is the monthly contribution rate set for workers in the informal economy.	SLE 30 (US$1.30)	**190,266**[o]	2.1

Source: Country background papers.

The cost of extending subsidized health insurance to persons with disabilities would be relatively low across the three countries analysed. Based on the assumptions described above, extending subsidized health insurance would cost between 0.01 and 0.09 per cent of GDP, and between 0.07 and 0.37 per cent of government expenditure (*see Figure 5.7*). The variation in costs is directly linked to the scale of coverage and unit costs described above. These figures could be considered relatively small, given the potential impact on access to health care for persons with disabilities. It should, nevertheless, be emphasized that such measures would only partially address the health-care costs of persons with disabilities, due to broader weaknesses in social health insurance and health-care systems, and the existence of specific gaps in inclusion of services relevant to persons with disabilities within benefit packages.

Figure 5.7. Cost of extending fully subsidized health insurance to persons with disabilities in Cambodia, Mauritania and Sierra Leone, 2025


Percentage of GDP

Percentage of government expenditure

Source: Authors' calculations.

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[o] Based on UNICEF analysis of disability prevalence using the dataset of the Sierra Leone Integrated Household Survey (SLIHS) 2018.

Rehabilitation and assistive technology

The extent to which the financing of rehabilitation and assistive technology is included in wider health financing mechanisms varies by country. While many countries do include rehabilitation services in wider health financing, there are also many cases where it is financed via other channels, sometimes in the form of vertical programmes for persons with disabilities.[37] This is the case, for example, in Cambodia, where a system of physical rehabilitation centres is managed by a combination of the Ministry of Social Affairs, Veterans and Youth Rehabilitation and non-governmental organizations (NGOs).[38] Similarly, many social security schemes provide rehabilitation services as part of benefit packages addressing employment injury. The picture in terms of assistive technology is similar; however, in low- and middle-income countries the role of vertical programmes is even more pronounced than for rehabilitation. Social welfare ministries, NGOs and disability funds often play a key role in this space.[39] **There is a strong case for greater inclusion of both rehabilitation and assistive technology in wider health financing mechanisms as this is more conducive to achieving universal health coverage for persons with and without disabilities alike**.[40]

While there are few examples of comprehensive costing of extending rehabilitation services, there are a growing number of tools to support such processes. A key question for countries seeking to expand the scope of rehabilitation services covered by health-care benefit packages is which services should be a priority. The WHO's 'Package of interventions for rehabilitation' outlines the most essential interventions for rehabilitation for 20 health conditions and provides tools to prioritize the target population and define a service package. It was recently used in Georgia to develop the country's first rehabilitation service package covering services related to five conditions: stroke, traumatic brain injury, spinal cord injury, fractures and amputation. The process included a costing exercise which collected information on the duration of rehabilitation sessions, the number of sessions required for different conditions, the cost of workforce time and the need for services among the population. The costing estimated a total cost of GEL 30 million per year (US$11 million),[41] equivalent to 0.04 per cent of GDP in 2023.[p]

There have also been notable developments in recent years in quantifying the cost of assistive technology. Assistive technology is typically included in the costing of broader rehabilitation services, but there may also be cases where there is a need for dedicated costing. One side of this equation is to better understand the price of priority assistive devices at a national level. A key development in this context was the development of the Priority Assistive Products List (APL) by the WHO in 2016, and the development of national-level priority product lists tailored to the country context.[42] The APL is currently being revised, as described in *Box 5.4*. The other side of the equation is to better understand the need for assistive devices, which is being explored using tools such as the WHO's Assistive Technology Capacity Assessment tool (ATA-C) and rapid assistive technology assessment (rATA).[43] Nevertheless, there are limited examples of comprehensive national-level exercises to estimate the cost of expanding provision of assistive technology.

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[p] Authors' calculations based on GDP data from International Monetary Fund, 'World Economic Outlook Database'.

Box 5.4 WHO assistive products price review

The WHO is updating its APL to help countries develop national lists tailored to their specific needs and resources. This update involves collecting data on assistive products based on four indicators: need, benefits, risks and price. For the price indicator, the process includes conducting a price review by gathering price and service life data for selected assistive products from 12 countries, representing a mix of low-, middle- and high-income nations globally.

The price for each product is calculated using the formula:

PriceAnnual = (PriceProduct/ServiceLifeProduct) + (PriceAccessories/ServiceLifeAccessories) + PriceConsumables

where the lowest prices of the product, accessories and consumables are divided by their respective service lives. This information is entered into an online APL evaluation form, which generates a weighted score based on price, risk, need and benefit. The resulting prioritized list will be refined and reviewed through stakeholder consultations and with the support of the WHO Technical Advisory Group on assistive technology.

The price review is currently under way, and the results will be published in the upcoming edition of the updated APL, scheduled for release in late 2025.

Source: Input provided by the World Health Organization Assistive Technology Team.

Education

Evidence is scarce on the financing gap for building inclusive education systems in low- and middle-income countries. This is partly linked to deeper issues around the planning and budgeting of disability-inclusive education. Disability-inclusive education related expenditures are rarely identified in stand-alone budget lines or budget programmes, while funding for special schools – which are at odds with a CRPD-compliant approach – are more often identified. Instead, it may be subsumed within other budget lines such as teacher training or provision of learning materials. Analysis by Kerr and Kurzawa (2023) highlights that this can result in disability inclusion getting lost under other priorities.[44]

Costing disability-inclusive education efforts means clearly defining and collecting reliable data on different kinds of costs. Education sector analysis guidelines developed by United Nations Educational, Scientific and Cultural Organization (UNESCO) et al. (2021) for inclusive education for persons with disabilities provide a useful reference point for national costing exercises.[45] The types of costs of inclusive education programmes can include disability screening, accessibility, equipment, assistive technology, staffing (including specialized teaching staff) and training. Identifying the scale of these costs entails collecting data from existing education systems and, potentially, from pilots of inclusive education programmes. They will depend significantly on the scope and ambition of the programme. Once a unit cost for provision of inclusive education support is identified, the size of the beneficiary population also needs to be identified.[46]

Some recent initiatives shed light on the cost of inclusive education in low- and middle-income settings. Sightsavers – with support from IrishAid and UK Aid – has undertaken analysis in Cameroon, Kenya, Nigeria and Senegal, seeking to estimate the cost of supporting children with disabilities in mainstream schools (*see Box 5.5*). Another notable initiative is the creation of a tool for costing interventions that leverage technology to support learners with disabilities as part of the World Bank's Tech-EnableD Disability Inclusive Education (TEDDIE) instrument. The Excel-based tool is designed to cost out a five-year plan to implement a minimum package that includes digital devices, tools and hardware, including assistive technologies; software, platforms and apps; non-tech teaching and learning materials; reasonable accommodations; teacher and specialist training; and maintenance costs.[47]

Box 5.5 Costing of inclusive education interventions in Cameroon, Kenya, Nigeria and Senegal

Sightsavers has conducted costing studies based on its experience implementing inclusive education projects with government and NGO partners in Cameroon, Kenya, Nigeria and Senegal. The primary goal was to estimate the incremental cost of supporting children with disabilities in mainstream schools, analyse how costs are distributed across activities and identify key cost drivers. These estimates were based on routine financial data from project implementation and, where available, government data.

The cost of interventions supporting children with disabilities ranged from US$434 to US$1,232 per child per year, varying by countries. In Cameroon, expenditure data were used to model the budget impact, showing that scaling such interventions to 428 government primary schools (about 3 per cent of all primary schools) between 2022 and 2030 would require approximately 0.5 per cent of the 2022 basic and secondary education budget.

There are some important considerations for interpreting the figures and how they can be applied to national scale-up. The costs partly reflect the focus on capacity-building and did not include certain government expenditures, such as teaching staff salaries and assistive devices. Additionally, the studies were based on a relatively small number of schools (between three and nine in each country). At the same time, national scale-up would likely benefit from economies of scale, and certain activities, like training and curriculum development, would not need to be repeated frequently.

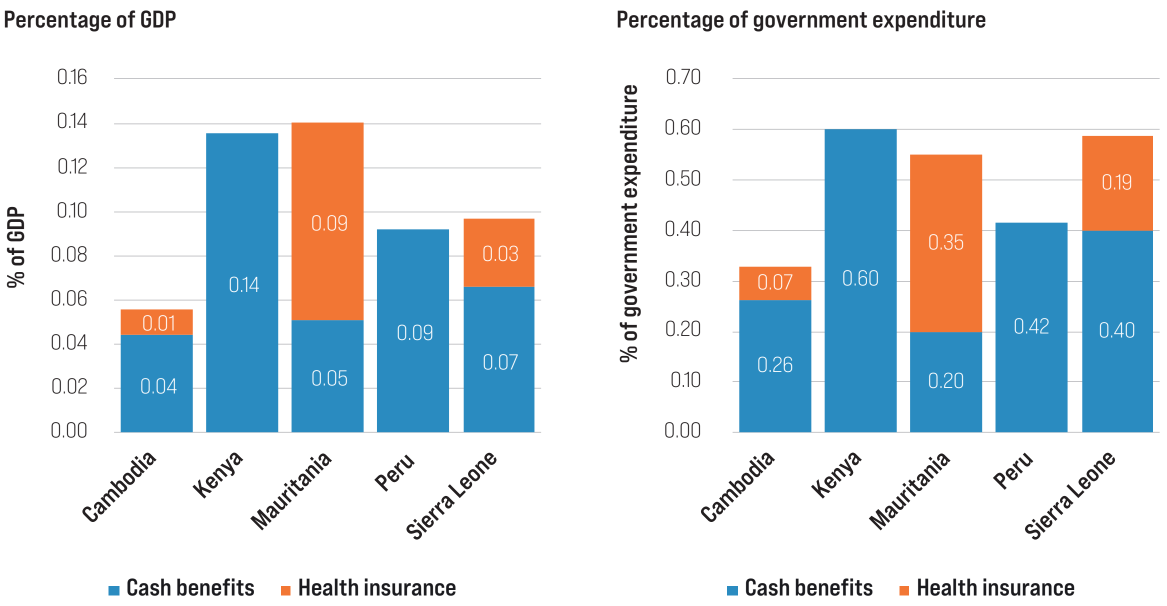
Source: Chatharoo et al. (2018); Engels et al. (2022); Trotignon and Jones (2024).[48,49,50]

Summary

Overall, the analysis of the financing gap highlights the need for better evidence, methods and tools for costing programmes and services that support disability inclusion. While it was possible to cost disability cash benefits and (where relevant) extension of health insurance across the five countries, it was not possible for other key areas. These include rehabilitation services, provision of assistive devices and inclusive education, as discussed above, but also other areas such as development of care and support services. In part, this is linked to the much greater difficulty in defining the unit cost of these different programmes and services, and the scale of the beneficiary population. However, ongoing initiatives indicate that better evidence of practice and costing tools would enable much more progress to be made on costing the financing gap for disability inclusion.

Even with the limited package of interventions costed, closing the financing gap and accelerating disability inclusion would require a significant increase in resources relative to current expenditures. As shown in *Figure 5.8*, the combined cost of expanding disability cash benefits (with the conservative scenario adapted for the national context) and expanding health insurance would cost between 0.05 and 0.15 per cent of GDP across the five countries, or between 0.3 and 0.6 per cent of government expenditure. These figures are relatively modest compared to the scale of overall public expenditure, and more than achievable for a country with the political will to accelerate disability inclusion. Nevertheless, they are also many times higher than existing levels of expenditure across the five countries, indicating the need for a significantly increased effort.

Figure 5.8. Combined financing gap for expansion of cash benefits in Cambodia, Kenya, Mauritania, Peru and Sierra Leone (including health insurance in Mauritania and Sierra Leone), 2025



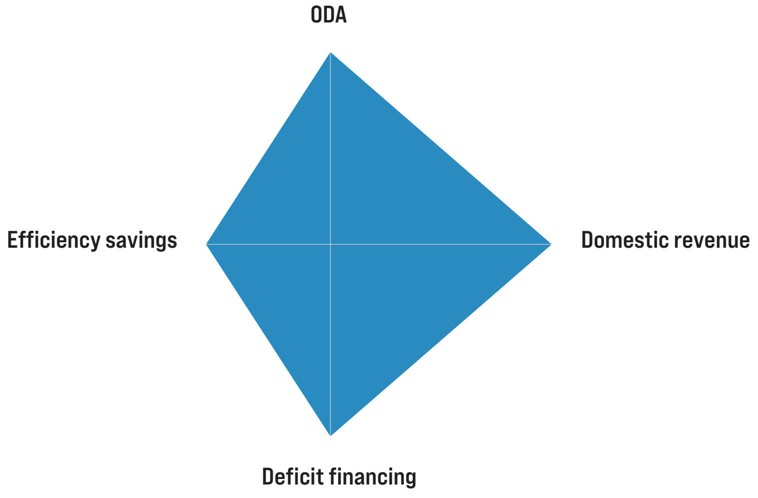
Source: Authors' calculations.

Note: The financing gap indicates the cost of expenditure after reform minus current levels of expenditure.

Strategic approaches to optimize the use of maximum available resources

Resources for disability inclusion can come from a variety of different sources. As discussed earlier in this chapter, these can include a range of public and private sources. From a public finance perspective, a core concept for identifying resources for a particular purpose is that of 'fiscal space'. Fiscal space is commonly defined as the "availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position".[51] Sources of fiscal space can be divided into four main categories: domestic revenues, deficit financing, efficiency savings and ODA (*see Figure 5.9*). They are discussed below with reference to disability inclusion, drawing on evidence from the case study countries.

Figure 5.9. The fiscal space diamond



Source: UNICEF (2021).[52]

Domestic revenues

Domestic revenues include the full array of tax and non-tax revenues that contribute to financing the national budget. The extent to which policies and programmes supporting disability inclusion can be financed by the national budget will therefore be strongly influenced by the broader picture of domestic revenue.

While the situation varies from country to country, levels of domestic revenue in low- and middle-income countries fall well below those of high-income countries in absolute terms, primarily due to the smaller size of the economies from which domestic revenues can draw. Four of the five countries considered in this chapter are either low- or lower-middle-income countries (*see Figure 5.10*) that face substantial challenges to revenue mobilization. In these countries, levels of revenue also tend to be smaller relative to the size of the economy. Government revenue across the five case study countries ranges from 13 to 23 per cent of GDP, which is relatively low by international standards, and especially those found in high-income countries (*see Figure 5.11*). Tax revenue (which excludes non-tax revenue and grants) is below 15 per cent of GDP in Cambodia and Sierra Leone – a level considered a "tipping point" for achieving sustainable economic and social development.[53,54]

Nevertheless, many low- and middle-income countries are gradually expanding domestic revenues through a mixture of tax policy and administrative reforms, and an increasing tax base created by economic growth and formalization of the labour market. In some cases, specific revenue sources (such as sin taxes,[q] employment quota levies or revenue from lotteries) may be earmarked for disability-related expenditures, sometimes via national disability funds (as in countries such as Argentina, Thailand and Yemen). Health insurance and broader social security funds also draw primarily on one form of revenue (payroll contributions) to finance benefits and services that may support disability inclusion.

Efficiency savings

Financing disability inclusion can also be supported by making existing expenditures more efficient. This can apply at the level of disability-specific expenditures, such as by reallocating budgets away from activities that contradict CRPD standards, such as segregated special schools and institutionalized care, to inclusive education and community care and support systems that enable disability inclusion. The low levels of disability-specific expenditure in many low- and middle-income countries, however, mean that the scope for such redistribution may be limited. Redistribution can also happen away from mainstream expenditures assessed as being ineffective or regressive, towards supporting disability inclusion. One issue to consider is that there are not always straightforward ways within budgeting processes to reallocate funds for specific purposes between ministries or levels of government.

One relevant factor to consider from the perspective of efficiency is the scale of total expenditures in social sectors. A country with substantial investments in education, health and social protection will likely be better able to mobilize resources for disability inclusion from within those budgets than one where these sectors are severely underfunded. Expenditure on these sectors varies significantly across countries *(see Figure 5.12).*

Efficiency can also be achieved by ensuring that current spending promotes accessibility or employment, such as through the systematic inclusion of accessibility requirements and social clauses in public procurement.

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[q] Sin taxes can be defined as "excise taxes imposed on the consumption of potentially harmful goods for health". See Miracolo, A., M. Sophiea, M. Mills and P. Kanavos, 'Sin taxes and their effect on consumption, revenue generation and health improvement: a systematic literature review in Latin America', *Health Policy and Planning*, vol. 36, no. 5, June 2021, pp. 790–810.

Deficit financing

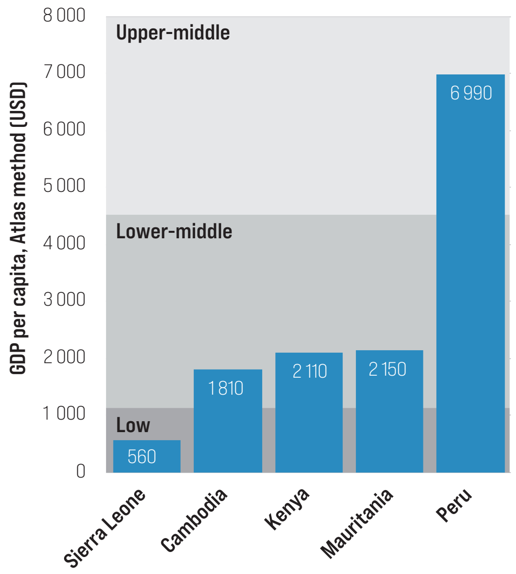
Most countries run some level of government deficit, with a proportion of expenditure financed by borrowing. This can be from both domestic and international private capital markets, from national development banks and funds (including social security funds), and from International Financial Institutions (such as the World Bank, regional development funds, the IMF and others). Borrowing from International Financial Institutions can be a particularly relevant source of financing for disability inclusion, as it is more likely to focus on disability-related issues, and loans may be provided on concessional terms. One example of such programmes is the US$162 million loan for the RIGHTS project to strengthen the social protection systems and capability of the State of Tamil Nadu in India to promote inclusion, accessibility and opportunities for persons with disabilities, financed by the World Bank.

While some level of government deficit can be a sustainable way to finance government expenditures that underpin sustainable development, many low- and middle-income countries are facing significant challenges in terms of debt sustainability. Among the case study countries, government deficits range from less than 3 per cent of GDP in Cambodia, Mauritania and Peru to over 5 per cent in Kenya and Sierra Leone. A combination of high levels of public debt, large deficits and significant debt service costs means that both Kenya and Sierra Leone are considered at high risk of debt distress.

Official Development Assistance

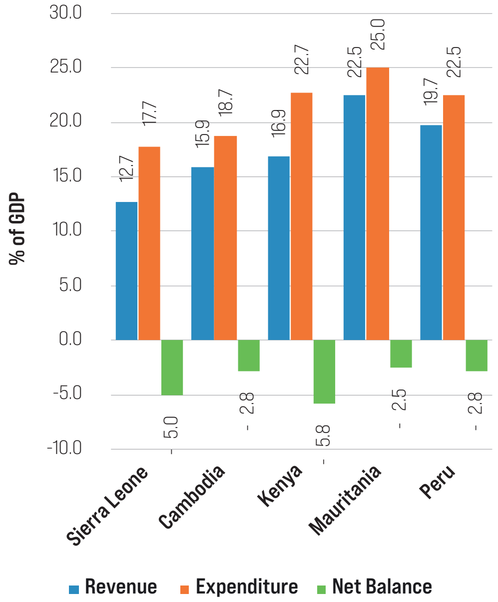
ODA is a particularly important source of fiscal space for the world's lowest-income countries, where it often forms a significant proportion of government revenues. Among the case study countries, this is particularly notable in the only low-income country (Sierra Leone), where grants from international organizations and foreign governments account for 6.4 per cent of GDP. The figures are lower – but still significant – in Cambodia and Mauritania (between 1 and 2 per cent of GDP) (*see Figure 5.13*). The role of ODA in relation to disability inclusion will depend both on the extent to which it provides resources for disability-focused government activities, and the extent to which ODA resources focused on broader issues are designed and implemented in ways that support disability inclusion. It is worth noting that – even when not channelled via national governments – ODA can play an important role in filling significant gaps in government service delivery, providing technical support and developing new service models. A similar role can be played by private development finance (for example, from philanthropic foundations) and activities financed by public fundraising (often delivered by national and international NGOs).

Figure 5.10. GNI per capita, Atlas method (current US$), 2023, with income group



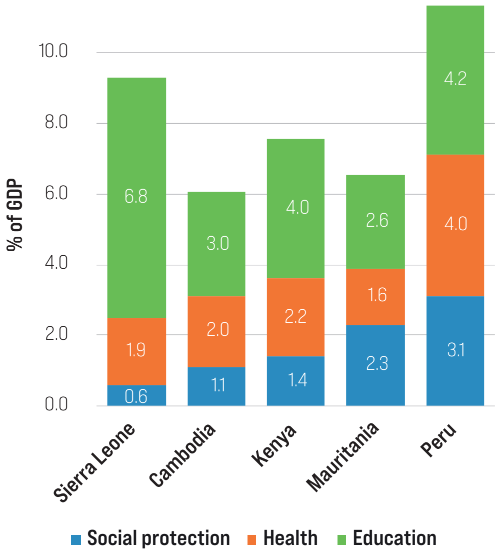
Source: World Bank and OECD (2024).[55]

Figure 5.11. Key fiscal indicators, 2023



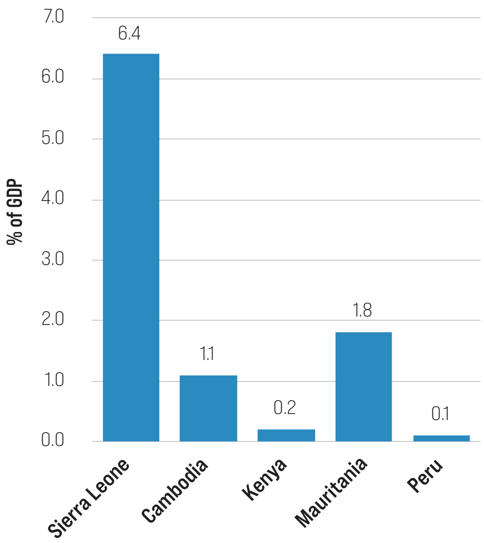
Source: IMF (2024).[56]

Figure 5.12. Social sector spending, percentage of GDP, latest years



Source: ILO (2024) and UNESCO Institute for Statistics (UIS) (2024).[57,58]

Figure 5.13. Government grant revenue,[r] percentage of GDP, latest year



Source: Country IMF Article IV reports.[59,60,61,62,63,s]

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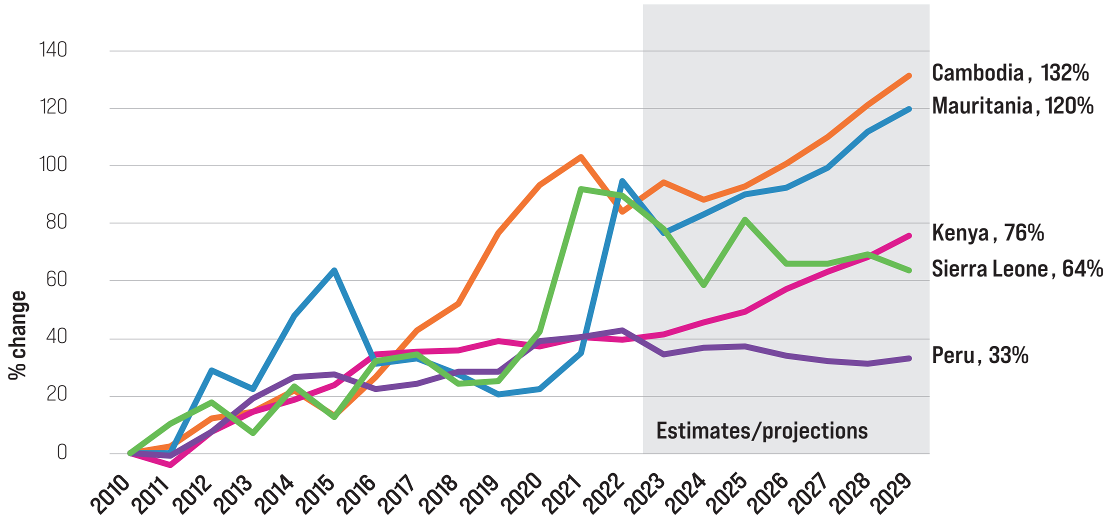
r From foreign governments or international organizations.

s Years of data (actual) are 2021 for Cambodia, 2021/2022 for Kenya and 2022 for Mauritania, Peru and Sierra Leone. Data for Cambodia and Peru relate to general government expenditure and Kenya, Mauritania and Sierra Leone to central government expenditure.

While the picture varies substantially across countries, the general trend in many low- and middle-income countries is of gradual increases in levels of fiscal space over time. One indicator is the historical and projected level of government expenditure. *Figure 5.14* shows the percentage change in the real size of government expenditure per capita in the five case study countries since 2010 and projected up to 2029 based on data collated by the IMF. Between 2010 and 2024, per capita government expenditure increased by between 37 and 88 per cent across the five countries and is forecast to increase by between 33 and 132 per cent by 2029 – implying the trend is set to continue. This would mean that expenditures would have more than doubled across the period in Cambodia and Mauritania. Peru has a flatter trajectory, with some fall in the real value of per capita expenditure between 2024 and 2029, and the overall trajectory in Sierra Leone is more erratic. Changes in the size of government revenue result from changes in the scale of revenue (from tax, ODA and other sources) and levels of borrowing, but also from economic growth, which increases the pool of resources from which domestic revenues can draw. There are important caveats to interpreting these figures, not least that increases in expenditure should not be assumed to be sustainable, especially given challenges of debt risks, debt servicing and other factors. Nevertheless, they do highlight the common picture across low- and middle-income countries of sustained increases in expenditure per capita over time.

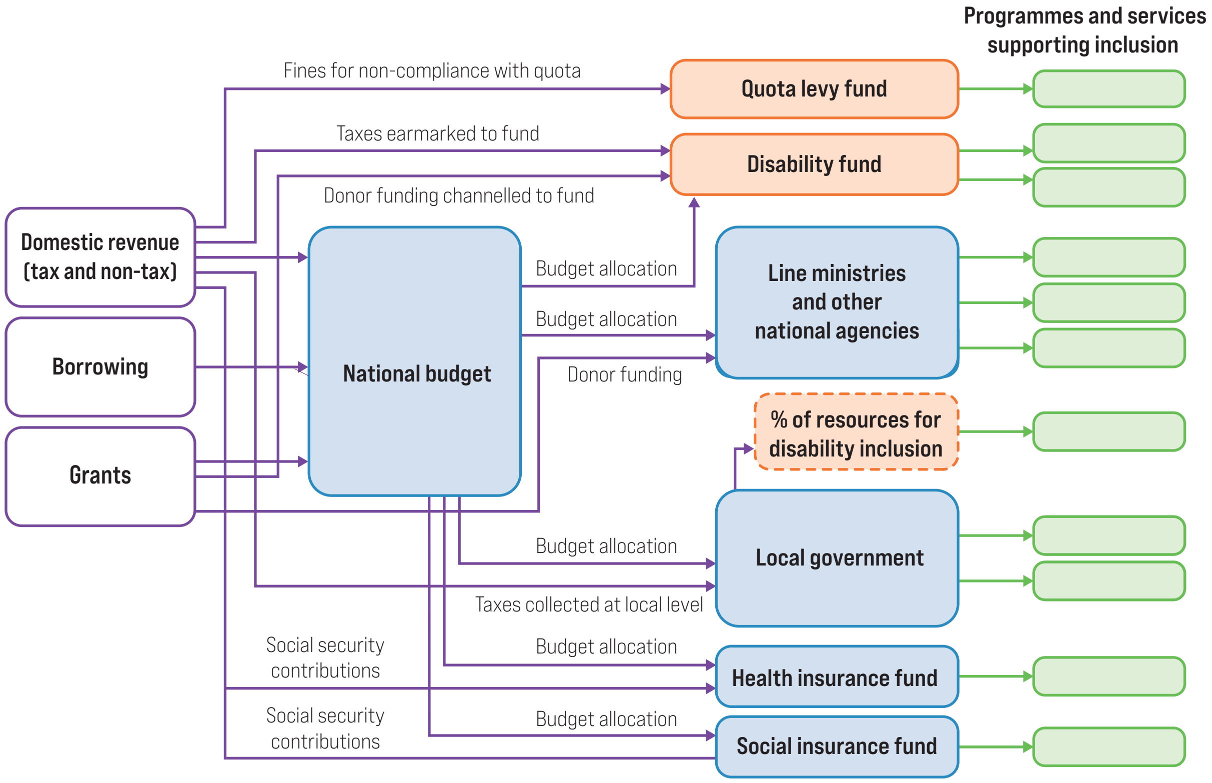
Figure 5.14. Percentage change in government expenditure per capita (constant prices), 2010–2029



Source: IMF (2024).[64]

The following subsections discuss different ways to strategically mobilize different sources of finance for disability inclusion. In practice, the way in which different kinds of resources do or do not flow towards disability inclusion is complex. As illustrated in *Figure 5.15*, even when only considering flows via the public finance system, there are an array of different ways in which resources from different sources (domestic revenue, borrowing and grants/ODA) may flow towards disability-related programmes and services. This picture is even more complex when considering the contribution of private resources from families, communities, NGOs and businesses. The following discussion highlights that navigating this environment means **setting strong foundations** in terms of legal frameworks, policy and strategic planning, and coordination. Given the centrality of the national budget to financing disability inclusion, **harnessing the budget cycle** to support disability inclusion is critical to ensure that existing and future resources are used to their best effect. There are, nevertheless, more specific financing channels that can be enablers of disability inclusion. These include **disability funds**, which exist in many countries across the world, **local government finance**, and **social security and health insurance funds.** The role of **international financing sources** also deserves dedicated attention. Finally, **public procurement** and **public–private financing** are key for both how governments deliver programmes and services, and how they best mobilize private sector resources.

Figure 5.15. Simplified visualization of public finance resources for programmes and services supporting disability inclusion



Source: Authors' elaboration. See background paper on financing mechanisms for disability inclusion.

Note: Disability-specific mechanisms are in orange.

Laying the foundations

Well-developed legislation, policies and strategic plans are a key foundation for mobilizing resources for disability inclusion. They include those that are specifically focused on disability inclusion, as well as those referring to broader sectors (such as education, health and social protection) that clearly address disability. Crucially, they should establish the roles and responsibilities of different actors across government in relation to disability inclusion, and the priority actions for accelerating disability inclusion. In doing so, they create the legitimacy for relevant government departments to identify financing sources and negotiate budget allocations for key priorities. Policy development and strategic planning are likely to be particularly influential from a budgeting perspective where they directly consider key budgetary implications – for example, through the development of costed plans. For instance, Mauritania and Zimbabwe are two countries that have recently incorporated costing exercises into national disability strategies and policies (*see Box 5.6*).

Box 5.6 Costing of disability policies and strategies in Mauritania and Zimbabwe

Mauritania

The government of Mauritania prioritized developing and adopting the National Strategy for the Inclusion and Promotion of the Rights of Persons with Disabilities in combination with social protection reforms, recognizing that these efforts would be most effective when supported by a strong, rights-based disability policy framework. Following the 2023 Concluding Observations from the CRPD to the Government of Mauritania, in 2024 the country initiated, with the support of UNICEF, a participatory process involving 12 workshops with 17 ministries, government agencies, OPDs and partners. This led to the Strategy's official adoption by the Council of Ministers in December 2024.

The approved Strategy outlines the development of a costed action plan, with the Government committing to progressively increase budget spending on disability from a 2024 baseline of 0.13 per cent of budget expenditure (0.03 per cent of GDP). It affirms the need for contributions from all ministries, regional councils and municipalities, with each expected to allocate a share of their budgets (yet to be defined) to disability inclusion. The costing of the action plan was consolidated in February 2025 and was supported by the transition of Mauritania to programme budgeting as government contributors were acquainted with costing approaches, arbitrages and prioritization requirements. A significant portion of this increased investment is expected to support social protection measures.

Zimbabwe
The Government of Zimbabwe has sought to develop a robust regulatory framework and system to support the effective implementation for the National Disability Policy. This includes a Costed Action Plan developed under the leadership of a multi-stakeholder Technical National Coordination Committee. A United Nations Global Disability Fund programme implemented by UNESCO, UNDP and United Nations Population Fund supported the Costed Action Plan to be developed in collaboration between 17 government ministries, two main national umbrella OPDs and two human rights commissions. Prior consultations were carried out with diverse OPDs in 2022, and their inputs were incorporated into the plan.

This programme included a training of key government actors on CRPD-compliant budgeting approaches. An important step in this process was a review of a validated draft Costed National Action Plan to align it with the Ministry of Finance's operational processes. The Costed Action Plan now serves as the foundation for coordinating efforts and guiding resource allocations and resource mobilization from the national Treasury as well as development partners and donors, for effectively implementing the National Disability Policy.

The Costed National Action Plan calls for investment that is directed towards high impact interventions and activities across sectors to promote the rights of persons with disabilities. In total, delivery of the action plan is projected to cost between US$8 million and US$16 million annually across the period of implementation.[65] This would equate to between 0.02 and 0.04 per cent of GDP.[t]

Source: Input from UNICEF Mauritania country office (for Mauritania) and Global Disability Fund (for Zimbabwe)..

Effective mobilization of resources for disability inclusion also requires coordination by different actors within government. A common challenge for accelerating inclusion of persons with disabilities is fragmented delivery of services across government. Without adequate coordination, this can also adversely affect budgeting for disability inclusion, with multiple ministries or agencies competing for allocations to programmes with overlapping objectives. This can be addressed by mechanisms that coordinate the planning and delivery of programmes for persons with disabilities across government (see discussion on coordination in *Chapter 2*). Another key aspect of this is the distribution of roles and responsibilities between central and subnational levels of government.

The ability to secure adequate allocations for disability inclusion will be supported by the development of a strong investment/business case. This is relevant for both government and non-government actors, including line ministries or government agencies justifying a request for a budget allocation, or civil society organizations lobbying for a particular policy to be financed. Much of this business case will rely on the broader

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[t] Authors' calculations based on GDP data from International Monetary Fund, 'World Economic Outlook Database'.

legislative and policy foundation described above; however, the budget formulation process is an opportunity to summarize the key evidence and highlight the urgency of an investment. Given the interest of ministries of finance on economic returns on investment, this can be a key moment to emphasize the costs of exclusion and gains of inclusion (*see Box 5.1*). An investment case can include drawing on new data and evidence – for example, from impact evaluations – to explain the specific outcomes of a particular investment. It is also a moment for line ministries to highlight their capacity to implement new, improved or expanded programmes – for example, by referring to a strong record of implementation and budget execution. The importance of developing a strong business case is likely to be greater where budgets are oriented towards results, as with a programme-based budgeting approach.

Budgeting for disability inclusion

The national budget cycle provides a key strategic entry-point for mobilizing resources for disability inclusion. As noted above, most public finance resources (from domestic revenue, deficit financing and ODA) are channelled via the national budget towards expenditure allocations on the wider remit of government activities. The budget cycle is the mechanism through which these resources – which are often growing over time – can be secured for key activities supporting disability inclusion. It is also the mechanism through which decisions on efficiency savings and reallocation are made. A CRPD-compliant approach to budgeting entails a number of aspects, including:

- **Ensuring adequate budget allocations**, both to disability-specific programmes and policies, and to support mainstreaming of disability inclusion across government (*see Box 5.7*). These should reflect roles and responsibilities of different agencies and levels of government in policy implementation.
- **Moving away from non-CRPD-compliant allocations**, such as financing of institutionalized care and segregated special schools, towards more inclusive arrangements
- **Avoiding retrogression** – that is, the reduction of allocations made to support disability inclusion
- **Ensuring revenue policies and administration** do not increase the costs for persons with disabilities or harm them.

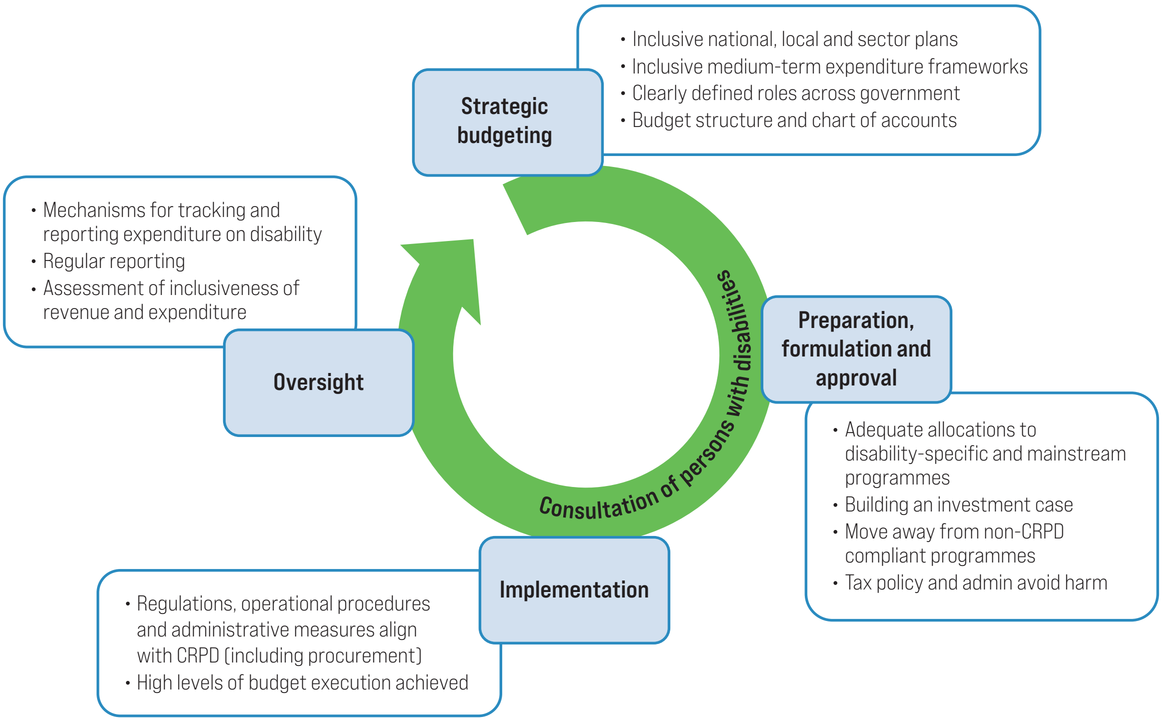
Box 5.7 Towards inclusive Integrated National Financing Frameworks (INFFs)

Originating from the 2015 Addis Ababa Action Agenda, Integrated National Financing Frameworks (INFFs) help countries align financial resources with their national development plans, drawing on domestic and international, public and private funding. [66]

INFFs provide an important tool to identify pathways and mainstream financing for disability inclusion and leave no one behind.[67] However, while issues such as gender equality have been considered in many countries, there do not appear to have been concrete examples of disability inclusion being proactively included in the development of INFFs at a national level.

The budget cycle provides a number of key moments to support the mobilization of resources for disability inclusion. While the nature of the budget cycle can vary significantly from country to country, it is possible to identify key stages where a CRPD-compliant approach can be put into practice. *Figure 5.16* visualizes the four main stages of the budget cycle: strategic budgeting through which broad policy goals are translated into budget decisions; the annual preparation, formulation and approval of budgets; budget implementation; and budget oversight.[68]

Figure 5.16. Ensuring disability inclusion across the budget cycle



Source: Adapted from UNICEF (2021) and UNICEF (2024).[69,70]

In terms of strategic budgeting, medium-term budgeting processes are particularly relevant for financing progressive realization of disability inclusion. Many countries develop MTEFs and medium-term revenue frameworks (MTRFs) as a way to more strategically plan government revenue collection and expenditure allocation beyond a single budget year – usually over a three- to five-year period.

Budgeting for disability inclusion is also supported by budget structures that reflect key programmes and policy objectives. One overarching challenge in budgeting for disability inclusion is the use of a line-item approach to constructing the national budget. This focuses on the cost of inputs typically presented by different ministries but provides limited information on the purpose of different activities. In the case of disability, these typically include activities such as special schools, provision of assistive devices, medical services targeting persons with disabilities, and dedicated cash benefits.

Many countries are moving towards programme-based budgeting that seeks to refocus resource allocation on the achievement of results rather than management of inputs and government structures.[71,72] This can create opportunities for more strategic budgeting for disability inclusion. Peru has taken steps to use a programme-based budgeting approach, with two programmes under health and education dedicated to disability inclusion.[u] An associated approach is to adjust the reporting structures of the national budget to better identify and track disability-related expenditure. As part of Kenya's Public Finance Management Reform Strategy 2023–2028, the National Treasury is updating the budget manual, reconfiguring the Integrated Financial Management System to improve reporting of programme outcomes, while the Office of the Controller of Budget – with the support of UNICEF – is seeking to update the expenditure reporting template for national and county-level reporting to improve disaggregation, including in relation to disability.

Effective budget oversight requires robust and transparent mechanisms for tracking and reporting disability-related expenditures, and dedicated analysis of execution and equity. Weaknesses in availability of data on budget allocations and expenditures are a significant limitation to oversight of national budgets. In terms of disability inclusion, this is exacerbated by the limitations in budget structures described above. This is also affected by the limitations of common government financial statistics frameworks for tracking government expenditure that supports disability inclusion. Even where these exist, data may not be adequately disaggregated to analyse budget allocations and actual expenditures. Both governmental and non-governmental actors need to go beyond a simple inventory of budgeted or actual expenditures to better understand aspects such as budget effectiveness and equity. This involves connecting budget data to broader analysis of the need for services, and deeper evaluations of the impact and implementation of different programmes and services. Country experiences of formal systems to track disability inclusion expenditures are relatively scarce, but the case of Bogota in Colombia provides a valuable example of how this might operate in practice (*see Box 5.8*).

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[u] These are: "Inclusión de niños, niñas y jóvenes con discapacidad en la educación básica y técnico productive" (PP 0,106) and "Prevención y manejo de condiciones secundarias de salud en personas con discapacidad" (PP 0,129). See country background paper for further information.

Box 5.8 The disability budget tracker in Bogota, Colombia

Since 2022, the Capital District of Bogotá has implemented a budget tracker to monitor expenditures related to persons with disabilities as part of a broader set covering areas such as peacebuilding, gender equality, youth and civic culture. While Colombia does not yet have a national-level disability tracker, Bogotá's initiative builds on national efforts to promote budget tracking at subnational levels. The disability budget tracker allows analysis of expenditures aimed at the social inclusion of people with disabilities, their families and caregivers to help agencies to plan their activities based on a comprehensive view of the public efforts already undertaken. Government entities report on activities, categorizing them as having either a direct impact (focused on disability inclusion) or an indirect impact (contributing through broader initiatives).

As of 2023, the district government of Bogota marked COP 106 billion (US$26 million)[73] representing 0.36 per cent of their total expenditure in 2023.[v] Analysis by sector shows that 75 per cent of the expenditures were in the area of protection, well-being and social justice, with health and autonomy being the next most important sector (17 per cent). Indicative data shows that expenditure with an indirect impact on disability inclusion was COP 10.7 billion (USD$2.6 million).[74]

Source: Inputs provided by the Secretaríat Distrital de Integración Social in Bogotá.

Persons with disabilities (and representative groups) should be involved across the budget cycle. Participation of persons with disabilities in broader legislative and policy processes is a key foundation for engagement in the budget cycle, particularly in its links to strategic budgeting processes. The annual budget formation and approval process is therefore a key moment. Many countries have defined activities in their budget formulation processes for public participation, such as budget hearings. It is critical that such activities proactively involve OPDs, and that accessibility is accounted for in both the circulation of draft budget documents and the organization of the hearings themselves. Beyond participation in these formal processes, OPDs and other organizations working on disability can proactively engage in budget formulation – for example, by analysing budget proposals, collaborating with relevant line ministries and agencies, and lobbying parliamentarians who play a key role in budget approval. During implementation, OPDs are likely to have a unique understanding of persons with disabilities' experiences of policy delivery and may also be partners in implementation. Finally, OPDs have a central role to play in budget oversight, both as an actor in any formal oversight processes, and in their capacity to hold governments to account by scrutinizing budget implementation. *Box 5.9* provides some experiences of budget advocacy.

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[v] Authors' calculation based on budgeted data from Secretaría de Hacienda (Bogotá), 'Informe de Ejecución Presupuestaria – 2023–2024'.

Box 5.9 OPDs' engagement in budget advocacy in Fiji, India and the Philippines

India

The engagement of OPDs in budget analysis began in 2011, led by the National Disability Network as part of preparing a national parallel report on the CRPD. This process raised concerns about the adequacy of disability-related budget allocations from both union and state governments. Two network representatives received training in budget analysis from the Centre for Budget and Governance Accountability, which coordinates the People's Budget Initiative. Initially, analysis focused on the national level, revealing limited prioritization and low allocations for disability inclusion. Later, the analysis expanded to cover all subnational units, uncovering significant disparities between states in funding levels. The budget analysis findings have since contributed to integrate key asks of OPDs' advocacy into broader civil society policy demands in response to the national budget.

Philippines

As in India, OPD engagement in budget advocacy began as part of monitoring of the CRPD. This commenced with data analysis being carried out by budget experts. Subsequently, to build understanding and ownership among OPDs, a core team of members of the Philippines CRPD coalition carried out the work. This core team worked within the Alternative Budget Initiative – a consortium of civil society organizations undertaking analysis of the annual budget – and coordinated inputs from OPDs into the process. However, it has been challenging to secure ongoing funding to continue analysing the annual budget, and to proactively engage in advocacy.

Fiji

In Fiji, budget advocacy has been led by the Fiji Disabled People's Federation (FDPF), with strong buy-in from the members and the leadership and adequate resourcing. This is critical, as budget advocacy takes time and yields results only after a certain investment. A budget team assembled from representatives of the five OPDs, OPD leaders and young emerging leaders has engaged in budget analysis and budget advocacy. Engagement started in 2014 and took place alongside policy processes towards the ratification of the CRPD (2017) and the 2018 Rights of Persons with Disabilities Act. The budget advocacy has been key to making the most of this momentum and ensuring that policy commitments have been supported by increased budget allocations. Budget allocations supporting disability inclusion more than doubled between 2018 and 2024, supporting several initiatives, including a new disability allowance and a bus fare subsidy.

Source: Cote and Balsubramanian (2022).[75]

Disability funds

Many countries have disability funds defined in national legislation, although not all are implemented in practice. Various laws on disability in countries across the globe provide for some form of disability fund, and such funds have been established in Argentina, the Plurinational State of Bolivia, Cambodia, India, Kenya, Malawi, Yemen and Zambia, among others. The key features of these funds are outlined in *Table 5.4*. Other countries, such as Eswatini, Sierra Leone, Sri Lanka and the United Republic of Tanzania, make provision for such funds in legislation but have not put them in place. The objective of these funds is generally described as being to support activities relating to disability, but their specific objective in relation to other disability-related programmes and services is generally not clearly defined.

While these funds often define a broad set of potential revenue sources, in practice these tend to be much more limited. As illustrated in *Table 5.4*, potential revenue sources for disability funds in different countries include earmarked taxes, donations, fines, revenue from assets and interest, and allocations from national budgets. In practice, however, many funds are primarily or exclusively reliant on allocations from national budgets.

Quota levy funds, which draw on revenue from fines paid by companies that have not complied with employment quotas, are a notable exception. Such funds exist in countries including China, France, Germany, Mongolia, Montenegro and Thailand.[76] Cambodia's disability fund (Persons with Disabilities Foundation – PWDF) primarily relies on allocations from the national budget, but around 10 per cent of revenues are from fines for non-compliance with employment quotas. There are other country-specific exceptions, such as the Fondo Nacional para la Inclusión Social de las Personas con Discapacidad (FONADIS) in Argentina, whose revenue sources include fines on cheques issued in the banking system without adequate funds.

The types of activities financed by disability funds vary, but some key expenditures – such as cash benefits – are not generally included. Activities financed by disability funds span the full array of potential policies that can support persons with disabilities, including support for education, access to health care, rehabilitation and assistive technology, employment and livelihood activities, as well as OPDs and wider policy activities. Modalities vary in terms of whether funds directly provide goods and services to individuals with disabilities or finance projects implemented by governmental or non-governmental partners. One particular trend is that, in countries with non-contributory cash benefits in place, these are not financed from disability funds. This is notable given that – as discussed in *Chapter 2* – cash benefits are often the largest single disability-specific expenditure.

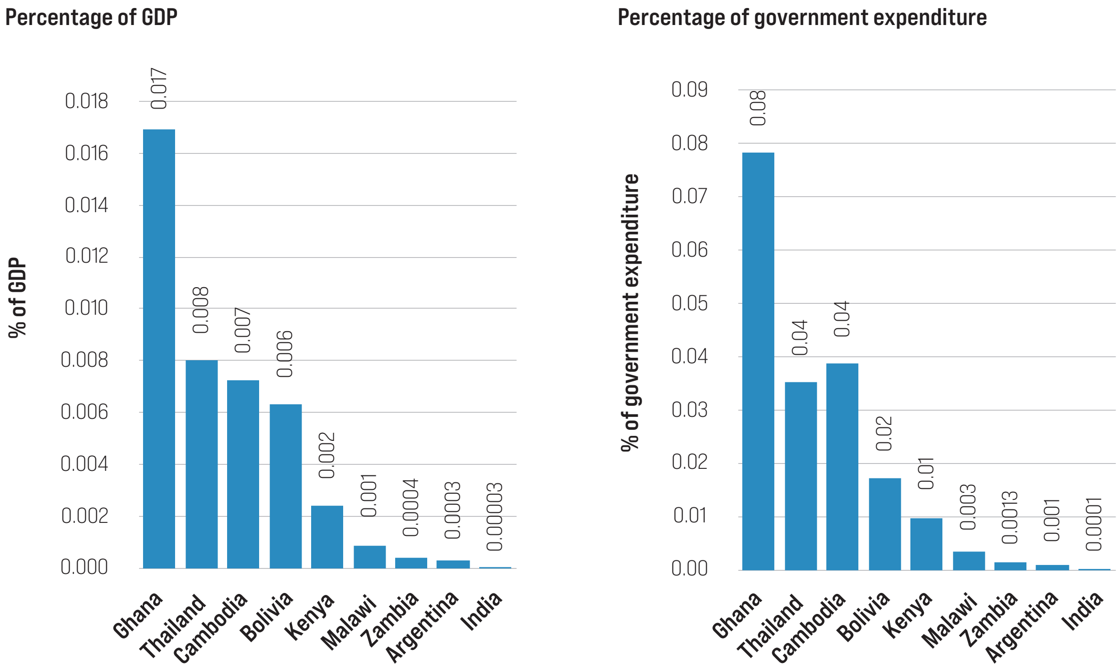
Table 5.4. Key features of disability funds, selected countries

				Funding sources (legal)									Activities financed (legal)												
Country	Name	Year established	Legal basis	Budget	Donations	Interest	Rent from property	Employer quota levy	Other fines and fees	Lottery	Earmarked tax	Transferred assets	Education	Rehabilitation and health	Loans to PWD / livelihoods	Assistive devices	Individual support	Research	Support to OPDs/NGOs	Training	Cash benefit / allowance	Cooperation/Advocacy/Awareness	Cultural activities	% of GDP	% of govt. expenditure
Argentina	Fondo Nacional para la Inclusión Social de las Personas con Discapacidad -National Fund for the Inclusion of Persons with Disabilities (FONADIS)	2022 (based on a fund that had previously existed since 2003 - Fondo Nacional para la Integración de las Personas con Discapacidad)	Decreto 187/2022						●		●		●	●	●			●	●			●		0.0003	0.001
Bolivia	Fondo Nacional de Solidaridad y Equidad (National Solidarity and Equity Fund)	2011	Decreto Supremo No839 el 6 de abril de 2011	●	●								●	●	●									0.006	0.017
Cambodia	Persons with Disabilities Foundation (PWDF)	2009	Disability Law 2009 (Article 46)	●	●			●					●	●	●	●								0.0072	0.039
India	National Fund for Persons with Disabilities	2016 (there was former fund created in 1986, with the same name)	Rights of Persons with Disabilities Act, 2016			●																	●	0.000	0.000
Kenya	National Fund for the Disabled of Kenya	1980	Trustees (Perpetual Succession) Act Cap. 164 of the Laws of Kenya on 6th April, 198	●	●		●								●	●	●					●			
Kenya	National Development Fund for Persons with Disabilities	2003	Persons with Disabilities Act 2003	●	●	●							●		●	●			●	●	●	●			
Malawi	Disability Trust Fund	2012 (legal basis), 2019/20 (first budget allocation, but no allocations as of 2023/24) - Official launch in 2024	2012 Disability Act	●	●	●			●				●			●	●	●		●		●		0.001	0.003
Thailand	Fund for Empowerment of Persons with Disabilities	2007 (replacing fund established in 1991)	Persons with Disabilities Empowerment Act 2007	●	●	●		●		●	●	●			●									0.008	0.035
Yemen	Handicap Care and Relief Fund (HCRF)	2002	Law No. 2 of 2002	●	●	●			●				●	●		●			●		●				
Zambia	National Trust Fund for Persons with Disabilities	2012	Persons with Disabilities Act 2012	●	●										●			●		●				0.000	0.001

Source: Background paper on financing mechanisms for disability inclusion. Knox (2025).[77]

Overall, the scale of disability funds is small relative to wider government expenditures and the scale of expenditure on disability inclusion. *Figure 5.17* shows the total revenue or expenditure[w] for a selection of disability funds where data are available. It also includes the disability-earmarked component of Ghana's District Assemblies Common Fund (DACF), which is often described as a disability fund (see section on local government financing, below). In most countries, disability fund revenue or expenditure tends to constitute less than 0.01 per cent of GDP, or less than 0.04 per cent of government expenditure. In many cases, this means that the total size of disability funds constitutes only a small proportion of total government expenditure on disability. For example, the allocation from the national budget to disability funds in Kenya (which has two funds) varied between 11 and 21 per cent of total disability-focused expenditure between 2019 and 2024.[x]

Figure 5.17. Annual revenue or expenditure by disability funds as a percentage of GDP, latest year


Percentage of GDP

Percentage of government expenditure

Source: Background paper on financing mechanisms for disability inclusion. Knox (2025).[78]

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[w] Revenue or expenditure is used depending on the financing modality of a fund. For example, for funds fully financed by government budget allocations (e.g., Kenya), the revenue from the national budget allocation is used. For funds with an accumulated fund from which annual disbursements are made (e.g., Thailand), the actual expenditures are used.

[x] Based on budget analysis described in *Chapter 2*.

It is likely that funds with more clearly defined funding sources and functions will make a more effective contribution to disability inclusion financing. Where a disability fund is financed primarily by government budget allocations and finances a wide array of disability-related activities, it is not obvious what added value this provides to the financing of clearly defined programmes or policies that seek to address specific dimensions of disability inclusion. At worst, the establishment of very small funds could risk giving an illusion of action on disability inclusion while being small in size and potentially duplicating or crowding out activities of dedicated line ministries. The clearest added value of disability funds is arguably where they draw on specific and legally defined revenue sources and finance a set of activities that complement those of line ministries, and the wider disability sector.

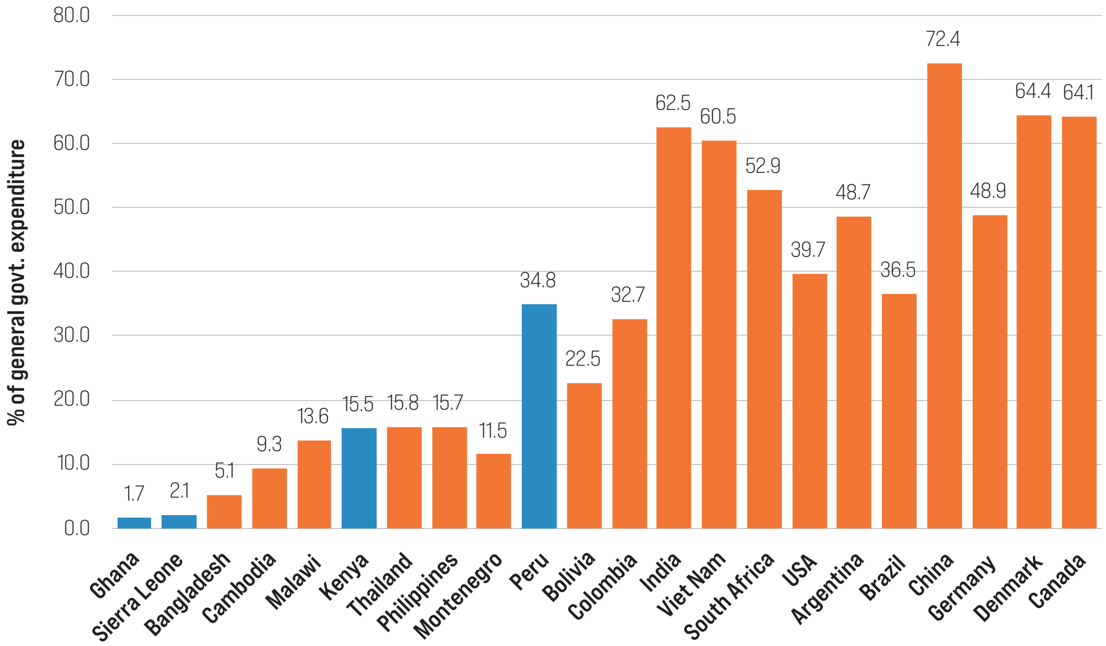
Local government financing

The financing of local government has important implications for disability inclusion. One important principle that is used in public finance decisions is of subsidiarity – that is, government functions should be performed at the lowest level of government that can perform them efficiently.[79] Local governments should logically manage the implementation of various programmes and services that target persons with disabilities or mainstream disability inclusion. For example, the proximity of local governments to persons with disabilities means they are in a strong position to manage activities such as delivering care and support services (such as personal assistance and home-based care), transport support, livelihood activities, and key aspects of disability certification and case management. Similarly, local governments typically play a key role in delivering health and education services, and thus in ensuring disability inclusion in these areas. It is therefore critical that local governments have adequate resources for these activities.

An important determining factor in the capacity of local governments to resource disability inclusion is the overall level of fiscal decentralization. This is related to both the legally defined roles of government and its responsibility for managing expenditures in practice. As shown *Figure 5.18*, the share of government expenditure that happens at subnational level – an indicator of fiscal decentralization – varies substantially by country. It ranges from 1.7 per cent in Ghana to 72 per cent in China. These figures do not indicate the specific role of local governments within layers of subnational government, and in some cases represent the role of regional government or – in the case of federalized countries such as Brazil and India – the role of states within the public finance system. Nevertheless, even in non-federalized countries, there is significant variety – for example, between 2 per cent of government expenditure in Ghana and Sierra Leone, and 35 per cent in Peru. The availability of these resources will have a strong bearing on the capacity of local governments to deliver key activities to support disability inclusion.

Within this broader picture, one notable approach to resourcing disability inclusion at the local level is to earmark a proportion of local revenues for disability-related programmes and services. The most established – and best documented – example is the disability fund in Ghana, which is made up of an allocation of 3 per cent of the DACF (*see Box 5.10*). Peru and the Philippines have also had such mechanisms in place in the past, but neither appears to be in place at the time of writing.[80]

Figure 5.18. Subnational government expenditure as a percentage of government expenditure, 2020, selected countries



Source: OECD-UCLG World Observatory on Subnational Government Finance and Investment.[81]

Another way to account for disability inclusion in local governments' financing instruments is in the way in which allocations to local governments are calculated. In Sierra Leone, for example, the grants to local councils for devolved social welfare activities are calculated using a formula which is weighted to account for both the population of persons with disabilities and the population aged 60 and over.[82] Analysis is not available on the implications of this mechanism, especially in the overarching context of very small social welfare budget disbursements. However, this approach could be considered in other countries, albeit with some caution. On the one hand, such a mechanism may help to channel additional resources to areas with higher disability prevalence which would have higher costs for service delivery. On the other hand, care is required in the interpretation of disability prevalence data given that methodological issues may lead to undercounting of persons with disabilities in some areas – for instance, rural areas.

To make effective use of resources, implementation of programmes and services at subnational level need to be supported by adequate technical and human capacity. One issue found across countries is that even where allocations are made to disability-related activities at subnational level, local governments have limited technical capacity and guidance to implement effective approaches.

Box 5.10 District Assemblies Common Fund (DACF) in Ghana

Ghana earmarks 3 per cent of resources transferred from central to local government to support persons with disabilities – often described as a form of disability fund.[83,84,85] This is a component of the DACF, a mechanism by which 5 per cent of total central government revenue is provided to all Metropolitan, Municipal and District Assemblies (MMDAs) in Ghana for local development activities. This is an arrangement rooted in the 1992 Constitution of Ghana and is part of broader processes towards fiscal decentralization. A defined share of these revenues is earmarked for different activities. including 3 per cent for persons with disabilities.

The main aims of the DACF for persons with disabilities were described in 2010 guidelines from the National Council on Persons with Disability as relating primarily to minimizing poverty among persons with disabilities in the informal economy, and “enhancing their image through dignified labour”. In practice, the use of the DACF has tended to focus on giving one-off cash grants as startup capital to persons with disabilities without formal employment, to support livelihood generation. However, from 2018 the fund’s operations moved to provide also in-kind items or equipment. They have gradually expanded to cover other activities, including educational support, medical support, provision of assistive devices, and capacity-building of OPDs. Persons with disabilities secure support by applying directly to their MMDA.[86]

Research on the implementation of the DACF allocation to disability has found mixed experiences. Some beneficiaries have reported the important impact of the scheme on making their livelihood activities more profitable, in turn enhancing their sense of dignity and their participation in family and community life. However, one commonly reported issue has been that the amount of support provided by the fund is inadequate, both when provided as a cash grant and when provided in kind. In some cases, this appears to relate to MMDA officials spreading the allocation thinly to reach as many persons with disabilities as possible.[87,88]

The resources allocated to disability under the DACF, equal to only 0.02 per cent of GDP in 2024, remain limited and cannot address adequately the diversity of support needs of persons with disabilities. A concern is that the fund’s broad scope may disincentivize national systems from addressing at scale certain responsibilities themselves. For instance, the provision of assistive technology would be more effective, predictable, and sustainable if covered by the national health insurance scheme rather than relying on the fund.

However, while levels of fiscal decentralization in Ghana remain relatively low (*see Figure 5.18*), the DACF earmarking provides a mechanism to automatically channel greater resources to support disability inclusion if the country moves towards greater fiscal decentralization over time.

Social security and health insurance funds

Disability is typically a core concern of social security funds and, to a lesser extent, social health insurance funds. Within the broader mandate of providing social protection benefits to insured workers, social security funds often provide benefits dedicated to disability, such as general disability (or 'invalidity') benefits, and those specifically focused on employment injury. Although health insurance schemes focus on the broader mandate of financing health care providing health care to persons with disabilities is inevitably a core part of this mandate.

Key priorities for addressing disability inclusion within social security funds include extending coverage and moving away from a narrow focus on incapacity to work. In many higher-income countries, disability-related benefits – and also those related to sickness and employment – play a central role in providing social protection to persons with disabilities.[89] This is related to the high coverage of the labour force by such schemes, which are also often partly financed by the national budget. By contrast, coverage of social security funds in low- and middle-income countries tends to be mostly limited to a minority of workers found in formal employment, sometimes alongside a small number of informal economy workers. Extending coverage to more persons with disabilities relies on broader efforts to extend coverage to the informal economy, as well as reducing specific barriers to persons with disabilities. A core dimension to this effort is to increase the access of persons with disabilities to formal employment. Another challenge with social security funds is the tendency for eligibility to be tightly linked to capacity to work. There is important scope to refine these benefits to better support persons with disabilities, cover disability-related costs and enable them to participate in the labour force.[90]

There are various ways in which social health insurance funds can better address disability inclusion. A useful framework for considering the options to improve disability inclusion are the three dimensions of universal health coverage: population coverage, service coverage and financial protection.[91] Relatively lower levels of employment and higher levels of poverty mean that persons with disabilities will be less likely to be covered by social health insurance schemes unless specific subsidized arrangements are in place. Many countries have moved to extend coverage by waiving the contribution to social health insurance for persons with disabilities, which is paid from the national budget. However, it is also critical that social health insurance benefit packages cover services of particular relevance for persons with disabilities (such as rehabilitation services and assistive technology), and that co-payments at the point of accessing services are minimized.[92] Viet Nam has sought to address some of these issues in extending health insurance over the last decade (*see Box 5.11*).

Box 5.11 Accelerating disability inclusion within social health insurance in Viet Nam

Coverage of social health insurance in Viet Nam has increased significantly in recent years, from 71 per cent of the population in 2014 to 93 per cent in 2023. Coverage is achieved by a mixed system whereby some workers – mainly those in formal employment – make the full contribution, some make a subsidized contribution, and the state budget fully subsidizes the contribution for others. Within this arrangement, persons classified as having either severe or extremely severe disabilities are automatically covered under a fully subsidized arrangement. Co-payments are also not required to access services. As a consequence, coverage of social health insurance among persons with disabilities is higher (at 96 per cent) than among the population as a whole (93 per cent).[93]

Some important gaps in the social health insurance arrangements remain, however. Assistive devices are not included in the social health insurance benefit package, and while rehabilitation is included, there are notable gaps in the scope of services covered. In practice, availability of rehabilitation is also inconsistent across different locations.

Source: ILO (2025, 2021).[94,95]

Public procurement

Public procurement is a critical way to optimize the use of available resources for disability inclusion. The scale of government resources channelled through public procurement mechanisms (by which governments and State-owned enterprises purchase goods, services and works from an external supplier) is vast. Latest estimates suggest it accounts for 15 per cent of global GDP, and in some cases more than half of government expenditure.[96,97] Public procurement is also used across all sectors of government. This makes it an important instrument to ensure that disability inclusion is mainstreamed beyond sectors that involve disability-specific service delivery. An interest in the role of public procurement to support disability inclusion reflects a broader shift away from seeing procurement as only relating to fiscal savings, to recognizing its role for broader socioeconomic development outcomes.[98]

Public procurement can support disability inclusion in a variety of ways. These can be classified as three main channels, as follows.

- **Promoting accessibility:** This involves integrating accessibility standards with which bidders for government contracts must comply. This could relate to contracts in a wide range of activities, including infrastructure, transport, information technology, and delivery of goods and services. For instance, the European Union's Public Procurement Directive 2014/24/EU, for example, specifies that suppliers to Member States must incorporate accessibility for persons with disabilities and design for all users into their products or services for tenders to be considered in bidding.[99]

- **Supporting employment of persons with disabilities through preferential contracting**[y] or social clauses in public procurement: This involves awarding contracts to suppliers that meet certain conditions on employment of persons with disabilities or that are run by persons with disabilities, or NGOs. The purpose of this approach is to support the economic and social empowerment of persons with disabilities. One approach to this is to set aside a proportion of contracts to suppliers meeting these conditions. For example, Kenya's Public Procurement and Disposal Preference and Reservations Amendment Regulations Act (2013) reserves 30 per cent of the government's procurement purchases for micro and small enterprises owned by young people, women and persons with disabilities.[100] Similarly, in the Philippines, the 2005 Disability Affairs executive order (No. 417) requires that 10 per cent of all government procurement is from cooperatives including persons with disabilities.[101]
- **Innovation:** Public procurement fosters innovation for disability inclusion by leveraging purchasing power to create demand for inclusive solutions. Examples include public transportation authorities requiring fully accessible buses, leading to innovations such as low floors and automated wheelchair ramps. In the United States, mandates for accessible voting machines have driven audio-based interfaces. Local government procurement also can support inclusive innovation. In Spain, Alicante's Public Procurement of Innovation methodology led to the development of the AI Layer (AL21) system to address the digital divide faced by many citizens and improve accessibility for persons with disabilities and older adults, aiding navigation and electronic procedures.

Despite this potential of public procurement to support better use of available resources for disability inclusion, it remains relatively untapped in low- and middle-income countries. While there have been important developments in public procurement regulations to support accessibility in high-income countries, especially with regards to transport and information technology, there are few examples of low- and middle-income countries that have successfully rolled out such standards. Challenges in rolling out such standards include political pushback from suppliers, and challenges of enforcement – which are exacerbated by less formalized business environments. In the area of preferential contracting, one issue is that procurement regulations may have unrealistic expectations of the number of suppliers that can meet the conditions. In Kenya, for example, just 8 per cent of all tenders worth KES 5 million or more issued between 2013 and 2016 were awarded to small and medium-sized enterprises owned by young people, women or persons with disabilities, and just 5 per cent of registered businesses were owned by persons with disabilities.[102] Another risk is that preferential contracting promotes segregated working environments such as sheltered workshops, which may provide below-market wages and poor employment conditions.[103]

International funding sources

According to data from the World Bank, average net ODA received as a percentage of GNI of low- and middle-income countries has shown a general downward trend, from 1.8 per cent in 1991 to around 0.7 per cent in 2022[104]. Thus, while absolute ODA amounts may have increased or remained stable, their proportion relative to the growing economies of these countries has decreased.

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[y] For more details, see: United Nations Economic and Social Commission for Asia and the Pacific, 'Preferential Contracting for Persons with Disabilities: Approaches to Improving Employment Opportunities and Outcomes for Persons with Disabilities and Disability Inclusion in Business Practices', Policy Paper No. 2022/6, UN ESCAP, Bangkok, 2022.

Despite this overall trend, ODA continues to play a vital role in specific sectors and regions. In the Least Developed Countries, particularly those affected by conflict or with limited access to capital markets, ODA remains a significant source of funding for essential services such as health care, education and infrastructure development, as well as for disability inclusion, considering the overall comparatively low level of domestic financing.

In recent years, there has been a shift to allocating ODA to address global challenges, including climate change, humanitarian crises and health pandemics. This reorientation reflects the international community's recognition of the interconnected nature and scale of these issues. However, there is also a risk of defunding emergence of needed systems and services that may seem outside those broader issues.

As shown in *Chapter 2*, there has been over the last decade notable progress with regards to international cooperation and disability inclusion with the adoption of disability inclusion strategies by the UN as well as other multilateral and bilateral donors, and the work of the Global Action on Disability Network (GLAD). The roll-out of the OECD-DAC disability marker has been an important step in generating data on international development flows; however, its use is limited, since more than half of all allocable ODA is unmarked. Among 141 ODA recipient countries, on average 67 per cent of total allocable ODA activities are unmarked which limits significantly monitoring capacities of government. However, if considering only the donors using the DAC marker, this falls to 27 per cent (*see Chapter 2, Table 2.3*). This shows that **use of the marker by more donors as well as greater availability of data from donors using alternative approaches could significantly improve understanding of ODA contribution to financing disability inclusion**. One approach to achieve this would be to make the disability marker mandatory on the same basis as the gender equality marker. There is also scope to strengthen the guidelines on use of the marker and to undertake further analysis on how it is currently used in practice. National governments can also seek to include disability markers or indicators in their databases of international funding flows.

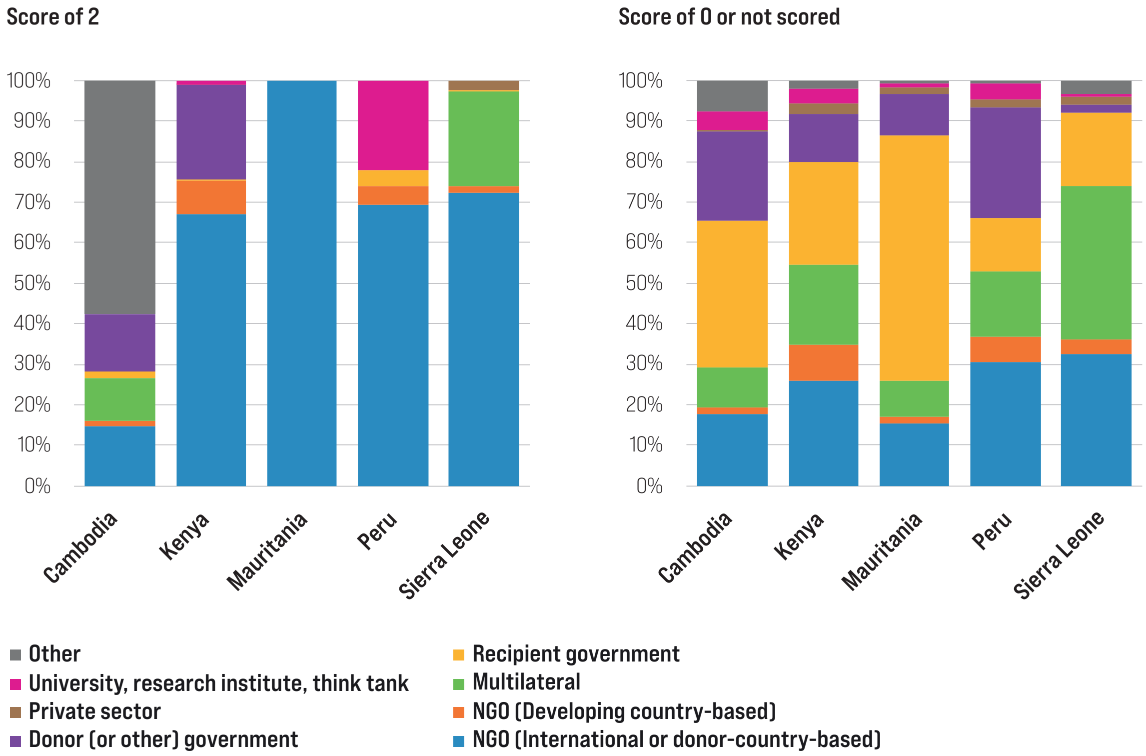
A key priority for making the best use of available resources is to ensure that all programmes and infrastructure supported by ODA are accessible to persons with disabilities and do not finance services that undermine inclusion. It should be noted that some donors, such as USAID, have specific regulations to ensure that their procurement related to construction and information technology, for instance, includes accessibility requirements. Contractual procedures for European Union external action require that technical specifications for purchases intended for use by natural persons should include design for all users' requirements, including accessibility for persons with disabilities.

Steps should also be taken to ensure disability mainstreaming in all international funding activities across a broader array of sectors such as industry, agriculture, energy, financial services, governance and humanitarian response. A key way to do this is for donors to define standards relating to disability inclusion that need to be met in the delivery of ODA. One example of this is the World Bank's Disability Inclusion and Accountability Framework (last updated in 2022), which seeks to support the mainstreaming of disability inclusion within the organization's activities and investments. It sets out a core approach of addressing disability inclusion in its general policies that govern its lending and knowledge operations, including environmental and social safeguards, and procurement policies that client governments must follow.[105]

In addition, **there also is a need to increase the share of ODA that specifically targets inclusion of persons with disabilities, to help build the required support systems and strengthen capacities of key stakeholders**. The available data presented in *Chapter 2* indicate that globally less than 0.5 per cent of ODA flows (US$ Commitments) was scored as principally targeting disability inclusion in 2023.

In all cases, it is important to consider how ODA is channelled and in which way it can contribute best to support the progressive development of sustainable government services and programmes. *Figure 5.19* shows the channels through which ODA commitments flowed between 2019 and 2023 in the five case study countries featured in this chapter. A notable trend is that funds with a principal objective of disability inclusion (score of 2) are most likely to be channelled via international and donor-country-based NGOs, which often co-finance programmes. This contrasts with ODA scored 0 or unscored, which is more likely to be channelled via national governments and multilaterals. While these trends require further investigation, they do raise questions such as the extent to which national governments may be identifying disability inclusion as a priority within donor-financed initiatives.

Figure 5.19. Value of ODA grant (US$ commitments) by disability marker score and channel, 2019–2023



Source: Authors' calculation based on the OECD Creditor Reporting System (CRS) database.

Enhancing ODA financing for disability inclusion will therefore require from donors more systematic consideration for disability inclusion across their portfolio in any given country but also **greater demand from national governments for support in financing disability inclusive programmes and disability specific investments**. This implies that disability inclusion has been included in national development plans and financing strategies as well as the availability of costed national disability action plan developed with national stakeholders (*see earlier section on Laying the foundations*). The participation of OPDs early in the development of major programmes co-financed by donors and governments could also lead to greater inclusion.

Greater and **more systematic consideration for disability inclusion in discussion between government and donors can contribute to better use of innovative international financing mechanisms more commonly used for other financing needs**. With ODA trends facing significant uncertainty and challenges faced by many countries in relation to debt sustainability, use of innovative arrangements such as debt for development swaps can contribute to greater financing for disability inclusion without generating additional debt. One recent example of joint planning of international cooperation funding to support disability inclusion is a debt swap arrangement agreed in 2024 between Jordan and Germany (*see Box 5.12*).

Box 5.12 Use of a debt swap to support inclusive education in Jordan

As part of broader approaches to address debt sustainability, some countries and donors have sought to use debt-for-development swaps (debt swaps). These are agreements to redirect funds planned for debt payments towards an agreed development objective.[106] Jordan, a middle-income country, faces significant challenges in maintaining debt sustainability. In 2023, the nation's public debt-to-GDP ratio reached nearly 90 per cent due to a combination of external pressures and domestic shocks. With an ambitious goal to reduce this ratio to 80 per cent by 2028,[107] the government is committed to innovative financing that not only strengthens fiscal sustainability but also advances human rights.

In 2024, the Government of the Federal Republic of Germany and Government of the Hashemite Kingdom of Jordan agreed on a debt swap to support three development measures, one of which relates to disability inclusion. This debt swap will finance a EUR 5 million project to support disability inclusion within the Jordanian education sector to address major barriers in access to education of children with disabilities of scholar age, with only an estimated 8 percent of them enrolled in public schools in 2024. The project, implemented in collaboration between the Higher Council for the Rights of Persons with Disabilities and the Ministry of Education, will include upgrades to school buildings to support accessibility, provision of equipment and assistive technologies, teacher training and curriculum adaptation. It is estimated that the project will benefit 32 schools. After the three-year implementation period, it will benefit approximately 14,300 students every year, including around 2,100 students with disabilities.

Mobilizing adequate international funding resources for disability inclusion also means recognizing disability within key global financing instruments, such as those related to climate change. International funding flows are often organized around key global challenges, and it is important that the dimension of disability inclusion is not lost within these. For example, there has been a gradual increase in international climate finance in recent years, with a substantial proportion channelled through multilateral funds such as the Green Climate Fund, the Global Environment Facility and the Climate Investment Funds.[108] Given the particular ways in which climate change impacts persons with disabilities (*see Chapter 3*), it is critical that these funds include targeted actions to address disability. One notable reference point is a 2024 background paper by the Climate Investment Funds, which provides an operational framework for disability inclusion within climate investments.[109]

Finally, setting voluntary time bound targets at country level to reach a share of ODA funded projects with disability inclusion as one of their objectives could contribute to greater reporting and more attention to disability inclusion in the exchange between governments and donors. This could also generate momentum supporting further mobilization of domestic resources.

Private sector and civil society contributions

In addition to mobilizing public resources across ministries and different levels of government, resourcing acceleration of disability inclusion implies also strategically leveraging private resources, ranging from community contributions and civil society efforts to philanthropy, remittances and private sector investment. Governments can do this to complement their initiatives, foster innovation and ensure sustainable disability-inclusive services. This section explores key pathways and strategies for engaging private resources, providing examples from around the world to illustrate effective models.

Harnessing the power of community-based organizations and non-profits

Community-based organizations, OPDs and non-profits are critical stakeholders in delivering community-level services that address the specific inclusion requirement of persons with disabilities. These groups often serve as the first responders to local challenges and a leading source of innovation and community mobilization, making them well positioned to develop solutions jointly with local and central governments.

In many countries, community-based inclusive development programmes seek to address the health, education and social inclusion needs of persons with disabilities, especially in rural areas or informal urban settlements. These programmes often involve partnership between community-based organizations, local authorities, and national and international NGOs, possibly with a national framework facilitating their expansion, such as in the Philippines.[110]

Governments can further support such collaborations by creating regulatory frameworks that standardize services and enable scale-up, such as accreditation programmes that enable non-profits that meet national disability standards to access public financing.

Fostering private sector and civil society partnerships

The private sector's potential to innovate and deliver impactful disability-inclusive solutions is immense and widely untapped. Governments can build on partnerships between private companies and civil society to develop services that the public sector can eventually adopt and scale up.

An interesting example comes from Fiji, where the Spinal Injury Association of Fiji collaborates with Vodafone ATH Fiji Foundation as well as PhysioNet UK to import and produce low-cost assistive technology tailored to the needs of persons with disabilities. Initiated in 2009, the partnership has since contributed to delivering over US$13 million worth of mobility devices and services[111]. Over time, the public health-care system has started to support some of these services.

Incentivizing private sector investment

Private sector actors can be encouraged to invest in disability inclusion through targeted government incentives. Tax exemptions for companies that employ persons with disabilities or invest in accessibility improvements are effective mechanisms for driving corporate action. Additionally, voucher programmes can enable persons with disabilities to access private sector services, such as purchasing assistive technologies, with partial financial support from the government.

In Bangalore, India, Uber has launched uberASSIST and uberACCESS, in partnership with the information technology company Mphasis, to enhance transportation accessibility for persons with disabilities and older adults. Thanks to initial funding from Mphasis, uberASSIST provided trained drivers in standard sedans to assist riders with mobility challenges, while uberACCESS offered wheelchair-accessible vehicles equipped with hydraulic lifts. While the initiative dwindled due to the COVID-19 crisis, in 2024 Uber expanded its services with Uber WAV (Wheelchair Accessible Vehicle), connecting riders using motorized wheelchairs with trained drivers operating vehicles equipped with ramps or lifts.[112]

Maximizing the impact of remittances

In many low- and middle-income countries, remittances from diaspora communities represent a significant source of income. These funds can be leveraged to co-finance disability-related initiatives, especially at the local level. For example, in the Education for Employment in North Macedonia (E4E@mk) project, combined contributions from the Swiss Agency for Development and Cooperation (SDC), the Macedonian Chamber of Commerce and the diaspora support persons with disabilities to develop their vocational skills.[113] Such efforts can be amplified through government matching funds, which double the impact of individual contributions and ensure alignment with national disability strategies.

Engaging religious and faith-based funding mechanisms

Religious institutions are often deeply embedded in communities and can mobilize voluntary funding for disability inclusion. Governments can collaborate with these institutions to channel resources towards impactful projects while providing technical support and oversight.

Collaborating with philanthropic foundations

Philanthropy plays a crucial role in funding pilot projects and research for disability inclusion. Foundations can provide the resources needed to test innovative approaches, while governments can facilitate coordination and scale-up.

An interesting example is the We Can Work initiative, a partnership between the Mastercard Foundation and Light for the World, which aims to enable young women and men with disabilities in Ethiopia, Kenya, Uganda, Rwanda, Ghana, Nigeria and Senegal to access to work by 2030. As part of the broader Young Africa Works strategy, which seeks to reach 30 million young people, the initiative will embed disability inclusion across all foundation programmes in these countries.[114]

Innovative financial mechanisms for disability inclusion

Innovative financing tools, such as social impact bonds and blended finance, can offer additional ways to attract private investment while achieving measurable disability inclusion outcomes. Social impact bonds, for instance, tie funding to specific results, encouraging private investors to support programmes with proven effectiveness.

For instance, the International Committee of the Red Cross (ICRC) Humanitarian Impact Bond financed the creation of three new Physical Rehabilitation Programme (PRP) centres, staff training, efficiency testing and the development of a data management system. The Human Impact Bond's was most successful in its ability to attract funding for large-scale, costly experimental efficiency measures in the PRP by using an outcomes-based model that shared risk between investors, the ICRC and donors, encouraging donor support.[115]

Sector-specific opportunities for disability-inclusive investment

Governments can incentivize investment of private resources across various sectors to maximize their impact on disability inclusion in a number of ways, such as:

- **Technology:** Public–private partnerships with technology companies can drive the development of accessible digital tools, such as screen readers or voice recognition systems.
- **Assistive technologies:** By reducing investment risks, governments can encourage private companies to innovate in assistive technologies, which offers significant social and financial returns.
- **Health care:** Collaboration with private health-care providers can expand access to telemedicine, therapy apps, and adaptive equipment for persons with disabilities.
- **Education:** Supporting education technology (EdTech) companies that develop accessible learning platforms can bridge education gaps for children with disabilities.
- **Financial services:** Inclusive banking initiatives, such as those by Wells Fargo and Santander Argentina, illustrate how financial institutions can meet the needs of persons with disabilities while tapping into an underserved market.

By strategically using public resources to promote the engagement of community-based organizations, non-profits, the private sector and diaspora communities, and leveraging innovative financial mechanisms, governments can address resource gaps, pilot and scale impactful initiatives, and promote sustainable inclusion.

Conclusion

This chapter highlights a fundamental challenge in advancing disability inclusion: while many low- and middle-income countries have made significant progress in adopting and reforming disability legislation following the ratification of the CRPD, the translation of these commitments into tangible financial investments has been slow and inconsistent.

In many low- and middle-income countries, disability-related public spending remains marginal, and disability inclusion rarely features in national development and financing strategies. A lack of systematic and high-quality data complicates efforts to accurately assess these expenditures and estimate the financing gap. However, preliminary observations indicate emerging benchmarks:

- 0.1 per cent of GDP appears to be a level of expenditure that enables countries to implement a basic set of interventions, reaching a certain scale though often limited and in few sectors. Many low-income countries fall below this threshold, with small-scale, isolated programmes.
- 0.5 per cent of GDP is the level of expenditure found in in low- and middle-income countries with more comprehensive interventions, and with social protection programme at scale.

For comparison, OECD countries spend an average of 1.5 per cent of GDP solely on social support for persons with disabilities.

Disability-related expenditures are typically concentrated in three sectors: education, health and social protection.

- **Education:** While numerous countries have adopted inclusive education policies, these have not translated into scaled-up financing mechanisms. Budget allocations for learners with disabilities often remain marginal and may be directed towards special schools rather than building inclusive education systems in line with legal and policy frameworks increasingly being adopted.
- **Health:** Ministries of Health allocate funds for rehabilitation and assistive devices, but these resources are often insufficient and fragmented. Comprehensive financing strategies to ensure accessibility to all health-care services, including early intervention and sexual and reproductive health, are still lacking in many contexts.
- **Social protection:** This sector has seen the most notable growth in disability-related spending. Countries like Cambodia and Zambia have scaled up cash transfers through top-ups to existing schemes while others, such as Fiji and Peru are implementing stand-alone disability benefits. Countries such as Uganda are exploring child disability grants, and many are also investing in disability management information systems, an essential step towards effectively identifying persons with disabilities and scaling up targeted support programmes.

To maximize the impact of available resources, **disability-related spending needs to be mainstreamed across all ministries**. Ensuring that all public services and infrastructure – not just those traditionally associated with disability – are accessible is critical for fostering genuine inclusion.

Equally important is the coordination between ministries to optimize allocation and use of available resource. For example, financing for assistive technology often falls between the responsibilities of health, social welfare and education sectors without clear coordination, leading to inefficiencies and service gaps. Sign language interpretation is often funded by a single ministry at small scale, while all ministries require a sign language interpretation system to make their services accessible. Resource-pooling mechanisms such as a disability fund could be used for this purpose.

Given the significant challenges to increasing resource allocation in some contexts, ensuring that existing funds contribute to disability inclusion is essential and has been shown to be achievable. **First, policy choices matter: resources must be directed towards programmes that facilitate inclusion, rather than those that reinforce segregation**. For instance, reallocating funds from residential care institutions or segregated schools to community support services or inclusive education may present administrative challenges but offers significant efficiency gains in supporting inclusion while reducing long-term transition costs.

Public procurement also represents an untapped opportunity to foster disability inclusion through existing public spending. While some low- and middle-income countries have social clauses mandating the employment of persons with disabilities, public procurement remains underutilized in promoting broader inclusion – for instance, in ensuring accessibility and driving innovation, particularly in sectors such as technology, where international accessibility standards are well established and widely applied.

A significant barrier to inclusive financing remains the lack of data – both in tracking disability-related expenditures and in costing planned interventions. Without comprehensive data, inclusive budgeting is challenging, which hinders efforts to integrate disability inclusion into budget discussions, national development plans and financing strategies. Improving budget data collection and monitoring, as well as evidence generation on financing gaps and cost-effective interventions, are essential for closing this gap.

Beyond data, inclusive budgeting requires meaningful engagement of OPDs and parents of children with disabilities in budget discussions and advocacy. While there has been growing engagement of OPDs in a few countries, it remains overall limited and needs to be significantly strengthened with further involvement of a diversity of persons with disabilities to ensure that national budgets and financing strategies promote equitable distribution of resources.

Local authorities play a pivotal role in advancing disability inclusion, particularly in decentralized governance systems where they are directly responsible for delivering public services and managing infrastructure at the community level. Earmarked funds at the local level, such as Ghana's DACF, demonstrate how decentralized financing mechanisms can create dedicated resources for disability inclusion. Local governments are also well positioned to engage OPDs and community stakeholders in budget planning and monitoring processes.

Several countries have established disability funds or adopted legal frameworks to create them; however, few of them are fully operational with clear objectives and adequate resources. Disability funds are likely to be more successful when they draw on clearly defined and dedicated funding sources, such as in Argentina, and in schemes also drawing on fines from employment quota systems (as in Cambodia and Thailand). However, it is equally important that the purpose and intended activities of these funds are defined in a way that adds value to the wider disability sector.

Beyond domestic public resources, governments can leverage and catalyse private resources by creating an enabling environment and incentivizing investment. For instance, in building care and support systems, governments can adopt schemes that complement and enable equitable and effective mobilization of civil society and community resources. Though currently limited in scale, innovative financing and private sector contributions offer emerging opportunities, particularly for specific services such as accessible transport and assistive technology. Public–private partnerships and impact investing can serve as catalytic forces in expanding resources for disability inclusion.

Finally, ODA and international philanthropy remain critical resources for developing disability-related services and promoting inclusion in low- and middle-income countries. In some countries, ODA spending on disability-inclusive programmes is equal to – or even exceeds – total public disability-specific expenditures. But there is potential to ensure greater inclusiveness of ODA spending. Facilitating early engagement of OPDs in the design of major ODA-funded programmes – not only disability-specific programmes – would be a significant step forward. The Global Disability Summit initiative to enhance reporting and set a target for the disability inclusiveness of ODA activities at country level could unlock more and better resources across sectors. However, it is essential that government donors and civil society develop more integrated financing strategies that foster greater alignment between domestic and international financing efforts to accelerate inclusion.

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Conclusion and recommendations

With near universal ratification of the Convention on the Rights of Persons with Disabilities (CRPD), governments have the responsibility to protect and ensure the realization of all rights for all persons with disabilities. In most low- and middle-income countries, they need to substantially increase dedicated public spending to do so, as well as foster coordinated, multisectoral approaches aligned to the CRPD. Meanwhile, global trends – including climate change, technological advances, the evolving care and support economy, humanitarian crises and emergencies, and urbanization – present both additional challenges and, in some cases, opportunities to accelerate inclusion.

Beyond government, accelerating the inclusion and participation of persons with disabilities requires a whole-of-society approach, with contributions from various stakeholders. For example, the private sector plays a critical role in ensuring compliance with national accessibility standards, innovation, as well as investing in assistive technology development, and creating opportunities for employment of persons with disabilities. Organizations of Persons with Disabilities (OPDs) hold governments and societies to account, advocating for changes, fostering inclusive decision-making and advancing rights-based governance. Communities, families, OPDs, non-governmental organizations (NGOs) and other actors are pivotal in creating inclusive and gender-responsive care and support systems.

While the pace and depth of change vary globally, and further progress is needed in many settings, recent decades have shown that societies, communities and services can evolve and become more inclusive for children and adults with disabilities. Persons with disabilities are participating more in school, work and community and political life as required support becomes increasingly available. Meanwhile, communities are becoming more open through enhanced accessibility and stigma reduction efforts. This increased visibility and engagement then creates greater confidence and awareness amongst diverse stakeholders on the benefits and need for inclusion, which in turn can lead to further commitment to removing barriers and providing support. National and local governments have a crucial role to enable and maintain this positive cycle of inclusion to ensure sustainable progress towards full participation and inclusion for all persons with disabilities.

Even in contexts where government resources are more limited, authorities across sectors can prioritize core programmes supporting persons with disabilities and their families and initiate removal of barriers. They can facilitate mobilization of all stakeholders by providing quality data, removing administrative obstacles, reducing costs of interventions, incentivizing positive actions, coordinating the contributions of public entities, civil society, private sector and development agencies. and foster meaningful participation of persons with disabilities.

Recognizing the diversity of contexts, resources and constraints as well as the progressive arch towards inclusive systems, this report makes six recommendations for governments, OPDs, development agencies and other stakeholders to accelerate inclusion in a diverse and changing world.

Recommendation 1: Harmonize national legal, policy and regulatory frameworks with the CRPD, including in response to evolving global and local trends.

- **Governments:**
  - Review and align national laws, policies and regulations with CRPD standards, ensuring comprehensive rights protection with a focus on monitoring and enforcement and in close consultation with OPDs.
  - Integrate CRPD principles into laws and policies adopted or reformed in response to evolving global and local trends (e.g., technology regulation, climate change policies, migration laws).

- **Organizations of persons with disabilities:**
  - Advocate for legal harmonization across sectors and ensure disability rights remain a priority on the legislative agenda. Actively engage in policy dialogues, consultations and on-going legislative processes to influence reforms that reflect the diverse experiences and needs of persons with disabilities.

- **Development agencies, civil society and other actors:**
  - Provide technical assistance, capacity building and policy support to help governments align national frameworks with international disability rights standards. Facilitate knowledge exchange, best practices and multi-stakeholder collaboration.

Recommendation 2: Enhance generation and use of data and evidence to inform disability-inclusive policies and practices at scale across sectors.

- **Governments:**
  - Invest in high-quality data systems and activities (e.g., censuses, surveys, research, administrative data) that embed disability-related questions in a harmonized manner. Conduct disability-specific surveys or integrate disability-focused modules into data collection to identify barriers and support needs.
  - Routinely analyse and publish data on disability, including disaggregation of standard indicators by disability and, where possible, by other characteristics (e.g., gender, age, socioeconomic status). Use this data to inform policies and programmes.
  - Shape and commission policy-relevant research agendas, fostering collaboration between governments, OPDs, research institutions, civil society and other stakeholders.

- **Organizations of persons with disabilities and other civil society actors:**
  - Advocate for stronger data collection and analysis that reflects the realities, priorities and concerns of persons with disabilities.
  - Promote and contribute to citizen-generated data to complement official statistics, including documenting grassroots innovations, success stories and lessons learned for effective disability-inclusive practices.

- **Academia and research institutions:**
  - Conduct high-quality research on the lived experiences of persons with disabilities and assess the impact and cost-effectiveness of policies and programmes on their inclusion. Include a focus on diversity of experiences amongst persons with disabilities and the impact of global trends. Work collaboratively with governments, OPDs and other stakeholders to ensure research is policy-relevant and inclusive.

- **Development agencies:**
  - Provide financial and technical support for disability data collection efforts, including upgrading data systems, financing new research and strengthening the analysis of existing datasets.
  - Systematically integrate disability into programme data collection, including in baseline assessments, monitoring and evaluation, to ensure that disability inclusion is embedded in all development initiatives.

Recommendation 3: Mainstream inclusion and accessibility comprehensively across all policies, systems and services, including in actions to respond to global trends.

- **Governments:**
  - In consultation with OPDs, systematically integrate accessibility and inclusion measures across all national and local policies and programmes, considering the diversity of persons with disabilities and diverse requirements for inclusion. Consistently monitor efforts towards inclusion across sectors and promote cross-sectoral coordination.
  - Ensure dedicated funding for mainstreaming inclusion, including budgets for accessibility measures, reasonable accommodations and workforce capacity-building.

- **Organizations of persons with disabilities:**
  - Collaborate with governments, other advocacy groups, service providers, the private sector and other stakeholders to identify priorities and best practices for mainstreaming inclusion. Actively contribute to the design, implementation and monitoring of inclusive policies, services and programmes to ensure they reflect the diverse lived experiences and requirements for inclusion of all persons with disabilities.

- **Employers and providers of goods and services:**
  - Identify and address barriers that prevent equitable access for persons with disabilities (e.g., creating accessible products, infrastructure, services and workspaces; removal of physical and informational barriers; provision of reasonable accommodations).
  - Develop innovative solutions that can promote accessibility and inclusion of persons with disabilities.

- **Development agencies and other actors:**
  - Provide financial and technical support to governments, OPDs and service providers to mainstream inclusion and accessibility. Ensure that all own and funded programmes, projects and internal operations uphold accessibility and disability inclusion standards and meaningfully engage with OPDs, including in humanitarian intervention, reconstruction and recovery. Promote knowledge-sharing and capacity-building initiatives to drive systemic change.

Recommendation 4: Identify and address individual disability-related support needs.

- **Governments:**
  - Develop accessible and reliable systems to identify persons with disabilities of all ages and assess their support needs. Facilitate access to existing schemes and services through case management, supported by interoperable disability management information systems across health, education, social protection and other sectors.
  - Progressively expand, in partnerships with OPDs, civil society and the private sector, comprehensive packages of support (e.g., cash transfers, concessions, assistive technology, care and support services, inclusive education) and accelerate efforts to achieve deinstitutionalization of children and adults with disabilities. Coverage must be equitable amongst persons with disabilities across the country.

- **Organizations of persons with disabilities:**
  - Co-design and monitor systems to assess individual support needs and development of corresponding services to ensure that they align with rights-based approaches.
  - Pilot innovative service models and proof-of-concept initiatives to showcase the types of services required for effective disability inclusion.

- **NGOs and private sector:**
  - With OPDs and local governments, test and pilot innovative services and products, including assistive technology and support services that address the diverse support needs of persons with disabilities. Contribute to scaling up services across the country in partnership with national governments.

- **Development agencies:**
  - Support the piloting and scaling up of innovative, context-relevant, quality services, products and systems, including disability management information systems, care and support services, assistive and digital technology. Strengthen case management systems to streamline service delivery and inform policy and planning.

Recommendation 5: Scale up financing for disability inclusion.

- **Governments:**
  - Track disability-related public expenditures, assess financing gaps and develop costed action plans with the meaningful participation of OPDs to inform national and local budgets, development plans and financing strategies with the aim to increase and optimize public spending to scale up inclusion across sectors.

  - Strengthen coordination between sectors and between national and local governments to optimize resource allocation and prevent service fragmentation.
  - Consider strategies such as time-bound budget earmarking across ministries to ensure all sectors contribute to inclusion as well as targeted financing mechanisms, such as disability funds, with clear objectives and dedicated resources.
  - Adopt public procurement regulations that ensure accessibility and inclusiveness of infrastructure, goods and services purchased with public funds and promote innovation and employment of persons with disabilities.
  - Facilitate and co-finance contributions of civil society for expansion of service delivery. Enable and leverage private sector investment and innovative financing models.
  - Systematically consider disability inclusion in negotiation with development agencies to expand resources for disability inclusion across sectors. Involve OPDs in internationally funded programmes.

- **Organizations of persons with disabilities:**
  - Advocate for increased and equitable financing for disability inclusion that is responsive to the requirements of all children and adults with disabilities. Actively participate in national, local and programme-specific budget processes.
  - Strengthen partnerships with development agencies, civil society and the private sector to drive investment in disability-inclusive services and solutions.

- **Development agencies:**
  - Expand disability-inclusive financing through mainstreaming across existing investments and supporting new targeted programmes. Align funding with national financing strategies to maximize impact and engage OPDs to identify priorities for investment.
  - Strengthen reporting mechanisms on disability-inclusive financing to improve transparency and accountability. Facilitate cross-sectoral coordination and knowledge sharing to promote best practices and drive sustainable financing models.

Recommendation 6: Strengthen cross-sectoral coordination mechanisms and meaningful participation of persons with disabilities in their diversity.

- **Governments:**
  - Appoint and empower disability focal points in all ministries and local authorities to promote inclusion. Establish or expand cross-sectoral disability coordination mechanisms with mandatory participation from key ministries, local governments and OPDs. Ensure sustainable funding to support coordination structures and cross-sectoral initiatives.
  - Support capacity development and operation of OPDs so they can effectively represent the diversity of persons with disabilities and their families in reforms across sectors.
  - Encourage joint planning, implementation and monitoring of disability-inclusive policies across sectors, ensuring clear accountability frameworks to uphold commitments.

- **Organizations of persons with disabilities:**
  - Advocate for representation in coordination mechanisms and engage proactively in policy dialogues to ensure local and national governments, as well as development agencies and other actors, are accountable for their disability inclusion commitments.
  - Ensure intersectional representation by amplifying the voices of women, children and marginalized persons with disabilities in decision-making processes.

- **Development agencies:**
  - Fund and provide technical assistance for national coordination and OPD participation.
  - Demonstrate effective practice for meaningful dialogue and collaboration among governments, OPDs, civil society, the private sector and development partners across funded programmes.

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