Leaving No-one Behind:
Building Inclusive Social Protection Systems for Persons with Disabilities

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In memory of our dear colleague
Krystle Kabare

Executive summary

A Introduction

Worldwide, it is estimated that more than one billion people live with a disability. Persons with disabilities – and their households – are more likely to live in poverty and have lower standards of living than persons without disabilities. Many experience higher costs in their daily living expenses as a result of their disability. The challenges faced by persons with disabilities vary across the lifecycle as well as between cultures, societies, genders and economic classes. Access to social protection can play a key role in enhancing the wellbeing of persons with disabilities.

This report examines how to make social protection systems and schemes more inclusive of persons with disabilities. The research underpinning the report comprised a review of relevant literature, an analysis of household survey datasets and consultations with key stakeholders and persons with disabilities in seven low- and middle-income countries: Brazil, India, Kenya, Mauritius, Rwanda, South Africa and Zambia.

B Types of social protection schemes for persons with disabilities

From the perspective of disability, social protection schemes can be classified into four types: disability-specific schemes, for which only persons with disabilities are eligible; disability-relevant schemes, which are largely accessed by persons with disabilities (old age and veterans' pensions); targeted mainstream schemes, for which 'capacity to work' is a key criterion; and, mainstream schemes for which persons with disabilities are usually eligible on an equal basis to others.

Disability-specific and disability-relevant schemes are offered across the lifecycle and are funded by general government revenues (tax-financed) and contributions. Key schemes funded by general taxation include: disability benefits for children that help families address the additional costs they face and compensate for any loss of income resulting from increased care responsibilities; disability benefits for people of working age and old age pensions, which offer income replacement to those who cannot or should not work; personal independence benefits which compensate people with disabilities for the additional costs they face; and, financial support for carers who have experienced a loss of income. Although only a few low- and middle-income countries provide specific child disability benefits, at least 32 low- and middle-income countries have disability benefit schemes for persons of working age. There are 67 tax-financed old age pensions across

low- and middle-income countries, of which 35 offer universal coverage either through a universal or pension-tested social pension. There are few examples of carers' benefits in low- and middle-income countries.

C Levels of investment in social protection for persons with disabilities

There is no comprehensive information available on the overall level of investment by countries in social protection for persons with disability. While over 80 per cent of high-income countries invest at least 1 per cent of GDP in disability-specific benefits for persons of working age, only six low- or middle-income countries – Brazil, Georgia, Kyrgyz Republic, Mauritius, Namibia and South Africa – invest more than 0.3 per cent of GDP. However, in some countries, when social insurance disability benefits are included, the level of investment is higher: for example, the proportion of GDP invested in disability benefits for both children and adults of working age is 1.5 per cent in Brazil and 1.4 per cent in Uzbekistan. Across low- and middle-income countries, old age pensions – which, to large extent, benefit persons with disabilities – comprise the largest social protection schemes: 24 countries invest more than 0.5 per cent of GDP in tax-financed old age pensions, reaching 4.8 per cent of GDP in Georgia. It is not possible to determine the level of investment within mainstream schemes in persons with disabilities because there is little disaggregated data on recipient household members, but it is likely to be minimal given that the majority of investment in mainstream programmes benefits those without disabilities.

D Coverage of persons with disabilities by social protection

In most low- and middle-income countries, coverage of both persons with and without disabilities by social protection is low, and there is little evidence on the extent to which persons with disabilities specifically access schemes. Nonetheless, there is some evidence that the type and severity of functional limitation can influence access to national social protection schemes and systems, although it varies by country. For example, in South Africa, access to tax-financed schemes is lower for those with seeing and hearing difficulties while, for most types of disability, coverage is slightly less among those with the most profound functional limitations when compared to those with less severe – but still significant – limitations. In India, the pattern is different, with more of a balance in coverage across people with different types of functional limitations.

There is also some evidence that coverage of persons with disabilities varies across and within different types of schemes. The coverage of people of working age by disability benefits is above 3 per cent in Mauritius, Georgia and South Africa while, among other

low- and middle-income countries with disability-specific benefits, it is less than 2 per cent, and negligible in many. Universal old age pensions and disability benefits offer much higher coverage of persons with disabilities than those targeted at the poorest members of society. Yet, as Nepal demonstrates – where the universal Disability Allowance only reaches 0.4 per cent of the working age population – not even universal benefits guarantee access to everyone who is eligible due to implementation barriers.

The evidence on the coverage of persons with disabilities by mainstream schemes is limited and results are variable. For example, in South Africa, 67 per cent of children aged 5-17 years with a severe functional limitation access the Child Support Grant compared to 63 per cent of children without a disability. In contrast, in Indonesia's *Program Keluarga Harapan* (PKH) conditional cash transfer programme, the coverage of households including a person aged 15 years and over with a severe functional limitation is 2.2 per cent, which is lower than the coverage of those without a person with a disability (2.5 per cent). There is minimal information available on the access of persons with disabilities to public works schemes. However, in India's MGNREGA, only 8 per cent of people with a severe functional limitation living in rural areas are employed in the programme, compared to 12.5 per cent of persons without a disability.

E Values of transfers offered to persons with disabilities

The relative value of social protection transfers varies across countries, which partly determines their impacts. However, there is a positive relationship between the value of transfers and the coverage of the population across disability benefits and old age pensions: at higher coverage levels there is a tendency for transfer values to be higher.

F Impacts of social protection on persons with disabilities

There have been few studies examining the impacts of social protection schemes on persons with disabilities. A small number of disability-specific benefits have been evaluated, with most studies from South Africa. They offer some evidence on incomes and consumption, education, health, livelihoods and psychosocial impacts. For example, in Cam Le district in Vietnam, the Disability Allowance has had a positive impact on the ability of recipient households to meet basic food needs, with the allowance primarily used for food, clothing, household expenses and to access general health services. In a survey in Tanahun, Nepal, half of households with a Disability Allowance recipient as a member reported that it helped them meet basic food requirements. In South Africa, the Care Dependency Grant was reported to have improved the general health of 98 per cent of beneficiary households surveyed. However, there is very little information on the

impacts of mainstream schemes and old age pensions on persons with disabilities, due to an absence of disaggregated data.

The research also undertook a simulation that demonstrated that South Africa's tax-financed social protection benefits were responsible for an overall reduction in the food poverty rate for persons with severe functional limitations of 46.8 per cent. Simulated impacts are much lower in India. The difference between the two countries is due, to a large extent, to the lower relative transfer values and coverage in India compared to South Africa.

G Barriers to accessing social protection and measures to address them

In all types of schemes, persons with disabilities experience a wide range of barriers in accessing social protection. These barriers exist at various levels, including in the broader policy and governance environment as well as in the design and implementation of both national systems and individual schemes.

Policy level

Social protection systems and schemes are more likely to be disability-inclusive if there is a broader national disability-sensitive environment. However, many social protection systems in low- and middle-income countries operate within environments that are unfavourable to persons with disabilities and characterised by low levels of awareness and understanding, discrimination and weak institutions. The institutional structures established to address disability often have limited capacity to do so effectively. It is common for responsibilities for disability to be relegated to a weak social development ministry and, within the ministry, to be further relegated to a poorly resourced institution. This may partially explain why many countries have social protection systems that are not particularly disability-inclusive. The development of inclusive systems is likely to be enhanced if service delivery for persons with disabilities is embedded within all ministries, including those responsible for social protection policy and delivery, and if there is a strong demand from citizens. Disability organisations have an important role to play in building this demand.

Design level

Disability-specific social protection schemes require a mechanism to identify those who are eligible on the basis of their disability. It is a controversial and highly debated topic, and the type of mechanism often reflects the prevailing notion of disability within a country. A disability approach, which incorporates an assessment of how social and

environmental factors affect an individual's ability to carry out their daily lives, is often regarded as preferable to an impairment approach – often referred to as a medical approach – which measures only the level of impairment. A disability approach is more compliant with human rights and more likely to address the specific requirements of individual persons with disabilities. Nonetheless, an impairment approach still dominates across low- and middle-income countries.

Disability assessment mechanisms have a number of challenges which can result in the mechanisms themselves becoming barriers to access. Some of these challenges are related to the design of the mechanisms and the criteria used. For example, even though medical assessments do not take into account the social and environmental context of persons with disabilities, they are, as mentioned above, still used in many countries. Further, the conflation of disability with incapacity to work is a barrier for those in employment. Across the case study countries, Brazil was the only example of a country that integrated an assessment of the social and environmental context alongside a medical assessment.

Other barriers can arise during the implementation of disability assessments. These include: an insufficient number of assessors or the use of assessors who are not properly trained; long distances to travel for the assessment; and, a requirement of multiple documents – such as medical records – which can increase the amount of travel and, therefore, costs. Disability assessment mechanisms are often not adequately monitored to ensure their quality. However, the research found some examples of better practice, such as the initiatives in Zambia and Rwanda, of visiting communities to undertake assessments.

Where investment is limited, countries often restrict the coverage of social protection systems and schemes, which limits the number of persons with disabilities who access them. There are several means of doing this at the scheme level, including narrowing the geographical coverage and narrowing the category of persons selected (such as limiting disability benefits to those regarded as experiencing more severe disabilities, as happens in Nepal, or using a high age of eligibility for old age pensions). Another means is to restrict schemes to those living in poverty. The research found examples across various types of schemes in which poverty-targeting has been associated with the significant exclusion of persons with disabilities, including those living in poverty. Universal coverage reduces this exclusion but requires a higher level of investment.

The use of conditions in social protection schemes can create significant barriers for families with children with disabilities or parents/carers with disabilities. Some conditional cash transfer programmes have modified their use of conditions to try to reduce exclusion but there is no evidence of their level of success. Disability and human

rights experts appear divided on the approach to take. Some argue that, if conditions are not enforced and sanctions applied, children with disabilities may miss out on the benefits of attending school or health facilities. Others argue that the most inclusive approach would be to waive the conditions for children with disabilities (as is the case in Mozambique, Eswatini and Palestine) and for parents/carers so that they are not sanctioned or excluded from schemes. Given the high exclusion errors in conditional programmes, they could also be modified to offer transfers to children with disabilities on a universal basis, with no enforcement of means tests and conditions.

The available evidence shows that persons with disabilities are excluded from public works schemes for a number of reasons. For example, measures are often not put in place to facilitate employment among those persons with disabilities who are able to work but require additional support, while those unable to work are necessarily excluded. Some countries have introduced measures to enhance the inclusion of persons with disabilities – such as quotas in South Africa and India – but these measures have had limited success. The Government of Andhra Pradesh in India has, however, taken specific measures to be more disability inclusive by increasing the number of days that can be worked by persons with disabilities, as well as modifying the work norms including undertaking less daily work for the same wage.

Implementation level

Further barriers for persons with disabilities arise during the implementation of social protection schemes (in addition to those outlined above). These can include: communications on the existence of schemes and application criteria that are not adapted to the requirements of some persons with disabilities; complex application processes that are challenging to navigate; the difficulties and costs associated with travelling to registration centres; challenges in entering registration centres; and, limited capacity and discriminatory attitudes among staff receiving applications. The research found a number of examples of good practice in addressing some of these areas. For example, in Zambia, registration is undertaken within the communities themselves while, in Brazil, applicants are compensated for their travel costs. In South Africa, significant effort has been made to improve the accessibility of registration centres, such as building ramps and disability accessible toilets. The report makes a range of recommendations to reduce implementation barriers.

Further challenges can arise during the payment process, in particular when recipients have to travel long distances to collect their cash. Some people with disabilities are physically unable to do this. Some countries, such as Kenya and Uganda, have set minimum standards for the distance recipients need to travel to collect their cash, while

some programmes – as happens in South Africa – allow recipients to name a trusted alternate who is authorised to pick up the transfer on their behalf.

Social protection schemes should have grievance mechanisms, yet there are few examples across low- and middle-income countries of them working effectively and even fewer that have been adapted to meet the needs of persons with disabilities. South Africa has a relatively elaborate grievance mechanism with most complaints relating to disability benefits. The South Africa case, however, demonstrates that an effective grievance mechanism for persons with disabilities requires investment from governments, including by supporting persons with disabilities who are required, during their appeal, to undertake more intensive and costly medical assessments. The Government of Zambia has designed a complaints mechanism for its Social Cash Transfer programme although it is yet to be implemented. It plans to use multiple channels to enable greater access for persons with disabilities and will task community leaders and volunteers with helping persons with disabilities use the complaints mechanism.

Social protection systems require effective monitoring mechanisms to identify challenges and implement improvements. However, the research did not find examples of social protection monitoring mechanisms that robustly monitor the experiences of persons with disabilities. Further, few management information systems (MISs) include indicators on disability. While there has been significant investment by development partners and governments in the evaluation of social protection schemes in developing countries, there have been few evaluations of disability-specific schemes and minimal incorporation of disability into the evaluation of mainstream and pension programmes. This could easily be achieved by including the Washington Group Set of Questions in all quantitative evaluations.

Citizens should be able to hold the state to account in the design and delivery of social protection schemes. Across developing countries, there are a number of examples of NGOs undertaking this role, using citizens' groups to monitor programmes. Other relevant social accountability mechanisms involve citizens using the judiciary, human rights commissions or ombudsmen to hold government officials accountable. However, there are few examples of social accountability mechanisms being undertaken effectively and sustainably in social protection programmes, and the research did not find examples of disability being effectively included. Disability organisations could play a key role in mainstreaming disability into social accountability and citizen monitoring mechanisms.

H Links between social protection schemes and other public services

There is growing interest in building linkages between social protection schemes and other public services, to enhance their impacts on recipients. If effective linkages are to be established, adequate investment in national social work systems is critical. However, across most low- and middle-income countries, investment in social work is inadequate and social work systems are very weak.

There are some low- and middle-income countries offering a range of benefits to persons with disabilities, in addition to social protection. In Nepal, for example, holders of a disability card are able to receive a 50 per cent reduction in land and internal air transport. Some social protection initiatives have linked recipients with additional services and support, which can benefit persons with disabilities: for example, Kenya has provided recipients of both its Inua Jamii Senior Citizens' social pension and its Persons with Severe Disabilities Cash Transfer with access to free hospital insurance.

While there are many active labour market programmes for persons with disabilities, there are few linked to recipients of social protection. However, some countries have approaches to encourage recipients of disability benefits into work: for example, some allow recipients to work up to a certain wage threshold, without their benefits being affected. Further, in Brazil it has been proposed that recipients of the Benefício de Prestação Continuada (BPC) scheme could place their benefit on hold if they obtain a job and, if they become unemployed again, they can re-join the BPC without undergoing a further assessment, although this is still to be implemented.

I Conclusion

A high proportion of the world's population live with a disability, facing a range of challenges across the lifecycle. Social protection can play a key role in empowering persons with disabilities by offering them a minimum income as well as financial support to address the additional costs they face, which can be substantial. Yet, the majority of persons with disabilities in low- and middle-income countries are excluded from social protection schemes. Disability, therefore, needs to rise up the social protection policy agenda. This will only happen if policy makers and those engaged in social protection are more aware of its importance, not just for persons with disabilities themselves, but for societies and economies more broadly.

Social protection systems and schemes are more likely to be disability-inclusive if there is a broader national disability-sensitive environment. Other key areas identified by the

research include: generating better data on disability by incorporating the Washington Group of Questions into household surveys and evaluations of social protection schemes; placing responsibility for disability at a high level within governments; establishing disability-specific and old age pension schemes in countries where they do not exist and expanding coverage in countries where coverage of these schemes is low; ensuring that communications about social protection schemes are adapted to the requirements of persons with disabilities; improving disability assessment mechanisms; identifying and removing barriers to access social protection schemes; building awareness among staff working on social protection schemes so that they better understand how to address the requirements of persons with disabilities; and building disability-sensitive monitoring systems. There is much to be done but, if no-one is to be left behind, it is imperative that a much greater focus is placed on building disability-inclusive social protection systems and schemes.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APIS	Annual Poverty Indicators Survey (Philippines)
ARV	Antiretroviral
ATM	Automated Teller Machine
BCWIS	Botswana Core Welfare Indicators Survey
BIP	Basic Invalid’s Pension (Mauritius
BISP	Benazir Income Support Programme (Pakistan
BOBI	Barème Officiel Belge des Invalidités
BPC	Benefício de Prestação Continuada (Brazil)
BRP	Basic Retirement Pension (Mauritius)
CBT	Community Based Targeting
CCT	Conditional Cash Transfer
CD4	Cluster of Differentiation 4
CDG	Care Dependency Grant
CGP	Child Grants Programme (Lesotho)
CRAS	Social Assistance Reference Centres
CRPD	Convention on the Rights of Persons with Disabilities
CSSR	Centre for Social Science Research (South Africa)
CT-OVC	Cash Transfers for Orphans and Vulnerable Children (Kenya)
DFID	Department for International Development
DPO	Disabled People’s Organisations
ECAM	Enquête Camerounaise auprès des Ménage (Cameroon Household Survey)
ECOM	Enquête Congolaise auprès desménages (Congolese Households Expenditure Survey)
ECVMA	Enquête Nationale sur les Conditions de Vie des Ménages et l'Agriculture (National Survey on Household Living Conditions and Agriculture) (Niger)
EDAM	Enquête Djiboutienne auprès des ménages (Djibouti Household Survey)
EH	Encuesta de Hogares (Bolivia)
EICV	Integrated Household Living Conditions Survey (Rwanda)
ELEP	Enquête légère pour l’évaluation de la pauvreté (Limited Poverty Assessment Survey) (Guinea)

ENNVM	Enquête Nationale sur le Niveau de Vie des Ménages (Household Living Standards Survey) (Morocco)
EPAM	Enquête Permanente Auprès des Ménages
ESS	Ethiopia Socioeconomic Survey
FARG	Genocide Survivors' Support and Assistance Fund (Rwanda)
GDP	Gross Domestic Product
GHS	General Household Survey (South Africa)
GLSS	Ghana Living Standards Survey
GSOP	Ghana Social Opportunities Project
HBS	Household Budget Survey (Lesotho)
HIECS	Household Income, Expenditure, and Consumption Survey
HIES	Household Income and Expenditure Survey (Liberia)
HISP	Health Insurance Subsidy Programme (Kenya)
HIV	Human Immunodeficiency Virus Infection
HSCT	Harmonised Social Cash Transfer
ICF	International Classification of Functioning, Disability and Health
IFLS5	Indonesia Family Life Survey 5
IHDS	India Human Development Survey (India)
IHDS-II	India Human Development Survey-II
IHS3	Third Integrated Household Survey (Malawi)
ILO	International Labour Organisation
INSS	Instituto Nacional de Seguro Social (Brazil
IOF	Inquérito Sobre Orçamento Familiar (Household Budget Survey)
KIHBS	Kenya Integrated Household Budget Survey
LCMS	Living Conditions Monitoring Survey (Zambia)
LEAP	Livelihood Empowerment Against Poverty (Ghana)
LIPW	Labour-Intensive Public Works (under Ghana Social Opportunities Project) (Ghana)
LODA	Local Administrative Entities Development Agency
LSHTM	London School of Hygiene and Tropical Medicine
LSMS	Living Standards Measurement Study
NCTPP	Nahouri Cash Transfers Pilot Project (Burkina Faso)
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act (India)
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme (India)
MIS	Management Information System

NGO	Non-Governmental Organisation
OECD	Organisation for Economic Cooperation and Development
OPCT	Older Persons' Cash Transfer (Kenya)
PICES	Poverty, Income, Consumption and Expenditure Survey (Zimbabwe)
PNAD	National Household Sample Survey (Pesquia Nacional Amostra de Domicílios) (Brazil)
PKH	Program Keluarga Harapan (Indonesia)
PMT	Proxy Means Test
PNSF	National Programme of Family Solidarity (Programme National de Solidarité Famille) (Djibouti)
PPP	Purchasing Power Parity
PSNP	Productive Safety Net Programme (Ethiopia)
PwSD-CT	Persons with Severe Disabilities – Cash Transfer (Kenya)
RAMED	Regime for Medical Assistance to the Most Deprived (Morocco)
RDRC	Rwanda Demobilisation and Integration Commission
RIADIS	The Latin American Network of Non-Governmental Organizations of Persons with Disabilities in their Families
RSSB	Rwanda Social Security Board
SASSA	South African Social Security Agency
SCT	Social Cash Transfer (Zambia)
SNPDP	Secretária Nacional de Promoção dos Direitos da Pessoa com Deficiência Brasilia (Brazil)
SUSENAS	National Socio-Economic Survey (Indonesia)
TASAF	Tanzania Social Action Fund
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
US$	United States Dollar
VHLSS	Vietnam Household Living Standards Survey
VUP	Vision 2020 Umurenge Programme (Rwanda)
WHO	World Health Organisation
WMS	Welfare Monitoring Survey (Georgia)

1 Introduction

The World Health Organisation (WHO) and World Bank's (2011) *World Report on Disability* estimated that, globally, there are more than one billion people living with a disability. For those aged 15 years and above, it was estimated that between 785 and 975 million of the world's population live with a disability and between 110 and 190 million experience very significant difficulties in functioning (i.e. they have impairments which have a direct impact on their life choices).[1] Childhood disability prevalence (0-14 years) was estimated at 93 million children (5.1 per cent) with a 'moderate or severe' disability, with 13 million children (0.7 per cent) experiencing a 'severe disability.'

Furthermore, a relatively high proportion of households include a person with a disability. Table 1-1 indicates that, across eight countries examined as part of this research, household surveys indicate that between 22 and 52 per cent of households include a member with a functional limitation and between 4 and 14 per cent have a member with a severe functional limitation.

Table 1-1: Proportion of households including a member with a functional limitation across eight low- and middle-income countries

Country	Year of survey	Households with at least one member with functional limitations	
		Moderate and severe functional limitation	**Severe functional limitation**
India	2011/12	22%	8%
Indonesia	2015	24%	6%
Ethiopia	2013/14	25%	8%
Malawi	2013	25%	4%
South Africa	2015	28%	10%
Uganda	2009/10	44%	13%
Uzbekistan	2018	45%	14%
Liberia	2014	52%	14%

Source: Analysis by Development Pathways of the following household survey datasets: India IHDS-II 2-11/12; Indonesia SUPAS 2015; Ethiopia ESS 2013/14; Malawi IHS 2010/11; South Africa GHS 2015; Uganda UNHS 2009/10; and, Liberia HIES 2014/15. Information on Uzbekistan is taken from Kidd et al (2019a).

[1] Based on 2010 population estimates and 2004 disability prevalence estimates from the World Health Survey and Global Burden of disease, in WHO and World Bank (2011).

Disability, therefore, is a policy issue affecting a relatively high proportion of the population in any country. A failure to address the challenges facing people with disabilities can have a profound impact on individuals, households, communities, broader society and national economies. For example, across 10 low- and middle-income countries, it has been estimated that losses in productivity due to not effectively addressing disability range from 1 to 7 per cent of Gross Domestic Product (GDP).[2]

While persons with disabilities experience physical, mental, intellectual or sensory impairments, as the Convention on the Rights of Persons with Disabilities (CRPD) points out, it is the interaction of these impairments with barriers created by society which generate an individual's disability. These barriers hinder the full and effective participation of persons with disabilities in society on an equal basis with others. (See Annex 1 for a further discussion on the definition of disability).

Box 1-1: Disability related terms used in the report

Disability is the result of an interaction between an impairment and the barriers created by society. Therefore, to be precise, in this report the following terms are, at times, used instead of disability:

Functional limitation: a restriction in the ability to perform an activity or a task in an efficient, typically expected, or competent manner. The Washington Group Set of Questions, for example, measure functional limitations. The short set of Washington Group questions assesses whether people have difficulties in functioning in six core domains: walking, seeing, hearing, remembering, self-care and communication. This term is often used in the report to describe the results from quantitative analysis, since the analysis can only assess the functional limitations reported in the dataset and cannot determine the level of disability (which would require an understanding of the barriers faced by individuals).

Impairment: an injury, illness, or congenital condition that causes or is likely to cause a loss or difference of physiological or psychological function.

Social protection can play a key role in enabling persons with disabilities to overcome some of the barriers they face, in particular those generated by higher costs of living and inadequate incomes. However, barriers can also be created that hinder the access of persons with disabilities to social protection schemes and, therefore, limit their ability to fully participate in society.

Social protection, though, is a contested term, with multiple definitions. In this paper the focus is on schemes offering regular and predictable income transfers to individuals, families and households, which is at the core of all definitions. In this context, it is

[2] Buckup (2009) in Banks and Polack (2014).

synonymous with the term ‘social security’, which is often used to refer to national systems of income transfers.

Access to social protection and social security for all persons is recognised as a basic human right across a range of human rights conventions and many national Constitutions. The CRPD itself – in Article 28 – recognises “the right of persons with disabilities to social protection".

This report is part of a research project commissioned by the United Kingdom’s Department for International Development (DFID) called *‘Leaving No One Behind: How social protection can help people with disabilities move out of extreme poverty’*. The research examines how to make social protection systems and schemes more inclusive of persons with disabilities. This report is one of a number of outputs from the research project. Others include: a literature review; an annotated bibliography on disability and social protection; seven country case study reports; and, an extensive analysis of datasets as well as summary reports of the analysis.

Research on the access of persons with disabilities to social protection has, to date, been limited and mainly focused on disability-specific schemes. Furthermore, persons with disabilities are only rarely considered in broader research on social protection. The study, therefore, examines access to both disability-specific and mainstream schemes, bringing together existing evidence and the findings from the country case studies and dataset analysis.

The report is organised as follows. Chapter 2 provides an overview of the approach and methodology used in the research. Chapter 3 offers an overview of the challenges faced by persons with disabilities which could be addressed by investment in effective social protection systems and schemes while Chapter 4 provides a summary of the different types of social protection schemes offered to persons with disabilities. Chapter 5 examines the evidence on the effectiveness of social protection in addressing the challenges faced by persons with disabilities, focusing on levels of investment, coverage, transfer values and impacts. Chapter 6 considers the barriers faced by persons with disabilities in accessing social protection, encompassing the overarching environment, policy decisions and the design and implementation of social protection schemes. Chapter 7 focuses on the linkages between social protection schemes and other services and how these can be enhanced while Chapter 8 offers a short conclusion.

2 Overview of the research approach and methodology

The *Leaving No One Behind* research has sought to answer a number of specific research questions, using multiple methods and ensuring a strong rights-based approach. The overall research methodology is described in more detail in the following sections.

2.1 Research questions

The overarching research question was:

- What works to effectively meet the needs of people with disabilities through social protection programmes and systems in low- and middle-income countries?

There were a number of associated sub-questions:

- In low- and middle-income countries, to what extent are social protection systems (both mainstream and disability-specific schemes) reaching people with disabilities (both as participants/beneficiaries, and as household members)? How effective are the programmes?
- What are the specific examples of good practice (and also what has not worked) in both mainstream and disability-specific social protection programmes and what lessons might apply elsewhere? The research should consider contextual factors and identify which aspects of different programmes are likely to work better in different settings.
- What aspects of social protection systems are necessary to ensure effective targeting and/or effects for people with disabilities? This includes information about institutional arrangements and capacity, government buy-in, financing and links to other sectors.
- How can examples of good practice from different programmes and different countries be brought together to create a social protection system for people with disabilities that takes into account the specific context in low- and middle-income countries and is effective in providing income support to people with disabilities?

2.2 The human rights focus in the research

Since all persons with disabilities have the right to access social security and social protection, the analysis of social protection systems within this research has been grounded in a human rights-based perspective. Human rights principles can provide guidance on building disability inclusiveness into national social protection systems and schemes, based on the following key principles (see Annex 2 for a more detailed description):

- Equality and non-discrimination;
- Accessibility;
- Adaptability;
- Adequacy of benefits;
- Respect for the dignity and autonomy of the individual;
- Right to privacy;
- Transparency and access to information;
- Accountability; and,
- Meaningful and effective participation.

2.3 Challenges in identifying disability during the research

The research aimed to cover disability broadly, examining physical, cognitive and mental disabilities, taking into account the social model of disability. However, the data available has created some limitations in analysing differences between people with distinct types of impairments and disabilities. Much of the quantitative analysis is dependent on the Washington Group Set of Questions, which are strong in some areas, but weaker in others. For example, they are less effective in identifying cognitive and mental disabilities. Furthermore, on specific limitations identified by the Washington Group questions, many samples are not large enough to provide statistically significant results if disaggregation is too detailed.

In the literature, there is limited information on specific types of impairment and disability, which is a further hindrance, although there are, occasionally, interesting findings. Within the country case studies, the research sought, as far as possible, to interview people with different types of impairments, along with Disabled People's Organisations (DPOs) and Non-Governmental Organisations (NGOs) working with and for people with different types of impairment. However, again, in many countries, broader data on disability and social protection is limited.

2.4 Sources of information

This report draws on information from three main sources, while Annex 3 describes how specific research questions were addressed:

- A review of the existing literature on social protection for people with disabilities;
- Secondary quantitative analysis of household survey datasets; and,
- Seven country case studies of disability and social protection. In addition, a review was undertaken of social protection for persons with disabilities in high income countries.

Each of the components of the research are discussed in more detail below.

2.4.1 Literature Review

The literature review encompassed academic publications, evaluations, published reports and other grey literature. No quality assessment was conducted. This was deemed the most useful approach given the time available and the fact that a recent systematic review on social protection and disability, conducted by Banks et al (2016), found only 15 academic studies that met the quality criteria, eight of which were from South Africa. In addition, much of the information on programme operations is in more technical rather than academic papers. The approach to the literature review is discussed in more detail in Annex 4. Overall, 54 peer reviewed articles and 76 other texts were found, alongside 149 less relevant texts (usually dealing with some aspect of either social protection or disability).[3] There were two outputs from the literature review: a comprehensive thematic report and an annotated bibliography.

2.4.2 Quantitative Analysis

The quantitative study consisted of secondary data analysis of existing household surveys, listed in Table 2-1. The datasets were selected because they included questions on both functional limitations and social protection. The purpose of the analysis was to build an overview of current living conditions of persons with disabilities in different contexts, assess the effectiveness of social protection systems and schemes in reaching persons with disabilities, and – in some cases – simulate the impacts of the schemes. The analysis also examined the effectiveness of the proxy means test (PMT) targeting methodology in

[3] Subsequent to the initial literature review, other relevant literature was found and was included either in the country reports or this overview paper.

Ethiopia, Malawi and Liberia.[4] In addition, the research examined old age pension coverage for Georgia and Bolivia, both of which have universal old age pensions.[5]

Table 2-1: Household survey datasets analysed during the research

Country	Dataset
Ethiopia	Ethiopia Socioeconomic Survey (ESS) 2013/14 (2nd Wave)
India	India Human Development Survey (IHDS-II) 2011/12 (2nd Wave)
Indonesia	Indonesia Family Life Survey 2014/15 (5th Wave)
Malawi	Integrated Household Survey 2010/11 (Third survey)
Rwanda	EICV 4 Survey (2014)
South Africa	General Household Survey (GHS) 2015

Note: Annex 5 describes the datasets in more detail.

In undertaking the analysis, individuals were classified according to their functional limitations in a number of ways and the terms used below are employed in this report:

- ***Any functional limitation*** includes everyone with at least one functional domain coded according to any degree of difficulty reported;
- ***Severe functional limitation*** includes everyone with at least one functional domain coded as a 'lot of difficulty,' or 'unable to do.'
- ***Persons with a 'lot of difficulty'*** refers to everyone with at least one functional domain coded as 'a lot of difficulty.'
- ***Persons described as 'unable to do'*** refers to everyone with at least one functional domain coded as 'unable to do.'

The analysis examined the following areas:

- A socio-economic profile of people with functional limitations across a number of key socio-economic outcomes and compared with those without disabilities. This includes poverty estimates among people with functional limitations and, in some cases, estimates of disability related costs.
- A comparative analysis of the living conditions of people with functional limitations both with and without access to social protection programmes.
- An assessment of the coverage of persons with disabilities by social protection benefits and an analysis of the effectiveness of selection mechanisms.
- An analysis of the impacts of social protection schemes using microsimulations.

[4] Additional analysis was undertaken of the Ethiopia Socioeconomic Survey 2015/16 and Liberia's Household Income and Expenditure survey 2014/15.
[5] Analysis was undertaken of Bolivia's Household Survey (Encuesta de Hogares) 2015 and Georgia's Household Budget Survey 2013.

The analysis was summarised in a range of Excel sheets and in short reports for each country. Resource constraints limited the analysis of the six household survey datasets and, as a result, it was not exhaustive. A further key limitation in the research was the size of the datasets, in particular the number of persons with functional limitations. This meant that the ability to disaggregate the analysis by, for example, type and severity of functional limitation was limited, in particular when the analysis was linked to specific social protection programmes, some of which also had a limited number of observations. With the smaller datasets, some of the margins of error are larger.

2.4.3 Country case studies

The case study countries – Brazil, India, Kenya, Mauritius, Rwanda, South Africa and Zambia – were selected through a consultative process with DFID, both with its headquarters and offices in the potential case study countries, as well as with members of the project's External Advisory Group and a number of other experts. The criteria for selecting the countries are outlined in Annex 6. The countries selected encompass low- to upper-middle-income countries and offer a diversity of contexts. The social protection schemes examined as part of the case studies are outlined in Table 2-2. In addition, a desk study on social protection for persons with disabilities in high-income countries was undertaken to identify any lessons that could be adapted to developing countries.

The case studies involved a review of relevant literature and a country visit of between 5 to 10 days duration by teams of 2 to 3 researchers. A wide range of key informants were consulted – including researchers, government officials, representatives from NGOs and DPOs – as well as people with disabilities. Government reports, administrative information and other secondary literature was collected, which was later reviewed and analysed. In India and South Africa, the country visits were also complemented by the analysis of household datasets. The studies in Brazil, India, Zambia and South Africa also involved 1 to 2 day visits to communities in rural and urban areas to talk with persons with disabilities and other local stakeholders. The topics covered in each country study can be found in Annex 7. Eight reports were produced, including the desk study on high-income countries.

Resource constraints inevitably meant that data collection was limited to a few low and middle-income country contexts, purposively sampled to try and identify good practice, prioritising breadth of study over depth. The literature review and quantitative analysis broadened the evidence base. The findings were complemented by the researchers' combined experience of working on social protection and disability across a wide range of low- and middle-income countries, as well as discussions with other international experts on the topic.

Table 2-2: Country case studies - focus schemes

Scheme	Category of population	Number of beneficiaries	Value of transfer (% of GDP per capita)	Type of financing	Cost (% of GDP)	Remarks
Brazil						
Benefício de Prestação Continuada (BPC)	Very low-income persons with disabilities and older people	4,274,943 individuals (2,349,905 working age people with disabilities)	35%	Tax-financed	0.75%	Based on the Brazilian Constitution with guidance in the Organic Law of Social Assistance. The programme guarantees a monthly minimum wage to older people and people with disabilities who are unable to care for themselves. The programme's means test has a very low income threshold, meaning that most people with disabilities are unable to benefit.
Previdencia Social Old Age Pension	Men over 65 years and women over 60 years or 35 years of contributions for men and 30 years of contributions for women. For Previdencia Social Rural: at least 15 years of work in rural employment.	15,172,414 individuals	70% of the beneficiary's average monthly salary; increases gradually every 12 months by 1% up to a maximum of 100%, with a minimum monthly benefit equivalent to the minimum wage (currently 35% of GDP).	Contributory although the Rural Pension is tax-financed	3.7%	Mainly contributory, but those who can claim to have worked in the agricultural sector for 15 years are able to access the minimum pension. The funding for the Rural Pension comes from general government revenues and is transferred to the Previdencia Social.
Previdencia Social Disability Pension	Workers with a disability	3,353,955 individuals	Temporary disability benefit: 100% of monthly salary for the first 15 days; after that, it is 91%. Partial permanent disability benefit: 50% of monthly salary. Total permanent disability benefit: 100% of monthly salary (raised by 25% if the beneficiary requires a carer).	Contributory	0.79%	The insured must be assessed with a permanent incapacity to work by the National Social Security Institute (INSS) and have at least 12 months of contributions. The contribution period is waived if the disability is the result of an accident. Employment must cease.
Previdencia Social Sickness Benefit	Workers who become ill	1,612,657 individuals	50% of monthly salary; 91% of monthly salary after 15 days.	Contributory	0.38%	Requires 12 months of contributing to the social security scheme (except temporary sickness which does not require a minimum contribution).
Previdencia Social Survivors' Pension	Survivors of insured workers.	7,545,905 individuals	100% of the pension the deceased received or was	Contributory	1.64%	The deceased was a pensioner or insured at the time of death. Eligible survivors include the widow(er) or partner and children

			eligible to receive is paid; 100% of the minimum wage for rural workers.			younger than 21 years (no limit if the person has a disability); in the absence of the above (in order of priority), parents and siblings younger age 21 years (no limit if the person has a disability). The pension is split equally among eligible survivors
Salario Familia	Workers with children under the age of 14 (or parents of people with disabilities regardless of the age of the person with a disability)	9,400,000 children	Those with monthly salaries up to BRL 806 (£207) per month receive BRL 41.37 (£11) per child per month. Those earning between BRL 806 and BRL 1,213 (£311) receive BRL 29.16 (£7.5)	Tax-financed	0.06%	People who are working must apply for the benefit directly through the employer. People who are receiving the old age pension, sickness benefits, disability pension or the Previdencia Social Rural can apply through the Instituto Nacional de Seguro Social (INSS).
India						
Indira Gandhi National Disability Pension Scheme (IGNDPS)	People with disabilities aged 18-59 years	1,087,361 individuals	Central government: • 3.45% Tamil Nadu: • 11.5% Andhra Pradesh: • 11.5%-17.26%	Tax-financed	0.002%	A medical disability assessment is used. Recipients must be assessed with an impairment of 80 per cent or above, be aged between 18-59 years and live in households identified as Below Poverty Line. The Central Government provides a basic benefit and each state is able to add to this.
Indira Gandhi National Old Age Pension Scheme (IGNOAPS)	Older people aged 60 years or over and living in Below Poverty Line household	22,981,127 individuals	Central government: • 3.45% (60-79 years) • 5.75% (80+ years) Tamil Nadu: • 11.5% Andhra Pradesh: • 3.45%-5.75%	Tax-financed	0.18%	Living in a household identified as Below Poverty Line. The Central Government provides a basic benefit and each state is able to add to this.
Indira Gandhi National Widows' Pension Scheme (IGNWPS)	Destitute, 40 years and above and should be a widow.	6,333,059 individuals	Central government: • 3.45% (60-79) • 5.75% (80+) Tamil Nadu: • 11.5% Andhra Pradesh: • N/A	Tax-financed	0.05%	Living in a household identified as Below Poverty Line
Tamil Nadu Maintenance Grant	People with disabilities	134,200 individuals	11.5%-17.26%	Tax-financed from State Government revenue.	Not known	Recipients have to be below 59 years of age, in a Below Poverty Line household and certified with at least 75% disability (45% for people with mental disabilities and 40% for people with muscular dystrophy or affected by leprosy)
Tamil Nadu Differently Abled Persons Pension (DAPP)	People with disabilities	207,422 individuals	11.5%	Tax-financed from State Government revenue.	Not known	Recipients have to be 18 years and above. Disability level 40% and above. Fixed assets not exceeding Rs. 50,000.

National Rural Employment Guarantee Scheme (MGNREGS)	Rural population, willing to work	109,152,000 (active workers)	Wages are fixed centrally at different levels for each state	Tax-financed	0.28%	The programme is demand-based and provides an entitlement to a minimum of 100 days of work a year to each household living in rural areas.
Kenya						
Persons with Severe Disabilities Cash Transfer Programme (PwSD-CT)	People with disabilities including children	41,374 households	16.6%	Tax-financed	0.02%	For vulnerable households living in poverty that include persons with severe disabilities requiring 24-hour support from a caregiver. It is not an individual entitlement but rather a household benefit with recipients identified through administration of both a community-based selection process and a proxy means test. The effectiveness of the selection process is yet to be assessed. Many vulnerable households with members living with severe disabilities remain unsupported.
Mauritius						
Basic Invalid's Pension (BIP)	People with disabilities	26,205 individuals	26.42%	Tax-financed	0.49%	Universal, but beneficiaries must be assessed with at least 60% disability in a medical disability assessment using impairment tables.
Basic Retirement Pension (BRP)	Older people	197,745 individuals	60-89 years: 26.42% 90-99 years: 76.73% 100+ years: 101.89%	Tax-financed	2.91%	Provides universal coverage for older people aged 60 and above, including many people with disabilities. An additional benefit is available to beneficiaries of the BRP with severe disabilities.
Rwanda						
Vision Umurenge (VUP) Direct Support Programme	Extremely poor households in the lowest Ubudehe category with no labour capacity	85,899 households	15.7%-44% Average payment of 25%	Tax-financed with donor support	0.3% for both VUP programmes combined	Offers transfers to households living in extreme poverty without labour capacity. Eligibility is based upon the Ubudehe social categorisation which utilises a simple proxy means test to classify the population into levels of well-being. Communities determine whether someone is regarded as having a disability – which is taken to imply no labour capacity – and there is no formal guidance.
Vision Umurenge (VUP) Public Works Programme	All extremely poor households with labour capacity	103,584 households	Average annual payment is the equivalent of 13.8% of GDP per capita	Tax-financed with donor support	0.3% for both VUP programmes combined	Offers short-term employment to households living in extreme poverty that have some labour capacity. The average number of days worked per year is 67. The programme was recently expanded to include a new component targeted at households with only one person regarded as capable of work but who also has care responsibilities (known as Expanded Public Works).
Direct Support from the Genocide Survivors' Support and Assistance Fund (FARG)	Survivors of the Genocide who are living in poverty and recognised as in need	23,836 individuals	15.7% to 209% Payment varies according to level of perceived need	Tax-financed	Not known	Offers transfers to individuals living in poverty who survived the Genocide and are recognised as in need, such as persons with disabilities, older persons, orphans and widows. FARG staff work with local leaders and district staff to assess eligibility.

						FARG staff assess applicants on a case-by-case basis and make recommendations for higher or lower support.
Disability Benefit provided by the Rwanda Demobilisation and Integration Commission (RDRC)	Veterans who were engaged in the Rwanda conflict regardless of which side they fought on.	3,059 individuals	43%-107% Payment varies according to level of impairment	Tax-financed	Not known	Offers disability benefits to military veterans living with a disability. A medical disability assessment system is used to determine the category of disability which in turn defines the level of support offered. The programme does not target those living in poverty but is open to all those who fulfil the military and disability criteria. Benefit levels are generous, highlighting the State's commitment to addressing the needs of former combatants as a contribution to the peace process.
Rwanda Social Security Board	Contributors to the scheme	Not known	Depends on contributions Minimum pension of 16.7%	Contributory	Not known	*Old age, disability and survivors' pension*. Employees and employers each pay a contribution of 3% while the self-employed have to pay a 6% contribution. To obtain the disability pension, persons must have been members of the scheme for three years and assessed as having lost 50% of their earning capacity. The value of the disability pension is 30% of the insured's monthly average earnings in the previous five years plus 2% of average monthly earnings for each 12-month period of coverage exceeding 180 months. The minimum pension is 50% of the legal minimum wage, which varies across employment sectors. Recipients can also receive financial support if they require constant care, paid at 40% of the disability pension. The old age pension is paid at 60 years of age. *Work injury benefit*. The contribution is paid by employers at 2% of salary. It is not open to those who are self-employed. The benefit is paid at 75% of the insured's average daily earnings in the three months before the disability began until s/he fully recovers or the disability is certified as permanent, up to 180 days. If the insured is assessed as having a total disability, they are paid 85% of their average monthly earnings in the three months before the disability began. They can also receive a care allowance.
South Africa						
Child Support Grant	Children 0-17 years without the Care Dependency Grant (CDG)	12,045,291 individuals	5.4%	Tax-financed	1.26%	Given to children aged 0-17 years, based on an affluence test (a form of means test).

Foster Care Grant	For Foster Carers, determined by Court Order	504,541 individuals	13.8%	Tax-financed	0.13%	Given to foster carers, based on a court order. It is not means-tested.
Care Dependency Grant	Children with disabilities under the age of 18 years	143,043 individuals	23.4%	Tax-financed	0.07%	Given to the caregivers of children with disabilities who have a permanent and severe medical disability and are under the age of 18 years. Recipients are determined via a medical assessment and an affluence test (a form of means test).
South Africa Disability Grant	Adults with disabilities aged 18-59 years	1,081,866 individuals	23.4%	Tax-financed	0.50%	Adults up to 60 years of age receive the Disability Grant after which they are transitioned onto the Old Age Grant. Recipients are determined via a medical assessment and an affluence test (a form of means test).
Old Age Grant	Aged over 60 years	3,247,008 individuals	23.4%	Tax-financed	1.43%	Provided to those aged 60 years and above, on the basis of an affluence test (an unverified means test)
Grant in Aid	Recipient of CDG, Disability Grant or Old Age Grant, with additional care needs	152,070 individuals	5.4%	Tax-financed	0.01%	Given to recipients of the Care Dependency, Disability and Old Age Grants if they are determined, via a medical assessment, of being in need of additional care support.
Zambia						
Social Cash Transfer (SCT)	Households including a person with a severe disability or a person aged 65 years and above	240,000 households	6% for households with older persons and 12% for those with severe disabilities	Tax-financed	0.12%	The scheme has used various designs, most of which are still operating in the areas where beneficiaries were selected for those designs. The most recent design offers benefits for households including older persons and persons with severe disabilities. The scheme currently uses a medical assessment to identify disability and a proxy means test as a form of affluence test to determine eligibility. For persons with severe disabilities, the transfer value is doubled. However, the higher payment appears to not be given to all older persons with severe disabilities – as they are thought to be 'old' rather than 'having a disability' – but the proportion is not known.

Source: The information in this table is taken from Kidd et al (2018); Kidd et al (2019b); Kidd and Kabare (2019); Wapling and Schjoedt (2019a); Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019c). Data on expenditure of Salario Familia is for the year 2012, taken from Kidd and Huda (2013). Information on the Rwanda Social Security Board is taken from the ISSA website at: https://www.issa.int/en/country-details?countryId=RW®ionId=AFR&filtered=false. *Note*: While Bolsa Familia is probably the most well-known social protection programme in Brazil, the BPC and Previdencia Social schemes are the schemes that offer disability specific benefits and, in terms of funding, are much larger than Bolsa Familia. Wapling and Schjoedt (2019a), therefore, due to time constraints, focused mainly on the BPC and Previdencia Social schemes, rather than Bolsa Familia.

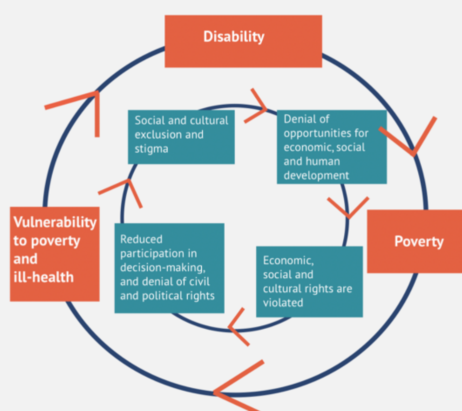
3 Challenges facing persons with disabilities

Across the world, persons with disabilities – and their households – are more likely to live in poverty and have lower standards of living than persons without disabilities.[6] This is the result of systemic institutional, attitudinal and environmental barriers that impact on persons with disabilities' opportunities to participate in economic and social activities, resulting in reduced access to, for example, education, employment, and healthcare, as well as more limited incorporation within social, economic and political networks.[7] People with disabilities, therefore, face greater challenges in acquiring the human and social capital needed to convert capabilities into functionings, thereby impacting on their capacity to access adequate incomes.

Box 3-1: The link between poverty and disability

As Figure 3-1 indicates, disability and poverty are closely linked: those who live in poverty are more likely to become disabled while those with a disability are much more likely to be living in poverty. The risk of disability increases for those living in poverty as a result of reduced access to basic healthcare and increased vulnerability to malnutrition and preventable diseases. Those in poverty are also more likely to live in dangerous or polluted environments with low quality housing, reduced access to safe drinking water and sanitation. They are also more likely to inhabit areas which are prone to the effects of natural disasters, dangerous traffic and higher rates of violence. So, disability and poverty mutually reinforce each other, contributing to the increased vulnerability and exclusion experienced by persons with disabilities around the world.

Figure 3-1: The disability and poverty cycle



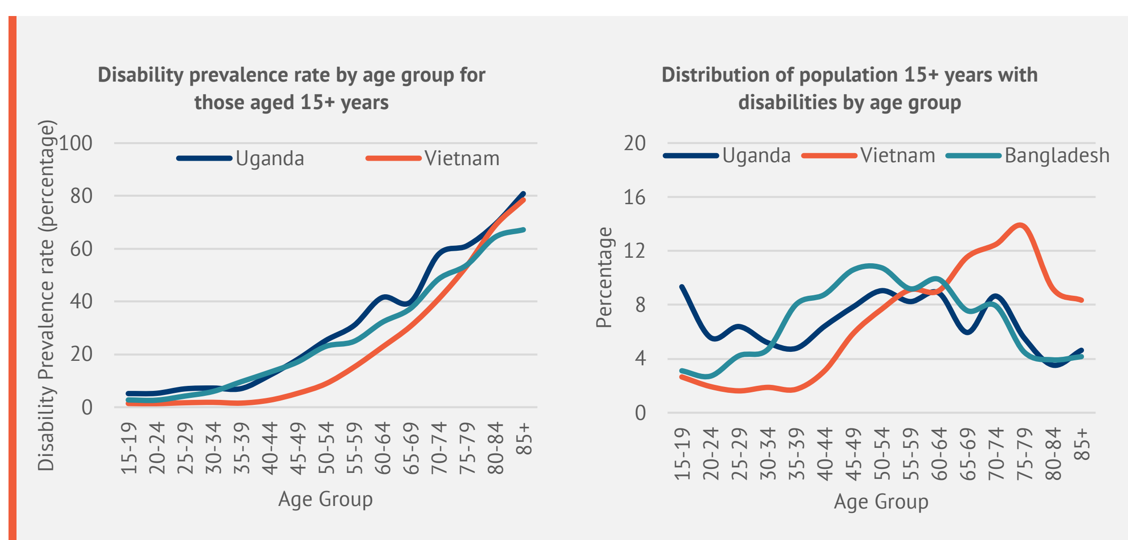
Source: Based on Banks and Polack (2014)

Overall, disability prevalence increases with age and, on average, the highest prevalence rates globally are found among older populations (60 years and above) with an estimated 46.1 per cent experiencing a moderate or severe functional limitation. Rates are even higher among the older, as Figure 3-2 shows for Bangladesh, Uganda and Vietnam.[8]

[6] WHO and World Bank (2011)
[7] Yeo and Moore (2003); Groce et al (2011); Trani and Loeb (2012).
[8] WHO and World Bank (2011).

However, as Figure 3-2 also indicates, the age group within which the highest absolute numbers of persons are found can vary, depending on the demographics within a country. Countries with older populations are likely to have the highest numbers of persons with disabilities among older persons (as in Vietnam) while in countries with young populations, such as Uganda, the highest numbers are likely to be among younger members of the population. In a study of 15 developing countries, Mitra et al (2013) found disability prevalence was higher among women than men in all countries and, in most countries, this gender gap was between 3 and 5 percentage points.[9]

Figure 3-2: Disability prevalence rates and number of people aged 15 and over with disabilities in Bangladesh, Uganda and Vietnam



Source: Data on Uganda and Bangladesh are from analyses undertaken by Development Pathways using the Uganda National Panel Survey for 2010 and the Bangladesh Household Income and Expenditure Survey for 2010, respectively; data on Vietnam were taken from Kidd, Abu-el-Haj et al (2016).

The challenges faced by persons with disabilities vary across the lifecycle and also between cultures, societies, genders and economic classes. In many societies, **children with disabilities** face particular challenges in becoming visible, with parents often ashamed of their children, who are frequently hidden away. The country case studies heard from key informants about men abandoning their wives on the birth of a child with a disability, with the mothers also having to leave work to care for the child. In addition, the costs of medical treatment, travel and habilitation/rehabilitation can be substantial. In many low- and middle-income countries, where there is limited or no support for children with disabilities, families can be thrown into destitution following the birth of a child with

[9] Mitra et al (2013).

a disability.[10] In some cases, grandparents step in to care for the child, often without access to a pension. Children with disabilities also face the challenge of exclusion from education, with lower participation rates in primary and secondary education, which has a lifelong impact on social and economic opportunities.[11] Furthermore, they often face the challenge of poor quality education, with insufficient resources allocated to schools, inadequate training for teachers and an absence of teaching assistants.

As a result of more limited access to education, many **working age adults** with disabilities have lower skills and experience significant disadvantages in accessing employment. This is exacerbated by discrimination, with women with disabilities often at a greater disadvantage than men.[12] Becoming disabled during working age can have a devastating impact on family wellbeing. For example, in Bangladesh, a study found that 87 per cent of those of working age who became disabled left employment within one year while 90 per cent of their spouses had to provide them with care. As a result, 54 per cent of caregivers had to forgo at least 15 hours of work per week, and often substantially more.[13]

The prevalence of disability is highest among **older persons,** as indicated Figure 3-2. As people age, they experience increasingly poor health which can cause permanent impairments and withdrawal from the labour market. As impairments become more severe, older people become increasingly reliant on others for care and support. This can place a financial strain on households with fewer working adults, in particular when there is limited support from the State.

While there is no reliable information on the levels of economic wellbeing among persons with disabilities, across the countries studied in this research, the vast majority of persons with severe functional limitations were living in households with low levels of per capita consumption. Figure 3-3 compares the average per capita consumption of persons with severe functional limitations and of those without disabilities in four countries (Ethiopia, India, Malawi and South Africa). In all four countries, the majority of people live on less than US$2.50 per day, and in some, it is the vast majority: in Ethiopia, almost 85 per cent of people live on less than $1 per day and in Malawi, the proportion is around 70 per cent. Whether or not persons with severe functional limitations have higher or lower consumption varies between countries (for example, in India, households including persons with severe functional limitations have higher per capita consumption than those

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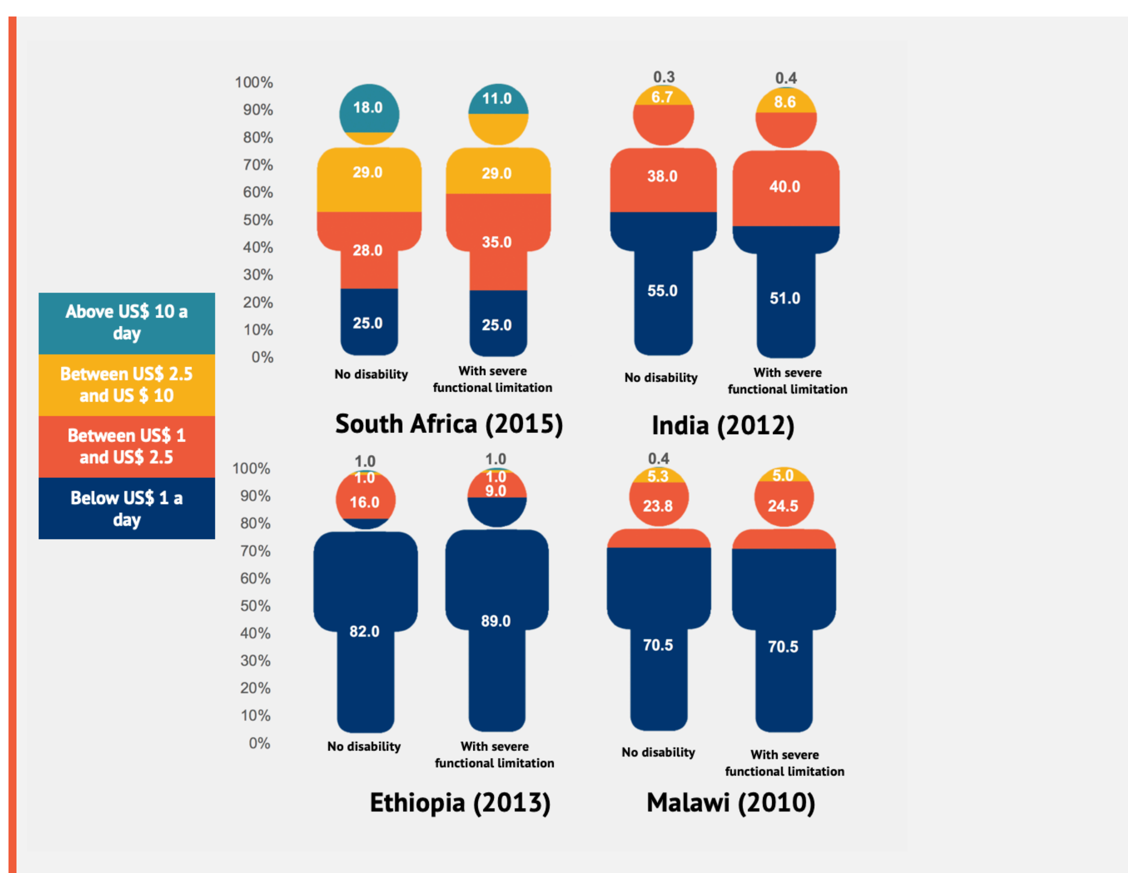
[10] For examples, see Kidd and Kabare (2019); Kidd et al (2018b).
[11] Filmer (2008); Groce and Bakshi (2009); WHO and World Bank (2011).
[11] O'Reilly (2003).
[11] Chowdhury (2005).
[12] O'Reilly (2003).
[13] Chowdhury (2005).

with no disability). However, caution should be adopted when interpreting these results: higher average consumption among persons with severe functional limitations may be the result of high mortality rates among persons with disabilities living in poverty in these countries, meaning that some households living in poverty may have lost disabled members.

Figure 3-3: Proportion of persons with severe functional limitations and no disability living under different per capita levels of consumption in Ethiopia, Malawi, South Africa and India



Source: Estimates are taken from the South Africa GHS 2015; Ethiopia ESS 2013/14; Malawi IHS3 2010/11 and India IHDS 2011/12 datasets. Nominal dollars were used. In South Africa, the official exchange rate in 2015 used (Local Currency Unit to US$) was 12.8. In terms of Purchasing Power Parity (PPPs), for South Africa the equivalent values are: US$1 is PPP US$2.14; US$2.50 is PPP US$ 5.35; US$10 is PPP US$ 21.40. For India, income was first adjusted to differences in regional poverty lines in 2012 and inflated to 2015 using the IMF's price index. The exchange rate used (Local Currency Unit to US$) was 64.2. In terms of PPPs, the equivalent values for India are; US$1 is PPP US$3.33; US$2.50 is PPP US$8.33; and US$10 is PPP US$33.32. The exchange rates and PPP conversion factors are from the World Bank (available at data.worldbank.org). For Ethiopia, the exchange rate for 2013 used (LCU to US$) was 18.71. In terms of PPPs: US$ 1 is PPP US$2.69; US$2.50 is PPP US$6.71; US$10 is PPP US$ 26.85. For Malawi, the exchange rate for 2010 used (LCU to US$) was 150.49. In terms of PPPs: US$1 is PPP US$1.93; US$2.50 is PPP US$4.82; US$10 is PPP US$19.28.

Box 3-2: Understanding poverty lines and poverty rates

Countries use poverty lines and poverty rates to monitor their progress in tackling poverty over time. Furthermore, each country can choose its own poverty line as well as the assumptions used to determine the poverty rate. Therefore, when comparing countries, results can be counter-intuitive. So, for example, while Kenya has a national poverty rate of 36.1 per cent, Uganda – a poorer country in terms of GDP per capita – has a national poverty rate of only 21.4 per cent. However, if Kenya and Uganda were to use the same assumptions and international poverty lines – $1.90 (PPP) per day – then Uganda would have a higher poverty rate (45 per cent) than Kenya (31 per cent).

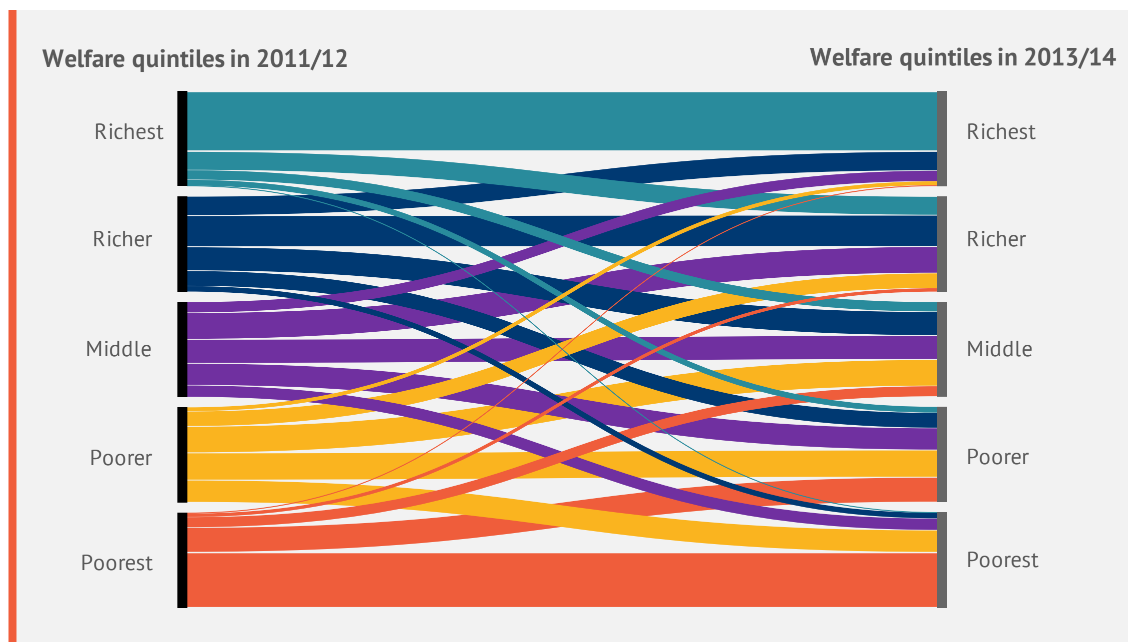
Poverty rates do not indicate the number of persons actually living on low incomes, nor do they take into account consumption and income dynamics which demonstrate that a high proportion of the population fall below poverty lines over a relatively small period of time. Therefore, poverty rates significantly underestimate the real number of people living in poverty. When determining social policies – including on social protection – it is necessary to use a more sophisticated analysis to understand who is really in need of social protection and how best they can be reached.

Indeed, the standards of living of persons with disabilities – and their households – are lower than suggested by consumption figures and poverty rates. Persons with disabilities face significant 'disability related expenses'– referred to by Sen (1999) as a 'conversion handicap' – which reduce their standards of living when compared to households without a member with a disability with similar incomes and consumption. These expenses are the result of, for example, higher expenditure on transport, education, rehabilitation, assistive devices, medicines and care needs. These costs can be considerable, ranging from an additional 10 per cent of household consumption to more than 50 per cent, depending on the particular context.[14] Among older persons with disabilities, the costs can be even higher, as the research found in South Africa (see Annex 8).

Furthermore, Figure 3-4 – which shows how the relative ranking of households in Uganda, by wealth quintile, changed in only two years – indicates that incomes and consumption in developing countries are highly dynamic, as people experience shocks and crises or take advantage of opportunities. Therefore, in addition to high levels of poverty, the majority of persons with disabilities – as well as the general population – in low- and middle-income countries face the risk of income insecurity and families can experience a significant reduction in wellbeing if hit by a crisis (such as ill-health, the birth of a child, disability, theft and unemployment[15]).

[14] Cf. Devandas-Aguilar (2015).
[15] While it may seem strange to classify the birth of a child as a *crisis,* in financial terms it often is, as family costs increase while incomes fall, especially if one of carers has to leave the labour force.

Figure 3-4: Movement of households across wealth quintiles in Uganda between 2011/12 and 2013/14



Source: Kidd and Gelders (2016).

In absolute terms the number of persons with disabilities is continually rising. Since the risk of disability increases as people age, enhanced life expectancy across the world – which is resulting in older populations – is leading to increases in the number of persons with disability. More people are also surviving what, in the past, would have been fatal trauma and diseases with associated disabling impacts, contributing to global increases in the numbers of people living with chronic health conditions and non-communicable diseases such as cancer, diabetes, cardiovascular disease, hypertension and kidney and liver disease.[16]

Given the combination of widespread low incomes and insecurity among persons with disabilities and the additional costs they face, the majority of people with a disability in developing countries would benefit from access to social protection and some form of income security, either from disability-specific or mainstream schemes. Indeed, as noted earlier, all persons with disabilities have the right to access social protection.

[16] WHO and World Bank (2011).

4 Social protection for persons with disabilities

There are many different types of social protection schemes with designs varying across countries. This section will give a brief overview of the types of social protection systems found across high-, middle- and low-income countries, before moving on to a description of the types of schemes that are offered to persons with disabilities.

4.1 An overview of social protection systems and schemes

Social protection benefits are typically financed from two sources: either from general government revenues (referred to here as 'tax-financed' schemes) or social insurance (which involves people – usually employees with co-contributions from employers – paying contributions that are used to finance the benefits themselves).[17] Box 4-1 offers a simple description of the difference between social insurance and private contributory schemes. In some low- and middle-income countries, external development assistance also finances social protection programmes, either as grants or loans (if the latter are concessional they are classified as official development assistance, but they could be regarded as government financing, since the loans have to be repaid).

Ideally, countries should offer a combination of tax-financed and contributory schemes. The main aim of tax-financed schemes is to provide some form of minimum income security to recipients while contributory schemes offer consumption smoothing across the lifecycle to those who can afford to save. Tax-financed, social insurance and private contributory schemes should be designed as a single system.

[17] Some social insurance schemes are 'pay-as-you-go' and are used to directly finance recipients of the benefits. In contrast, other social insurance schemes create funds that act as savings schemes: the funds can be invested and, when people become eligible the amount paid is linked, in part, to how well the fund has performed in terms of its investments.

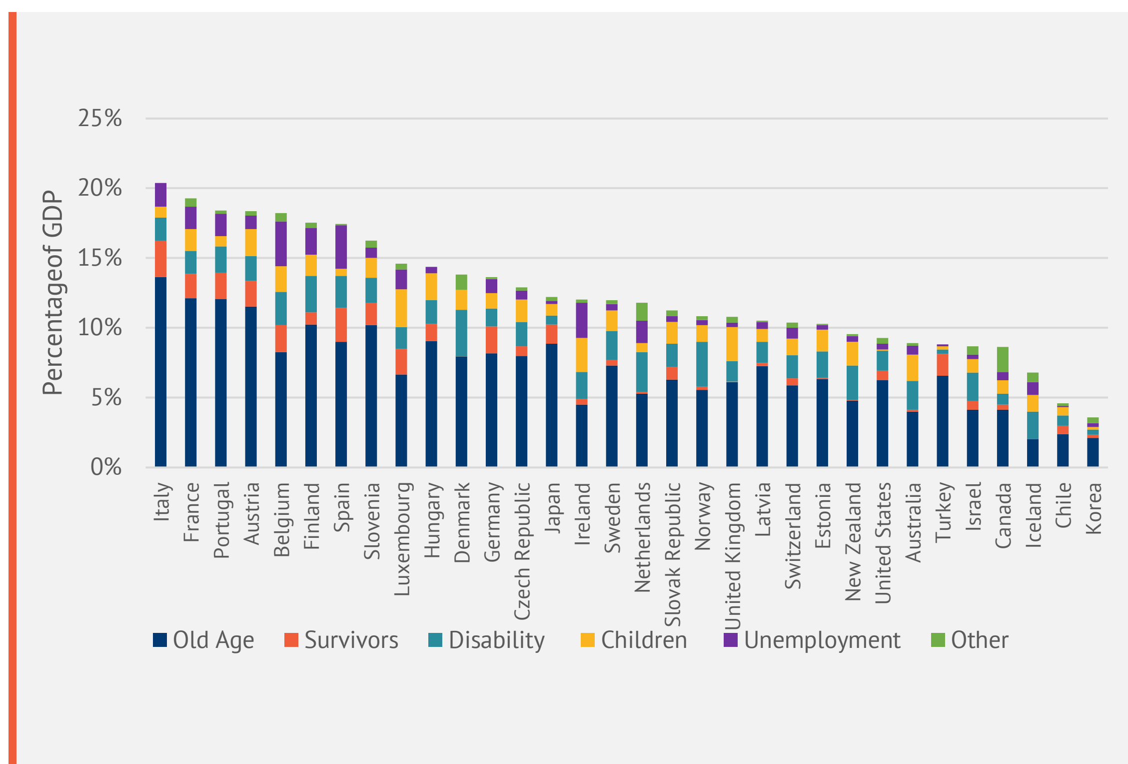
Box 4-1: Types of contributory schemes

There are many different types of contributory schemes, but one simple classification is to differentiate between social insurance and private schemes. Social insurance schemes are managed or overseen by government and include some form of solidarity principle. This means that there is some sharing of benefits between members, with higher contributors receiving less than they invested and lower contributors receiving more. They are also, usually, mandatory. Private contributory schemes are run by the private sector but are usually regulated by government. They may or may not incorporate a solidarity principle. Social insurance schemes can offer a range of benefits, but the main types are old age, disability and survivors' pensions, employment injury benefits, sickness benefits, unemployment insurance, and maternity insurance. Barr and Diamond (2008) provide an excellent overview of contributory social protection schemes.

Countries with more mature social protection systems direct resources towards addressing lifecycle risks, as indicated by Figure 4-1 which shows the level of investment in social protection schemes in high income countries (which averaged 12 per cent of GDP in 2013). These systems usually comprise both social insurance and tax-financed schemes, complemented by private schemes (although the latter are not included in Figure 4-1). A large proportion of investment is either in disability-specific or old age pension schemes, which, as discussed later in the report, deliver the majority of their benefits to persons with disabilities. Increasing numbers of low- and middle-income countries are also building lifecycle social protection systems and some, such as Uzbekistan and Brazil, are investing similar levels as high-income countries, when measured as a percentage of GDP.[18]

[18] Kidd and Huda (2013); Kidd and Abu-el-Haj (2014); and, Kidd et al (2019a).

Figure 4-1: Levels of investment in 2013 in social protection schemes in high-income countries (both social insurance and tax-financed investment)



Source: OECD Social Expenditure Database.

4.2 An overview of social protection schemes for persons with disabilities

When categorising social protection for persons with disabilities, a division is commonly made between disability-specific and mainstream schemes.[19] Palmer (2013) further subdivides mainstream schemes by identifying a specific category of programmes – 'targeted mainstream schemes' – which explicitly include disability as a named category of potential beneficiary.[20] Examples of the latter include early versions of Zambia's Social Cash Transfer programme, Rwanda's Vision 2020 Umurenge Programme (VUP) Direct Support programme, and Ghana's Livelihood Empowerment Against Poverty (LEAP) scheme.[21]

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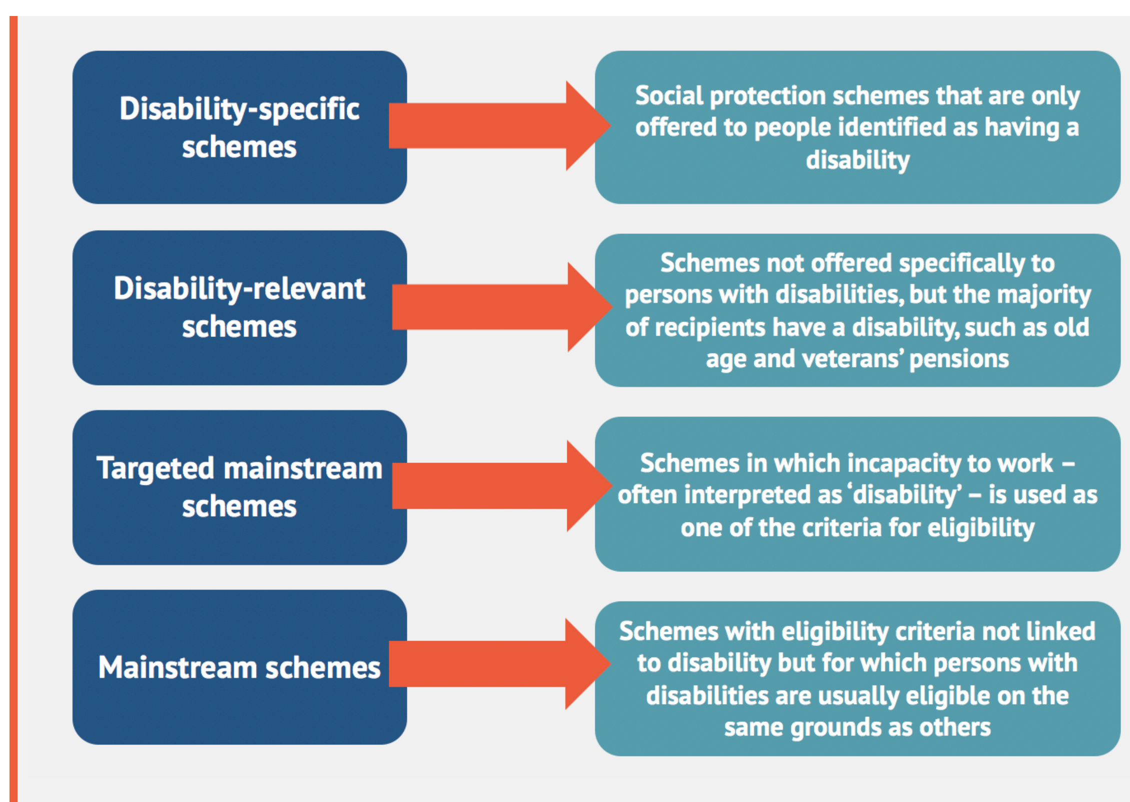
[19] For examples, see Mitra (2005); Palmer (2013).
[20] Schneider et al (2011) disaggregate "social assistance schemes" as either including an *implicit* disability targeting criteria (i.e. there is an expectation that persons with disabilities are among the poorest households) or an *explicit* targeting criteria (i.e. by which they include disability-specific programmes and those that Palmer (2013) refers to as targeted mainstream schemes).
[21] See Kidd and Kabare (2019); Kidd et al (2019b); International Labour Organization (ILO) (2014).

This report similarly distinguishes between disability-specific and mainstream schemes, but categorises old age and veterans' pensions as **disability-relevant schemes** rather than mainstream schemes. This is because one of the main reasons for an old age pension is to offer income replacement to those with a reduced capacity to engage in the labour force, often due to disability, while veterans' benefits are usually given to older persons or persons with disabilities. Indeed, the world's first old age pension – instituted in Germany by Bismarck – was intended to be for those aged over 70 years who were unable to work due to age and invalidity.[22] Figure 4-2 outlines the typology of social protection schemes used in this report.

Figure 4-2: Typology of social protection schemes used in this report



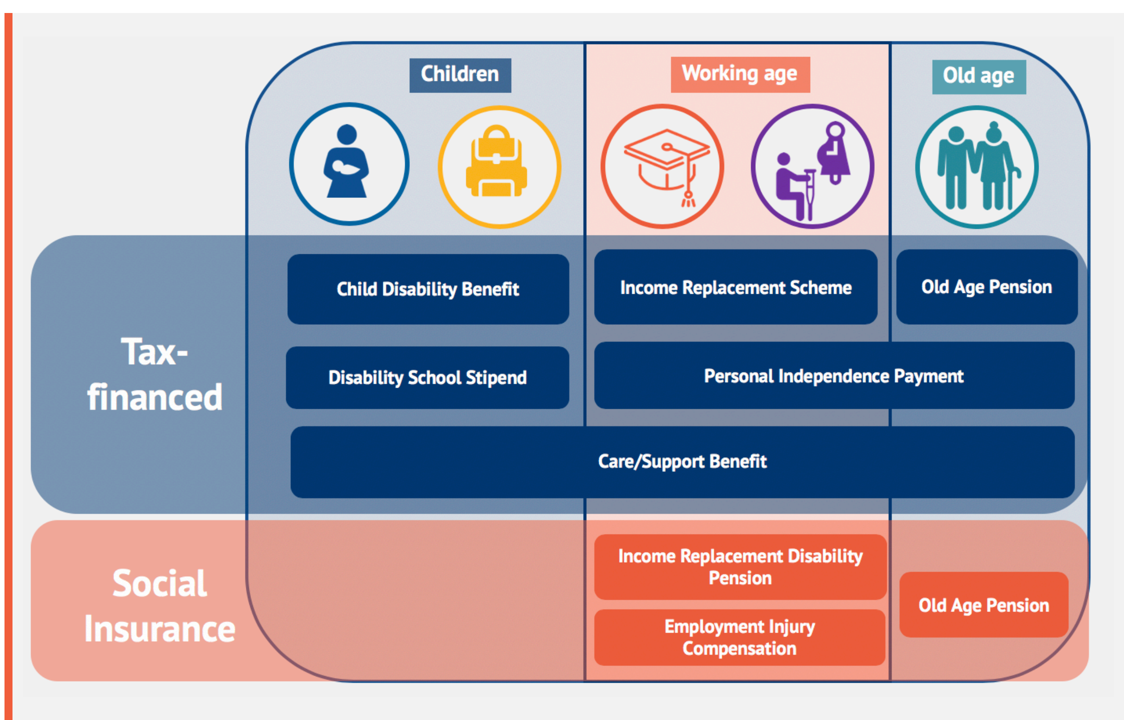
Note: While people with disabilities are usually able to access mainstream social protection schemes on the same basis as others, there are exceptions. For example, in South Africa, children who are in receipt of the Care Dependency Grant are not permitted to access the mainstream Child Support Grant.

Figure 4-3 outlines a further simple typology of disability-specific and disability-relevant schemes, across the lifecycle, based on the types of schemes that are commonly found in countries that have more mature, disability-inclusive, social protection systems. A combination of these is most likely to best serve the interests of persons with disabilities.

[22] Hill (2017).

In the context of the progressive realisation of the right to social security, it may take many years for countries to establish such systems. The types of disability-specific and disability-relevant benefits vary across the lifecycle and are described in more detail below.

Figure 4-3: Typology of disability-specific and disability-relevant benefits across the lifecycle



4.2.1 Disability-specific schemes for children

Two types of disability-specific benefit are offered to support ***children with disabilities,*** both of which are tax-financed.

- A ***Child Disability Benefit*** aims to help families address the extra costs of caring for a child with a disability, which can be considerable.
- A ***Disability School Stipend*** is offered to children with disabilities to help overcome the additional costs of attending school.

Few low- and middle-income countries provide specific child disability benefits. However, examples can be found in Bangladesh, Mauritius, South Africa and Uzbekistan. Nepal appears to be the only low- or middle-income country offering a Disability School Stipend scheme.

4.2.2 Disability-specific schemes for persons of working age

Disability-specific schemes for people of working age are generally financed either from contributions or government revenues (or a mixture of the two). At least 32 low- and middle-income countries have schemes financed by government revenues and the main types of tax-financed scheme are:[23]

- An ***Income Replacement Benefit*** is offered to those persons with disabilities who are unable to work. It aims to provide them with a basic income, replacing a wage.
- A ***Personal Independence Payment*** compensates people with disabilities for the disability related costs they face. It is an essential benefit if persons with disabilities are to have opportunities and standards of living that are equal to people without disabilities. When these benefits are in place, payments are provided whether or not recipients are in work.

In some high-income countries, those in receipt of an Income Replacement Payment are also eligible to receive a Personal Independence Payment. In contrast, in low- and middle-income countries, disability-specific schemes for those of working age are generally envisaged as Income Replacement Benefits; the research found no examples of Personal Independence Payments being implemented outside high income countries. However, there are examples of disability benefits for working age adults being paid at different rates based on levels of severity of the disability, such as in Nepal and Uzbekistan. It is possible that this reflects an assumption that those with a less severe disability are more likely to be in employment and so should receive less.

Social insurance disability benefits become available to people who experience a disability after they have become members of a social insurance scheme (although often they only become eligible if they have been members of the scheme for a minimum period). Typically, there are two types of social insurance disability pension:

- A ***Disability Pension*** – sometimes called an Invalidity Benefit – is aimed at those who experience an impairment while they are a member of a scheme, which inhibits their ability to work. This is, in effect, a form of income replacement.
- ***Employment Injury Compensation*** benefits are paid to those who have experienced an injury during work, for which compensation is given, ideally until the recipient is recovered from the injury.

[23] A list of disability benefits can be found at Development Pathways' Disability Benefit Database at: https://www.developmentpathways.co.uk/.

4.2.3 Disability-specific and disability-relevant benefits in old age

Once people reach ***old age***, persons with disabilities accessing tax-financed Income Replacement Schemes usually transition onto ***Old Age Pensions***, as they are commonly paid at the same rate. Old Age Pensions are the most common type of social protection scheme, with the highest coverage and levels of investment. The ILO (2017) reports that 186 out of 192 countries for which information is available provide pensions in the form of a periodic cash benefit, while some of the remaining six provide lump-sum benefits through Provident Funds or similar programmes. Of the 192 countries, 39 per cent offer only contributory schemes (of which the majority are social insurance schemes), whilst 6 per cent offer only tax-financed schemes (of which the majority are universal). 55 per cent combine both contributory and tax-financed pension schemes. According to Pension Watch, 67 tax-financed Old Age Pensions can be found in low- and middle-income countries.[24] Of these, 35 offer universal coverage either through a universal or pension-tested social pension.

Box 4-2: Veterans' Benefits

Many low and middle-income countries provide regular transfers to Veterans, often to those who fought in wars of liberation. Examples include relatively large schemes in Timor Leste and Vietnam, both of which pay transfers that are significantly higher than those paid to recipients of their social pensions. Although the research did not find reliable information on the proportion of recipients with a disability, it is likely that a large proportion of Veterans' Benefit recipients do experience some form of disability, due to their age or injuries from war.

When pension systems offer universal coverage, they implicitly offer universal coverage of older persons with disabilities, making them a very disability-inclusive form of social protection benefit. However, when coverage is not universal, some older persons with disabilities are excluded from schemes, with the proportion depending, to a large extent, on the overall coverage of the pension system (see Section 5.2.3 for further discussion).

In theory, older persons with disabilities should also be eligible for ***Personal Independence Payments***. However, additional payments to compensate for the extra disability costs for older persons are rare in developing countries. Nonetheless, Zambia offers a form of additional payment in that older persons who can show they have a severe disability can receive a double payment.[25] Personal Independence Payments in old age are more common in high-income countries.

[24] HelpAge International's Pension Watch Social Pensions Database

[25] Kidd et al (2019b).

4.2.4 Carers' or Support Assistants' Benefit

Often people have to give up work – either partially or completely – to care for disabled family members with significant support needs. This can happen at any stage in the lifecycle of a person with a disability and can have a major negative impact on a family's standards of living. In many high-income countries, these family members are compensated for their loss of income by receiving a ***Carers' (or Support Assistants') Benefit***. However, the research found few similar benefits in low- and middle-income countries: Jordan and Iraq have schemes for carers of people with 'chronic mental illness;'[26] Vietnam offers a benefit to carers of persons with severe disabilities;[27] and, South Africa's Grant-in-Aid programme is meant to compensate some of the costs of carers, although it is paid to the person with the disability rather than the carer.[28] Nonetheless, if Carers' Benefits were provided in low- and middle-income countries, they would enhance the well-being of persons with disabilities with significant care needs (as well as their families).

In many high-income countries, when persons with disabilities with major care needs do not receive support from close family members, the State often steps in to provide this support through paid assistants who make regular visits to the home of the person requiring assistance. Across low and middle-income countries, this support is rare and many people with significant care needs can be left isolated. One option is for countries to re-think their design of social protection public works so that, instead of building infrastructure, some people could be paid wages to offer care services.

[26] Bjork et al (2017).
[27] Government of Vietnam (2017).
[28] Kidd et al (2018).

5 Effectiveness of social protection for persons with disabilities

The effectiveness of a national social protection system or scheme for persons with disabilities is defined in this report as the impacts on the wellbeing of the national population of persons with disabilities or, in the case of a scheme, those who are eligible. However, impacts are dependent on a range of factors, with the most significant being coverage of a scheme or system and the value of transfers. The more eligible people that are covered by social protection and the higher the transfer values, the greater should be the impacts, assuming the scheme is designed and implemented well.[29] If schemes have higher levels of investment, then coverage and/or transfer values – and, therefore, impacts – can also be higher. This section will examine evidence on the different aspects of the effectiveness of social protection, including the level of investment, coverage of schemes and systems, transfer values and impacts on recipients.

5.1 Investment in social protection for persons with disabilities

There is no comprehensive information on the overall level of investment in social protection for persons with disabilities, which encompasses disability-specific schemes, old age pensions and mainstream programmes together. Therefore, this section will focus mainly on tax-financed disability-specific and old age pensions, for which there is more information.

Over 80 per cent of high-income countries invest at least 1 per cent of GDP in disability-specific benefits for persons of working age, with the highest investment in Denmark, at 2.2 per cent of GDP (although this is a combination of tax-financed and social insurance schemes).[30] In contrast, levels of investment in low- and middle-income countries are much lower. Figure 5-1 shows the 17 low- and middle-income countries with the highest levels of investment (out of a total of 33 low and middle-income countries known to have tax-financed disability specific benefits). Only six countries – Brazil, Georgia, Kyrgyz Republic, Mauritius, Namibia and South Africa – invest more than 0.3 per cent of GDP.[31]

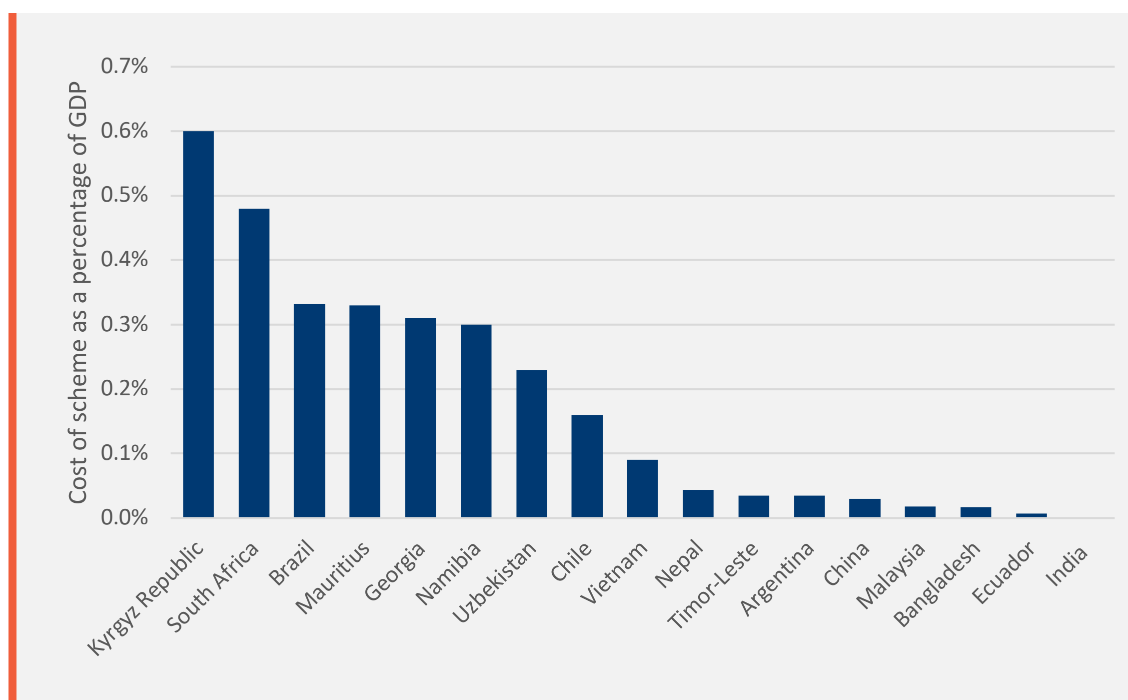
[29] Note: It could be possible to pay too high a transfer value if, for example, it discourages those who are able to work from working.

[30] Information taken from OECD Social Expenditure Database at http://stats.oecd.org/. It relates to 2013.

[31] Wapling and Schjoedt (2019a). Note: In Brazil, if social insurance pensions are included, alongside the main tax-financed disability benefit – the Benefício de Prestação Continuada – the level of investment would be above 1.5 per cent of GDP.

However, in a few countries, when social insurance disability benefits are included, the level of investment is higher: for example, in Brazil, a total of 1.5 per cent of GDP is invested in disability benefits for both children and working age adults while in Uzbekistan, it is 1.4 per cent of GDP. Nonetheless, in most developing countries with disability-specific benefits, the level of investment is negligible.

Figure 5-1: Level of investment in tax-financed disability-specific benefits for working age adults in the highest investing low- and middle-income countries



Source: Abu Alghaib (2015); Bank of Namibia (2013); Kidd (2014a); Kidd and Abu-el-Haj (2014); Kidd and Damerau (2016); Kidd et al (2019a); Kidd et al (2018); Wapling and Schjoedt (2019a); Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019c); ILO and Development Pathways (2016); Banks et al (2018a); Banks et al (2018b); Development Pathways' Disability Database, at https://www.developmentpathways.co.uk/. *Note*: This graph does not include details on countries that invest less than India on disability-specific benefits, as a proportion of GDP.

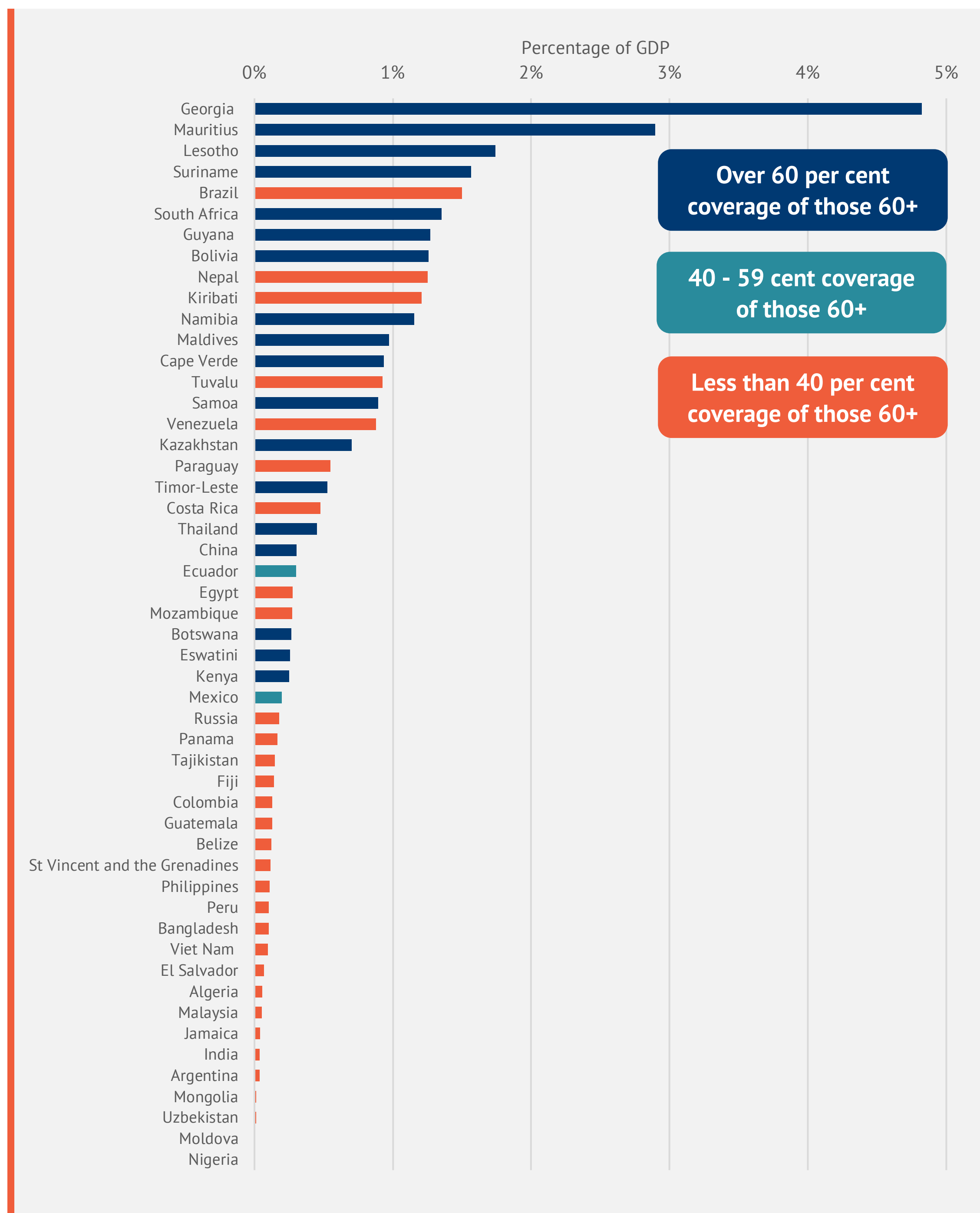
There is minimal information available on the level of investment in child disability benefits in developing countries. The only schemes with meaningful levels of investment identified by the research are South Africa's Care Dependency Grant, which costs 0.07 per cent of GDP, and Uzbekistan's child disability benefit, which requires 0.22 per cent of GDP. While Mauritius has recently established a child disability benefit, its expenditure is not known.[32]

[32] Kidd et al (2018); Wapling and Schjoedt (2019c); Kidd et al (2019a)

It is a different picture with old age pensions. Across developing countries, old age pensions comprise the largest social protection schemes in terms of investment and coverage.[33] Figure 5-2 indicates the level of investment in tax-financed social pensions across 51 low- and middle-income countries – which are all those known to have national social pensions – differentiating between the level of coverage of schemes among those aged 60 years and above. 19 countries invest more than 0.5 per cent of GDP in tax-financed old age pensions, with the highest level of investment at 4.8 per cent of GDP in Georgia. Since, as noted earlier, 46 per cent of people aged 60 years and over worldwide have a moderate or severe functional limitation – and the proportion is higher as age increases – the majority of this investment is likely to reach persons with disabilities.[34] Some developing countries with large-scale social insurance schemes invest much more in old age pensions. For example, in Brazil, the total investment in old age pensions – both social insurance and tax-financed (but not including the civil service pension) – is 4.5 per cent of GDP. In Mongolia, it is 5.1 per cent of GDP and in Uzbekistan, it is 7 per cent of GDP.[35]

[33] For example, in Georgia, around half of all households include a pensioner while only around 15 per cent of households are on the country's Targeted Social Assistance scheme (World Bank 2009; Kidd and Gelders 2016).
[34] World Health Organisation (2012).
[35] Wapling and Schjoedt (2019a); Kidd and Abu-el-Haj (2014); and Pension Watch Database at http://www.pension-watch.net; ILO SECSOC at http://www.ilo.org/dyn/ilossi/ssimain.home; Kidd and Damerau (2016); Development Pathways Disability Benefit Database.

Figure 5-2: Level of investment in tax-financed social pensions across a range of low- and middle-income countries, differentiated by coverage



Source: HelpAge International's Pension Watch Social Pensions Database; Kidd et al (2018); Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019c); Kidd (2014a); Kidd and Khondker (2015); Kidd and Huda (2013); Kidd, Abu-el-Haj et al (2016); Kidd, Greenslade et al (forthcoming); Kidd et al (2018); Lesotho NSPS 2014/15 – 2018/19; SASSA (2016/2017); CEPAL: Non-contributory social protection programmes in Latin America and the Caribbean database, at https://dds.cepal.org/bpsnc/index-en.php. *Note*: the graph includes all countries known to have national social pensions according to data from Pension Watch, at http://www.pension-watch.net/social-pensions-database/social-pensions-database--/. It does not include social pensions that are restricted to specific areas of countries, such as Uganda's Senior Citizens' Grant, Zanzibar's pension and the pension in New Ireland (Papua New Guinea).

It is not possible to determine the level of investment in persons with disabilities within mainstream schemes because there is little data on persons with disabilities in recipient households. However, it is likely to be minimal given that levels of investment in most mainstream schemes – in particular poverty targeted household transfers – are low. None of Latin America's household-based social assistance schemes have budgets above 0.4 per cent of GDP.[36] However, there are schemes with higher expenditures in other regions. For example, investment in Georgia's Targeted Social Assistance scheme is 0.9 per cent of GDP, although, in the country context, this is small given that it is less than a quarter of the investment in Georgia's universal old age pension. Ethiopia's Productive Safety Net Programme (PSNP) is just over 1 per cent of GDP, although it is almost entirely funded by donors, and Palestine's Cash Transfer Programme is 1.6 per cent of GDP, with around half funded by donors.[37] Further, given that people with disabilities are a minority of the population, the majority of spending in mainstream schemes supports those without disabilities.[38]

Expenditures are relatively high in some child benefit schemes – such as Mongolia's universal Child Money scheme (1.4 per cent of GDP) and South Africa's Child Support Grant (1.3 per cent of GDP) – but few inclusive child benefit schemes exist in developing countries.[39] Again, the total value of the transfers reaching children with disabilities is not known, although it will be small since children with disabilities are 5.1 per cent of the total population of children worldwide.[40]

Therefore, the evidence suggests that when countries implement disability-specific schemes and old age pensions, they invest more in persons with disabilities than when implementing mainstream schemes.

[36] Kidd and Damerau (2016).
[37] World Bank (2017).
[38] Kidd (2017); Kaur et al (2016).
[39] Note: Mongolia's Child Money scheme was universal up to January 2018 when it was targeted at 60 per cent of children, under pressure from international donors (see Kidd 2018). However, due to concerns from the government, the coverage was subsequently increased to 80 per cent.
[40] WHO and World Bank (2011).

5.2 Coverage of persons with disabilities by social protection

In most developing countries, coverage of both persons with and without disabilities by social protection is low. Moreover, there is little evidence on the extent to which persons with disabilities access social protection systems and schemes. This section examines the available evidence on coverage across national social protection systems, disability-specific schemes, old age pensions and mainstream schemes. Each section also considers the extent to which coverage varies according to type and severity of impairment.

5.2.1 Coverage of persons with disabilities by national social protection systems

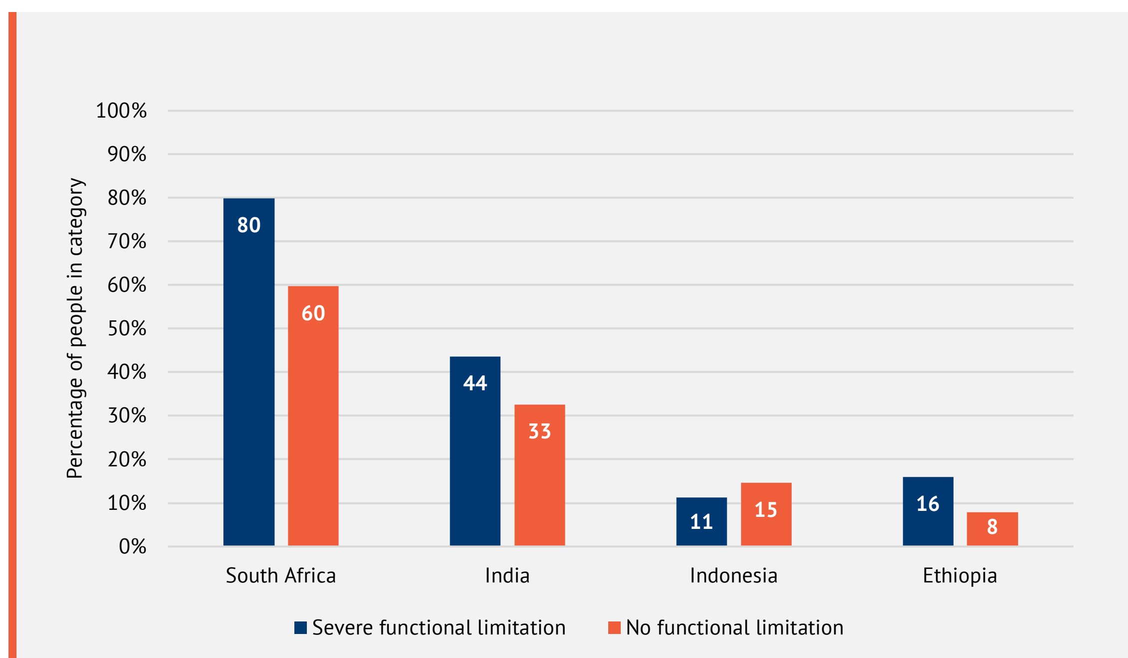
Figure 5-3 examines the proportion of persons across the national population living in households with access to tax-financed social protection benefits in four low and middle-income countries (Ethiopia, India, Indonesia and South Africa). It compares coverage of those without a disability and those with severe functional limitations.[41] South Africa has significantly higher overall investment in social protection than the other countries, alongside relatively high coverage. South Africa and India both have disability-specific and old age pension schemes alongside mainstream schemes (such as an affluence-tested child benefit in South Africa[42] and a self-targeted public works programme in India). Meanwhile, Indonesia and Ethiopia rely mainly on poverty targeted mainstream household transfer schemes: In Indonesia, the main schemes are a conditional cash transfer and a school stipend and, in Ethiopia, they are a public works programme and a transfer (a direct support programme) for households living in poverty with minimal labour capacity. Countries with universal schemes are not included in this example, due to an absence of appropriate datasets.[43]

[41] The information is based on analysis of national household survey datasets undertaken as part of this study

[42] Note: Affluence-testing refers to a mechanism designed to exclude the better-off rather than identify the poorest members of society.

[43] Note: In other words, the research could not find datasets with both reliable questions on functional limitations and information on universal schemes.

Figure 5-3: Coverage of persons with severe and no functional limitations living in households participating in tax-financed social protection schemes



Source: Analysis by Development Pathways of the following household survey datasets: South Africa GHS 2015; India IHDS-II (IHDS-II) 2011/2012; Indonesia IFLS5 2014/2015; and, Ethiopia ESS 2013/2014.

Social protection schemes in South Africa and India cover a higher proportion of the population of persons with severe functional limitations than in Indonesia and Ethiopia. Furthermore, due to South Africa and India's disability-specific schemes and old age pensions, as well as Ethiopia's 'targeted mainstream' Direct Support benefit, persons with severe functional limitations are more likely to be reached in these three countries than in Indonesia. For example, in South Africa, 38 per cent of persons with severe functional limitations live in households accessing the Old Age Grant and 18 per cent access the Disability Grant. Indonesia, in contrast, does not have a national disability-specific or disability-relevant programme. Therefore, the coverage of persons with severe functional limitations across its social protection system – either as direct or indirect recipients – is lower than that of persons without a disability.[44] Nonetheless, in each country studied, there remain significant gaps in the coverage of persons with severe functional limitations by tax-financed schemes.

Furthermore, when the coverage of persons with disabilities as direct recipients is examined, the coverage is significantly lower: in South Africa, 65 per cent of persons with

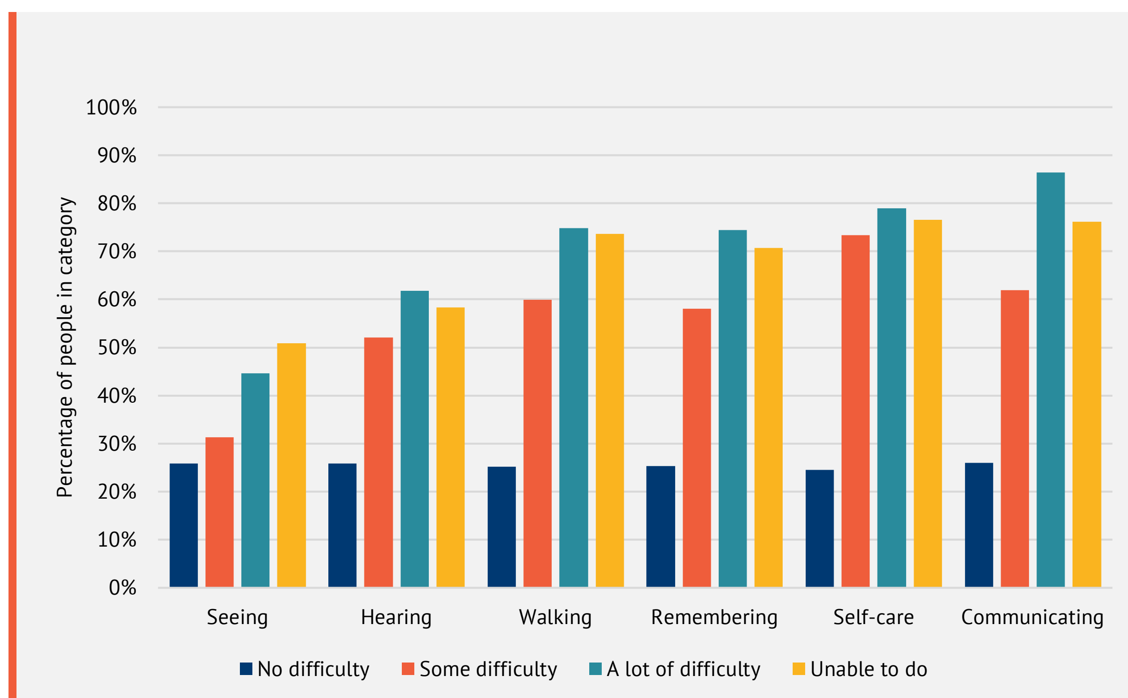
[44] Kidd (2014a).

severe functional limitations are the direct recipients of a social protection transfer – with 34 per cent of these accessing the Old Age Grant and 18 per cent the Disability Grant – while, in India, it is only 23 per cent.[45] The datasets for Indonesia and Ethiopia do not indicate who is the direct recipient of the transfer.

In South Africa, there is some evidence that the type and severity of the functional limitation influences access to national social protection systems.[46] As Figure 5-4 indicates, access to tax-financed schemes is lower for those with seeing and hearing difficulties, compared to those with difficulties walking, remembering, undertaking self-care and communicating. However, across all categories, apart from seeing, there is slightly less coverage among those with the most profound functional limitations ('unable to do') when compared to those with less severe limitations (classified as 'a lot of difficulty'). In India, there is more of a balance across types of functional limitation, although, again, among certain categories – mainly linked to self-care – those with the most profound functional limitations ('unable to do') are less likely to receive a benefit than those with 'a lot of difficulty.'[47] The reasons are unknown but may well be the result of barriers created during implementation, which are explored further in Section 6, and the challenges that some people with more severe disabilities face in registering for schemes due to their impairments.

[45] Kidd et al (2018); Wapling and Schjoedt (2019b).
[46] Kidd et al (2018).
[47] For further information, see Wapling and Schjoedt (2019b).

Figure 5-4: Percentage of people within each domain of functioning that are in receipt of a social protection benefit in South Africa, by level of severity



Source: Analysis by Development Pathways of South Africa GHS 2015.

In low- and middle-income countries, members of social insurance schemes are a minority of the workforce due to the limited size of their formal economies. For example, in Pakistan, only three per cent of those aged 15-64 years are members of a social insurance scheme. In Indonesia, the proportion is 6.4 per cent, while it reaches 28 per cent in Malaysia.[48] Therefore, the effectiveness of social insurance schemes in offering benefits to a large proportion of persons with disabilities of working age is currently limited. Nonetheless, there are exceptions: for example, the coverage in Brazil of the *Previdencia Social* scheme is 67 per cent of the population aged between 16 and 59 years employed in the private sector.[49] As a result, a relatively high proportion of persons with disabilities of working age are likely to be able to access social insurance benefits, although there is no data on the exact numbers.

[48] World Bank Pensions Database in OECD (2013).
[49] National Household Sample Survey (*Pesquisa Nacional por Amostra de Domicílios* - PNAD) of 2009, at http://www.social-protection.org/gimi/gess/ShowTheme.action?id=1789.

5.2.2 Coverage of persons with disabilities by disability-specific schemes

The existence of disability-specific benefits does not guarantee that all persons with disabilities can access social protection (and, indeed, some persons with disabilities do not require social protection, although they may need it in the future). In Europe, 28 per cent of working age persons with disabilities receive a disability benefit, although the low proportion probably reflects the inclusion of many persons with mild functional limitations within the disability prevalence rates and the fact that not all persons with disabilities require disability benefits.[50] In low- and middle-countries, coverage varies significantly. In India, 11 per cent of persons with a severe functional limitation aged 18-59 years receive the national Disability Pension while 36 per cent of persons with a severe functional limitation receive South Africa's Disability Grant, although this rises to 57 per cent among those characterised as 'unable to do'.[51] Furthermore, Saloojee et al (2007) found that only 55 per cent of eligible families received South Africa's Care Dependency Grant for children with disabilities.

Although Mauritius, Nepal and Uzbekistan offer universal disability benefits, not all people with severe disabilities access the schemes. The research estimated that 73 per cent of persons with severe disabilities access the Mauritius Basic Invalid Pension. Furthermore, in one district of Nepal, a survey found that only 50 per cent of eligible persons with disabilities were in receipt of the Disability Allowance[52] and, in Uzbekistan, only 52 per cent of children with severe disabilities access its universal child disability benefit.[53] Therefore, not even universal benefits guarantee access if there are other barriers to overcome.

Given that countries use very different measures of disability prevalence – with varying degrees of accuracy – a comparison of relative coverage can be made by examining coverage across the working age population.[54] Figure 5-5 shows how, across 14 low- and middle-income countries with the highest levels of investment in disability benefits, coverage varies. Overall, while three countries have coverage above 3 per cent, in 11 countries the coverage is less than 2 per cent and as little as 0.4 per cent for Nepal's universal Disability Allowance. Coverage in countries with lower levels of investment in disability benefits is minimal.

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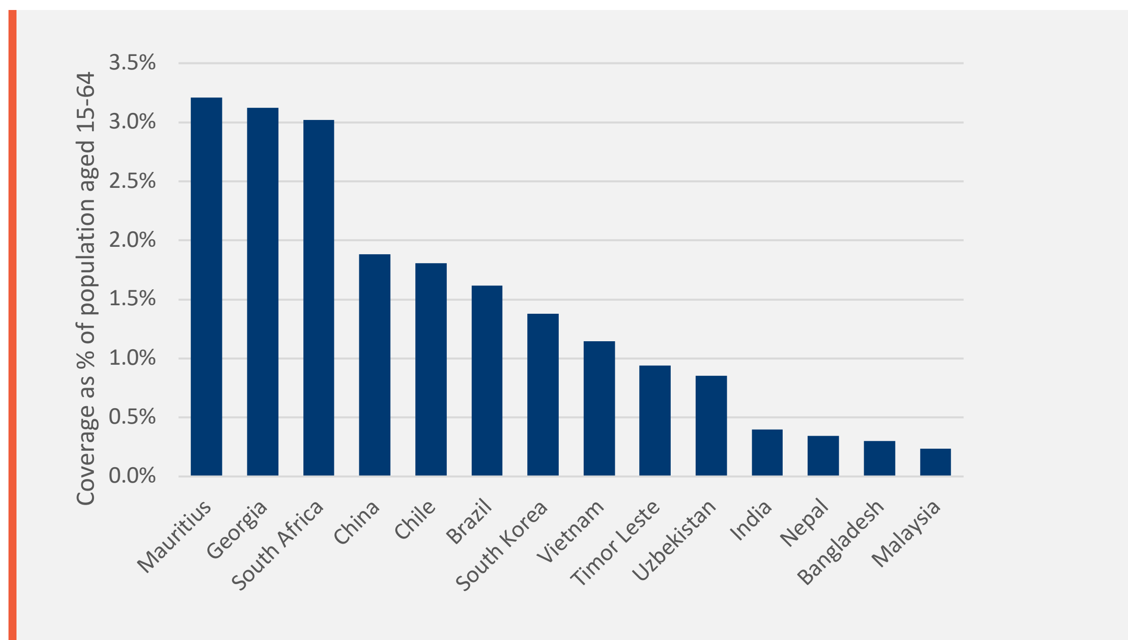
[50] ILO (2014).
[51] Wapling and Schjoedt (2019b); Kidd et al (2018). Note: Mitra (2010) found that around 42 per cent of eligible individuals were not enrolled in South Africa's Disability Grant.
[52] Wapling and Schjoedt (2019c); Banks et al (2018b)
[53] Kidd et al (2019a).
[54] Note: The comparison is made across those of working age because most recipients of the disability benefits are of working age. However, in some schemes, a small number of children and older persons may be included.

Figure 5-5: Coverage of tax-financed disability benefits for those of working age in low- and middle-income countries (recipients as percentage of population aged 15-64 years)



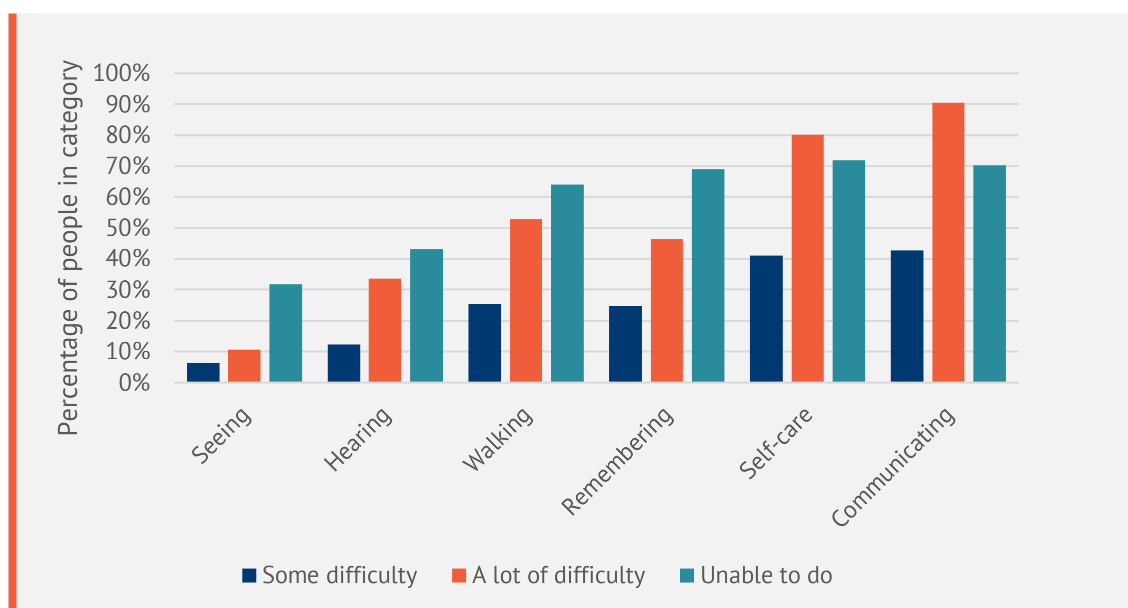
Source: Wapling and Schjoedt (2019a), Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019c); Kidd et al (2018); Development Pathways Disability Database at http://www.developmentpathways.co.uk; Kidd (2013); Kidd (2014b); Kidd and Damerau (2016); Kidd, Abu-el-Haj et al. (2016); World Bank (2013b); Zhang (2012). *Note*: The data available is only for tax-financed schemes and does not include coverage from social insurance programmes (although, in most countries, the numbers receiving social insurance disability benefits are likely to be low).

As observed in Section 5.1 for social protection systems as a whole, access to disability benefits can vary according to the type and severity of functional limitation. Figure 5-6 shows that, in South Africa, those with seeing and hearing difficulties are less likely to receive the Disability Grant compared to those with other functional limitations, a result also noted by Coulson et al (2006).[55] Furthermore, among those with self-care and communication limitations, those with the most profound limitations ('unable to do') are more likely to be excluded from the grant than those with 'a lot of difficulty.' In India, those with seeing and walking difficulties are less likely to receive the Disability Pension, although, across all functional domains, those with the most profound disabilities have a higher rate of access.[56] In Brazil, the least represented group on the Benefício de Prestação Continuada (BPC) programme were those with visual impairments, with the highest prevalence among those with intellectual impairments.[57] In some countries, specific types of disability are not recognised as eligible. These include autism and other

[55] Note: In contrast, Jelsma et al. (2008) did not find differences in coverage linked to type of impairment.
[56] For more information, see Wapling and Schjoedt (2019b).
[57] Subbarao (1996) and Medeiros et al (2006).

spectrum disorders, haemophilia and thalassaemia in India, microcephaly in Brazil, and Downs Syndrome in Indonesia.[58]

Figure 5-6: Percentage of people aged 18-59 years within each domain of functioning that receive a Disability Grant in South Africa, by level of severity



Source: Analysis by Development Pathways of South Africa GHS 2015.

5.2.3 Coverage of persons with disabilities by old age pension schemes

Worldwide, only 52 per cent of older people have access to a pension, and coverage varies significantly by country and region. So, while coverage is 92 per cent in Northern, Southern and Western Europe, in Latin America and the Caribbean, coverage is 56 per cent and only 47 per cent across Asia and the Pacific. Elsewhere, regional coverage is even lower and fewer than one in five older people in sub-Saharan Africa receive a pension (although coverage is high across much of Southern Africa).

There is limited evidence available on the coverage of older persons with disabilities by old age pensions. Nonetheless, the low coverage of pensions in many countries implies high levels of exclusion of older persons with disabilities. The old age pensions that provide the greatest coverage of older persons with disabilities are universal schemes. Georgia's universal social pension reaches 98 per cent of those of eligible age (women can receive the pension at age 60 years and men at age 65 years), while Bolivia's

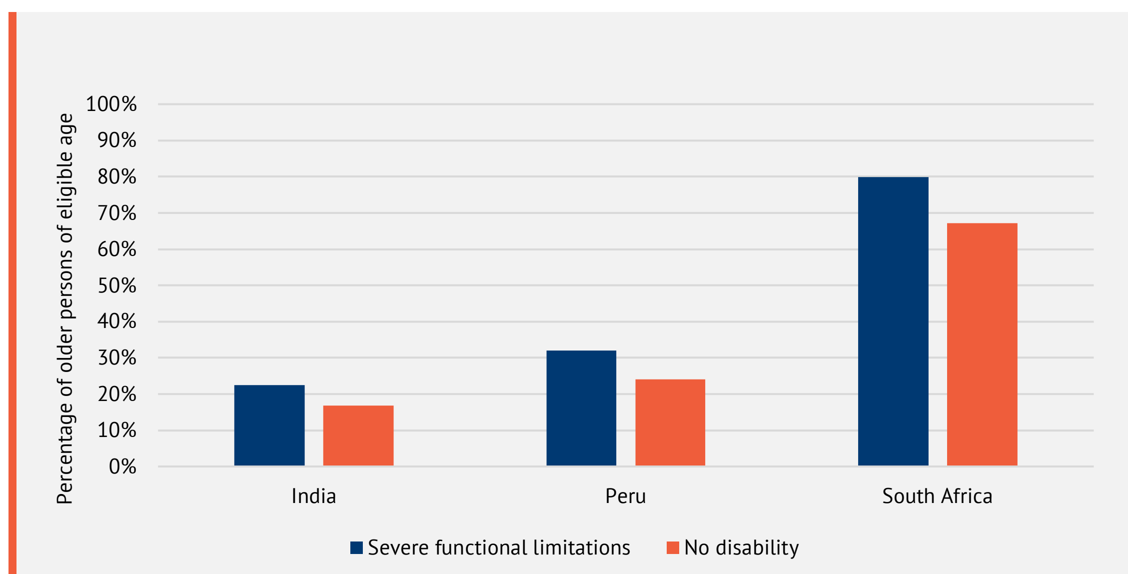
[58] Whitworth et al (2006); Kidd (2014c); and Wapling and Schjoedt (2019a).

universal pension reaches 88 per cent of eligible older persons. This implies that there is high coverage of older persons with disabilities.[59] Persons with severe functional limitations who receive Zanzibar's universal pension – which is offered to people aged 70 years and above – comprise a significant proportion of all pension recipients: 42 per cent of all male recipients and 57 per cent of all female recipients have a severe functional limitation.[60]

However, when social pensions are targeted at those living in the greatest poverty, the coverage of older persons with severe functional limitations is much lower: in Peru, coverage is only 32 per cent of people aged 65 years and above, and in India, it is 22 per cent of those aged 60 years and above.[61] South Africa is an example of a country that uses a means test to exclude those regarded as affluent from the old age pension: coverage of those with severe functional limitations aged 60 years and above is 80 per cent. However, as Figure 5-7 indicates, the coverage of older persons with severe functional limitations across India, Peru and South Africa is higher than the coverage of persons without disabilities. This may be due to the means test since older people without disabilities are likely to have higher incomes than people with disabilities. In the Philippines, 67 per cent of recipients of the means-tested social pension – which is for those aged 77 years and above – were found to have a severe functional limitation, compared to 54 per cent of non-recipients of a similar age.[62]

[59] Analysis undertaken of datasets in Georgia and Bolivia. There is no information on persons with disabilities in the datasets but the high coverage of all older persons implies also high coverage of persons with disabilities.
[60] Galvani and Knox-Vydmanov (2017).
[61] Wapling and Schjoedt (2019b); Bernabe-Ortiz et al (2015).
[62] Knox-Vydmanov et al (2016).

Figure 5-7: Coverage of older persons of eligible age with severe functional limitations and no disabilities by means-tested social pensions in India, Peru and South Africa

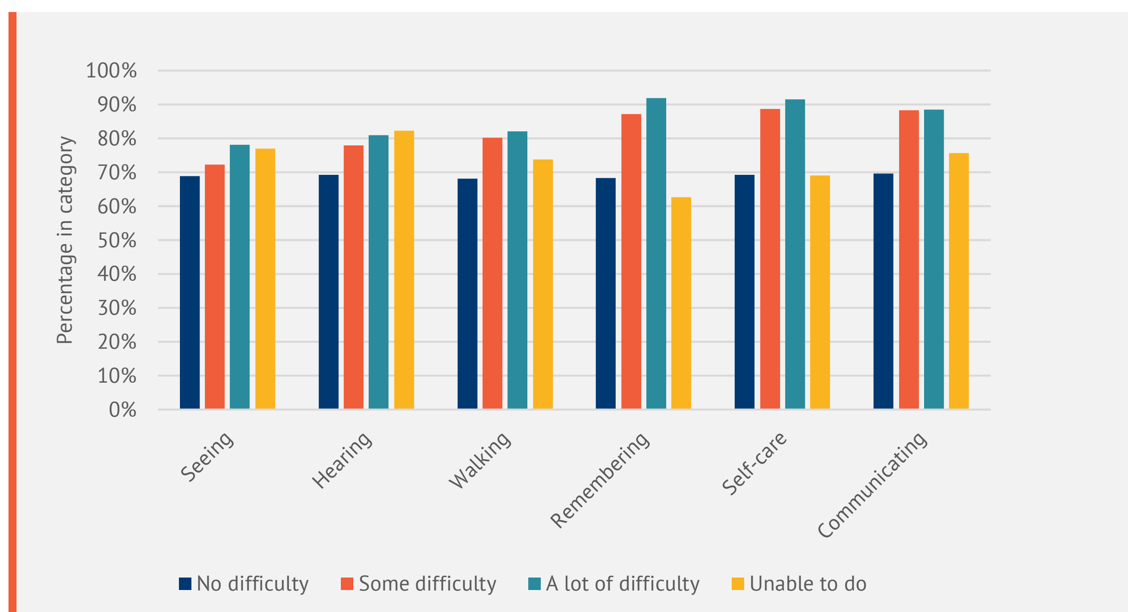


Source: Kidd et al (2018); Wapling and Schjoedt (2019b); Bernabe-Ortiz et al (2015). *Note*: In Peru, the data does not indicate the coverage at national level, but only within the area studied by Bernabe-Ortiz et al (2015).

As with other benefits, the coverage of means-tested old age pensions varies by type and severity of impairment.[63] Figure 5-8 shows the coverage of the Old Age Grant in South Africa: it indicates that coverage is higher among those with remembering, self-care and communication challenges. However, among those with the most profound functional limitations – in other words, 'unable to do' – coverage is lower than among those with less severe limitations, except among those with hearing difficulties. In India's Old Age Pension, the differences are not so great, although the data indicates that those with greater functional limitations related to walking and being able to use the toilet independently are slightly less likely to receive the pension when compared to those with less severe limitations.[64]

[63] Note: Due to an absence of appropriate datasets with questions on disability, it is not possible to test this for universal schemes.
[64] Wapling and Schjoedt (2019b).

Figure 5-8: Percentage of people aged 60 years and above within each domain of functioning that are receiving an Old Age Grant in South Africa by level of severity of impairment



Source: Analysis by Development Pathways of South Africa GHS 2015.

5.2.4 Coverage of persons with disabilities by mainstream schemes

The coverage of mainstream benefits in developing countries varies greatly. The largest poverty-targeted household benefits – such as in Brazil, Colombia, Mexico, Georgia, Pakistan and the Philippines – reach around 15 to 20 per cent of all households, while Sri Lanka's Samurdhi programme reaches 30 per cent of households.[65] Mainstream categorical and lifecycle schemes – such as survivors' or child benefits – have varying coverage levels, depending on the extent to which they are targeted at those living in poverty or other sub-categories of the population. Mongolia's universal Child Money scheme, for example – which used to offer a benefit to all children aged 0-17 years – reached 99 per cent of all children in 2016, while South Africa's means-tested Child Support Grant reaches 63 per cent.[66] In contrast, Nepal's Child Protection Grant for *Dalit* children aged 0-4 years living in extreme poverty reaches 13 per cent of children in the 0-4 years age group (and 4.9 per cent of all children aged 0-17 years).[67]

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[65] Kidd (2017); Kidd and Damerau (2016).
[66] Kidd and Damerau (2016); Kidd et al (2018); Bista et al (2018); Analysis by Development Pathways of Mongolia's 2016 Household Socioeconomic Survey.
[67] Kidd and Damerau (2016); Okubo (2014).

The evidence on the coverage of persons with disabilities by mainstream schemes is limited, since the subject has rarely been investigated by researchers and the programmes themselves infrequently disaggregate data by disability. Within mainstream lifecycle benefits – such as child benefits – coverage of persons with disabilities is highest when the schemes are universal and successfully reach the majority of the age category (as in Mongolia's Child Money programme, before it was targeted). In South Africa's Child Support Grant – which is means-tested but offers high coverage – 67 per cent of children aged 5-17 years with a severe functional limitation access the grant compared to 63 per cent of children without a disability.[68] However, among those aged 12-17 years, the proportion is lower: only 32 per cent of children with a severe functional limitation receive the benefit compared to 58 per cent of those without a disability.[69] There is no information on the reasons for this disparity.

The national coverage of persons with disabilities by poverty-targeted household-based schemes is always limited, due to the fact that only a proportion of households nationally are selected. Bernabe-Ortiz et al (2015) note that only one per cent of persons with disabilities nationally are included in Peru's Juntos conditional cash transfer programme although, in one geographic area, they found that 86 per cent of families with children with disabilities were on the programme compared to 56 per cent of families with children without disabilities. However, in Indonesia, the coverage of households with at least one member aged 15 and over with a severe functional limitation in the *Program Keluarga Harapan* (PKH) conditional cash transfer programme is only 2.2 per cent. This is lower than the coverage of households without persons with disabilities (2.5 per cent), although it is within the margin of error.[70]

When poverty-targeted social assistance schemes include 'labour incapacity' or 'inability to work' as a criterion – in other words, when they are targeted mainstream schemes – they may be more likely to include persons with disabilities. This is the case for the Direct Support component of Ethiopia's Productive Safety Net Programme (PSNP), where 8.8 per cent of persons with a severe functional limitation live in beneficiary households compared to 2.1 per cent of persons without a disability.[71] Similarly, in Rwanda, 5 per cent

[68] Kidd et al (2018). This result needs to be treated with caution since the identification of children with severe functional limitations is challenging and, in South Africa, many carers are likely to have conflated slower development of young children with a functional limitation. Information on functional limitations is only available for children aged 5 years and above.
[69] In South Africa, children in receipt of the Care Dependency Grant are unable to receive the Child Support Grant. However, according to the analysis of the General Household Survey of 2015, this does not explain the low access among children aged 12-17 years with a severe functional limitation.
[70] Analysis by Development Pathways of Indonesia IFLS 2014/2015 dataset.
[71] Analysis by Development Pathways of Ethiopia ESS 2013/2014 dataset.

of households with a member with a 'severe disability' were in receipt of VUP Direct Support, compared to 0.8 per cent of households without a disabled member.[72]

There is limited information on the coverage of persons with disabilities by public work schemes but, due to the overall low coverage of the schemes, few persons with disabilities within the broader national population are able to participate. Research for this study found that in Ethiopia's PSNP, 5 per cent of all persons aged 15 years and above nationally who had a severe functional limitation had worked on the public works component of the programme in the previous 12 months, compared with 2.9 per cent of persons aged 15 years and above without a disability. However, this result is distorted by one region – the Southern Nations, Nationalities, and People's Region – where coverage of persons aged 15 years and above with a severe functional limitation is 21 per cent.[73] In four of the other six regions, coverage of persons aged 15 years and above with a severe functional limitation is 2 per cent or less[74] while, for those without a disability, coverage ranges between 2 per cent in the region of Harari to 34 per cent in Afar. In four regions, the coverage is greater than 6 per cent. In Rwanda, only 4 per cent of households with a member who has a severe disability accessed the VUP public works scheme in 2014, although overall coverage was low since only 3 per cent of households without a disabled member accessed the scheme.[75] And in India, 29 per cent of households in rural areas without a member with a disability participate in the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) scheme while, for households with a member who has a severe functional limitation, coverage is 28 per cent.

However, these numbers do not indicate the extent to which persons with disabilities participate as workers since information is limited to the household. Nonetheless, available information for India's MGNREGA shows that only 8 per cent of persons with a severe functional limitation living in rural areas are employed in the programme, compared with 12.5 per cent of persons without a disability.[76]

Analysis from South Africa indicates that the level of access to mainstream benefits can vary according to the type and severity of functional limitation. Figure 5-9 indicates the differential levels of access for children across South Africa's Child Support Grant. Of particular significance is the very low coverage among those children with the most

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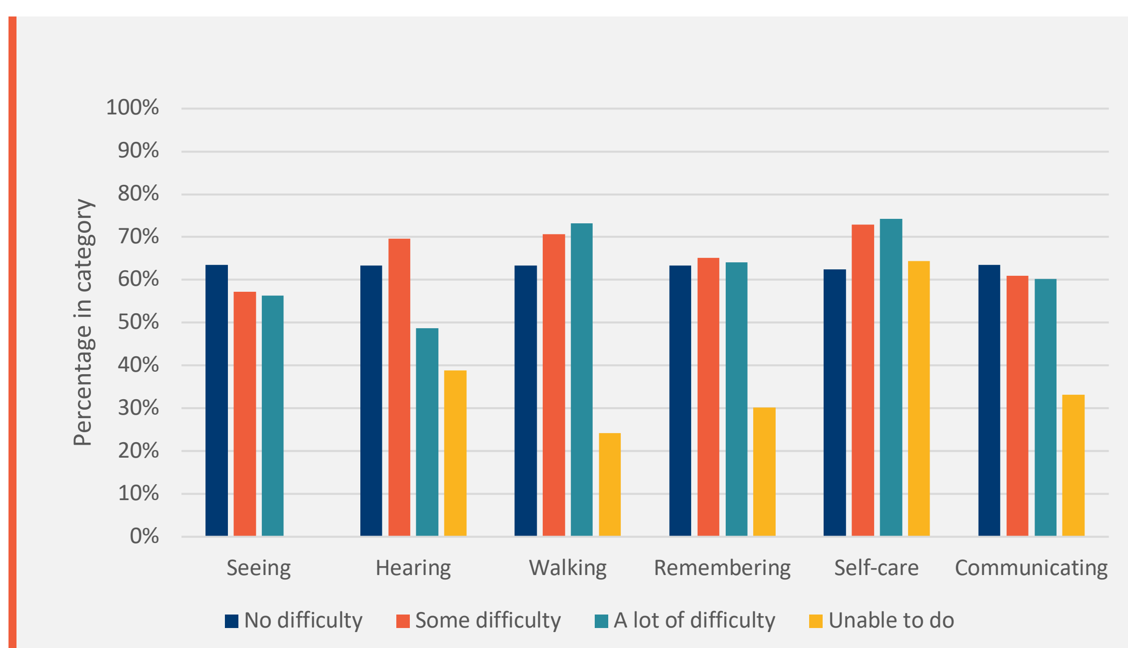
[72] Analysis by Development Pathways of Rwanda EICV 4 dataset. Note: The question in the household survey refers to whether persons have a 'major disability.'
[73] Analysis by Development Pathways of Ethiopia ESS 2013/2014 dataset.
[74] In one region – Diredwa – the point estimate coverage is 8 per cent of all persons over 15 years with a severe functional limitation – and in the other region, the number of cases was too small to determine coverage.
[75] Analysis by Development Pathways of Rwanda EICV 4 dataset.
[76] Wapling and Schjoedt (2019b).

profound functional limitations ('unable to do'). In part, this is due to some receiving the Care Dependency Grant – since children cannot access both benefit – but 37 per cent of children with the most profound functional limitations do not receive either scheme.[77] When coverage of carers of children is examined, there are also variations linked to the type of functional limitation: exclusion from the Child Support Grant is higher for carers with walking difficulties.[78]

Figure 5-9: South Africa - Percentage of children aged 5-17 years within each domain of functioning that are receiving a Child Support Grant by level of severity

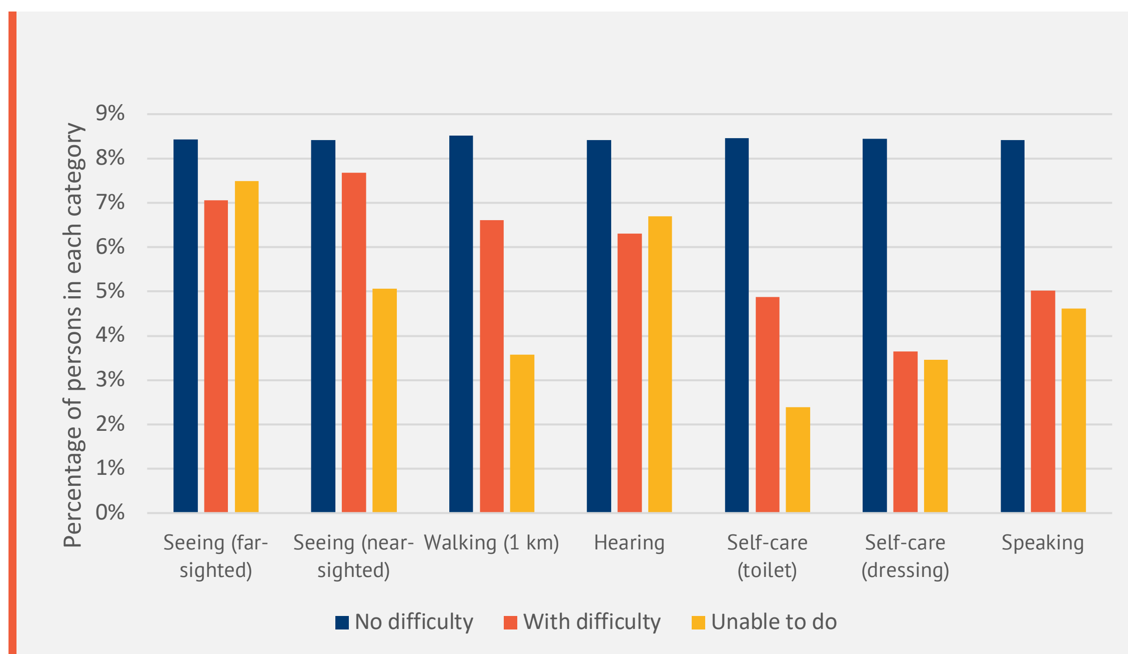


Source: Analysis by Development Pathways of South Africa GHS 2015. *Note*: Caution needs to be taken with these results since, apart from the functional domain 'self-care,' there are less than 50 observations for the category 'unable to do.' For the functional domain 'seeing', there were insufficient observations in the category 'unable to do' to be able to undertake meaningful analysis.

The only evidence available on the levels of access to public works by type and severity of functional limitation is from India's MGNREGA scheme. Figure 5-10 indicates that among persons 'unable to do,' the highest inclusion of workers is among those with seeing (far sighted) and hearing impairments. Among those with seeing, self-care, walking and speaking functional limitations, access to the scheme is lower.

[77] Kidd et al (2018).
[78] UNICEF and SASSA (2013).

Figure 5-10: Employment in India's MGNREGA programme, by type of functional limitation and degree of severity



Source: Analysis by Development Pathways of the India IHDS-II 2011/2012 dataset.

5.3 Value of transfers for persons with disabilities

There is no right answer to the question of the appropriate value of social protection transfers.[79] Ideally, the values should be high enough to achieve the aim of the programme but, in the case of those able to engage in the labour market, not too high to create employment disincentives. In practice, governments often have to find a balance between the coverage of a scheme and the value of the transfer. So, for example, higher coverage can come at the price of lower transfer values, and vice versa. On the other hand, government budgets are never fixed and higher coverage can build political alliances across economic classes that can generate higher transfer values.[80]

Transfer values vary greatly across social protection schemes for a range of other reasons, including their purpose and their popularity (which can translate into greater political commitment). This section will look briefly at the evidence on different types of schemes.

[79] The value of contributory transfers for persons who qualify for an invalidity benefits is not discussed here. These are often set by a formula taking into account salary levels and years of service. Convention 102 of the ILO outlines internationally agreed minimum levels.

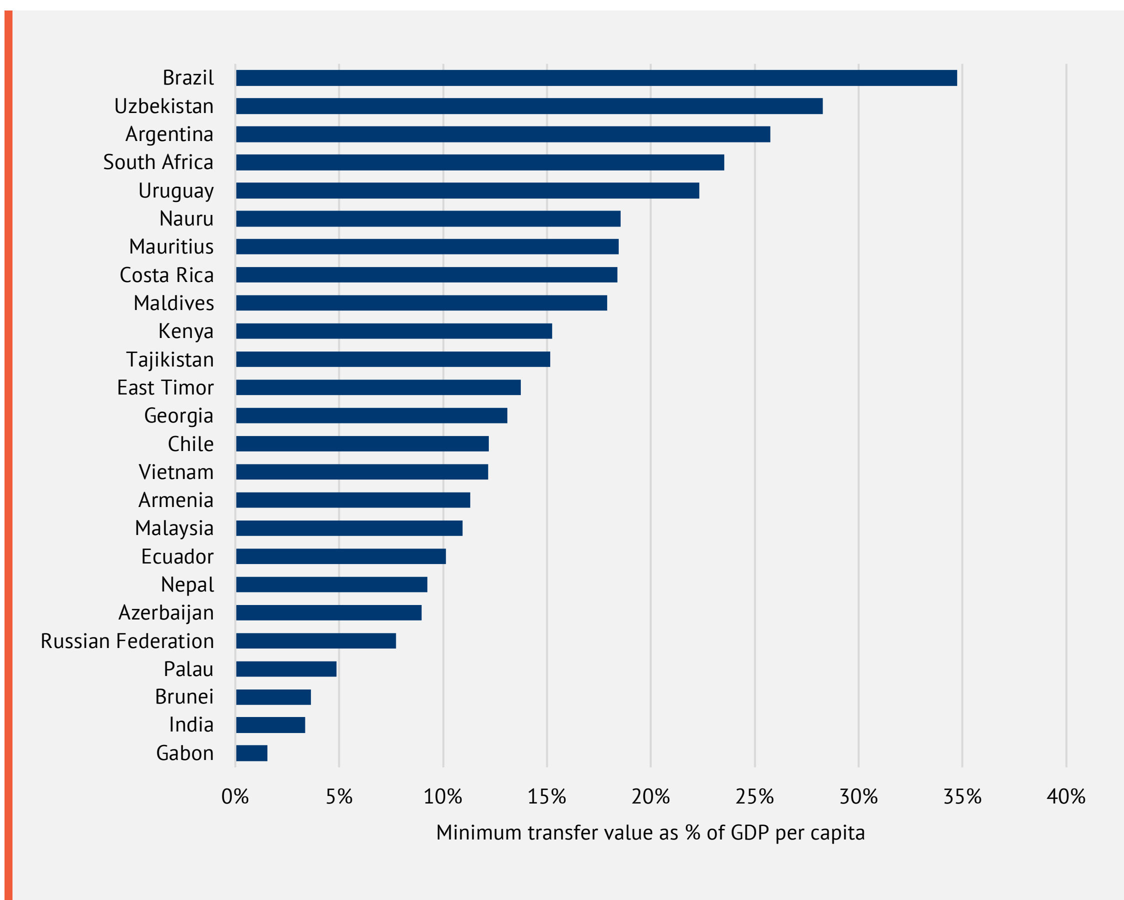
[80] For further discussions, see: World Bank (1990); Sen (1995); Mkandawire (2005); Pritchett (2005); Kidd (2015a).

5.3.1 Transfer values in disability-specific schemes

As indicated in Section 4.2, disability-specific schemes can have different objectives which should translate into different transfer values. Child disability benefits are meant to compensate for disability related costs although, in some cases, they are probably intended to offer income support to carers. One of the highest value transfers is South Africa’s Care Dependency Grant. This was set at Rand 1,510 (US$106) per month which, in 2016, was 23.4 per cent of GDP per capita, the same value as the adult Disability and Old Age Grants. However, while the value appears to be relatively generous, during the South Africa Case Study research a number of respondents stated that it was insufficient to cover the disability related costs of many children with more severe impairments.

Disability income replacement schemes should, as far as possible, offer people an adequate standard of living, since they assume that recipients are not in employment. They are often set at the value of the national social or minimum old age pension, since they have similar aims. Some countries – such as South Africa – automatically transfer disability pension recipients onto the old age pension once they reach the age of eligibility. Figure 5-11 shows the value of disability transfers as a percentage of GDP per capita across 26 low- and middle-income countries for which information could be found. Most – if not all – of these schemes aim to provide income replacement. They range from nearly 35 per cent of GDP per capita in Brazil to 1.6 per cent in Gabon.

Figure 5-11: Minimum values of disability benefits for persons of working age as a percentage of GDP per capita, across low- and middle-income countries with a tax-financed disability benefit



Source: Development Pathways Disability Benefit Database (2018), at http://www.developmentpathways.co.uk. *Note*: some countries have additional schemes in place for carers of persons with disabilities, students with disabilities, or retired soldiers with a disability which have not been included in this graph.

However, even in countries with higher value transfers, the absence of a Personal Independence Payment means that the amount given as income replacement may not be sufficient. For example, Goldblatt (2009) argues that, while South Africa's Disability Grant is high enough in value to enable people to meet their basic subsistence needs, it does not cover the additional costs faced by persons with disabilities. Recent analysis of the South Africa Disability Grant data shows that approximately 25 per cent of recipient households experienced hunger in the preceding year, compared to 16 per cent among the general population. Further, a third of households receiving the benefit had experienced running out of money to buy food (compared to a fifth of the general

population).[81] In Vietnam, a number of beneficiaries interviewed during qualitative research conducted on the disability benefit complained that its value was too low to have much impact (see Box 5-1 for views of recipients).[82] In addition, qualitative research in Nepal – in which a purposive sample of 35 recipients of the disability benefit were interviewed – has found that even the relatively high value transfer was perceived by all respondents as insufficient.[83]

Box 5-1: Views of recipients of Vietnam's disability benefit on the value of the transfer

Interviews with beneficiaries of Vietnam's disability benefit have indicated a common sentiment – that the grant is too low to make much of a difference but is better than nothing. One beneficiary stated that, *"the allowance is only enough for breakfast. It is not much, so how can it affect poverty reduction?"* while another said that at least it allowed them to pay electricity bills or support some housing repairs. One 70-year old widow stated: "*I am too old to work and I have to take care of my adult daughter who is disabled. We have no other regular source of income but her monthly social assistance. I have one other son, but he has to take care of his own family and just sends me a little money occasionally. We two therefore rely on this amount to live - there is no other way. We even try to spend as little as possible, because we have to save money for health care and for her care when I die.*"

Source: Watson (2015).

Personal Independence Payments aim to address disability related expenses and should, as far as possible, compensate for actual disability related expenses, which will vary according to the type and severity of the disability. Yet, there are no schemes with this specific objective in low- and middle- income countries. Denmark is an example of a high-income country that tailors the value of the benefit to the specific needs of the individual, which are assessed by a social worker.[84] Others – such as the United Kingdom's Personal Independence Payment – simplify the process by offering three to four bands of transfer values, within which each individual is placed.

As indicated earlier, there are some income replacement schemes for persons of working age in low- and middle-income countries that offer variable transfer values to those classified as having differing levels of severity of disability and, therefore, implicitly – and simply – attempt to address the question of disability related costs. In Nepal's Disability Allowance, those classified as having the most severe impairments receive more than three times the value of transfer as those with less severe impairments, with the highest

[81] Department of Sociology and Social Anthropology (2014).
[82] Watson (2015). Some caution should be exercised in interpreting this result as the research was not a comprehensive quantitative analysis and no measure was made of consumption.
[83] Banks et al (2018a).
[84] Schjoedt (Forthcoming).

benefit at NR 2,000 (US$19) per month or 27 per cent of GDP per capita.[85] In Uzbekistan, in 2013, those classified in 'Category 1' in the 'Allowance for Disabled from Childhood' scheme received double the value of transfer as those in 'Category 2', with the highest transfer at Soum 156,000 (US$74, or 51 per cent of GDP per capita).[86] And, in Vietnam's Disability Allowance, values varied from VND 405,000 (US$18) per month – or 9 per cent of GDP per capita – for those classified as having 'severe disabilities,' to VND 540,000 (US$24) per month – or 12 per cent of GDP per capita - for those with 'extremely severe disabilities.'[87]

Schemes meant to compensate carers/assistants of persons with disabilities for giving up work should, again, be linked to ensuring an adequate standard of living, in line with the number of hours of work forgone. However, as indicated earlier, there are few such schemes in low- and middle-income countries. Vietnam's carers' benefit is valued at VND 270,000 (US$ 12) per month, or 7.5 per cent of GDP per capita,[88] and South Africa's Grant-in-Aid programme offers Rand 350 (US$ 24) per month, equivalent to around a quarter of the Old Age and Disability Grant (at 6 per cent of GDP per capita).[89]

5.3.2 Transfer values in old age pensions

As with other transfers, the values of old age pensions vary greatly. Across low- and middle-income countries, there are examples of transfer values that are equivalent to – or greater than – those in many high-income countries, as measured as a percentage of GDP per capita. Figure 5-12 shows the values of transfers across 52 low- and middle-income countries with nationwide schemes and indicates that there is a relationship between the value of transfers and coverage among the population aged 65 years and above: where coverage is higher there is a tendency for transfer values to be higher.[90] In fact, when the sample is restricted to only those countries scoring 5 and above in the Economist Intelligence Unit's Democracy Index – marked in orange – the correlation is slightly stronger in more democratic contexts. Indeed, some countries with high coverage and low transfer values – such as China, Brunei and Vietnam – are authoritarian regimes. In fact,

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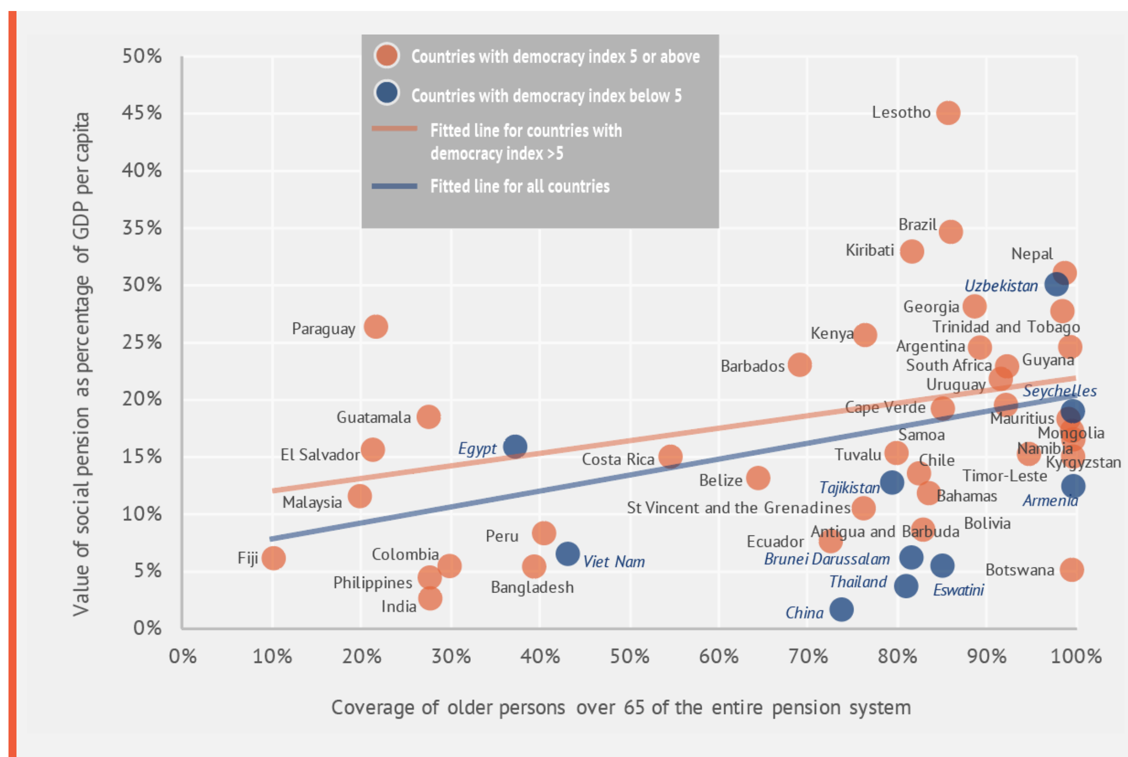
[85] Banks et al (2018a). Note: These were the two highest categories out of a four-tiered classification system, so many persons with less severe impairments receive nothing.
[86] Kidd and Abu-el-Haj (2014). Note: Previously, those classified in 'Category 3' also received a transfer, but it was removed in 2013. The transfer values are the same for Uzbekistan's contributory Disability Pension.
[87] Banks et al (2018b).
[88] Government of Vietnam (2017).
[89] Kidd et al (2018).
[90] Note: A range of schemes with high but not universal coverage for those aged 65 years and above are, in fact, universal schemes but with a higher age of eligibility.

seven of the ten countries scoring below 5 on the Democracy Index have transfer values below the trendline.

Figure 5-12: Comparison of transfer values of old age pensions as a percentage of GDP per capita among a selection of low- and middle-income countries with high and low coverage



Source: HelpAge International's Pension Watch Social Pensions Database (2015), at http://www.pension-watch.net/social-pensions-database/social-pensions-database--/; Wapling and Schjoedt (2019a); Kidd and Damerau (2016). Democracy Index figures are retrieved from The Economist Intelligence Unit, at https://infographics.economist.com/2018/DemocracyIndex/. *Note*: R^2 value for fitted line of all countries: 0.1433; R^2 value for fitted line of countries with democracy index >5: 0.1675. Countries that have a score of 5, or above, in the Democracy Index, are marked in orange.

Overall, 23 low- and middle-income countries offer pensions with transfers valued at more than 15 per cent of GDP per capita – and 19 of these have coverage above 60 per cent – with the highest value found in Lesotho. Yet, in many countries, transfer values are very low, with 7 countries paying less than 5 per cent of GDP per capita (only one of which has high coverage and a score above 5 in the democracy index). Minimum social pension values in almost all high-income countries range from 11 per cent to 35 per cent of GDP per capita, since they are part of pension systems with coverage ranging from 73 per cent in Israel to 100 per cent in many countries. These high values may well reflect

the likely strong popular support for pensions in the mainly democratic contexts of high-income countries.[91]

5.3.3 Transfer values in household-based poverty targeted schemes

Poverty-targeted household transfer schemes have low transfer values when compared to many universal individual social protection schemes and, furthermore, are expected to be shared across the household, which further reduces their effective per capita value. A review of nine household transfer schemes in Asia by Kidd and Damerau (2016), found that six had transfer values for entire households of less than 10 per cent of GDP per capita (or around 2 per cent of GDP per capita per person). The main exceptions were programmes in Georgia (at 33 per cent of GDP per capita per household or 6 per cent of GDP per capita per person) and Uzbekistan (at 50 per cent of GDP per capita per household, or 10 per cent of GDP per capita per person).[92] Both are countries that are significant investors in social protection, yet the majority of their spending is on individual lifecycle schemes. *Bolsa Familia,* Brazil's poverty targeted household transfer scheme, offered, in 2015, an average household benefit of 7 per cent of GDP per capita – less than 2 per cent of GDP per capita per person – while the country's old age and disability pensions offered a minimum of 35 per cent of GDP per capita per person.[93]

Furthermore, very few household transfer schemes attempt to address disability-related costs by offering higher transfer values for households including persons with disabilities. In Peru's Juntos programme, some carers of children with disabilities believed that the cash they received was insufficient to meet the needs of their children, in particular when the child's impairment resulted in additional costs for families, such as through the purchase of diapers or medicine. Zambia, however – as indicated earlier – in its Social Cash Transfer scheme, doubles the value of the transfer for households including a person with a disability (although many older persons with disabilities do not benefit from the additional payment, probably because their impairment is regarded as 'old age' rather than a disability).[94]

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[91] Pension Watch database at: http://www.pension-watch.net
[92] The figure for Uzbekistan has been updated using information from Kidd et al (2019a).
[93] Wapling and Schjoedt (2019a).
[94] Kidd et al (2019b). Note: The more recent design of Zambia's Social Cash Transfer programme more closely resembles old age and disability benefits, rather than household poverty targeted schemes.

5.4 Impacts of social protection on persons with disabilities

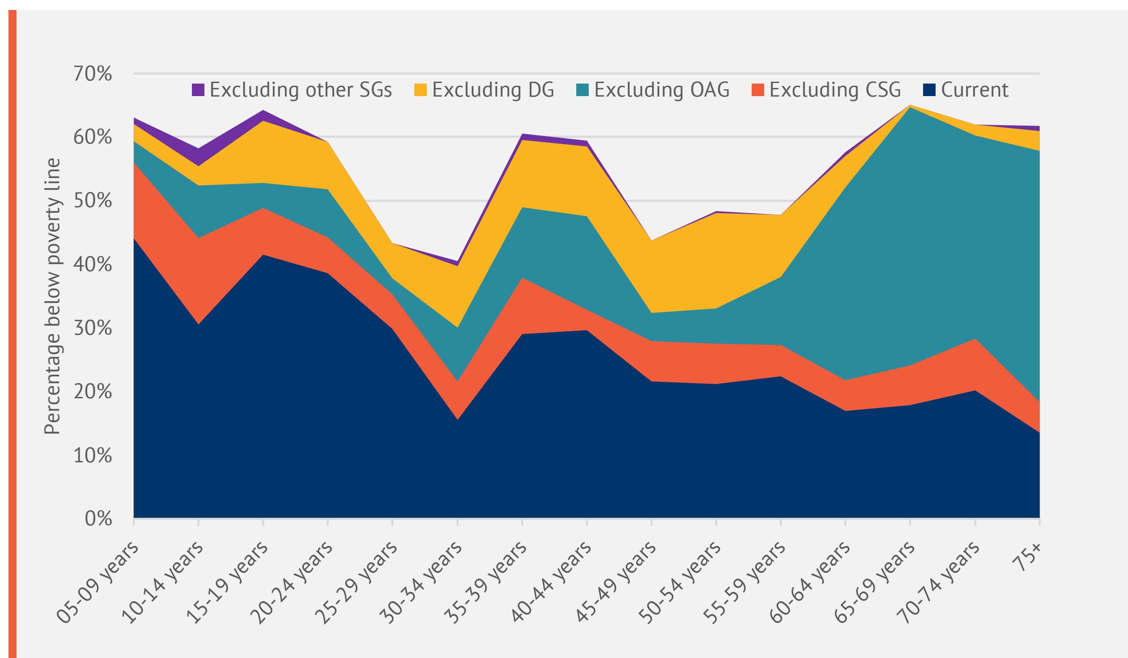
There have been few studies examining the impacts of social protection schemes on persons with disabilities, since they are rarely identified in evaluations of programmes. While a small number of disability-specific benefits have been evaluated – with most studies coming out of South Africa – there is very little information on the impacts of mainstream schemes and old age pensions on persons with disabilities, due to an absence of disaggregated data. The absence of evidence should not be taken to mean that social protection does not have positive impacts on persons with disabilities, but rather reflects their general invisibility as the subjects of social protection research and evaluation. This section will examine, mainly, the impacts of disability-specific benefits.

5.4.1 Impacts on incomes and consumption

Figure 5-13 shows the simulated impacts of all South Africa's tax-financed social protection benefits on the food poverty rate for persons with severe functional limitations across various age groups.[95] The overall reduction in the food poverty rate is 46.8 per cent and the greatest impacts are on older persons with severe functional limitations, mainly as a result of the Old Age Grant. The Disability Grant reduces the food poverty rate among beneficiary households by 71.6 per cent and, across all households with a member with a severe functional limitation, by 22.5 per cent.[96] In India, similar simulations show that the Indira Gandhi National Disability Pension Scheme reduces the poverty rate among beneficiary households by 11.6 per cent and, across all households with a member of working age with a severe functional limitation, by just over one per cent.[97] The difference in impacts between the two countries is due, to a large extent, to the lower relative transfer values and coverage in India compared to South Africa.

[95] Kidd et al (2018).
[96] Kidd et al (2018). Note: The food poverty line and poverty lines considered were in 2011 prices Rand 335 and Rand 779 per person per month, respectively.
[97] Wapling and Schjoedt (2019b). Note: The poverty lines considered are Tendulkar poverty lines in 2012 prices.

Figure 5-13: Impacts of tax-financed social protection benefits in South Africa on food poverty of persons with severe functional limitations, across age groups



Source: Analysis by Development Pathways of South Africa GHS 2015.

In the broader literature, there is minimal evidence of the impacts of disability benefits on household incomes. In South Africa, a range of studies have found that the Disability Grant has mixed impacts on family incomes, although the studies have only examined selected communities. For example, in Eastern Cape, household incomes and possessions were higher among households with persons with disabilities than among those in a control group while, in the Western Cape, they were similar.[98] One survey found that, for many recipients of the Disability Grant, it was their main source of income and that 98 per cent of recipients used it for general household expenses.[99]

The limited evidence available indicates that basic necessities are the main area of expenditure rather than the additional disability-related costs. In one survey, over 75 per cent of recipients of South Africa's Disability Grant and 74 per cent of recipients of the Care Dependency Grant noted that purchasing food was their main expenditure, with others being clothes, electricity and services.[100] In Namibia, another survey found that over 90 per cent of the disability benefit was spent on basic necessities, including food.[101]

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[98] Loeb et al (2008); Booysen and van de Berg (2005). Note: In the Eastern Cape, households with persons with disabilities possessed, on average, 9.3 items based on a list of 41 items in comparison to an average of 7 among the control group.
[99] De Paoli et al (2012).
[100] De Koker et al (2006).
[101] Eide et al (2003).

And, in Cam Le district in Vietnam, Banks et al (2018b) found that the disability benefit had a positive impact on the ability of the recipients' households to meet basic food needs. Among the households surveyed, the allowance was reported to be primarily used for food, clothing, household expenses and access to general health services. In Tanahun, Nepal, half of households with a recipient of the Disability Allowance who were surveyed reported that it helped them meet basic food requirements.[102] A range of other studies have noted that disability-specific benefits support people in covering their basic needs.[103]

5.4.2 Impacts on health

There is limited evidence of the impacts of disability-specific benefits on the health of recipients and household members. In a survey in South Africa, 93 per cent of Disability Grant beneficiaries stated that the benefit had improved the general health of the household, with most saying this was due to the consumption of higher quality food. Others indicated that it had helped them purchase medicines or pay medical fees.[104] The Care Dependency Grant was reported to have improved the general health of 98 per cent of beneficiary households surveyed, although there is some evidence of families using the grant to support other children.[105] In Brazil, Schwarzer and Querino (2002) found that persons with disabilities were better able to access private and higher quality medical services as a result of the Benefício de Prestação Continuada. In LSHTM's study in Vietnam, over a third of the respondents reported that the Disability Allowance helped them to receive medical care.[106] In Tanahun, Nepal, two-thirds of surveyed recipients of the Disability Allowance indicated a positive health impact as a result of using the benefit to receive medical care.[107] In Kenya, around 90 per cent of surveyed recipients of the Persons with Severe Disabilities Cash Transfer affirmed that the programme had had positive impacts on their health.[108]

[102] Banks et al (2018a).
[103] For examples, see Gooding and Marriot (2009); Berry and Smit (2011); Graham et al (2013); Mitra (2008; 2010); Palmer et al (2012); Palmer (2013); Watson (2015).
[104] de Koker et al (2006).
[105] de Koker et al (2006); Kidd et al (2018).
[106] Banks et al (2018b)
[107] Banks et al (2018a).
[108] Ministry of East African Community, Labour and Social Protection (2016).

5.4.3 Impacts on education

Schools can be challenging for some children with disabilities to access so the impacts of a disability benefit on education may be limited if other services are not in place. Indeed, there is little evidence on the impacts of social protection benefits on the attendance or performance at school of children with disabilities. Nonetheless, in South Africa, even though a profile of social security beneficiaries found that 11 per cent of those receiving the Care Dependency Grant (CDG) spent most of the transfer on school fees, 37 per cent of children aged 7-18 years who were receiving the grant were not in school. The main reason given was the absence of support for children with disabilities in schools.[109] In Vietnam, some recipients of the disability benefit stated that the benefit helps them support their children's education. One recipient stated: "*I save my monthly allowance to buy books or pay tuition fees for my child. I know education is very important. I am disabled and poor and I did not have a chance to study. I want my child to continue to go to school, to improve his knowledge and find a job in order to have a better life than myself.*"[110]

5.4.4 Impacts on livelihoods and labour market participation

Although evidence shows that social protection benefits enable recipient households to engage in livelihoods activities and the labour market, this is a topic that has been little researched among persons with disabilities. In Kenya, when payments were delayed and high consolidated sums were paid, the disability benefit transfers were used for larger investments, such as purchasing livestock, improving houses or paying school fees.[111] In fact, some beneficiaries of the programme suggested giving annual transfers so that they could be used for investment. In contrast, in South Africa, Lorenzo (2003) noted that it is difficult to use the Disability Grant for investment, since, as noted above, often most of the grant is used to cover basic expenses. Nonetheless, Samson et al (2004) found that households with a recipient of South Africa's Disability Grant have 22 percentage points higher labour market participation rates than those without social grants, although it is unclear whether the worker is the person with a disability or another member of the household. In fact – as will be discussed in Section 6.2.4 – there is some evidence that the linking of disability-specific benefits to incapacity to work has created perverse labour market incentives.

[109] de Koker et al (2006).
[110] Watson (2015).
[111] World Bank (2013a).

5.4.5 Empowerment, social stigma and psychosocial impacts

In Bangladesh and India, Gooding and Marriot (2009) note that disability benefits contribute to greater self-respect. In Bangladesh, they reported that people with disabilities were found to have greater self-confidence and were encouraged to leave their homes and meet new people when receiving disability benefits, possibly an effect that has been strengthened because the transfer led to the creation of self-help groups. Disability benefits in Vietnam were found to reduce the level of stress experienced by people with disabilities and their families, in particular by ensuring that their relative with a disability would have some financial support if left by him/herself in the future.[112] There is some evidence that the Disability Grant in South Africa may help women escape abusive relationships, since they could move out of the home.[113] South Africa's Care Dependency Grant has also encouraged families to increase the visibility of their children with disabilities and overcome stigma, increasing access to other services.[114]

[112] Palmer et al (2010).
[113] Gooding and Marriot (2007).
[114] Kidd et al (2018).

6 Barriers to persons with disabilities accessing social protection and measures to address them

Persons with disabilities face a wide range of barriers in accessing social protection systems and schemes, much of which explain their low levels of access. These barriers exist at various levels, including within the broader policy and governance environment, as well as in the design and implementation of both national systems and individual schemes. This section will examine these barriers and identify good practice.

6.1 Barriers in the broader environment and measures to address them

Social protection systems and schemes are more likely to be disability inclusive if there is a broader national disability sensitive environment. In practice, however, many social protection systems in low- and middle-income countries operate within a broader environment that is unfavourable to persons with disabilities and characterised by low levels of awareness and understanding, discrimination and weak institutions. Therefore, those who are interested in promoting disability inclusive social protection systems and schemes should focus not only on the social protection sector, but also address related issues within the broader environment. Some of the key factors creating an unfavourable policy environment are outlined below.

6.1.1 The information context

A widespread challenge facing policy-making on disability is the limited information available on persons with disabilities within countries. The prevalence of disability is often underestimated due to the poor quality of disability data from national surveys. For instance, in India, the national census of 2011 gave a prevalence rate of only 2.1 per cent while, in Zambia, the figure from the 2010 census was only 1.9 per cent.[115] This is well below the WHO and World Bank (2011) estimate of worldwide disability prevalence of 15 per cent, as well as being below the level of disability prevalence found in some similar countries and in other datasets within the same countries. One consequence of inadequate information is that countries may underestimate the scale of the issue,

[115] Wapling and Schjoedt (2019b) and Kidd et al (2019b).

thereby resulting in low investment. Yet, as argued earlier, disability is a significant issue, affecting a high proportion of the population both directly and indirectly.

However, an increasing number of low- and middle-income countries are investing in improving their data collection on disability, both through household surveys and censuses. The most common tool in use is the Washington Group Set of Questions (short set) and, as seen in this study, it enables a more in-depth analysis of disability. A small number of countries have combined questions on disability with questions on social protection programmes, most of which have been analysed in this study.

6.1.2 The institutional and governance context

The institutional structures established to address disability are often unsatisfactory. It is common for responsibilities for disability issues to be relegated to a weak social development ministry and, within the ministry, to be further relegated to a poorly resourced institution, which is sometimes physically located outside the ministry itself. These institutions are often given policy, oversight, coordination and service delivery responsibilities, yet are not provided with the resources or authority to be effective. Examples in this research were found in Kenya, Rwanda and Zambia.[116] In South Africa, responsibility for disability issues has been gradually falling within the government hierarchy, from the Presidency to, currently, the Department of Social Development.[117] This research also heard that, in some countries, ministries without a specific mandate for persons with disabilities absolve themselves of their responsibilities towards them. For example, in Zambia the research heard about people with disabilities approaching other Ministries – such as health, education and, in one case, mining – and were told to go to "your institution." However, as Box 6-1 indicates, Brazil's National Secretariat for the Rights of Persons with Disabilities has had some success in mainstreaming disability.

The effective mainstreaming of disability will be more likely to occur if the responsibility for the oversight, coordination and monitoring of disability issues is placed at a high level within government – such as within the Presidency or at Cabinet level – and the responsible body is given adequate powers. Furthermore, service delivery for persons with disabilities should not be delegated to one institution, but should be embedded within all ministries, including those responsible for social protection policy and delivery.

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[116] Kabare (2018); Kidd and Kabare (2019) and Kidd et al (2019b).
[117] Kidd et al (2018).

Box 6-1: Brazil's National Secretariat for the Rights of People with Disabilities

Since 2000, the National Secretariat for the Rights of People with Disabilities[118] has played a significant role in placing people with disabilities at the centre of discussions and mainstreaming the rights of people with disabilities in all areas.[119] The Secretariat used to be part of the Secretariat for Human Rights (*Secretaria de Direitos Humanos da Presidência da República*) under the Ministry of Justice, but has now been elevated to a 'sub-ministry', a status equal to the Secretariat for Human Rights, with the Coordinator of the Secretariat having the status of vice-minister in the Ministry of Justice. It has existed as a separate secretariat since 2009.[120] Its main role is to articulate policies on disability and ensure mainstreaming of the rights of people with disabilities in cooperation with other ministries. The Secretariat only implements a few of its own programmes, including funding of centres for sign language interpretation and training of guide dogs for visually impaired people. However, it has played a key role in formulating cross-cutting legislation, in particular the Brazilian Law of Inclusion.

6.1.3 The capacity, awareness and analytical context

The case studies found that the level of awareness across governments on disability rights – including among those responsible for policy development – is low.[121] Disability is often poorly understood by policy makers – and their advisers – and as a result, can be ignored or deprioritised within policy making and the allocation of national resources. Disability is frequently approached from a medical or charity perspective with little, if any, awareness of social and rights-based approaches, even when the country is a signatory to the CRPD.[122] Indeed, the broader economic and social consequences of inadequate investment in supporting persons with disabilities are rarely appreciated. Discrimination against persons with disabilities is common across low- and middle-income countries: one example is of the people with disabilities in Bolivia who advocated for a disability benefit and experienced police brutality.[123]

Policymakers often do not recognise that disability is something that most people experience at some time in their lives. In contrast, persons with disabilities are often conceptualised as 'the other,' in other words that they are different to the rest of the population and, as a result, are often characterised as a 'vulnerable group.' Indeed, when policies to address disability are targeted at 'the poor,' the process of othering for persons

[118] Secretária Nacional de Promoção dos Direitos da Pessoa com Deficiência Brasilia (SNPDP)
[119] Interview - The Latin American Network of Non-Governmental Organizations of Persons with Disabilities in their Families (RIADIS)
[120] Since 2019, the Secretariat of Human Rights has become part of the Ministry of Women, Family and Human Rights.
[121] See Kidd et al (2018); Kidd et al (2019b); Kidd and Kabare (2019); Wapling and Schjoedt (2019a); Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019c).
[122] Cf. Devandas-Aguillar (2015).
[123] A video explains the struggles of persons with disabilities in Bolivia: https://www.theguardian.com/world/ng-interactive/2017/may/05/fighting-for-a-pension-disability-rights-protesters-in-bolivia-face-barricades

with disability is multiplied, since 'the poor' are usually regarded as yet another disadvantaged, vulnerable and incapable group. The view of persons with disability as 'the other' can result in less national support for investing in them.

6.1.4 The legislative and policy context

Although the CRPD has been ratified by 147 countries, many still have legislation that disempowers people with disabilities, largely as a result of a lack of understanding of disability as a rights issue.[124] It is widely recognised that all countries should establish legislation that is in line with the CRPD, prohibiting all forms of discrimination and embedding the rights of persons with disabilities so that they are treated equally with others. Furthermore, states should ensure equality of opportunities and outcomes by addressing the disability related costs and challenges that people with disabilities face in their daily lives.

There are examples of national policies on disability that have resulted in little change in social protection practice. For instance, although South Africa, in early 2016, developed a good policy on disability, its main recommendation on social protection – to align social grants to the cost of disability – has not yet been taken forward.[125] Once the principles of non-discrimination and equality are embedded within national legislation, the arguments to build a disability inclusive social protection system should have a much stronger foundation, since it can permit action to be taken within the judicial system. In South Africa, people with disabilities have made frequent use of legislation to challenge the denial of their applications for disability benefits.[126] Similarly, in Brazil, a total of 325,000 people were granted access to the BPC scheme by court order between 2004 and 2014, which amounted to 17 per cent of all approved applications in the period.[127] In fact, the number of court cases has increased since 2013, reaching the highest level in 2014 with 24 per cent of approved applications being granted by the courts.

6.1.5 The social accountability context

The development of disability-inclusive social protection systems is likely to be enhanced if there is a strong demand from citizens. Disability organisations have an important role to play in building this demand, and there are some examples of disability organisations and people advocating effectively for disability benefits. As mentioned above, in 2016 in

[124] Source: OHCHR (2017).
[125] Kidd et al (2018).
[126] Kidd et al (2018).
[127] Wapling and Schjoedt (2019a); Costa et al (2016).

Bolivia, persons with disabilities took direct action to demand a disability benefit and, while they did not gain their full demand, a bill was presented to Parliament that offered them half the value of the transfer requested, although it was restricted to persons with 'severe and very severe disabilities.'[128] In Zambia, while government respondents noted that disability organisations have not been particularly effective in lobbying the government on social protection matters, they reported that the government has felt pressured by persons with disabilities themselves, who have been known to go directly to the Minister responsible.[129] Respondents also indicated that this pressure has shaped the Zambian government's response and that, as a result, the Social Cash Transfer programme is gradually being changed into a disability and old age benefit.

As Fritz (2011) argues, 'It is crucial that advocacy for social protection for persons with disabilities is based from the very beginning on a rights-based understanding of disability rather than one based on charity for the poor and vulnerable.' However, in many contexts, advocacy is limited or has gaps. As Sightsavers (2007) has argued, one reason for the limited engagement of disability organisations on social protection is because eligibility for working age disability benefits is often linked to incapacity to work, which perpetuates an image of dependency and inability.[130] Fritz (2011) has stated: "The underlying assumption of conventional wisdom appears to be that persons with disabilities are dependent, passive recipients of support who cannot care for themselves or participate actively in society." As a result, some disability organisations shy away from advocating for disability-specific social protection benefits because they do not want to perpetuate an image of themselves as dependent and helpless.

Furthermore, disability is heterogeneous and the requirements of persons with disabilities can vary greatly. Similarly, the disability movement is heterogeneous and should not be expected to present a common, unified position. Some categories of disability have stronger advocates than others: for example, it is common for the mainstream disability movement to pay less attention to mental and intellectual disabilities and to sometimes ignore the issues facing older persons with disabilities.

[128] Watts (2017).
[129] Kidd et al (2019b).
[130] Cf. Sightsavers (2007). This view is typified by Devereux's (2002) description of persons with disability as: "surviv[ing] by being cared for within their families or communities, by institutional redistribution from the state (funded by taxes paid by the economically active), or by charity and begging (which is a form of work)."

6.1.6 The social policy context

The successful delivery of social protection schemes for persons with disabilities – and the enhancement of impacts – depends on other services being adequately funded. For example: medical assessments are likely to be more effective if there is a good healthcare system; a strong national social work system is likely to increase the inclusion of many of the most vulnerable people into social protection schemes and across other services;[131] and, effective employment policies for all citizens are likely to ensure greater equality of opportunities for persons with disability, including those receiving disability benefits. However, as discussed further in Section 7, in most countries the other services are still weak. In particular, social work services are limited in most of the case study countries, thereby hindering the access of persons with disability to social protection benefits. Even in the two countries with more developed social work services – Brazil and South Africa – both are overstretched, although in Brazil, social workers are playing a key role in facilitating the access of persons with disabilities to the Beneficio Prestação Continuado (see Section 6.2 for a more detailed discussion).[132]

6.1.7 The economic and fiscal context

It is challenging to build an inclusive social protection system if the broader economic and fiscal context is not favourable. In low- and middle-income countries with low levels of investment in social protection, the reason for the limited spending can be the result of a policy choice rather than limited fiscal space. Some case study countries are good examples of greater state investment in social protection, with Mauritius investing 4.6 per cent of GDP, South Africa 4 per cent and Brazil 13.5 per cent through both tax-financed and social insurance schemes.[133] In all three countries, the core expenditure is on lifecycle schemes with high coverage. In contrast, levels of expenditure in India, Rwanda and Zambia are much less. Ortiz et al (2017) argue that countries have a range of options if they wish to generate greater fiscal space for social protection. But, they are likely only to allocate greater resources to social protection if they are convinced of its social, economic and political value.

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[131] See Devandas-Aguillar (2016) for a discussion on support services for persons with disability, from a rights perspective.
[132] Wapling and Schjoedt (2019a); Kidd et al (2018).
[133] Information on levels of investment in social protection is taken from the case study papers. Information on Mongolia is based on calculations from National Statistics Office of Mongolia (2017); CEPAL: Non-contributory social protection programmes in Latin America and the Caribbean database, at https://dds.cepal.org/bpsnc/index-en.php; Kidd and Huda (2013).

6.2 Barriers created by key policy decisions and measures to address them

Policy decisions can create barriers that make it difficult for persons with disabilities to access social protection schemes. Key issues are discussed below although, for reasons of coherence, issues of programme design and implementation that directly relate to the policy decision are also discussed, rather than in the following sections which specifically address design and implementation barriers.

6.2.1 Disability assessment mechanisms

Disability-specific social protection schemes – along with some mainstream schemes that have disability as one of their criteria – require a mechanism to identify those who are eligible on the basis of their disability. This is a controversial and highly debated topic, and the type of mechanism often reflects the prevailing notion of disability within a country. As indicated earlier, the case studies found that social protection for persons with disabilities is often conflated with incapacity to work rather than being understood as a core tool in helping persons with disabilities engage in the labour market, and this feeds into the nature of the assessment mechanism. In South Africa, for example, the assessment process for the Disability Grant focuses on identifying those who are unable to work. Consequently, the disability assessment process itself can be a barrier to accessing disability-specific schemes, in particular for those who are able to engage in employment.

Disability assessments can be considered from two perspectives: the first is how disability is defined and identified; the second is the implementation of the assessment mechanism. The following sections will examine both aspects in turn.

6.2.1.1 Approaches to disability assessments

There is a range of approaches to assessing disability with current international debate classifying them into three broad types:[134]

An ***impairment approach*** (often referred to as a medical approach) employs a medical assessment to determine health conditions and the level and severity of impairment associated with them, often attaching percentages to the overall levels of impairment.

A ***functional limitations approach*** adds an assessment of the extent to which people's functions are restricted – within the domains of lifting, standing, handling, hearing, seeing and concentrating – to the medical assessment.

Box 6-2: Brazil's disability assessment mechanism for the Benefício de Prestação Continuada programme

Brazil's Benefício de Prestação Continuada programme undertakes its own disability assessment, based on a disability approach. An initial assessment is undertaken by a social worker to determine the barriers faced by the applicant in accessing employment. This is followed by medical and functional limitations assessments using the International Classification of Functioning, Disability and Health (ICF). Neither assessor is aware of the findings of the other. However, it is a complex and expensive model – with limited capacity to meet demand – and, due to insufficient human resources and a lack of coordination between the medical and social assessors, applicants may be obliged to make a number of visits to the assessment centre while also experiencing long waiting times. A similar approach could only be undertaken in countries with a strong social work system.

For more information, see Wapling and Schjoedt (2019a).

A ***disability approach*** incorporates an assessment of the extent to which social and environmental factors affect an individual's ability to carry out their daily lives, irrespective of their impairment. It can add this assessment to the functional limitations approach and is the most aligned with the definition of disability within the CRPD.

Although different countries follow distinct approaches to disability assessment – including across developed countries – there is a general consensus among disability experts that a disability approach is preferable. It is regarded as more compliant with a human rights approach and more likely to address the specific requirements of individual persons with disabilities. Nonetheless, an impairment approach still dominates across low- and middle-income countries. Annex 9 outlines the approaches used in the country case studies. Among them, only Brazil has made significant progress in incorporating a disability approach (see Box 6-2).

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[134] Note: This classification is based on papers produced for technical meetings on disability assessment, hosted by the World Health Organisation. For an alternative classification of approaches to disability assessment, see Bolderson et al (2002).

Box 6-3: Simple disability assessments by communities for household transfer programmes

Some countries have used assessments that are undertaken by community members, usually within mainstream programmes that include disability as one of the criteria. These community members have no training and are not qualified to assess disability. In Zambia, this resulted in large numbers of people being identified as having a severe disability so that they could access the Social Cash Transfer programme: in some communities, over 40 per cent of households were assessed as including a member with a severe disability. There are clear incentives for communities to exaggerate the number of eligible households. In response, Zambia has strengthened its medical assessment process, which is now used for determining access to the Social Cash Transfer. Further information can be found in Kidd et al (2019b).

In Rwanda, during the Ubudehe community-based classification process – which, as Section 6.2 explains, was used to select people for social protection programmes – around 460,000 people aged 18-64 years were classified as unable to work, which is the equivalent of around 8 per cent of all those in the age group. This is a significantly higher percentage than the numbers found in either the census or household survey, which suggests that communities may have inflated the numbers to give more people access to benefits. For further information, see Kidd and Kabare (2019).

Human resource availability is one factor that affects the choice of disability assessment. Even if more low- and middle-income countries wished to undertake a combined medical and social assessment, few countries have sufficient social workers and occupational therapists available to accompany the medical assessments. Many countries experience a serious shortage of social workers and, in countries such as Kenya, Zambia and Ghana, social workers have been given the responsibility of delivering cash transfer schemes, which has further reduced their ability to complete their other tasks, let alone support disability assessments.[135] South Africa has attempted to develop a combined social and medical assessment process, but it was never implemented as it was regarded as too resource intensive.[136]

Some countries that link access to disability benefits to work capacity – such as South Africa, Uzbekistan and Zambia – have medical officers who undertake the assessment of whether persons with disabilities can gain employment within the prevailing labour market context.[137] However, the medical officers in these countries – and, of course, in many others – do not have the relevant expertise to make these assessments.[138] In Uzbekistan, the United Nations Development Programme (UNDP) has recommended that it would be preferable for the assessment to be purely medical based until the state can

[135] Barrett and Kidd (2014).
[136] Kidd et al (2018)
[137] In Uzbekistan, the link with work capacity is probably a misinterpretation of the regulations by assessors as described in Kidd et al (2019a).
[138] Kidd et al (2018); Kidd et al (2019b) and Kidd and Abu-el-Haj (2014).

ensure that there are assessors with appropriate skills to undertake the work capacity assessments.[139]

Some low- and middle-income countries undertake panel-based assessments using local community members or officials. This does not necessarily conform to any of the three approaches above, since decisions are often left to the discretion of the committees making the decision. For example, in 2001, South Africa introduced community panels to replace a purely medical assessment for the Disability Grant. The panels were expected to include doctors, physiotherapists, occupational health professionals and community representatives. A key motivating factor for these panels was a desire to increase access to disability benefits in rural areas where there were few trained medical professionals or suitable health clinics.[140] However, the panels generated a significant increase in the number of people accessing the Disability Grant since the panelists were more sympathetic to applicants and allowed many people into the programme who did not have an impairment (but who they viewed as worthy of income support). At times, there was no medical assessor on the panel. Applicants also complained about a lack of confidentiality – in particular they were concerned about their personal medical information being revealed to others in the community – and that they were not being treated with dignity.[141] Eventually, there was a pushback from the Ministry of Finance and medical assessments were re-introduced.[142] Nepal and Vietnam currently employ panel assessments for their disability benefits.[143]

Disability assessments also vary in terms of the extent to which they are more generic or specific to particular benefits. In some countries – such as Kenya, Rwanda and Zambia – the disability assessment is undertaken by a central organisation thereby enabling people to access a range of benefits within countries, beyond being able to access social protection programmes. In other countries – such as South Africa and Brazil – the assessment is specific to the social protection scheme. Furthermore, social insurance schemes often undertake their own internal assessments to ensure closer control over access to benefits. For example, the Rwanda Social Security Board (RSSB) does not use the country's generic assessment, but employs its own doctors, although the assessment tool is the same. There are pros and cons to using a generic approach: it is more cost-effective than having programme-specific assessments but, on the other hand, it does not necessarily tailor the requirements of individuals to the aims of specific benefits.

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[139] Kidd and Abu-el-Haj (2014).
[140] MacGregor (2006); Mitra (2010).
[141] Goldblatt (2009).
[142] Kidd et al (2018).
[143] For further information on the disability assessments in Nepal and Vietnam, see Banks et al (2018a; 2018b).

There is no evidence available on the extent to which distinct types of assessment approaches produce different results in terms of access to social protection schemes, as this has not been tested in a low- and middle-income country context. Therefore, it is not possible to determine the extent to which the disability assessment approach itself creates a barrier. Nor is there any evidence on which approach may be more cost-effective, although, in principle, an assessment process involving more assessors – which is the case in Brazil since it uses both medical officers and social workers – is likely to imply higher costs.

6.2.1.2 Barriers created during the implementation of the disability assessment

Across low- and middle-income countries, the challenges with disability assessments go beyond the choice of approach. There are significant implementation challenges which, to a large extent, are the result of inadequate human and financial resources. Some of the main challenges are described below.

Many low- and middle-income countries have limited capacity to undertake medical assessments of any type. Often these countries do not have sufficient medical personnel available, which is reflective of weaknesses within the national health systems. In South Africa, it was reported that doctors may be reluctant to undertake assessments unless well-remunerated, since most prefer to focus on curative medicine. Indeed, the removal of doctors from primary and tertiary health care when human resources in the health sector are limited is problematic. In some contexts, when the assessment is specific to a programme, doctors may fear undertaking assessments since they may be blamed by rejected applicants: in South Africa, doctors have been threatened and even attacked by applicants.[144] In some countries where medical systems are already running at low capacity – such as in South Africa, Rwanda and Zambia – the institutions responsible for social protection schemes pay for doctors to undertake medical assessments or facilitate the assessment process, so as to cover gaps.[145]

In some countries – such as Lebanon and Tunisia – there is evidence of a gender imbalance within disability assessments.[146] In Lebanon, 60 per cent of those with a disability card are male, while in Tunisia, 50 per cent of men with disabilities have a disability card in comparison to 40 per cent of women with disabilities. However, it is unknown whether these differences are the result of biases among assessors or because women are less likely to be assessed.

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[144] Kidd et al (2018)
[145] Kidd and Kabare (2019); Kidd et al (2018) and Kidd et al (2019b).
[146] Bjork et al (2017).

Some countries – such as Brazil, Mauritius, South Africa and Zambia – have on-demand disability assessments. However, in other countries it may not yet be possible to establish an on-demand system or to conduct regular assessments, thereby impacting the accuracy and completeness of disability assessment data. As a result, over time, only limited numbers of persons with disabilities will benefit. For example, in 2015, Rwanda undertook a comprehensive medical assessment as a one-off initiative, with no plans for a further assessment due to a lack of funding.[147] The assessment process, however, only certified around 1.5 per cent of the national population, which meant that the majority of persons with disabilities were excluded.[148] While this may be a reasonable result for a one-off national assessment – and would be a good basis upon which to build – it is problematic if there are not regular follow-up assessments to include those missed initially or who subsequently develop impairments.

Issues with the assessment system are exacerbated if there is a lack of clarity among the general public about the purpose of a scheme and eligibility criteria. In South Africa, significant pressure has been placed on the system due to people who have chronic illnesses but do not have an impairment, who attempt to access benefits in a context of widespread poverty and unemployment.[149] Often, those with chronic illnesses are given temporary benefits by the South African Social Security Association (SASSA), which requires additional assessments to be undertaken in the future, thereby placing further pressure on the system.

In some countries, systems can come under stress by stipulations that everyone must undertake periodic reassessments even when there is no possibility of a physical improvement in their condition, such as in Brazil. While this may be in line with the social model of disability, it adds to workloads and costs: in such cases, it may be easier to undertake re-assessments only very infrequently, with people themselves volunteering for a further assessment if they believe their condition has deteriorated.

Poor physical accessibility is another challenge, with some persons with disabilities being required to travel long distances for assessments. For example, the limited availability of doctors can mean that applicants have to travel far to access medical assessment centres, in particular in more remote rural areas. Transport may not be available or, where it is,

[147] Kidd and Kabare (2019).
[148] Note: The EICV 4 household survey gave a prevalence of persons with a 'severe disability' of 3.9 per cent while other surveys have given up to 5 per cent. However, there are challenges with the surveys which mean that the prevalence of disability is likely to be underestimated.
[149] Kidd et al (2018) and Mitra (2010).

costs can be high, in particular for those needing to be accompanied.[150] In Nepal, it is difficult for many persons with disabilities who live in more remote areas to travel to district capitals for their assessment although, in some cases, those with obvious and very severe impairments can be certified by a senior local official within their community, so that they do not have to travel.[151] Sometimes, people may be asked to obtain other documentation prior to the assessment, thereby adding to their opportunity and transport costs: in South Africa, applicants for the Disability and Care Dependency Grants must obtain a prior referral letter from a medical professional, which, if required from a specialist hospital, can be difficult and costly to obtain.[152] In Zambia and Rwanda, there have been experiences of disability assessments being undertaken within communities by mobile units.[153]

The limited availability of medical assessors can result in insufficient time being set aside for assessments. In the case study countries, it was rare for assessments to take more than thirty minutes, which is insufficient for a robust review of patients, especially for more complex cases in a context where assessors do not have access to medical records and specialist tests. The medical examinations themselves can often be very cursory.[154] In many areas of South Africa, for example, assessments undertaken by the South African Social Security Agency (SASSA) itself can last no more than three minutes, with the result being that less visible impairments are often not identified.[155] In Rwanda, Mauritius and India, people with disabilities who were interviewed during the case studies also complained that the assessments, which assign a percentage of disability based on a purely medical assessment, are short, arbitrary and often undignified.[156] However, in the Western Cape region of South Africa, SASSA has contracted local clinics to undertake assessments resulting in longer assessments of 15-20 minutes, often with the medical records available for those who use the local clinic.

Medical professionals are often not trained to undertake disability assessments yet are expected to cover a broad range of impairments, many of which are outside their expertise, resulting in potential misdiagnosis. And, when training is given, it may not be adequate or relevant: in South Africa, doctors are only trained in administrative matters.[157] If the assessors do not have access to the medical records of applicants, it may be necessary to order additional specialist tests, which can further increase the financial

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[150] Kidd et al (2018); Kidd et al (2019b).
[151] Banks et al (2018a).
[152] Kidd et al (2018).
[153] Kidd and Kabare (2019); Kidd et al (2019b).
[154] Kidd et al (2018); Kelly (2016).
[155] Kidd et al (2018); Kelly (2016).
[156] Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019b); Kidd and Kabare (2019).
[157] Kidd et al (2018).

burden on applicants if, indeed, they are able to reach the hospitals where the tests have to be carried out. In the case study countries, there was no evidence that any of the required medical tests were paid for or subsidised by social protection institutions. If, however, assessments were undertaken by health systems, this could be used as a means of diagnosing conditions and offering treatments, if applicable.

As with any eligibility test, there is the risk that people can attempt to cheat the disability assessment which, if it happens, can undermine trust. It can also mean that assessments are made more stringent, which can create further barriers for many persons with disabilities. The WHO and World Bank (2011) argue that disability benefits have become a benefit of last resort in Organisation for Economic Cooperation and Development (OECD) countries, given that unemployment schemes are more difficult to access and it is challenging for those with low skills to find employment, which can put further pressure on the system. In South Africa – as Box 6-4 explains – significant pressure has been placed on the disability assessment mechanism as a result of widespread poverty and chronic illness.

There is little evidence of developing countries investing in appropriate monitoring and quality assurance of disability assessments. This may be because it is regarded as a further cost and complication, in particular in countries already struggling to offer a good quality assessment process. It may also be the result of a disconnect between ministries of health – and representative medical associations – and the ministry tasked with implementing social protection, with a reluctance by the former to be scrutinised by non-medical professionals. South Africa has panels of doctors that review a selection of disability assessment files, but they do not question the actual decision; rather, they look for patterns in the decision-making of the medical assessors.[158] In fact, the South African courts have decided that it is unconstitutional for an assessment of disability status to be undertaken, without an actual physical assessment taking place.

[158] Kidd et al (2018).

Box 6-4: South Africa's Disability Grant and the challenges with chronic illness

In South Africa, the large increase in recipients of the Disability Grant between 2000 and 2004 (from 600,000 to almost 1.2 million) appears to have been driven by the Acquired Immune Deficiency Syndrome (AIDS) epidemic. However, Nattrass (2006) argues that other drivers – apart from the rising prevalence of both AIDs and Tuberculosis (TB) – were unemployment, poverty and changes to the benefit system.[159] The main increase in recipients was among women, who were disproportionately affected by AIDS.[160] However, once antiretrovirals (ARVs) were introduced, many of the new beneficiaries no longer fulfilled the disability criteria. As a result, many of those on the Disability Grant should not have been strictly considered as having a disability. In 2015, 13 per cent of those receiving the Disability Grant reported having been diagnosed as having HIV/AIDS, compared to a rate of 4 per cent across the national population.[161] Most applicants for the Disability Grant continue to be those experiencing chronic illness.

There has been significant debate about whether the Disability Grant has resulted in people living with HIV/AIDs refusing to take ARV treatment so that they can continue to be ill and receive the benefit. As de Paoli et al (2012) note, with the introduction of ARVs, people living with AIDS and in extreme poverty face a dilemma: if they take their ARVs, their health would improve so that they would no longer qualify for the Disability Grant; but, without the Disability Grant, they would not be able to obtain adequate nutrition, which would reduce the effectiveness of the ARVs. Furthermore, obtaining employment is not an option for the majority and, even if employment were available, there are certain jobs that they cannot undertake, since that would exacerbate their condition (such as working nightshifts or working outside, which would increase their chance of an infection).

However, in de Paoli et al’s (2012) study, they did not find that the majority of people living with AIDS chose not to take their ARVs to regain access to the Disability Grant. Yet, at the same time, losing the grant had a negative impact on their physical and emotional wellbeing. Some people adopted an alternative strategy so as to remain on the grant: prior to the disability assessment, they took measures to lower their Cluster of Differentiation 4 (CD4) count temporarily so as to qualify for the benefit. This includes increasing alcohol consumption before attending the clinic and skipping some days of treatment to become slightly more ill. Others followed a pattern of being on a temporary Disability Grant for six months, then off it for six months, before returning to the scheme.

In low- and middle-income countries, there are few examples of good practice in disability assessments. Suggestions on potential ways to improve disability assessments, irrespective of the approach adopted, are outlined in Box 6-5. The key ingredient of success is for governments to take disability assessments seriously and invest sufficiently in implementing a good quality process, taking into account the national context and capacity constraints.

[159] Goldblatt (2009) and Mitra (2010).
[160] Goldblatt (2009).
[161] Source: South Africa’s General Household Survey (2015).

Box 6-5: Good practice in the implementation of disability assessments

- Train assessors in assessments and have continuous training. If assessors are to be paid to undertake assessments, have a good level of remuneration to attract the right quality of assessors.
- Make medical records of applicants available to medical assessors, on the agreement of the applicant.
- Have on-demand assessment mechanisms, thereby enabling persons with a disability to access them at any time.
- Conduct assessments as close to the residence of applicants as possible, to reduce their costs in accessing the system. Assessments should be well-coordinated – in particular if social and medical assessments are undertaken separately – to reduce the number of journeys. If additional tests are required, the social protection scheme or medical service should pay for them.
- Compensate applicants for their transport costs, at least if they are successful.[162] Or, successful applicants could receive a double payment for the first transfer.
- Make assessment centres physically accessible to everyone with an impairment. Similarly, provide other measures such as interpretation, including for those with hearing impairments.
- Always treat applicants with dignity and respect their right to privacy. They should actively participate in the assessment.
- Have high quality and disability-sensitive communications about the disability assessment process, in order to build awareness of the existence of the mechanism. This can also deter those who will clearly not qualify, so as to reduce pressure on the system.
- Closely monitor the decisions of assessors, to ensure that quality is being maintained. This will require a team of highly qualified experts to undertake the monitoring.
- Establish an accessible grievance mechanism to allow people to appeal the assessment.
- Ensure that applicants can be directed towards receiving further support that may be identified during the assessment, for example from social work, social care or health systems.

6.2.2 Impact of selection mechanisms on disability inclusion

As indicated by the analysis on coverage in Section 5.2, the higher the coverage of schemes and the social protection system overall, the higher the proportion of persons with disabilities that are likely to be included, with the most effective being schemes offering universal access. However, if the level of investment is limited, countries need to find some means of limiting coverage. Within specific schemes, in simple terms, countries have three basic options. They can: i) narrow the geographical coverage;[163] ii) narrow the category selected; iii) or, direct resources at those living in poverty. Narrowing the category involves limiting the age of eligibility or, in the case of disability-specific benefits, selecting those with more severe disabilities. Even if the category is narrowed, governments can still choose to restrict the programme further by targeting those living

[162] See Wapling and Schjoedt (2019a); Goldblatt (2009).
[163] Narrowing the geographic coverage is not common in schemes funded by national resources so is not discussed here. It is more common for national schemes to be rolled out on a geographic basis nationally. Programmes funded by donors are more likely to be located in specific regions due to the limited funds available.

in poverty. The research focused on two of these options – narrowing the category, and poverty-targeting – and each is discussed in turn.

6.2.2.1 Narrowing the category selected and the inclusion of persons with disabilities

Within categorical and lifecycle schemes, there are a number of examples of countries narrowing the category of the population that will receive a benefit when the overall level of investment is limited. Disability-specific schemes are commonly restricted to those categorised as having more severe impairments (or disabilities) rather than being provided to everyone with a disability. It is through disability assessments that governments make this decision. Zambia restricts the Social Cash Transfer (SCT) to those classified as having a 'severe disability', while South Africa and India use a percentage of impairment cut-off for their disability benefits (as does Rwanda for some schemes, although it is not yet linked to determining access to the VUP programme).[164] Nepal has four categories of disability and each has a different coloured card: those with a red card (known as 'complete disability') receive the highest value of transfer from the Disability Allowance, those with a blue card ('severe disability') receive a lower transfer, while those with yellow ('moderate disability') and white cards ('mild disability') are not eligible for the transfer, although they can access other types of assistance.[165] In theory, this would restrict the access of those with less severe disabilities to disability benefits while prioritising those with more severe disabilities. There is little evidence on whether this is the case but, in one district of Nepal, Banks et al (2018a) found that no-one with a yellow or white card was accessing the disability allowance.[166] This type of restriction is common across countries although the means by which it is done varies. Another means of restricting the category is through restricting disability-specific benefits to those deemed unable to work (see Section 0 on the challenges that this may cause).

Old age pensions often restrict the category by age of eligibility. For example, Nepal's universal old age pension was initially offered only to those aged 75 years and over, but the age was subsequently reduced over time to those aged 65 years and above, and to 60 years and over among Dalits and those in the poorest region of the country.[167] Vietnam's old age pension had an initial age of eligibility of 90 years and over, but this was subsequently reduced to 80 years and even lower in some Provinces. In 2017, the

[164] Wapling and Schjoedt (2019b); Kidd and Kabare (2019); Kidd et al (2018); Kidd et al (2019b).
[165] Banks et al (2018a).
[166] Note: Banks et al (2018a) did not examine the extent to which the different categories of disability had been accurately assessed.
[167] Kidd and Wylde (2011).

Government announced a further reduction to 75 years.[168] Furthermore, Kenya recently modified its poverty-targeted pension for those aged 65 years and over to become a universal old age pension, so that everyone aged 70 years and above now has access to a minimum pension.[169] By raising the age of eligibility rather than targeting a pension at those living in poverty, governments effectively prioritise the age groups in which the prevalence of disability is higher. However, this does mean that older people with disabilities who are below the age of eligibility are excluded.

Although the restriction of coverage within categories results in the exclusion of some persons with disabilities, it could be regarded as a positive prioritisation in a context of limited funds if it results in a higher proportion of the most vulnerable persons with disabilities being included. It is also an alternative to targeting the poorest which can result in the exclusion of many of the most vulnerable persons with disabilities. One advantage of restricting the category rather than targeting those living in poverty is that the scheme can still be offered to all citizens as an entitlement – once they become eligible – and, as a result, may be more popular than a programme targeted at those living in poverty. And, as has been seen in Vietnam and Nepal's old age pensions, the category may be broadened over time, thereby making schemes increasingly more disability inclusive.

6.2.2.2 Selection mechanisms to identify people living in poverty

Governments often decide to limit the coverage of social protection schemes by targeting benefits at those living in poverty. Some of the most common poverty-targeting methods that have been developed for use in low- and middle-income countries are proxy means testing, means testing and community-based targeting. How effective these methods are at including persons with disabilities is discussed below.

Proxy means tests and the inclusion of persons with disabilities

Over the past decade, the proxy means test (PMT) has become an increasingly common poverty targeting mechanism in low- and middle-income countries. PMTs estimate household incomes by measuring household assets, such as the type of house, possession of durable goods and productive assets, levels of education and demographic characteristics.[170] The design errors in proxy means tests are large: it is the norm for

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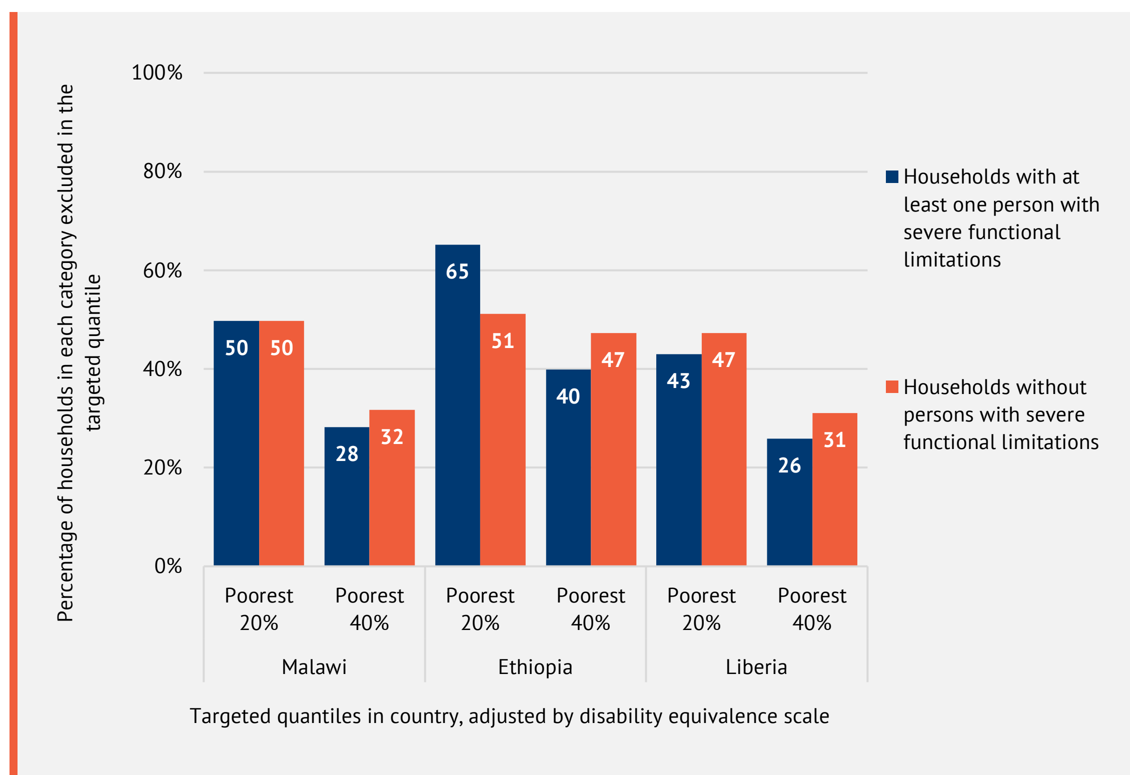
[168] Kidd, Abu-el-Haj et al (2016); Government of Vietnam (2017).
[169] Kidd et al (Forthcoming).
[170] For more detailed explanations of the proxy means test methodology and evidence on selection errors, see Kidd and Wylde (2011); Kidd et al (2017); Brown et al (2016).

around 50 per cent of the intended beneficiaries to be excluded when targeted at the poorest 20 per cent of the population. In addition, further inclusion and exclusion errors are introduced during implementation.[171]

Analysis undertaken as part of this research indicates that, when examining the design errors in PMTs, the exclusion of households with a member with a severe functional limitation can be similar to those of households without a member with a disability.[172] Figure 6-1 compares the percentage of households with and without a member with a severe functional limitation excluded as a result of the design of potential PMTs in Malawi, Ethiopia and Liberia, at various levels of programme coverage. Overall, there are only small differences in exclusion. When targeting the poorest 20 per cent of households, persons with severe functional limitations are more likely to be excluded in Ethiopia, there is no difference in Malawi and, in Liberia, they are slightly less likely to be excluded. However, conventional PMTs do not take into account the disability related costs experienced by persons with disabilities and their concomitant lower standards of living.[173] If they did, the design exclusion error among households with a member with severe functional limitations would be higher. Furthermore, as Annex 10 indicates, the selection of households by the proxy means test is relatively arbitrary.

[171] Note: Exclusion errors refer to the proportion of those in the target population that are excluded while inclusion errors refer to the proportion of beneficiaries who are not in the target population.
[172] Note: Due to an almost total absence of datasets that include information on both disability and programmes using PMTs, it is not possible to know whether, following implementation, the exclusion of persons with disabilities improves or worsens. In Indonesia, there was, however, an indication of persons with severe functional limitations having lower access to its schemes – which use a PMT – than persons without disabilities as well as high exclusion among those living in the greatest poverty (see Section 5.2.1. and 6.2.2.2.4).
[173] Bjork et al (2017) express concerns that many proxy means tests in Arab countries do not take disability into account.

Figure 6-1: Eligible households with and without a member with a severe functional limitation that are excluded by design by potential proxy means tests in Ethiopia, Liberia and Malawi



Source: Analysis by Development Pathways of the following datasets: Third Integrated Household Survey (IHS3) 2010/2011 dataset in Malawi; ESS 2013/14 in Ethiopia; HIES 2014/15 in Liberia.

If PMTs are to offer equality of access to persons with disabilities, their design needs to take disability into account by adjusting both for disability related costs and lower standards of living. This has rarely happened to date and, if analysts wanted to do this, they would need to include questions on functional limitations in the household surveys used to develop PMTs. As Annex 12 indicates, across twenty household surveys used to develop PMTs in Africa, only four included the Washington Group Set of Questions or Activities of Daily Living questions.[174]

There are at least two PMTs that have attempted to take into account disability when selecting recipients of social protection schemes. Pakistan's Benazir Income Support Programme (BISP) has attempted to increase the inclusion of persons with disabilities by increasing the PMT cut-off score for households with a disabled member, although there

[174] Other household surveys included questions on disability, but they were not of good quality.

is no evidence on the effectiveness of this option.[175] However, the identification of disability was dependent on having gone through a medical assessment which is challenging to access and means that those persons with disabilities that do not undertake the assessment are excluded. Furthermore, with a higher cut-off score – due to the errors in the PMT – many of those included are likely to be from better-off households (see Annex 11 for further explanation). In Palestine, an alternative method is employed: disability is included as one of the PMT proxies and given a weighting.[176] As in Pakistan, persons with disabilities have to go through a formal – and challenging – disability assessment to be recognised as having a disability for the PMT. Yet, this is only one proxy among many, and the majority of persons with disabilities are excluded anyway due to their being assessed as 'non-poor' or through design and implementation errors. According to Abu Alghaib (2018), many find this difficult to understand – in particular those living in extreme poverty who are excluded – since they had assumed that their classification as having a disability would guarantee them access to the scheme.[177] Other options to make PMTs more disability inclusive are discussed in Annex 11.

Nonetheless, even when PMTs are adapted for disability, the exclusion rate is still high for eligible households with members with a disability living in extreme poverty. Additional action is required if the exclusion of persons with disabilities is to be reduced further. One option is to have more highly trained enumerators who are able to override the PMT when it is incorrect. However, this would require a significant increase in the cost of undertaking a PMT since enumerators would require more training and higher pay, and the surveys of each household could take much longer.

PMT surveys are usually undertaken infrequently, often no more than every five years and sometimes longer.[178] For example, in Pakistan, there has not been a survey since 2009. As a result, a household experiencing a significant fall in wellbeing as a result of a member becoming disabled will not be able to access a social protection scheme until the next survey. This can be addressed by increasing the frequency of PMT surveys or by making applications on-demand. However, this would increase costs and on-demand applications would create challenges in a context of a fixed budget or a quota that restricts the number of households to be selected. A reliable mechanism to exit households from the

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[175] Kidd (2014c). Note: The cut-off score is raised from 16.17 to 20 if there is one person with a disability in the family and to 25, if there are two.
[176] Bjork et al (2017); Abu Alghaib (2018).
[177] According to Kaur et al (2016), 8.7 per cent of all recipients of the Cash Transfer Programme in Palestine have a disability. There is, however, no information on the number of heads of households on the programme that have a disability, nor is a definition given of 'disability.'
[178] Kidd (2017).

scheme would also be needed but there is no evidence of this having been developed in any country.

Means tests and the inclusion of persons with disabilities

While means tests – in effect the assessment of eligibility against income and, at times, assets – are recognised as the most accurate form of poverty targeting, they are rarely used in low- and middle-income countries due to the difficulty and cost in obtaining reliable information from those working in the informal economy.[179] However, there are examples of means tests being used, such as in South Africa and Brazil where applicants for schemes declare their income. In South Africa there is minimal verification – applicants have to sign an affidavit, although those who declare an income need to provide evidence, such as a wage slip.[180] Box 6-6 describes South Africa's means tests in more detail.

The effectiveness of unverified means tests varies. In Brazil, for example, the Bolsa Familia scheme – which targets just over 20 per cent of the poorest families – has exclusion errors of 49 per cent, although there is no information on the exclusion of persons with disabilities.[181] Since Bolsa Familia also employs a quota system for each municipality, the extent to which the quota, rather than the means test itself, drives exclusion is not known.

In South Africa, where coverage is much higher, exclusion errors across the general population are 20 per cent for the Child Support Grant (which reaches 62 per cent of children) and 8 per cent for the Old Age Grant (which reaches 73 per cent of older persons aged 60 years and above).[182] The success of South Africa's social grants in excluding those who are ineligible is likely to be, in part, the result of self-exclusion: applicants have to queue for long periods, which probably puts off some people with incomes above the eligibility line. Furthermore, many of the exclusion errors are due to other factors, rather than the means test. For example, many children are excluded from the Child Support Grant in the first few months of life due to delays in applying or the absence of birth certificates. Moreover, only 4 per cent of eligible White families apply.[183]

[179] Coady et al (2004).
[180] Personal communication from Pat Naicker of SASSA.
[181] Soares et al (2010).
[182] For further information on the effectiveness of targeting of South Africa's social grants, see Kidd and Bailey-Athias (Forthcoming).
[183] Kidd et al (2018); UNICEF and SASSA (2013).

Among persons with disabilities, exclusion errors in South Africa are also relatively low. Among older persons with severe functional limitations, the exclusion error for the Old Age Grant is 10 per cent when assessed against the income test.[184] The exclusion error is, however, higher among those who are married (19 per cent), compared to among those who are single (7 per cent).[185] Among children with functional limitations, exclusion errors from the Child Support Grant are 26 per cent and are lower among single caregivers compared to married caregivers (21 per cent compared to 37 per cent), potentially because married caregivers are confused by the means test and do not apply because they believe they are ineligible.[186]

Box 6-6: South Africa's means test

In 2016, the following annual income thresholds were used for eligibility for South Africa's social grants:

- Old Age, Disability and Veterans' Grants: R138,000 (£6,640) for a married person and R69,000 (£3,320) for a Single Person.
- Care Dependency Grant: R360,000 (£17,300) for a married person and R180,000 (£8,650) for a single person.
- Child Support Grant: R84,000 (£4,040) for a married person and R42,000 (£2,020) for a single person.
- In addition, applicants for the Old Age, Disability and Veterans' Grants had to pass an asset test. This was set at R1,980,000 (£95,200) for a married person and R990,000 (£47,600) for a single person.

It is less clear how effective the unverified means test is at identifying recipients of South Africa's Disability Grant.[187] In reality, 86 per cent of all persons with severe functional limitations should be eligible for the scheme – although some may be excluded by the asset test – corresponding to 95 per cent of those who are single and 77 per cent of those who are married.[188] However, the main challenge is not the inclusion of those who are ineligible according to the means test, but the exclusion of many of those who are eligible according to the income part of the means test. Around 58 per cent of those with severe functional limitations who are eligible for the Disability Grant according to their income are excluded, alongside 35 per cent of those classified as 'unable to do.' Some of the exclusion is likely to be the result of the employability test used for the Disability Grant, as only those not in employment can access the benefit: among those 'not in

[184] Note: This assessment has taken into account those receiving another form of old age pension.
[185] Note: According to the General Household Survey of 2015, 97 per cent of single older people with severe functional limitations receiving South Africa's Old Age Grant have no earnings so virtually everyone should be eligible for the scheme (assuming they are not excluded by the asset test).
[186] Note: The exclusion of children with functional limitations is not the result of families accessing the Child Dependency Grant – which would mean that they could not receive the Child Support Grant – since very few families in South Africa's General Household Survey were identified as accessing this scheme.
[187] Kidd et al (2018).
[188] Kidd et al (2018). This estimate is based on the income test only. It does not include the asset test.

employment' who have severe functional limitations, the exclusion errors are reduced slightly to 48 per cent, and among those classified as 'unable to do', the errors are reduced to 26 per cent (Section 0 discusses the employability test further).

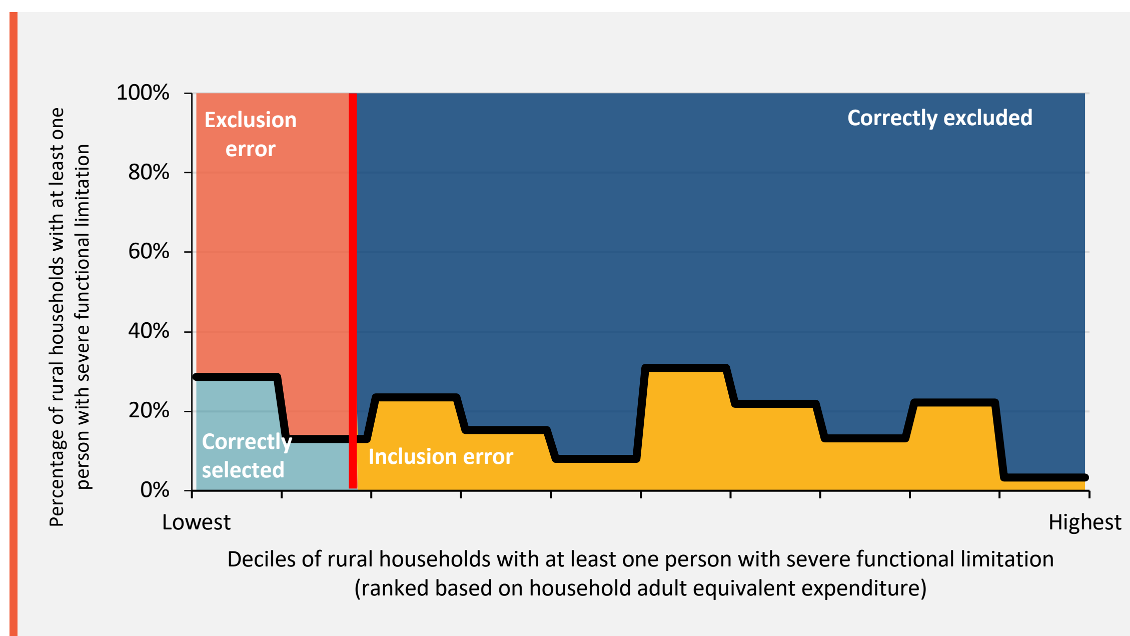
One challenge with a simple means test when used for mainstream programmes and old age pensions is that it disadvantages persons with disabilities – and their households – since they face higher costs of living as a result of their disability related costs. Consequently, some persons with disabilities who are above the income threshold would have lower standards of living than persons without disabilities who qualify for the programme instead.[189] Mitra (2005) argues in favour of raising the income threshold for assessing the eligibility of persons with disabilities in means-tested old age pensions and mainstream schemes, so as to place them on an equal footing.[190]

Community based targeting and the inclusion of persons with disabilities

Community Based Targeting (CBT) encompasses a wide range of methodologies but is rarely used for national social protection schemes. It is sometimes used in combination with other methods such as the PMT. The various types of CBT are not described in depth in this paper, but overall, there is a lack of information on the effectiveness of different methodologies in identifying persons with disabilities who are living in poverty. Ethiopia's Productive Safety Net Programme uses Community Based Targeting, but the exclusion errors across both components of the programme are very high, at 88 per cent of eligible households in areas where the programme is implemented and 80 per cent for eligible households including a person with a severe functional limitation.[191] Figure 6-2 shows the targeting effectiveness of the PSNP among rural households with a member who has a severe functional limitation. The red line indicates that all those to the left were the target population and that the effectiveness of the targeting is limited.

[189] Cf. Mitra (2005); Medeiros et al (2006); Gooding and Marriot (2007; 2009); Fritz (2011); Devandas-Aguilar (2015); Banks et al (2016).
[190] Note: Medeiros et al (2006) suggest combining the means test assessment with an assessment of expenditure based on an assessment of the family basket, thereby taking into account the additional costs of disability. However, this would be challenging to implement.
[191] Analysis by Development Pathways of the Ethiopia ESS 2012/2014 dataset. Rural households in the regions of Benshagul Gumuz and Gambelia were excluded from the analysis.

Figure 6-2: Coverage of rural households including a person with a severe functional limitation by Ethiopia's PSNP scheme – both Public Works and Direct Support – by consumption deciles

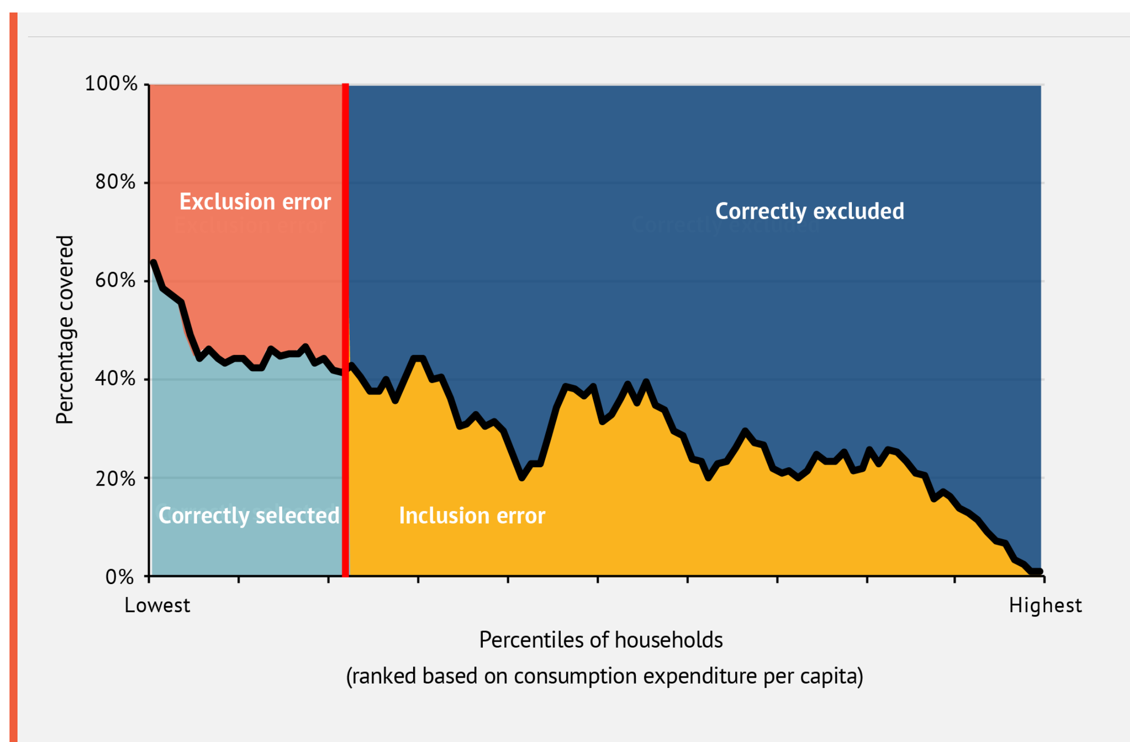


Source: Analysis undertaken by Development Pathways of the Ethiopia ESS 2012/2014 dataset. Caution should be exercised with the results for persons with severe functional limitations, as the sample size is small. Rural households in the regions of Benshagul Gumuz and Gambelia were excluded from the analysis.

In Rwanda, a community based socio-economic mapping system – known as Ubudehe – used to be employed to categorise all households in the country but, in recent years, has been used to select recipients of social benefits and services. Figure 6-3 indicates the effectiveness of this methodology in correctly identifying vulnerable households with a member who has a disability (in other words, those in Ubudehe categories one and two). The exclusion error is 53 per cent. Annex 14 indicates the effectiveness of including persons with disabilities in the VUP programme, which again, is limited. Rwanda has, however, updated the methodology used for Ubudehe categorisation with the introduction of a simple proxy means test (which is subsequently verified and validated by the local community), although there is no evidence that it is more effective. In fact, following the 2015 Ubudehe classification, almost 40 per cent of households appealed their classification.[192]

[192] LODA (2016).

Figure 6-3: The effectiveness of Rwanda's Ubudehe community based socio-economic mapping system in identifying households including a person with a 'severe disability' living in poverty according to consumption (Ubudehe categories 1 and 2 are identified)



Source: Analysis undertaken by Development Pathways of the EICV4 dataset.

Community based targeting creates a range of challenges for persons with disabilities: due to mobility challenges, they may not be present in community meetings when decisions are made; some may not participate in community discussions due to hearing or communication challenges; many persons with disabilities are ashamed to discuss their disabilities in public (which is, of course, an infringement of their right to privacy); children with disabilities may be hidden away, and unknown to the community; and, some may have already been socially excluded by their communities or are less well-connected to those in power. Indeed, given that disability is often viewed as a curse, it would not be surprising if certain persons with disabilities are less likely to be selected by a community and more likely to already be socially excluded.

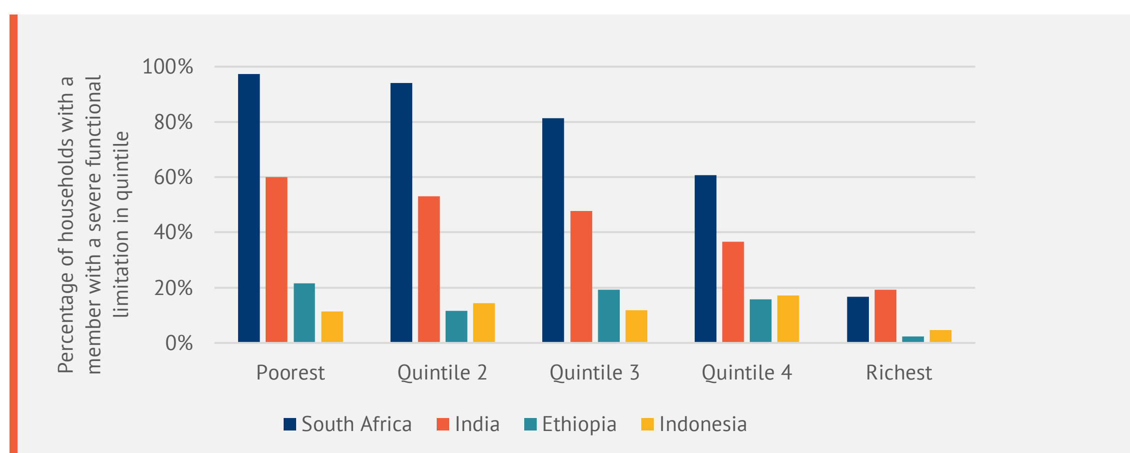
There are few options available for improving the implementation of CBT, apart from employing well-trained outside facilitators who should receive disability awareness training. There is, however, no evidence on whether the use of trained outside facilitators has led to greater inclusion of persons with disabilities. Furthermore, all decisions to include or exclude individual households should be well-documented by communities, so that exclusion can be monitored while enabling appeals by those excluded. However, this is almost never undertaken in CBT, and there is rarely an audit trail of decisions. And, as

the experience in Rwanda indicates, the rationale for using CBT as a selection tool for national programmes is weak.[193]

The impact of poverty targeting on the inclusion of persons with disabilities across social protection systems

While the use of poverty targeting can lead to the exclusion of persons with disabilities from specific social protection schemes, its use across the entire tax-financed social protection system can result in the exclusion of persons with disabilities living in poverty from all social protection schemes. Figure 6-4 shows the pattern of inclusion of persons with severe functional limitations across national social protection systems within four countries – Ethiopia, India, Indonesia and South Africa – using poverty targeting as the basis of their system. The higher the intended coverage across the entire tax-financed social protection system, the higher the overall coverage of persons with severe functional limitations living in poverty. So, South Africa – which aims to exclude the affluent rather than identify those living in the greatest poverty – has high coverage among those living in poverty. India has the next highest overall coverage among the poorest, and Ethiopia and Indonesia – which aim to only target the very poorest – have lower coverage. In Indonesia, coverage is lower for those living in the greatest poverty – the poorest quintile – than among those in the second to fourth consumption quintiles.

Figure 6-4: Persons with severe functional limitations aged 5 years and above living in households receiving a tax-financed social protection transfer, by consumption quintile



Source: analysis by Development Pathways of GHS 2015, IHDS-II 2011/2012, ESS 2013/2014 and IFLS5 2014/2015 datasets.

[193] For further discussion, see Kidd and Bailey-Athias (2016). Note: Zambia has also moved away from community based targeting as described in Kidd et al (2019b).

Assessing household or individual means

A key design question when using poverty targeting for individual benefits – such as in disability benefits and old age pensions – is whether to assess the means of the individual or the household. The right to social security is an individual right. Yet, if people are assessed against the income or well-being of their household, they may be determined as ineligible even if they themselves have no independent source of income. This is an infringement of their right to social security. Therefore, as happens in South Africa, the most effective means of including persons with disabilities in means-tested schemes – and which is most compliant with human rights – is to assess them against the income of the individual (and, in the case of child benefits, against the income of the caregiver).[194]

6.2.3 Household versus individual benefits

A further closely related design issue that affects the access of persons with disabilities to social protection is the identity of the recipient of the transfer itself. When programmes are individual entitlements – such as most disability-specific schemes and old age pensions – this is less of an issue, since in most cases the person with a disability receives the cash directly. With child benefits, the main carer – who is usually the recipient – is meant to use the cash for the child. However, in household transfer schemes, only one person in the household receives the cash and it is not possible to know with any reliability whether persons with disabilities access any benefits. If families do not prioritise the needs of people with disabilities, then those with disabilities may not receive an equitable share of the benefit. However, no studies have examined this potential issue yet. A challenge may arise with child disability benefits if parents decide to support others in the household. For example, it has occasionally been observed with South Africa's Child Dependency Grant that other children are prioritised over children with disabilities.[195] One way of addressing this would be for social workers to monitor the use of the benefit but, as indicated earlier, many low- and middle-income countries do not have effective social work systems.

[194] Kidd et al (2018).
[195] Kidd et al (2018).

6.2.4 Work capacity requirements for eligibility

As noted in Section 3, a challenge facing many persons with disabilities is that it is common for disability-specific benefits for working age people to be linked to capacity to work: in other words, they are only given to those who cannot work. This is often derived from the belief – as discussed earlier – that disability equals incapacity, and it fails to recognise that the vast majority of persons with disabilities are capable of working, as long as the enabling environment is favourable. Linking disability benefits for those of working age to incapacity to work excludes many persons with disabilities who are able to work – or are in employment – but who still need additional support. As Section 4.2 discussed, a personal independence payment that is not dependent on labour capacity can address this challenge.

Furthermore, there is some evidence that linking disability benefits to incapacity to work can generate work disincentives.[196] For example, South Africa's Taylor Commission (2002) noted that: "assessments ….. are constructed in such a way as to undermine the policy objective of maximising full participation in the world of work by creating a disincentive to work." In fact, in South Africa – which uses an employability test for its Disability Grant – only 10.3 per cent of recipients of the grant are in work (defined as having spent at least one hour in the previous seven days in employment), while only 2.8 per cent of those on a permanent benefit are in formal sector employment.[197]

In contrast, 44 per cent of non-recipients with a severe functional limitation are in work. Mitra (2008) argues that the Disability Grant may explain part of the decline in the employment rate of working age persons with disabilities that had happened in previous years in South Africa, while she also found that only 6.6 per cent of Disability Grant beneficiaries would be willing to accept a job.[198] Yet, it needs to be borne in mind that there are few jobs for persons with disabilities in South Africa due to the high prevalence of unemployment and, as Mitra (2010) argues – in contrast to her earlier statement – the Disability Grant may not have actually reduced the labour supply since it effectively absorbed those who were already out of the labour force. An impact evaluation by Kassouf and de Oliveira (2012) – based on household survey data from the years 2004-2006 – examined the effects of receiving Brazil's BPC on labour force participation. They found a reduction of 2 to 3 per cent among direct beneficiaries, with no significant effects on young co-residents aged 19-29 years, but with small negative labour force

[196] For a review of the evidence on disability benefits creating work disincentives in developed countries, see Bound and Burkhauser (1999); Taylor Commission (2002); Mitra (2005; 2008; 2010); Mutasa (2012); Bernabe-Ortiz et al (2015).
[197] Kidd et al (2018).
[198] Mitra (2010).

participation effects on adult co-residents aged 30-49 years (Kassouf and de Oliveira, 2012). This could potentially be an effect of the means test reducing the incentive of both the direct beneficiaries and family members to engage in formal sector employment. Box 6-7 discusses some of the challenges in determining incapacity to work.

It is evident that it makes little sense to develop a disability benefit system that discourages people from working. Fritz (2011), for example, argues that: “The challenge is to provide those persons with severe disabilities who cannot be expected to earn their own income with much-needed financial support and services, while at the same time not discouraging those who would like to be economically productive by denying them benefits based on their willingness to work.”

Box 6-7: The challenge of determining incapacity to work

While it is often assumed that incapacity to work is linked to physical, intellectual and mental capacity, in reality an effective work assessment should take into account the surrounding environment. In South Africa, for example, while many recipients of the Disability Grant are physically capable of some form of work, they are unable to find employment due to the prevailing high rates of unemployment. Indeed, as a result of discrimination and lower skill levels – often resulting from exclusion and discrimination during childhood – they find it more challenging than people without disabilities to obtain work. Therefore, in South Africa, SASSA has determined that capacity to work needs to take into account the prevailing labour market – in other words, the broader environment – rather than only the personal capacities of individuals.

Source: Kidd et al (2018).

In Mauritius, although it is assumed that persons with disabilities who are receiving the Disability Benefit are unable to work, in practice no labour restrictions are applied.[199] Section 7 offers examples of further initiatives to support recipients of disability benefits in accessing employment. Box 6-8 discusses the potential harm that can be caused by making disability benefits conditional on participation in employment.

[199] Wapling and Schjoedt (2019c).

Box 6-8: Work conditionalities in high-income countries

Geiger (2017) has documented the growing use of work conditionalities within disability and mainstream benefits for persons of working age with disabilities across some high-income countries. His study focused specifically on the Netherlands, Germany, Denmark, Sweden, Norway, the UK, the USA and Australia. If benefit recipients do not fulfil the conditionality, they are sanctioned. In the United Kingdom, it was found that persons with disabilities were 50 per cent more likely to be sanctioned than persons without disabilities in 2010 and 26 per cent more likely in 2014. While sanctions increase employment among persons without disabilities, there is also evidence that people end up in poorer quality jobs with lower wages. There is evidence – including a study by the UK's National Audit Office (2016) – that sanctions reduce employment among persons with disabilities. There is also evidence that work sanctions can lead to deteriorations in mental health.

6.2.5 Conditions

Some poverty-targeted household transfer and child benefit schemes make payments conditional on households complying with certain behaviours, such as children attending school or mothers participating in health clinics. If the conditions are not fulfilled, some conditional cash transfer (CCTs) programmes sanction households by the reduction or removal of the payment.

Conditions can create significant barriers for families with disabled children and parents/carers with disabilities in accessing social protection schemes, as has been found for CCT programmes in Jamaica, Peru, and the Philippines.[200] Since children with disabilities are less likely to attend school – often for reasons outside their control, such as limited accessibility, discrimination, high transport costs or lack of specialist teachers – they are more likely to be excluded from CCTs. Similarly, parents/carers with disabilities can face a range of challenges in complying with conditions, for example if they have mobility challenges.

Some CCT programmes are implemented in ways that should reduce the exclusion of children with disabilities. Many CCT programmes do not, in fact, enforce conditions and, in Mozambique, Eswatini and Palestine, conditions are waived specifically for children with disabilities.[201] There have also been recommendations to introduce 'nudges' into the design of schemes, instead of sanctions (for instance, the naming of South Africa's child benefit as a Child Support Grant is a form of a nudge).[202] Both these approaches should minimise the additional barriers that compliance with conditions creates for children and

[200] Mitra (2005); Life Haven (n.d.); Bernabe-Ortiz et al (2015); de Hoop et al (2017).
[201] Mitra (2005); Kidd and Wylde (2011).
[202] Benhassine et al (2012); Freeland (2013); Kidd (2016a).

parents/carers with disabilities, taking into account the greater challenges they face in attending school.

Some programmes have continued to implement conditions but in a modified form for children with disabilities. In Jamaica, if children with disabilities cannot access school, they are retained on the PATH programme but can only access the health grant component, thereby not receiving the payment linked to education.[203] Whether they have to comply with the health grant conditions is decided by a social worker. In the Philippines' Pantawid and Peru's Juntos programmes, if children with disabilities cannot comply with the condition, they can be replaced by another child in the household who can comply, in effect making the disabled child invisible.[204] Recently, for households with no other children, both programmes have introduced the approach used in Jamaica. Yet this approach may still exclude children with disabilities since it may be challenging to comply with the health conditions, while also reducing the value of transfer received. None of these approaches address the challenges faced by parents/carers with disabilities.

Disability and human rights experts appear divided on the approach to take. Sepulveda and Nyst (2012) argue that the use of conditions raises significant human rights concerns. They argue: "The exclusion of beneficiaries from a social protection programme for failure to comply with conditionalities is an extremely punitive measure that undermines beneficiaries' ability to enjoy their right to social security and may cause a serious deterioration in the standard of living that they are able to achieve." The fact that sanctions are more likely to be applied to children and adults with disabilities raises further concerns. Therefore, some people – motivated by human rights concerns – argue that the conditions should be waived for children with disabilities and, presumably, for parents/carers with disabilities.

In contrast, some people are concerned that, if conditions are not enforced and sanctions applied, children with disabilities may miss out on the benefits of attending school or health facilities. For example, Mitra (2005) notes: "If persons with disabilities are not induced to invest in human and health capital, the long-term poverty reduction effect that is expected from this investment is not achievable for this group."[205] Proponents of this viewpoint have made several recommendations on how to ensure that children with disabilities do not miss out: adapt the conditions and make compliance easier; offer

[203] Mitra (2005).
[204] Life Haven (n.d.); Vasquez et al (2015).
[205] Fritz (2011); Devandas-Aguilar (2015).

children with disabilities additional assistance to attend school; or, as Mont (2006) proposes, invest in more inclusive health and education services, although he recognises that this would be a medium- to longer-term endeavour. These concerns and proposals are based on the belief that conditions accompanied by sanctions add value, although there is no robust evidence demonstrating that this is the case.[206]

Some experts argue that the most inclusive approach would be to waive the conditions for children with disabilities and parents/carers so that they are not sanctioned and excluded from programmes.[207] Indeed, given the high exclusion errors in CCT programmes, they could be modified to offer transfers to children with disabilities on a universal basis, with no enforcement of means tests and conditions. In effect, this would create a child disability benefit within a CCT while the value of the transfer could also be increased to address the additional costs resulting from the child's disability. Alternatively, if governments prefer to use sanctions, they could follow the approach of Brazil. In the *Bolsa Familia* programme, non-attendance at school triggers a visit by a social worker who seeks to identify the challenges faced by the child and offers additional support.[208] Sanctions are only imposed after a number of warnings.

6.2.6 Public works

Some countries deliver social protection in the form of public works although, as Box 6-9 explains, the definition of public works as social protection is often unclear and the distinction between a labour-intensive infrastructure scheme and social protection public works – sometimes referred to as workfare – is blurred. This paper only considers social protection public works.

A common rationale for social protection to be delivered through public works programmes is that governments can be unwilling to offer unconditional transfers to working age recipients, as these are often perceived as handouts which will make

Box 6-9: Types of public works schemes

There are different types of public works schemes. The main distinction is between social assistance schemes and labour-intensive infrastructure programmes. The core objective of the former is to offer income security to recipients; the latter prioritises infrastructure while maximising the use of labour. Social protection schemes often try to 'target the poor' while labour-intensive infrastructure schemes are more interested in the quality of the workforce although, in most developing countries, the employees tend to be from low income households anyway. In both types of schemes, measures should be taken to not discriminate against persons with disabilities.

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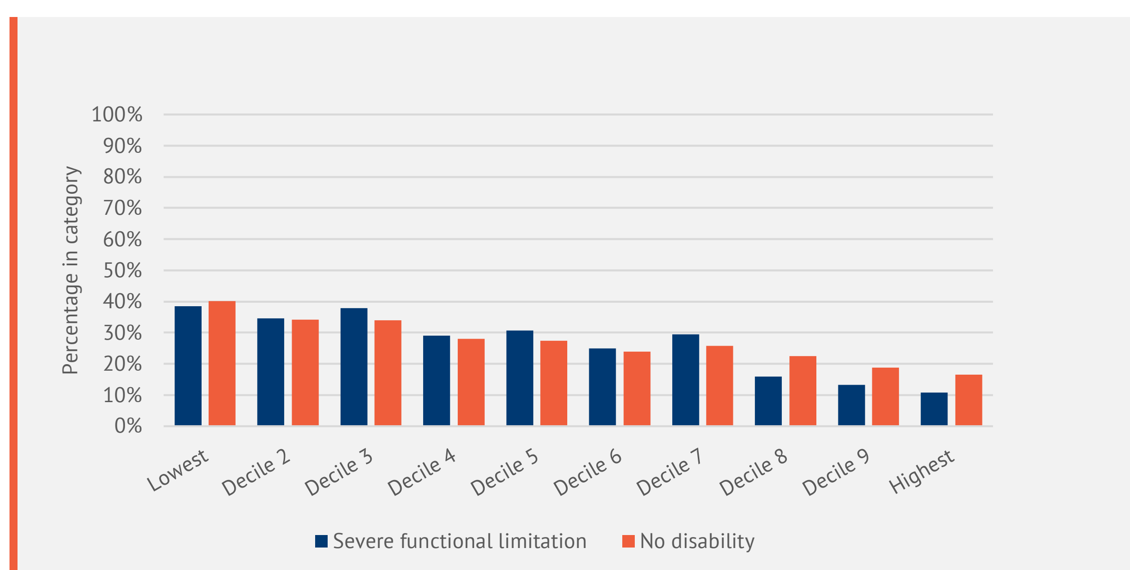
[206] Kidd (2016a).
[207] Cf. Devandas-Aguillar (2015).
[208] Kidd, Calder and Wylde (2011).

people dependent. Countries that have placed a major emphasis on public works as a social protection instrument include Ethiopia, Rwanda and India. While, in Ethiopia and Rwanda, public works are targeted at households living in poverty, in India, the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) is conceptualised as a form of entitlement, since every household in rural areas has a right to receive up to 100 days' work per year.

In Ethiopia, the PSNP public works component reaches 8 per cent of households that include a person with a severe functional limitation. The scheme intends to reach the poorest households and, when measured against coverage, the exclusion error for households that include persons with severe functional limitations is 74 per cent. Rwanda's VUP public works scheme reaches 5 per cent of households with a member who has a 'severe disability,' while the exclusion error when measured against coverage is 82 per cent (while Annex 14 shows who is included and excluded from the scheme by consumption percentile). Figure 6-5 indicates the effectiveness of self-targeting in India for households with persons with severe functional limitations and those without a member with a disability. Coverage is similar for both while it can also be seen that the majority of households living in poverty do not access the scheme.

Figure 6-5: Percentage of rural households with and without a member with a severe functional limitation participating in India's MGNREGS across consumption deciles in rural areas



Source: Wapling and Schjoedt (2019b). *Note*: Self-targeting refers to when people themselves can opt into a scheme.

Public works as social protection schemes are likely to exclude persons with disabilities for a number of reasons. For example, measures are often not put in place to facilitate employment among those persons with disabilities who are able to work but who need additional support. Furthermore, those unable to work will be excluded.

Some public works programmes have undertaken measures to facilitate the inclusion of persons with disabilities. One approach is to introduce quotas for persons with disabilities. For example, India's MGNREGS follows national legislation on employment in public programmes by allocating 3 per cent of work spaces to households with members with a disability, while South African public works schemes have an official target of 2 per cent.[209] However, the quota approach does not necessarily bring success: in India, Gooding and Marriott (2007) report participation of persons with disabilities of only 0.1-0.9 per cent while, in South Africa, it is only around 0.5-0.6 per cent. Analysis undertaken for this study found participation of those with severe functional limitations in India's MGNREGS to be 1.9 per cent of the total number of participants – which is still below the quota – while, among all those with severe functional limitations, only 8.4 per cent were engaged as labourers.[210]

Another approach is to introduce adaptations for persons with disabilities. One option is to identify tasks suitable for persons with disabilities and ensure they are given priority allocation. For example, in India, the MGNREGS scheme has adopted guidelines with detailed instructions for identifying tasks that are suitable for people with different types of disability while each State Government is responsible for specifying the type of work to be undertaken.[211] The Government of Andhra Pradesh has taken specific measures to be more disability inclusive by modifying the number of days worked and work norms: persons with disabilities – classified as having more than 40 per cent disability in a medical assessment – are individually able to access an additional 50 days of work per year (150 days rather than the normal 100 days for a household).[212] The amount of work that persons with disabilities have to accomplish during a day can be 30 per cent less than others, while receiving the same wages. Furthermore, there is also a provision for a small travel allowance for people with disabilities.[213]

The parents/carers of children with disabilities – and adults who require a high-level of care – can face significant challenges in accessing public works schemes. However, if they

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[209] Gooding and Marriott (2007).
[210] Wapling and Schjoedt (2019b).
[211] Note: This is specified in Section 9 of the 4th edition of the MGNREGA Operational Guidelines from 2013. For further information, see Wapling and Schjoedt (2019b).
[212] In the disability assessment, there is no clear guidance on what 40 per cent means (Wapling and Schjoedt (2019b).
[213] UNDP (2012) and Wapling and Schjoedt (2019b).

are to have equal access, childcare facilities would need to be put in place, with the carers properly trained in attending to the needs of the children under their care. The facilities would need to be inspected to ensure that they maintain adequate standards and do not compromise the health and wellbeing of the children. Rwanda is trialling an alternative form of public works programme to support those people of working age with significant care responsibilities (see Box 6-10).

Box 6-10: Public works for those with care responsibilities in Rwanda

In Rwanda's VUP programme, if a household has anybody considered to be 'able-bodied,' they are eligible for the public works component of the scheme: they are not eligible for the unconditional transfer, even if they have significant care responsibilities. However, the government has recently introduced a new design of the Public Works programme known as Expanded Public Works. This aims to provide a regular monthly income for households living in extreme poverty who have only one person regarded as eligible to work but who also has care responsibilities. Payment will be at the level of the equivalent of 10 days work per month and the type of work to be undertaken is likely to be road maintenance or assisting at Early Childhood Development Centres. There is no evidence yet on how successful the design will be and, given that the carers will spend time outside the home, it is unclear how continuing care will be provided.

Source: Kidd and Kabare (2019)

In many countries, contributing to social insurance funds is mandatory for everyone in employment but, although public works programmes offer a form of employment, it is rare for labourers to be given access to social insurance schemes. However, countries could consider extending insurance schemes to public works labourers. In Rwanda, for example, the national Rwanda Social Security Board believes that this would be a legal requirement for those participating in the Expanded Public Works programme described in Box 6-10, and that the public works programme should pay the contributions. This would benefit those participating in the programmes since they would gain access to additional protection if they experienced a disability, including from an employment injury, while also, potentially, being able to benefit from an old age pension.

6.3 Barriers in the implementation of social protection schemes and measures to address them

This section examines the key barriers for persons with disabilities that may arise in the implementation of social protection schemes, alongside examples of measures to mitigate the challenges. It will help explain why many persons with disabilities are unable to access social protection schemes, even when eligible. The discussion will not differentiate between disability-specific and mainstream schemes, as many of the issues are similar.

6.3.1 Awareness about social protection schemes

A key reason for persons with disabilities not accessing social protection schemes is a lack of knowledge about the existence of programmes. In South Africa, for example, many persons with disabilities and parents/carers of children with disabilities are unaware of the existence of the Disability and Care Dependency Grants or do not know how to apply.[214]

There are two main causes of the lack of awareness. People with certain types of impairments – such as seeing, hearing and learning challenges – find that accessing information is difficult, in particular if communications are not adapted to their requirements. Also, programmes do not always invest sufficiently in communications and are even less likely to adapt their communications to the needs of persons with disabilities, including those with literacy challenges. Often, staff employed to administer programmes have not been trained in how to communicate effectively with persons with disabilities. While a key role of social workers is to make the most vulnerable people aware of the existence of programmes and how to apply, as discussed in Section 6.1, in many countries social work systems are weak.

Although it is widely recognised that communications should be adapted to the requirements of persons with disabilities, the research found no evidence of good practice from either the literature review or case study countries. This may explain, in certain contexts, the exclusion of persons with certain types of functional limitations (such as those unable to see or hear). Box 6-11 outlines guidance on good practice.

Box 6-11: Disability sensitive communications in social protection programmes

Ideally, social protection programmes should develop specific communications strategies for persons with disabilities and ensure they are adequately resourced. The strategy should be tailored to the requirements of specific types of person: for example, for the visually impaired, publications can be in large print. Many persons with disabilities are illiterate, so communication should take this into account.[215] Full use should be made of disability organisations to help disseminate messages to their members and clientele. Information should be placed in locations commonly accessed by persons with disabilities, such as clinics and hospitals, social work offices, places of worship, local shops, etc. Of particular importance is the need to use multiple channels of communication.

[214] Gooding and Marriot (2009); Goldblatt (2005; 2009), Salojee et al (2007) and Kidd et al (2018).
[215] Cf. Mitra (2005).

6.3.2 Registration

Many of the causes of exclusion occur during the application and registration processes for social protection schemes. While these challenges can be linked to capacity limitations on the part of persons with disabilities, they become more disabling as a result of weak registration mechanisms. Some of the challenges faced by persons with disabilities are outlined below.

6.3.2.1 Application processes

Application processes for disability benefits are often difficult and complex to navigate, in particular when they incorporate disability assessments alongside the generic application process (see Section 6.2).[216] These challenges are exacerbated if other documents need to be obtained, such as birth certificates or identity cards, which may require visiting multiple offices. In South Africa, for example, in addition to visiting SASSA offices, applicants may also have to engage with the Department of Health, Department of Home Affairs, Police (to certify affidavits), Municipalities (for proof of residence) and Land and Housing Departments (for proof for the means test).[217] In Rajasthan, India, it can take around six months to approve disability benefits, but some people can wait for more than two years.[218] The World Bank (2007) reports that the main deterrent to applying for disability pensions in Rajasthan is the complexity of the process, which puts off around half of potential applicants. Indeed, applicants for disability and old age pensions across India often have to pay agents to undertake the application process on their behalf, which many people find challenging to cover.[219] Furthermore, the additional challenges faced by women, such as childcare responsibilities, are often not taken into account.[220] The process can become more daunting if applicants are only given temporary benefits – as often happens in South Africa – which means they have to repeat applications after only a short period.[221] As described in Box 6-12, in Brazil, measures have been put in place to support persons with disabilities when applying for the BPC scheme.

[216] See Salojee et al (2007); Gooding and Marriot (2007); World Bank (2007); Goldblatt (2009); Kidd (2014c).
[217] Goldblatt (2009); Kidd et al (2018).
[218] Dutta (2008).
[219] Wapling and Schjoedt (2019b); Pellissery (2005).
[220] Goldblatt (2009).
[221] Kidd et al (2018).

Box 6-12: Brazil's experience with registration for disability benefits

Brazil has significantly expanded its social work services system since 2004 and now has nearly 8,000 Social Assistance Reference Centres (CRAS) spread across the country. The CRAS offer counselling and awareness raising support to vulnerable families and function as one-stop shops for information about social security benefits and other forms of support available. This includes helping people with disabilities to understand the eligibility criteria for the main tax-financed disability benefit, the BPC, completing application forms, and assisting with appeals when applications are unsuccessful.

The length of time that it takes to make an application may not be taken into account when deciding the date of payment for a person's disability benefit. In South Africa, for example, while mainstream benefits are backdated to the date of first application, Disability and Care Dependency Grants are only backdated to the point at which the application is approved, which may be months after the commencement of the application, with SASSA often responsible for much of the delay. Similarly, in Brazil, payments are only made from the date the application is approved.[222] In contrast, in Mauritius, payments are backdated to when the first application was made, which should be regarded as good practice.[223] Box 6-13 outlines some potential measures that could be taken to make registration processes simpler for persons with disabilities.

Box 6-13: Potential measures to reduce the complexity of registration for persons with disabilities

- Analysing whether all the steps in the process are absolutely necessary with programmes themselves taking on the responsibility for collecting some of the information or documents required rather than obliging applicants to do it.
- Offering support to those persons with disabilities facing the greatest challenges, including assistance from social workers.
- Establishing one-stop shops so that a range of government services are brought together under one roof.
- Backdating payments to the first date of application.

[222] Wapling and Schjoedt (2019a) and Kidd et al (2018).
[223] Wapling and Schjoedt (2019c).

6.3.2.2 Mobility challenges

Registration centres can be a significant distance from applicants' residences, which can be a particular problem for persons with disabilities who have mobility or intellectual challenges. Some may live too far from registration centres to even attempt to apply, while others can face high transport costs: for example, a blind person may require a companion, while a

wheelchair user may be charged for two seats on a bus or may have to use a taxi. People may face multiple trips, in particular if disability assessments are undertaken at a separate time to the application for the scheme, or if other documents are required, such as identity cards.[224] In South Africa, Goldblatt (2009) found that some applicants withdraw from applying as a result of the costs.

There are a number of examples of good practice to support persons with disabilities who experience mobility challenges. In South Africa, SASSA offices have temporary outreach centres in public buildings within the heart of communities and teams responsible for outreach.[225] Zambia's Social Cash Transfer programme has used mobile units to undertake registration within communities.[226] In Brazil, applicants for the BPC programme have all their transport costs reimbursed – including the cost of an accompanying adult – regardless of whether or not

the claim is successful.[227] Some programmes also support persons with disabilities to access registration points: for example, in Zambia, community volunteers are utilised to support persons with disabilities who cannot register for schemes and, on occasion, the volunteers guide those undertaking registration to the houses of those who are unable to

Box 6-14: Other costs experienced by persons with disabilities during the registration process

Persons with disabilities can face a range of other costs in addition to transport. They may have to obtain additional documents, pay for childcare, or pay for assistance to navigate the process. Applicants also face opportunity costs, especially if they need to make a number of visits. In Rajasthan, India, Dutta (2008) estimated that the average cost of the application process – including obtaining documents, transport costs, unofficial payments and bribes – was equivalent to slightly more than the cost of a monthly benefit.

[224] Cf. Wilson (2005); Goldblatt (2009); and, Kidd et al (2018).
[225] Kidd et al (2018).
[226] Kidd et al (2019b).
[227] Wapling and Schjoedt (2019a).

leave their homes.[228] Box 6-15 outlines potential measures to address mobility challenges during registration.

Box 6-15: Options for addressing mobility challenges (distance and associated costs) during registration

- Undertake outreach programmes by setting up temporary registration points in communities on a regular basis.
- Offer free transport or reimburse costs to those making applications – which may be restricted to those who are successful in order to deter misuse of this benefit – or increase the value of the first payment to cover transport and other costs.[229]
- Offer logistical support to applicants, with government officials or community organisations supporting travel.[230] If there is an effective social work system, local social workers could arrange this support.

6.3.2.3 Accessibility of application centres

If application points – and their facilities – are physically inaccessible to persons with disabilities, a significant barrier is created.[231] Furthermore, people with disabilities may find it challenging to queue for long periods or may fear losing their place in the queue if they go to the toilet.[232] People with disabilities may have to take children to application points, due to their care responsibilities or to support their mobility, and may be dissuaded from applying if they face challenges in caring for them.

South Africa's SASSA has undertaken a range of measures to improve the accessibility of their offices.[233] Most SASSA offices are on the ground floor, but not all. SASSA is encouraging their regional branches to put braille in lifts but this is only done when they undergo regular refurbishment. Ramps are being built for all SASSA offices – currently 90 per cent have ramps – and there is a standard for the gradient of the ramp. While not all offices have disability accessible toilets, the regional branches are being encouraged to put them in place. There are, however, no standards for certain physical access issues, such as the width of doors or the height of door handles. There are also no automatic doors: however, SASSA have security guards in place that are meant to open the doors for those experiencing difficulties. SASSA has experimented with an accessibility audit of its premises although, due to challenges with the service provider, the audit was not

[228] Kidd et al (2019b).
[229] Cf. Goldblatt (2009).
[230] Cf. Goldblatt (2009).
[231] Cf. Goldblatt (2009).
[232] Cf. UNICEF and SASSA (2013).
[233] Kidd et al (2018).

finished. Box 6-16 outlines potential strategies for improving the accessibility of registration centres.

Box 6-16: Strategies to improve the accessibility of registration centres for persons with disabilities

- Develop minimum standards for accessibility and the environment within application points and ensure that these are monitored closely. Enable people to complain when standards are not met.
- Improve accessibility through wheelchair ramps, lifts and doors that open easily (or have attendants opening doors). Put toilet facilities for persons with disabilities in place.
- Consider fast-tracking the application process for persons with disabilities by, for example, ensuring that they are given priority in queues. Alternatively, ensure that waiting facilities are comfortable and, if queues are long, water is made available. The use of tickets, rather than having physical queues, can ensure that people do not lose their places if they need the toilet.
- Offer childcare facilities in application centres.

6.3.2.4 Capacity of staff

A further implementation barrier can be weak staff capacity.[234] Staff or enumerators may be unable to communicate with some categories of persons with disabilities, such as those with hearing or learning difficulties. In South Africa, Goldblatt (2009) found that some staff could not explain the eligibility criteria for the Disability Grant, or they would inappropriately screen applicants out due to their own misunderstandings. Furthermore, during applications, staff may not have the awareness to organise application processes that address the requirements of persons with disabilities. They may also exhibit discriminatory, hostile or demeaning behaviour.[235] In South Africa, the research found one example of a SASSA office in which one of the members of staff had a child with Downs Syndrome. As a result, she undertook awareness raising and informal training of her colleagues which resulted in the office being identified as particularly friendly for people with Downs Syndrome.[236] Box 6-17 outlines some measures that could be undertaken to build the capacity of staff.

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[234] Subbarao (1996); Dube (2005); Medeiros et al (2006); Gooding and Marriott (2007; 2009); Palmer (2013)
[235] Closs et al (2003); Dube (2005); and Subbarao (1996).
[236] Kidd et al (2018).

Box 6-17: Potential measures to improve staff capacity to engage effectively with persons with disabilities

- Include training on disability awareness in capacity development strategies and give disability awareness training to all staff, repeated on a regular basis.
- Provide translation services, including sign language.
- Make application forms accessible to those with visual difficulties. If enumerators visit houses to undertake poverty assessments and face language difficulties, they should return later with an interpreter.
- Include disability awareness objectives in staff performance plans.
- Examine staff behaviours towards people with disabilities in programme monitoring and have simple mechanisms to enable applicants to complain about problematic staff behaviour.

6.3.2.5 Duration of support and exit from schemes

A key issue in any social protection programme is the length of time that someone receives a benefit before being re-assessed. Any request to ask a person with a disability to re-apply increases the burden on them. In some cases, impairments may be temporary and offering a short-term benefit which can be renewed following a further assessment is appropriate, although the costs faced by applicants as a result of the re-assessment should be addressed. However, asking people with permanent impairments to re-apply places a burden on both the system and the individual. Poor quality medical assessments may misdiagnose permanent disabilities, making people re-apply needlessly: for example, there are many cases of Downs Syndrome being diagnosed as a temporary disability in South Africa.[237] In old age pensions, recipients often have to produce evidence of 'proof of life' to continue as recipients. This can be challenging for some older people with severe impairments. In South Africa, SASSA facilitates this process by visiting those aged over 75 years to obtain the proof of life, but this is not always carried out and may explain the lower rates of access to the old age pension among older people with severe functional limitations.[238]

[237] Kidd et al (2018).
[238] Kidd et al (2018).

Box 6-18: Potential measures to address challenges with the duration of support and exit from schemes

- Make the transfer permanent when an impairment is diagnosed as permanent, with the only requirement being to show proof of life every few years.
- When proof of life is required and has not been presented by a person with a disability, visit the households of persons with disabilities before removing them from a scheme.
- Once households with a member with a disability of any age access a social assistance scheme, maintain them on it as long as the person with a disability is resident and eligible, given that they face higher costs and risks.
- If persons with disabilities are offered a temporary benefit, give them assistance when they re-apply, including compensation for the costs arising from the application.

Poverty targeted schemes should, in theory, regularly remove recipients who are no longer eligible on the grounds of poverty (as well as removing those who are found to have been included erroneously). However, as indicated in Section 3, households in developing countries can have low and volatile incomes so not all of those that are exiting the schemes will have sustainably moved above the eligibility poverty line. However, given that many households with members with disabilities face higher costs and risks – and, as Section 3 indicated, can have low incomes even if they are above the eligibility line – removing them from poverty targeted schemes may induce negative consequences for their wellbeing.

6.3.2.6 Accessibility of transfer payments

Persons with disabilities, in particular those with mobility challenges, can face significant difficulties in accessing payments. Pay-points can be located at a significant distance from their homes, which imposes costs on recipients with disabilities, some of whom experience higher travel costs than those without disabilities.[239] For example, in South Africa, a quarter of Disability Grant recipients found it difficult to reach the pay-point due to their impairment.[240] Women with disabilities may face even higher costs: in South Africa, for example, some women pay a male companion to keep them safe when collecting their grant or, alternatively, to travel in taxis.[241] Some recipients of South Africa's Disability Grant pay up to 7 per cent of the value of the grant to collect payments.[242] Certain persons with disabilities can face challenges in entering pay-points and banks. There may, for example, be no wheelchair ramps or lifts.[243] Persons with

[239] Cf. Dutta (2008).
[240] De Koker et al (2006).
[241] Gooding and Marriot (2009); and, Goldblatt (2009).
[242] Goldblatt (2009).
[243] See Goldblatt (2009).

disabilities may experience long waiting times – as has been reported in Peru and South Africa – which may be challenging for some.[244] Persons that are visually challenged or wheelchair users may not be able to use conventional ATMs.

Some programmes have attempted to address the challenges faced by persons with disabilities in accessing payments. A common strategy is to ensure that pay-points are located as close as possible to beneficiaries, including by establishing minimum distance standards. While social protection programmes are increasingly using electronic payment systems, some may result in greater travel distances for some recipients, while some manual payments can be made closer to recipients: for example, in Zambia, school teachers are employed to make payments to beneficiaries close to their residence and, in some cases, take the payment to their houses (although this is, officially, not permitted).[245] Many programmes allow recipients to name a trusted alternate who is authorised to pick up the transfer on their behalf. Often, this is a family member but, in South Africa, there are regulations that allow one person to act as an alternate for a maximum of five recipients and, in cases of abuse of particularly vulnerable people, SASSA is able to step in to change the alternate.[246] In the Philippines, among recipients of the old age pension – 67 per cent of whom have a severe functional limitation – over a third used an alternate.[247] Mitra (2005) proposes making payments less frequent so as to reduce the need to travel and, indeed, in many countries payments are made every two or three months instead of monthly. However, if payments are made into bank accounts, recipients should be able to pick them up whenever they wish, which increases the flexibility with regard to when the payments can be accessed.

[244] Bernabe-Ortiz et al (2015); Kidd et al (2018).
[245] Kidd et al (2019b).
[246] Kidd et al (2018).
[247] Knox-Vydmanov et al (2017).

Box 6-19: Potential measures to improve access of persons with disabilities to payments

- Set minimum standards for payments that take into account the requirements of persons with disabilities. If independent payment service providers are procured, place these standards in their contracts.
- Allow persons with disabilities to name an alternate who can pick up payments on their behalf.
- If biometrics are used to confirm identity, take measures to ensure they are accessible for persons with disabilities.
- If ATMs are used, they should read out instructions and the amount in local languages to facilitate access for those with visual impairments. Consideration should also be given to the height of ATMs, so that barriers are removed for wheelchair users.

6.3.2.7 Grievance mechanisms

Social protection schemes should have effective mechanisms to enable applicants and beneficiaries to make appeals and complaints about programme decisions and implementation. This includes appeals against exclusion from schemes as well as complaints about programme operations. There are few examples in low and middle-income countries of good grievance mechanisms and even fewer that have made adaptations for persons with disabilities.[248] South Africa is an example of a country with a more developed complaints mechanism. Every applicant is provided with a letter detailing the results of their application and, when someone is rejected, they are told that they have the right of appeal within 30 days. The process is described in more detail in Box 6-20. Most appeals – around 95 per cent – are related to the Disability Grant since the criteria for the Child Support, Foster Care and Old Age Grants are quite straightforward: in fact, appeals are most commonly linked to the disability assessment, which is a component of the Disability Grant application. In Zambia, a complaints mechanism has been designed for the Social Cash Transfer programme although it is yet to be implemented.[249] It plans to use multiple channels to enable greater access for persons with disabilities and tasks community leaders and volunteers with helping persons with disabilities to access the complaints mechanism.

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[248] Kidd (2014b).
[249] Kidd et al (2019b).

Box 6-20: South Africa's complaints mechanism

Applicants for South Africa's social grants can appeal to a Tribunal which is independent of SASSA and reports to the Minister of Social Development. In the case of appeals on disability-specific grants, the Department for Social Development prepares a legal and medical report for the Tribunal, but it makes its decision independently. The Tribunal makes its decision on the basis of the documentation available but, when the Tribunal considers that the documentary evidence is inadequate, it can request that an additional medical assessment be carried out.[250] This is most likely to happen in complex cases (such as for people with cognitive impairments, traumatic brain injuries or psycho-social impairments) when the Tribunal considers that the original medical assessment was not comprehensive enough. The Tribunal makes an appointment for the applicant to see the relevant specialist. However, since these must be made via the public health system, they can take anywhere between three to nine months, making this a potentially lengthy process. The decision of the Tribunal is binding on SASSA. At the Tribunal stage, 93 per cent of the original decisions have been upheld, and it is likely that the high proportion is because many appellants have misunderstood the Disability Grant criteria. It is, however, likely that the Tribunal upholds appeals made by persons with complex disabilities who have been rejected by Medical Officers.[251] If the Tribunal upholds the original decision, the applicant can have a final recourse to a judicial review. Again, the decision of the judicial review is binding on SASSA.

Box 6-21 proposes some measures to help make grievance mechanisms more accessible to persons with disabilities.

Box 6-21: Potential measures to improve the accessibility of grievance mechanisms for persons with disabilities

- Programme communication strategy outlines how persons with disabilities will learn about the grievance mechanism.
- Multiple channels for appeals and complaints, such as complaints forms, telephone hotlines, approaches to staff, etc.
- Ensure people with communication challenges know how and where to access support, for example by calling hotlines or filling in forms.
- Access to support for persons with disabilities to be able to make appeals and complaints.

[250] Kidd et al (2018).
[251] Kidd et al (2018).

6.3.2.8 Monitoring and evaluation of social protection schemes

Social protection systems require effective monitoring systems to identify challenges and implement improvements. This can be undertaken through a range of mechanisms including regular visits to programmes, spot-checks and reports from management information systems. Monitoring reports should also be regularly reviewed by programme managers so that action is taken based on recommendations from the reports. However, there is little evidence of programmes in low- and middle-income countries undertaking regular monitoring of the access of persons with disabilities or the barriers faced. South Africa, for example, has a range of monitoring mechanisms – both within SASSA and the Department for Planning, Monitoring and Evaluation – but the indicators used are not sufficiently disaggregated to monitor the challenges faced by persons with disabilities.[252]

Few management information systems (MISs) include robust indicators on disability. While some include whether someone has a disability, they are often not based on any robust assessment nor is the data disaggregated by type or severity of functional limitation or impairment. One option for capturing data would be to incorporate the Washington Group Set of Questions during registration. However, Chirchir and Kidd (2011) note the additional expense of collecting this information and the need to keep it regularly updated.[253] Another option is for countries to build a comprehensive disability assessment database and create links between this database and social protection MISs, potentially through a Single Registry.[254] Zambia is currently developing a disability MIS to hold all national data on disability classification, although the limited level of investment in the scheme means that it will be challenging for it to function well.[255]

Box 6-22: Potential measures for more disability sensitive monitoring and evaluation of social protection programmes

- Establish guidance and indicators for the monitoring of social protection schemes that focus on critical issues linked to the access of persons with disabilities, as well as ensuring that the schemes are regularly assessed.
- Place disability as a standing item in social protection scheme management meetings.
- Include the Washington Group Set of Questions in all quantitative evaluations of social protection schemes, with analysis on disability mainstreamed through the evaluation reports.

[252] Kidd et al (2018).
[253] Life Haven (n.d.) recommends that data for the Pantawid scheme in the Philippines should include information on persons with disabilities, disaggregated by impairment category, gender, age, etc.
[254] Chirchir and Farooq (2016).
[255] See Kidd et al (2019b).

There has been significant investment by development partners and governments in the evaluation of social protection schemes in developing countries. Yet, there have been few evaluations of disability-specific schemes and old age pensions and little incorporation of disability into the evaluation of mainstream programmes, which could be easily achieved by including the Washington Group Set of Questions in all quantitative evaluations. In Uganda, for example, the evaluation of the Senior Citizens and Vulnerable Families Grants did not examine disability, despite both schemes having a strong disability focus.[256] However, ongoing evaluations of Zanzibar's and Kenya's universal old age pensions by HelpAge International include the Washington Group Set of Questions.[257]

6.3.2.9 Social accountability mechanisms

It is important that citizens are able to hold the state to account in the design and delivery of social protection schemes. Across developing countries, there are a number of examples of NGOs undertaking this role, using citizens' groups to monitor programmes. Other relevant social accountability mechanisms involve citizens using the judiciary, human rights commissions or ombudsmen to hold government officials accountable. However, there are few examples of social accountability mechanisms being undertaken effectively and sustainably in social protection programmes.[258] The inclusion of people with disabilities is usually not considered in social accountability mechanisms that are linked to mainstream programmes and old age pensions, and there is little evidence about which social accountability mechanisms are the most accessible for people with disabilities. In South Africa, for example, a social accountability mechanism implemented by an NGO to assess the performance of SASSA did not address disability.[259]

Social accountability mechanisms can be particularly important for people with disabilities since exclusion may be compounded by factors such as disability or older age. For instance, in South Africa's Old Age Grant, the combination of physiological and psychosocial changes in older age can exacerbate power imbalances between service users and providers.[260] Indeed, there are examples of persons with disabilities being excluded from social accountability mechanisms that are run by older persons: in Bangladesh, it was deemed socially unacceptable for older people with disabilities to become leaders of Older Persons' Citizen Monitoring Groups (OCM).[261] Furthermore, across

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[256] Kidd (2016b). Note: The evaluation was undertaken by Oxford Policy Management.
[257] Knox-Vydmanov and Galvani (2017) and personal communication with Charles Knox-Vydmanov.
[258] See Pellissery (2005); Kidd (2014c); Ayliffe et al (2017); Kidd et al (2018); Wapling and Schjoedt (2019b)
[259] Kidd et al (2018).
[260] Livingstone (2014).
[261] Livingstone (2011).

27 countries where older people's associations have undertaken monitoring, even when older persons monitor access to social protection, it was found that they did not collect disaggregated data on whether people with disabilities are included.[262]

Disability organisations could play a key role in mainstreaming disability into social accountability and citizen monitoring mechanisms. However, as discussed earlier, there can be a reluctance among disability organisations to engage with social protection policy and delivery. Some disability organisations are stronger than others – for example, those representing persons with learning difficulties are often relatively weak – and if the strong organisations only focus on their client groups, those represented by weaker organisations may miss out.

Box 6-23: Potential measures to enhance the disability inclusiveness of social accountability mechanisms

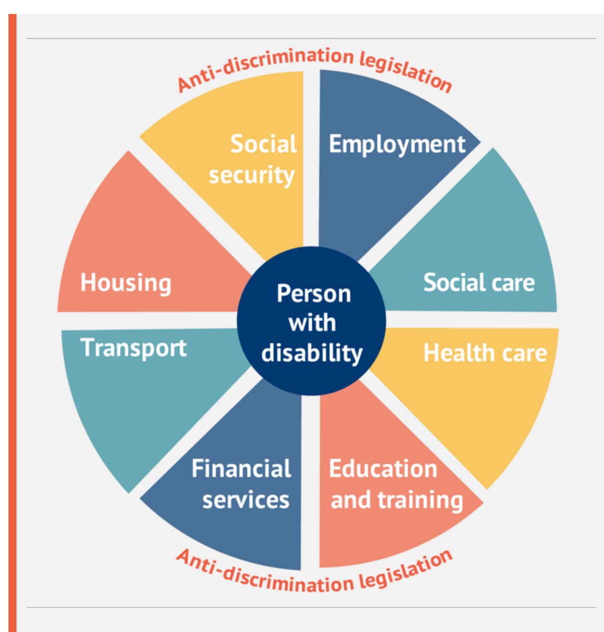
- Incorporate indicators addressing the challenges faced by persons with disabilities in social accountability mechanisms.
- Disability organisations to engage in social accountability mechanisms or to implement their own, actively including categories of persons with disabilities that go beyond the client groups of specific organisations.

[262] Livingstone and Knox-Vydmanov (2016).

7 Links between social protection schemes and other public services

There is a growing interest in building links between social protection schemes and other public services, in order to enhance the impact on recipients. This is often conceptualised as placing the social protection scheme at the centre and linking other services to it. An alternative visualisation would be to place persons with disabilities at the centre to ensure that they can access all services – including social protection – when required, as indicated by Figure 7-1 (which also highlights that access should be underpinned by anti-discrimination legislation).

Figure 7-1: Support required by people with disabilities cuts across a range of public services



Source: ILO and Development Pathways (2016).

As explained in Section 6, social workers play a critical role in helping vulnerable persons with disabilities access a range of services, including social protection. Implicitly, therefore, links are strengthened between social protection and other services through the focus of social workers on the individual or family. Therefore, if effective linkages are to be established between social protection and other services, adequate investment in national social work systems is critical. However, across most low- and middle-income countries, investment in social work is inadequate and social work systems are very weak.

There are some low- and middle-income countries that build linkages between services by offering a range of benefits to persons with disabilities, in addition to social protection. In Nepal, for example, holders of a disability card are able to receive a 50 per cent reduction in the cost of land and internal air transport.[263]

[263] Banks et al (2018a).

Some social protection initiatives have attempted to link recipients of social protection programmes with additional services and support, although there is little evidence that the initiatives have focused on persons with disabilities specifically. Kenya, however, has provided recipients of both its Inua Jamii Senior Citizens' social pension and Persons with Severe Disabilities Cash Transfer with access to free hospital insurance.[264]

While there are many active labour market programmes for persons with disabilities that support their access to work – see Box 7-1 for some examples – there are few that are directly linked to recipients of social protection. Some high-income countries are actively attempting to remove persons with disabilities from income replacement schemes by encouraging employment, often using conditionalities and sanctions as incentives. There is, however, some evidence that these schemes have no or negative effects and that the use of sanctions can lead to destitution and deteriorations in mental health (see Section 6.2.4).

There are a number of countries that have adopted alternative approaches to support recipients of disability benefits to access employment: for example, the ILO (2014) describes how some countries allow recipients of disability benefits to work up to a certain wage threshold, without affecting their benefits (such as Australia's Disability Support Pension). Within middle-income countries, there are few examples of labour market support being provided for recipients of disability benefits. In Brazil, however, two initiatives have been proposed to encourage recipients of the BPC disability benefit into work. Firstly, they can put receipt of the BPC on hold if they obtain a job and, if they become unemployed again, they can resume the BPC without undergoing a further assessment. Secondly, the 2015 Law of Inclusion has proposed an 'Inclusion Benefit' for people with disabilities who are working, which is set at the level of the BPC but is given to those in work. However, both initiatives are yet to be implemented.[265] In South Africa, the Ministry of Labour oversees nine Sheltered Accommodation Factories which provide employment to around 6-7,000 people with disabilities.[266] The wages are set at a level that means that workers can also pass the means test and access the Disability Grant. Nonetheless, if recipients of disability benefits are to be encouraged to work, many schemes would need to be re-designed to remove the work disincentive generated by employability tests. Two means of doing this would be to either remove the employability restriction, or else to reduce the reliance on only income replacement programmes by

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[264] Kidd et al (forthcoming).
[265] Wapling and Schjoedt (2019a).
[266] Informant in the Ministry of Labour in Kidd et al (2018). Note: The White Paper on the Rights of Persons with Disabilities states that employees in these enterprises receive the Disability Grant plus a "small, discretionary additional weekly payment for the work provider."

incorporating Personal Independence Allowances into the panorama of programmes for persons with disabilities.

Box 7-1: Active labour market programmes for persons with disabilities

Many countries have initiatives that support persons with disabilities in accessing employment. Some countries use employment quota systems. For example, in Brazil, between 2 and 5 per cent of those employed in the public sector and in private sector companies with over 100 employees should have a disability (with the proportion varying depending on the number of employees overall). In 2014, almost 360,000 people were employed under the scheme, which can be compared to the 20 million persons with disabilities that are economically active, according to the 2010 census.[267] Similarly, in Nepal, at least 5 per cent of public sector jobs should be for people with disabilities and there are tax breaks and other incentives for private sector employers to hire people with disabilities.[268] However, the quotas and employer incentives are underused and based in urban centres, thereby limiting access for people with disabilities living in rural settings. Furthermore, many of the people offered jobs have mild disabilities.

Some governments offer vocational training for persons with disabilities. In Indonesia, the Ministry of Manpower and Transmigration has provided training for persons with disabilities in vocations such as car mechanics, computing, sewing, carpentry and massage, but has reached few people. The Ministry of Social Affairs also offers training but, in 2008, it only reached 773 people which, in a country the size of Indonesia, is a tiny number.[269] Nepal also offers free vocational training for persons with disabilities but, again, it is underutilised.[270]

The South African government has a range of initiatives to encourage persons with disabilities to enter the labour force, including an Employment Equity Act which was passed in 1997. The Extended Public Works programme offers persons with disabilities opportunities to gain work experience in the public sector. There are also equity targets for both the private and public sector. However, according to the White Paper on the Rights of Persons with Disabilities, the Employment Equity Act has not resulted in a significant improvement in the employment status of persons with disabilities. The equity targets are below the disability prevalence rates, and much of the affirmative action assists those who are white and male, who often do not require significant support. Persons with psychosocial, mental, intellectual and hearing disabilities are less likely to access affirmative action. Indeed, persons with mental disabilities are often discriminated against in accessing affirmative action work opportunities.[271]

[267] Wapling and Schjoedt (2019a).
[268] Banks et al (2018a).
[269] Skills for Care (2013).
[270] Banks et al (2018a).
[271] Kidd et al (2018).

8 Conclusion

A high proportion of the world's population live with a disability, facing a range of challenges across the lifecycle. Social protection can play a key role in empowering persons with disabilities by offering them a minimum income as well as financial support to address the additional costs they face, which can be substantial. The CRPD stipulates that all persons with disabilities have the right to social protection. Nonetheless, this research has shown that there is low social protection coverage of both persons with and without disabilities in low- and middle-income countries and, for many persons with disabilities who are able to access social protection, the support they receive is often inadequate. However, a comprehensive analysis of the situation is constrained by limited data on persons with disabilities in national household surveys as well as in social protection programme monitoring and evaluation datasets.

The research has highlighted the types of social protection systems and schemes that could be put in place across the lifecycle, based on experiences in high income countries as well as some low- and middle-income countries. This includes a mix of appropriate disability-specific and disability-relevant schemes, as well as ensuring the access of persons with disabilities to mainstream social protection schemes on an equal basis with other members of society. Yet, many low- and middle-income countries do not currently make the level of investment in social protection systems that is necessary to adequately address the requirements of persons with disabilities.

Nonetheless, the research found examples of countries that are making progress in reaching people with disabilities at particular points of the lifecycle. Increasing numbers of low- and middle-income countries are offering disability-relevant universal old age pensions, thereby enabling the majority of older persons with disabilities to access income support. Further, some countries have established disability-specific schemes for children and working age adults, although their overall prevalence and coverage is much less than old age pensions. Of the countries with mainstream schemes, only a small number have schemes – mainly child benefits – offering relatively high or universal coverage which would enable them to include the majority of persons with disabilities within the target category. The research did not find evidence of mainstream social protection schemes targeted at the poorest members of society that are effectively reaching the majority of persons with disabilities, including those living in the poorest households.

The research has also shown that, even when social protection schemes are in place, persons with disabilities can face barriers in accessing them. In part, this may be related

to the type and severity of disability experienced by people, although the patterns of access vary from country to country. Analysis undertaken by this research found that, while people with more severe functional limitations are more likely to access social protection than those with milder limitations, there are examples of people with the most profound functional limitations being less likely to receive a benefit than those with less severe disabilities, in particular among people with challenges in remembering, communicating and self-care.

The barriers that people with disabilities face in accessing social protection schemes can be multiple, in particular if they also have to undertake a disability assessment. Common barriers include: ineffective communications on the existence of schemes and how to apply; complex and expensive application processes; long distances to travel to apply for schemes alongside the high costs of transportation; physical barriers at application points; weak staff capacity and discriminatory attitudes; and, inadequate grievance mechanisms. When schemes include conditions, further barriers for persons with disabilities can be created.

Examples of good practice to address barriers to access were identified and outlined in the report. Countries such as Brazil, Mauritius, South Africa and Zambia have on-demand disability assessments. Brazil has established centres across the country that inform people with disabilities about schemes and provide support through social workers, to help people apply for schemes and undertake complaints. In Zambia, assistance is provided by volunteers. South Africa has established a system of temporary outreach centres to allow people to apply for schemes closer to home. In Brazil, when people apply for the BPC scheme, their transport costs are reimbursed. Since applications for disability benefits can take a long time, Mauritius backdates payments to the first application. In South Africa, application centres are being made more accessible for people with disabilities. When receiving payments, some countries – such as South Africa and Uganda – allow alternates to receive transfers on behalf of persons with disabilities. And, often, minimum distances are established for people to travel to receive payments. However, even in middle-income countries with more advanced social protection systems, there is much to do to improve the situation.

The research found that some disability-specific benefits for people of working age – such as South Africa's – include an employability test. This can result in the exclusion of persons with disabilities from employment who, nonetheless, face additional disability-related costs which impact on their wellbeing and capacity to engage in work. Further, there is some evidence that the employability test may discourage people with disabilities from entering the labour market. The research suggests that alternative designs of working age disability benefits – either removing the employability test or putting in

place schemes that specifically address the additional costs experienced by persons with disabilities – may reduce work disincentives.

Making social protection schemes more disability-inclusive requires greater commitment from policy-makers. Yet, the research found that responsibilities for disability policy are frequently relegated to weak institutions, while there is often a low recognition among policymakers – and their development partners – of the importance of effectively incorporating persons with disabilities within national social protection systems. On the positive side, an increasing number of countries are investing in improving their data collection on disability within both household surveys and censuses. The most common tool in use is the Washington Group Set of Questions (short set) and, as seen in this study, it enables a more in-depth analysis of disability. This incorporation of high-quality data collection in household surveys and the monitoring and evaluation of social protection programmes needs to become commonplace.

Disability needs be given a much higher priority in the social protection policy agenda. Ultimately, the effective inclusion of persons with disabilities within social protection systems and schemes comes down to the willingness of political leaders to commit an adequate level of investment towards well-designed social protection systems. This will only happen if policymakers and those engaged in social protection are more aware of its importance, not just for persons with disabilities themselves, but for the broader society and economy. Social protection systems and schemes are more likely to be disability-inclusive if there is a broader national disability-sensitive environment. Other key actions to be undertaken include: generating better data on disability; placing the responsibility for disability at a high level within governments; establishing disability-specific and old age pension schemes in countries where they do not exist, and expanding coverage in countries where coverage of existing schemes is low; ensuring that communications about social protection schemes are adapted to the requirements of persons with disabilities; improving disability assessment mechanisms so that they do not exclude persons with disabilities; identifying and removing barriers to access social protection schemes; and, building awareness among staff working on social protection schemes so that they better understand how to address the requirements of persons with disabilities.

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Annex 1 Definitions of disability

There is no single agreed upon definition of disability (Mitra, 2006, p. 236). The UN Convention on the Rights of Persons with Disabilities (CRPD) also does not offer a definition of disability as such, although it does state in Article 1 that *'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'* (CRPD, 2006, p. 4).

In this report we follow this definition, which is in line with the social model of disability. While the study examines disability, it is important to note that we often refer to different terms to describe aspects of disability when reporting results from the research. The report in particular uses two key terms that are sometimes conflated with disability:

- *Functional limitation* refers to a restriction in the ability to perform an activity or a task in an efficient, typically expected, or competent manner. The Washington Group set of questions, for example, measures functional limitations. The short set of Washington Group questions assesses whether people have difficulties in functioning in six core domains: walking, seeing, hearing, remembering, self-care and communication.
- *Impairment* is an injury, illness, or congenital condition that causes or is likely to cause a loss or difference of physiological or psychological function.

While our analysis is based on the social model, it is also important to be aware of other models of disability, which underlie several of the social protection schemes analysed in our research. As outlined in Rohwerder (2015), the different models can be described as:

1. *The charity model of disability*, which focuses on the individual and tends to view people with disabilities as passive victims in need of care and whose impairment is their main identifier (Al Ju'beh, 2015, p. 20 in Rohwerder, 2015).

2. *The medical (or biomedical) model of disability* considers 'disability a problem of the individual that is directly caused by a disease, an injury, or some other health condition and requires medical care in the form of treatment and rehabilitation' (Mitra, 2006, p. 237). This model is widely criticised on various grounds, including for not considering the important roles of environmental and social barriers (Mitra, 2006, pp. 237, 82; Rimmerman, 2013, p. 27).

3. *The social model* of disability developed as a reaction to the individualistic approaches of the charitable and medical models (Al Ju'beh, 2015, p. 20; Rimmerman, 2013, p. 28). It is human rights driven and socially constructed (Woodburn, 2013, p. 85). It sees disability as created by the social environment, which excludes people with impairments from full participation in society as a result of attitudinal, environmental and institutional barriers (Mitra, 2006, p. 237). It places emphasis on society adapting to include people with disabilities by changing attitudes, practices and policies to remove barriers to participation, but also acknowledges the role of medical professionals (DFID, 2000, p. 8; Al Ju'beh, 2015, pp. 20-21, 83). The social model has been criticised for ignoring the personal impact of disability and for its emphasis on individual empowerment, which may be contrary to more collective social customs and practices in many developing countries (Al Ju'beh, 2015, p. 83-86; Rimmerman, 2013, p. 30).

4. *The human rights model* of disability is based on the social model and also seeks to transform unjust systems and practices (Al Ju'beh, 2015, pp. 20-21, 87). It takes the CRPD as its main reference point and sees people with disabilities as the 'central actors in their own lives as decision-makers, citizens and rights holders' (Al Ju'beh, 2015, pp. 20-21, 87).

5. *Interactional models* recognise that disability should be seen as neither purely medical nor purely social, as people with disabilities can experience problems arising from the interaction of their health condition with the environment (WHO & World Bank, 2011, p. 4). The most commonly used interactional model is the model underlying the International Classification of Functioning, Disability and Health (ICF) (WHO & World Bank, 2011, p. 5). This views disability as arising from the negative interaction between health conditions and the context – including environmental factors (products and technology; the natural and built environment; support and relationships; attitudes; and, services, systems, and policies) and personal factors (e.g. age, sex, motivation and self-esteem) (WHO & World Bank, 2011, p. 5). The ICF is presented as representing a workable compromise between medical and social models as a result of its greater recognition of the impact of environmental and structural factors on disability (WHO & World Bank, 2011, p. 4; Groce et al., 2011, p. 1500; Al Ju'beh, 2015, p. 84; Woodburn, 2013, p. 86). However, it has been 'severely criticised by prominent members of the disability movement, in the belief that it does not really analyse exclusion and discrimination of people with disabilities' (Groce et al., 2011, p. 1500; see also Al Ju'beh, 2015, p. 84). The capability approach to disability is another interactional model. It has been adapted from Sen's capability approach in economics (Mitra, 2006, p. 236, 238; WHO & World Bank, 2011, pp. 10-11). The capability approach allows researchers to analyse disability at the capability level (disability occurs when an individual is deprived of practical opportunities as a result of an impairment); and,

disability at the functioning level (an individual has a disability if they cannot do or be the things they value doing or being) (Mitra, 2006, p. 236, pp. 241-242). In this framework disability can be understood as a deprivation in terms of capabilities or functionings that results from the interaction of an individual's personal characteristics (e.g., impairment, age, race, gender); the individual's resources (assets, income); and the individual's environment (physical, social, economic, political) (Mitra, 2006, pp. 236-237, 239, 241; Trani & Loeb, 2012, p. S20). This model has often been compared to the ICF model (Mitra, 2014, p. 268). It stresses the individual's freedoms, as well as the possibility that economic resources, or the lack thereof, can be disabling (Mitra, 2006)

Annex 2 Rights-based approach

The following human rights principles informed the research:

Equality and non-discrimination: Social protection schemes should be available to all, and states should ensure that nobody is discriminated against in programmes and services. Social protection must promote gender equality and women's rights and take into account the different experiences of men and women and the life-cycle risks they face.

Accessibility: Social protection systems should be barrier-free and inclusive and ensure that everyone has equal opportunities to access them, which may require special measures being taken for particular categories of the population who may face additional barriers, such as those living with disabilities.

Adaptability: States must guarantee that social protection schemes are adapted to the needs of persons with disabilities and that policy responses are part of the mainstream social protection system. Differences among diverse groups need to be acknowledged and taken into account in the design and implementation of social protection policies.

Adequacy of the benefits provided: States should ensure that social protection schemes provide quality services and benefits of an adequate amount and duration to enable all beneficiaries to enjoy an adequate standard of living and ensure that persons with disabilities enjoy equal opportunities to access services and employment. It is key to ensure that the burden of disability-related extra costs does not nullify the enjoyment of the right to social protection.

Respecting the dignity and autonomy of individuals: Social protection systems must respect the inherent dignity of all individuals, since dignity is a fundamental right in itself and constitutes the basis of fundamental rights in international law. Social protection schemes must also avoid stigmatisation and prejudice. Governments should ensure that the implementation of social protection schemes does not hinder the rights of persons with disabilities or oblige them to renounce their legal capacity.

Ensuring the right to privacy: Social protection schemes must respect the right to privacy and international standards on confidentiality when collecting information identifying beneficiaries.

Transparency and access to information: Social protection systems must provide transparent and comprehensive access to information and communication on all aspects of programme delivery and services provided. In the case of persons with disabilities, information is to be accessible according to specific needs.

Accountability: States are to ensure access to accountability mechanisms, independent and effective complaints procedures, and effective remedies. States and responsible parties in social protection systems are to be held accountable for decisions and actions that might have a negative impact on the right to social protection for all. The responsibilities of institutions need to be clearly defined and stipulated in the legal framework to ensure accountability

Meaningful and effective participation: All citizens, including persons with disabilities, must have the right and ability to participate in all stages of social protection schemes, from design to implementation. Specific measures must be put in place to actively encourage and enable the participation of persons with disabilities and, if relevant, their caregivers. This right must be extended to children with disabilities.

Annex 3 Addressing the research questions

We addressed the research questions in a range of ways:

1. **In low- and middle-income countries, to what extent are social protection systems (both mainstream and disability-specific programmes) reaching people with disabilities (both as participants/beneficiaries, and as household members)? How effective are the programmes?**

The literature review provided us with a number of examples of the extent to which social protection systems reach people with disabilities and their effectiveness, although it also demonstrated how limited the evidence is, in particular since disability is rarely included in the evaluations of social protection programmes. Furthermore, the literature is strongly focused on disability-specific schemes.

We examined the effectiveness of schemes by looking at evidence on levels of investment, coverage, values of transfers and impacts.

- We obtained information on levels of investment through literature reviews and analysis of administrative data and budgets.
- We obtained information on coverage through the literature, administrative data and quantitative analysis of datasets.
- The information on the values of transfers was obtained from the literature review and through the case studies.
- We obtained information on impacts from the literature review, quantitative analysis (focused on simulations) and discussions with informants during the case studies.

2. **What are the specific examples of good practice (and also what has not worked) in both mainstream and disability-specific social protection programmes and what lessons might apply elsewhere? Consider contextual factors and identify which aspects of different programmes are likely to work better in different settings.**

Our analysis focused on a range of aspects of social protection programmes, in particular on access to schemes and payment systems. Our analysis of schemes was based on a model developed by Barrett and Kidd (Barrett and Kidd 2015), which divides the operations of cash transfer systems into two aspects: the administrative processes of the programme delivery and the organisational policies and systems that underpin the effective execution of cash transfers. The basic operational cycle of a cash transfer programme comprises four key administrative processes: the **registration mechanism;** the **enrolment mechanism;** the **payment delivery mechanism;** and, the **grievance and redress**

mechanism. We assess the accessibility of each of these administrative processes as well as the quality and appropriateness of disability assessment mechanisms.

We also assessed the organisational policies and systems that should underpin the delivery of the social protection schemes, with a particular focus on any measures taken to be more disability inclusive. The policies and systems include: a programme's institutional and human resource arrangements; operations manuals; training plans and strategies; management information systems (MISs); public communications strategies; and, monitoring and evaluation mechanisms. Most of the information for this analysis came from key informant interviews with programme managers in the case study countries. There is little analysis in the literature on programmes, although there is more information on common barriers to access that people with disabilities face. In the case studies, we interviewed local stakeholders to identify barriers faced by persons with disabilities and identified whether and how they have been overcome. We also looked more broadly at legislation and social protection policies to determine the extent to which they set out the parameters within which programmes are designed and implemented so that disability inclusiveness is strengthened.

3. **What aspects of social protection systems are necessary to ensure effective targeting and/or effects for people with disabilities? This includes information about institutional arrangements and capacity, government buy-in, financing and links to other sectors.**

To a degree, this research question is closely linked to the previous two. Both the literature review and the qualitative research in the case study countries provided information on barriers to access. Key issues examined included:

- **Disability assessment mechanisms:** We undertook a comprehensive review of the literature, but also examined how disability assessment works on the ground through the case studies.
- **Targeting design and mechanisms:** We examined different methods of targeting and the extent to which they are sensitive to the needs of people with disabilities, both within disability-specific programmes and mainstream schemes. The effectiveness of targeting was assessed through the analysis of household surveys and from the literature, as well as through consultations during the case-studies. Given the prevalence of proxy means tests (PMT), we undertook quantitative analysis of PMTs using national datasets to determine whether PMTs incorporate biases against people with disabilities and, if so, how these can be addressed.
- **Political economy:** The effectiveness of social protection systems in addressing disability may depend on the political economy within which the social protection system and disability rights operate. Within the case studies, we examined

whether and how the political economy has been influenced to generate more inclusive social protection systems, including examining the impact of CRPD ratification.

- **Broader legislation and policies on disability:** We examined whether effective disability legislation and policies influenced the ability of people with disabilities to engage with social protection, for example by addressing issues such as discrimination, establishing quotas, etc.
- **Conditions:** From the literature review and consultations, we examined the extent to which conditions in programmes – including work conditions – impact on people with disabilities and identify measures to address this.
- **Linkages to other sectors:** We examined the extent to which countries are building systems linking people with disabilities to a range of services, not just social protection. This question was addressed mainly through the case studies, but also through a review of the literature.
- **Institutional arrangements:** In many countries, disability issues are relegated to weak social ministries, impacting on the effectiveness of programmes for people with disabilities and the ability of them to influence programme design and policy. Through the case studies, we examined the extent to which institutional arrangements impact on the disability inclusiveness of social protection systems. We also examined broader national capacity strengthening mechanisms within government and the extent to which – and how – disability is incorporated.
- **Financing:** See discussion above on investment levels.

4. **How can examples of good practice from different programmes and different countries be brought together to create a social protection system for people with disabilities that takes into account the specific context in low- and middle-income countries and is effective in providing income support to people with disabilities?**

Based on the findings set out in the present report, we separately develop guidance on making social protection systems and schemes more disability inclusive.

Annex 4 Literature review

The literature search included a web-search, reviews of bibliographies and consultations with other researchers involved in similar work. In relation to each research question, the literature review synthesises results from the existing literature into a summary of what is and is not known, identifying areas of controversy in the literature.

During the literature search, we searched primarily for literature dealing specifically with disability and social protection in low- and middle-income countries, but also included indirectly related literature when it was deemed especially relevant, including key texts from the literature on poverty and disability, disability assessments, social protection for people with disabilities in developed countries and linkages with other sectors. The literature search included the following steps:

Searches in academic journals. We searched through the main social science academic databases, including ProQuest, Scopus, Taylor & Francis Online, Web of Science and Wiley online library. We also identified key journals and reviewed their archives in recent years, including the International Journal of Disability, Development and Education; Journal of Development Studies; Journal of Development Effectiveness; The Third World Quarterly; the Journal of Human Development and Capabilities; Prospect; Development in Practice; Journal of Policy Practice; and, the IDS Bulletin.

Searches for academic publications using Google Scholar: We carried out online searches using Google Scholar, employing a wide range of permutations of possible search terms, and subsequently refining the combinations looked for, in line with the results. We reviewed the first 300 search results.

Searches for evaluations, published reports and other literature using Google's main database: The main Google (Web) database has some specific search advantages compared to Scholar, notably in being more up to date and in covering news media, blogposts, and the extensive "grey literature" from corporate and professional bodies (as well as academic reports and working papers covered with a lag in Google Scholar). We specifically searched for existing evaluations of the main social protection programmes targeting people with disabilities, as documented in Development Pathways' database of disability benefits.

Search with Google Scholar Citations: Once a list of 'core' articles or books directly relevant to the research questions from the sources above had been identified, we looked for the key authors on Google Scholar Citations to search for other relevant publications by the same author. Examining citation numbers helped determine which sources were likely to

be the most important. We also reviewed other literature in Google Scholar that has cited an author's key works as these are likely to be relevant to the research questions. We also looked up co-authors of relevant literature.

Reviews of bibliographies: Once the academic and general web-searches were completed, we systematically reviewed the bibliographies of the key texts to identify any further documents. Development Pathways keeps an up to date bibliography in connection with its Disability Benefit Database, which was also reviewed to help ensure that we identified all relevant literature.

Annex 5 Datasets used in the quantitative analysis

The data used in the core part of the analysis is from six household surveys collected across six different countries with varying contexts. Some countries have well developed social protection systems, including disability benefits, while others have very limited social protection programmes. The surveys were carried out between 2010 and 2015 and were selected because they had questions to identify persons with disabilities as well as questions on access to social protection programmes. Ideally, the questions on disability should have either the Washington Group's short set of questions or activities of daily living questions. Below is a short description of each of the surveys, and a summary table.

Ethiopia (ESS, 2013/2014)

The Ethiopia Socioeconomic Survey 2013/2014 is the second wave of a three-wave socioeconomic survey in Ethiopia conducted by the Central Statistics Agency of Ethiopia together with the World Bank Living Standards Measurement Study. In contrast to the first wave – the Ethiopia Rural Socioeconomic Survey – the ESS includes urban areas from large towns and is nationally representative. The sample size is 5,469 households. The health section includes the Washington Group short set of questions on functional limitations, and questions on social protection programmes can be found in the "Assistance" section.

India (IHDS-II, 2011/2012)

The India Human Development Survey – II (2011/2012) is the second wave of a nationally representative panel survey and includes social and economic indicators, as well as other human development indicators. The IHDS-II has a sample size of 42,152 across all 33 states and union territories in India. Instead of the Washington Group questions, IHDS-II includes 7 questions of activities of daily living that cover 5 functional domains (seeing, walking, hearing, communicating and self-care). The survey also asks whether households are recipients of a number of social protection programmes in India: all schemes in the National Social Assistance Programme and the Mahatma Gandhi National Rural Employment Guarantee Act public works programme.

Indonesia (IFLS-5, 2014/2015)

The Fifth Wave of the Indonesia Family Life Survey was conducted in 2014–2015 by RAND, together with Survey Meter. The IFLS-5 surveyed 16,931 households across 13 provinces. It is representative of around 83 per cent of the population. The health module does not include the Washington Group questions but, instead, has a comprehensive set of questions on physical functioning, activities of daily living, and instrumental activities of daily living. Regarding questions on social protection programmes, the survey asks whether households are recipients of a number of social protection programmes in Indonesia.

Malawi (IHS3, 2010/2011)

Malawi's Third Integrated Household Survey is a nationally representative sample survey conducted by the National Statistical Office from March 2010 to March 2011. The sample consists of 12,288 households across all regions of Malawi. The Washington Group's short set of questions on disability is present in the health module, whereas questions on social protection can be retrieved from their "social safety nets" module.

South Africa (GHS, 2015)

The General Household Survey conducted in 2014 by the SSA in South Africa is a nationally representative sample survey. Over 20,000 households were surveyed across all regions of South Africa. The Washington Group's short set of questions are present in the health module and questions on social protection programmes can be found in the module "social grants and social relief".

Rwanda (EICV4, 2013/2014)

The Enquête Intégrale sur les Conditions de Vie des Ménages (EICV4) is the fourth round of Rwanda's nationally representative Integrated Living Conditions surveys. The EICV4 was conducted over a 12-month cycle from October 2013 to October 2014, and the sample size was 14,419 households. It did not contain a module including the Washington Group questionnaire: disability was assessed using a simple question about severe disabilities. However, it did contain a longer module for VUP (social protection) recipients.

Table A5-1 below summarises all datasets and highlights the modules of interest in each dataset.

Table A5-1: Summary of the datasets and modules of interest

	Ethiopia	India	Indonesia	Malawi	Rwanda	South Africa
Name of Survey	**Ethiopia Socioeconomic Survey (ESS)**	**India Human Development Survey**	**Fifth Wave of the Indonesia Family Life Survey (IFLS - 5)**	**Third Integrated Household Survey**	**EICV4 (Enquête Intégrale sur les conditions de vie des ménages)**	**General Household Survey**
Year of Survey	2013/2014	2011/2012	2014/2015	2010/2011	2013/2014	2015
Survey						
Nationally representative?	Yes	Yes	No	Yes	Yes	Yes
Number of households	5,469	42,152	16,931	12,288	14,419	21,601
Washington Group questions	Yes	No. Instead, ADL questions are provided	No. Instead, ADL and IADL questions are provided	Yes	No, instead question in health module on severe disability used	Yes
Modules and indicators of interest						
Demographics						
Gender	Yes	Yes	Yes	Yes	Yes	Yes
Marital Status	Yes	Yes	Yes	Yes	Yes	Yes
Relationship to the head	Yes	Yes	Yes	Yes	Yes	Yes
Income/Consumption [(b)]						
Average income/consumption per capita	Yes	Yes	Yes	Yes	Yes	Yes
Income sources	Yes	Yes	Yes	Yes	Yes	No
Education						
School attendance [(b)]	Yes	Yes	Yes	Yes	Yes	Yes
Highest level of education attained	Yes	Yes	Yes	Yes	Yes	Yes

Average expenditure on education	No	Yes	Yes	Yes	Yes	Yes
Labour *(b)*						
Labour force participation	Yes	Yes	Yes	Yes	Yes	Yes
Sector of employment	Yes	Yes	Yes	Yes	Yes	Yes
Self-employed/salaried workers	Yes	Yes	Yes	Yes	Yes	Yes
Housing						
Wall	Yes	Yes	No	Yes	No	Yes
Toilet facility	Yes	Yes	Yes	Yes	Yes	Yes
Fuel for lighting	Yes	Yes	No	Yes	Yes	No
Identifying beneficiaries of social protection: social protection or other income module	Social Protection	Other Income	Social Protection	Social Protection	VUP Module	Social Protection
Key social protection programmes	PSNP	NSAP and NREGA	PKH	Free maize and cash-for-work programme	VUP	Social Grants

Annex 6 Criteria for the selection of countries for the case studies

The case study countries were selected through an extended process of consultations with DFID, the research project's External Advisory Group and other experts. Initially, a long-list of countries was developed and a detailed matrix developed to establish the extent to which each country was likely to produce interesting findings, in particular with a view to identifying examples of best practice. The indicators examined for each country included:

1. **Access to information and avoidance of duplication**
    a. No other similar research ongoing on social protection and disability
    b. Researchers may be able to leverage additional research from ongoing programme
    c. DFID-funded social protection programme
2. **Legislation and policy**
    a. There is legislation addressing social protection and disability
    b. Disability is integrated into national policies/strategies on social protection
3. **Data on disability**
    a. National surveys include reliable data on people with disabilities
    b. National surveys include reliable data on people with disabilities and social protection programmes
4. **Assessment of disability**
    a. The country has a disability assessment mechanism for access to social protection – and other – benefits that could offer good lessons
5. **Types of schemes**
    a. There is a tax-financed adult disability benefit
    b. There is a tax-financed child disability benefit
    c. There is a tax-financed old age pension
    d. There is a child benefit that has taken measures to incorporate people with disabilities (children or carers)

e. There is a poverty targeted household benefit that has been modified in its design to incorporate people with disabilities
f. There is a public works programme that has been modified in its design to incorporate people with disabilities
g. There is a social insurance scheme that provides a disability benefit
h. There is a social insurance scheme with innovative designs to support people with disabilities
i. There are other programmes that have taken measures to incorporate people with disabilities

6. Design of social protection schemes

a. Communication strategies and materials are disability sensitive
b. Access of people with disabilities to registration and/or grievance mechanisms has been taken into account
c. Design of payments mechanisms has taken into account needs of people with disabilities
d. Compliance with conditions has taken into account the needs of people with disabilities
e. MISs include information on disability
f. Monitoring and evaluation have specifically incorporated disability
g. Capacity development of staff includes training on disability sensitive social protection

Based on information from the external advisory group and other experts in the fields of social protection and/or disability, for each of these indicators each country on the long-list was categorised as: a) Indicator present; b) Indicator not present; c) Indicator present, but with qualification; or, d) No information.

Details on the reasons for the final selection of countries are outlined in Table A6-1.

Table A6-1: Selection criteria applied to the countries chosen for the analysis

Research Question /Country	1. Coverage and effectiveness of disability-specific and mainstream programmes	2. Examples of good practice (and what has not worked) in disability-specific and mainstream programmes. Consider contextual factors.	3. Aspects of social protection systems necessary to ensure effective targeting and/or effects for people with disabilities.
South Africa	South Africa has a well-developed social protection system, including both a large disability benefit and mainstream programmes. There is a policy on the mainstreaming of people with disabilities within social protection. National data is available for analysis.	South Africa has lots of experience implementing both disability-specific and mainstream social protection programmes, and there has been a lot of research already that can be built upon.	Of interest is: the system of assessment; the accessibility of the programmes; how the schemes are communicated; and, the impact on the lives of persons with disabilities and their families.
Zambia	Zambia does not have a disability benefit, but it does have mainstream programmes which include people with disabilities in the target group, including the Public Welfare Assistance Scheme (low coverage) and the Social Cash Transfer Programme (higher coverage)	There has been a range of attempts to integrate persons with disabilities into mainstream programmes, with varying successes. There is an assessment mechanism.	Of interest is: the implementation of the assessment process; how access is achieved for persons with disabilities in mainstream schemes; how the schemes are communicated
Rwanda	Rwanda has a mainstream scheme which tries to incorporate persons with disabilities. The government has talked about making the VUP public works programme more inclusive, but they may not have done much in practice.	Has just developed a disability assessment mechanism.	Of interest is: the system in place for assessment and how this is being implemented; how access is achieved for persons with disabilities in mainstream schemes; how schemes are communicated; whether the range of schemes is sufficient to meet the needs of persons with disabilities.
Mauritius	Mauritius is an example of a country with a relatively advanced social protection system, with an interesting range of schemes, including a basic disability pension and a variety of other social assistance programmes that are supposed to include (some) people with disabilities (social aid, special allowance for children from low-	Provides an example of a different context, with a small population.	Of interest is: how the assessment process operates and whether it is capturing the most appropriate people; what impact is gained from the wide range of schemes available; how the schemes are communicated; how the schemes are funded.

	income groups, food aid scheme etc.) plus scholarships/stipends and (at least in theory) vocational training and an unemployment hardship relief fund that is additional to the disability pension (again, in theory - only 102 beneficiaries in 2010). National level data is available.		
India	There is a lot to learn from India and whilst it is not possible to cover the whole country, States like Tamil Nadu and Kerala offer some interesting possibilities because of the wide range of different schemes available.	There are many different possible schemes to review. For example: the Indira Gandhi NREGA and many other schemes, as well as the evolution of the disability card. Some efforts have been made to include more persons with disabilities in NREGA. Overall, there have been attempts to improve access but there remain a lot of concerns around how the schemes are actually implemented. It would also help to look at federal/state decentralised financing.	Possible local level collaboration with INGO like World Vision, disability activists and DPOs like 'Equals' (based in Tamil Nadu) who have been involved in collecting data linked to disability, income levels and registration with different schemes. 'Equals' have also done work on budget and public expenditures, led consultations with people with disabilities in communities and held discussion with authorities around streamlining and improving current schemes.
Brazil	An example of an advanced social protection system with good coverage and both disability benefits and mainstream programmes.	There should be interesting lessons learned from both the disability benefit and other social protection programmes. Also, there are interesting reforms of the disability assessment and determination system.	Of interest is: the system in place for assessment and how this is being implemented; how access is achieved for persons with disabilities in mainstream schemes; how schemes are communicated; and, whether the range of schemes is sufficient to meet the needs of persons with disabilities.

Annex 7 Topics covered in the country case studies

The topics examined during the country case-studies included the following:

- The economic, social and cultural context of the case study country;
- Review of the national data available on the prevalence of disability and the main challenges and opportunities facing people with disabilities, using a lifecycle model, including poverty-disability links;
- Governance arrangements within government linked to addressing disability, in particular with regard to social protection, but also across other public services;
- Examining whether and how the political economy has been influenced to generate more inclusive social protection systems;
- Analysis of the legislative and policy framework of relevance to people with disabilities and social protection;
- Analysis of the disability assessment mechanism used for the disability-specific programmes that were examined;
- An overview of the national social protection system and coverage of persons with disabilities;
- Identification of the extent to which people with disabilities are accessing social protection schemes, including an examination of selection mechanisms, the barriers to access faced by persons with disabilities, and initiatives to improve their access;
- The adequacy of benefits for people with disabilities, from both disability-specific and non-disability-specific schemes;
- The impacts of social protection schemes on people with disabilities; and,
- Whether and how social protection schemes are linked to other social services that are required by people with disabilities.

Annex 8 Examples of disability related costs

Persons with disabilities experience two forms of additional expenditure which persons with no disabilities would not necessarily experience. First, persons with disabilities are required to purchase items and services that are specific to their disabilities (e.g. assistive devices, rehabilitation and medicines). Second, when purchasing goods and services which are also purchased by persons without disabilities, persons with disabilities can incur extra costs (e.g. transport).

There is more than one approach to estimate disability related costs. Stapleton, Protik and Stone (2008) identified in the literature at least 3 different approaches: the 'goods and services used' approach, the 'goods and services required' approach, and the 'expenditure equivalent' approach, which is also known as the 'standard of living' approach. The first and second approaches estimate directly the additional costs experienced by persons with disabilities. The 'goods and services used' approach compares the costs of certain activities experienced by persons with and without disabilities. The 'goods and services required' approach is a subjective approach because it is based on people's opinions of what the extra costs are.

The third approach – the 'expenditure equivalent' – estimates the extra costs incurred by persons with disabilities indirectly. This method compares standards of living across households that have the same income and are similar in a number of observable variables but have different disability status. Thus, any difference in their standard of living is potentially only explained by the disability status.

The estimates vary significantly depending on the approach, country, age group and dataset used. Table A8-1 presents estimates in low- and middle-income countries when using the 'standard of living' approach. However, in a recent review of the topic, Mitra et al (2017) found – after analysing 20 peer reviewed journal articles that apply different methodologies across 10 countries – that the costs are consistent with the severity of disability.

Table A8-1: Additional costs experienced by persons with disabilities by applying the standard of living approach

Country	Additional costs
China	Between 8%-43% for adults and 18%-31% for families with children with disabilities (Loyalka et al 2014)
Vietnam	11.5% of income (Mont and Cuong 2011)
Indonesia	9% for urban areas and 8% for rural, in the most populous provinces. However, this analysis included those with less severe functional limitations.
South Africa	Around 40% for households with persons with a severe disability (Kidd, et al 2018)
India	20% to 58% for households with person with a severe disability (Wapling and Schjoedt (2019b)

In order to assess the additional costs faced by households with a member with a disability in South Africa and India, we used the standard of living method. In South Africa, three different measures of standards of living were considered: (i) a subjective poverty status, where households are asked if they consider themselves poor; (ii) a composite asset index formed by 10 different assets common to households irrespective of disability status;[272] and, (iii) a living standards measure developed by the South African Audience Research Foundation (SAARF) which is included in the 2015 General Household Survey. In India, we only considered a composite asset index formed by 33 different assets constructed in the 2012 India Human Development Survey.[273]

The findings for South Africa indicate that extra costs experienced by households with a member with a disability are significant and robust to different household compositions.[274] On average, a household with at least one member with a severe disability faces an additional cost of approximately 40 per cent if it is to attain the same standard of living of those households without any members with a disability. The figures are greater when the sample is restricted to elderly persons. When the sample is restricted to households with only 60+ members, households with a member with a severe disability have an additional cost of up to 80 per cent, depending on the standard of living that is considered in the analysis. These figures are substantial. When the average household income in South Africa is observed, this implies an additional cost of 40 per cent of household income, which is equal to approximately Rand 3,000 a month, and double the value of the Disability Grant. The calculations for the cost analysis can be found in Table A8-2.

[272] The composite asset index is formed by: TV, DVD, radio, computer, washing machine, fridge, microwave, sink, hot water, and vehicle.
[273] List the composite asset index for India is formed by items measuring household possessions and housing quality.
[274] The estimates for India can be found in the country specific excel workbook.

Table A8-2: Estimates of the extra cost of disability (moderate and severe) using different measures of standard of living - own calculations from GHS, 2015

Type of household:	All households			At least two adults			At least two adults and no children			Only 60+ members (up to two)		
Standard of living indicator:	Subjective poverty status	CAI	LSM	Subjective poverty status	CAI	LSM	Subjective poverty status	CAI	LSM	Subjective poverty status	CAI	LSM
HH income, log	.63***	.79***	.83***	.66***	.83***	.85***	.63***	.82***	.84***	.49***	.88***	1.04***
	(.03)	(.02)	(.03)	(.03)	(.03)	(.03)	(.04)	(.04)	(.04)	(.09)	(.12)	(.13)
Disability (binary)	-.16***	-.13***	-.07*	-.12*	-.15***	-.05	-.20**	-.18***	-.08	-.16	-.41***	-.29***
	(.05)	(.04)	(.04)	(.06)	(.05)	(.05)	(.08)	(.06)	(.07)	(.13)	(.10)	(.10)
Extra costs estimate as	.26***	.17***	.09*	.18*	.19***	.06	.32**	.22***	.09	.33	.46***	.27***
% of income	(.08)	(.05)	(.05)	(.10)	(.06)	(.06)	(.13)	(.08)	(.08)	(.28)	(.12)	(.10)
Equivalence scale	1.26	1.17	1.09	1.18	1.19	1.06	1.32	1.22	1.09	1.33	1.46	1.27
HH income, log	.63***	.79***	.83***	.66***	.82***	.85***	.63***	.82***	.84***	.49***	.89***	1.04***
	(.03)	(.02)	(.03)	(.03)	(.03)	(.03)	(.04)	(.04)	(.04)	(.09)	(.11)	(.13)
Disability (binary)	-.24***	-.31***	-.34***	-.22**	-.39***	-.34***	-.40***	-.49***	-.43***	-.39**	-.55***	-.44***
	(.08)	(.06)	(.06)	(.11)	(.09)	(.09)	(.15)	(.12)	(.13)	(.19)	(.14)	(.14)
Extra costs estimate as	.38***	.39***	.41***	.34**	.47***	.40***	.63***	.60***	.51***	.80*	.62***	.42***
% of income	(.12)	(.08)	(.08)	(.17)	(.11)	(.11)	(.24)	(.15)	(.15)	(.41)	(.18)	(.15)
Equivalence scale	1.38	1.39	1.41	1.34	1.47	1.40	1.63	1.60	1.51	1.80	1.62	1.42

Note: Point estimates are from ordered logit regressions. All regressions include household size, number of children (when relevant), and dummies for provinces, household head broad age groups, household head's gender, house tenure and whether household is rural. Robust standard errors clustered at the primary sample unit are in parentheses. *** p<0.01, ** p<0.05, and * p<0.1.

Annex 9 The approach to disability assessment in the case study countries

Table A9- outlines the approach taken by the case study countries to disability assessment.

Table A9-1: The approach to disability assessment used in Case Study countries

Country	Approach to assessment
Brazil	Brazil currently has two comprehensive disability assessment tools in use which have been recently designed based on the principles of the CRPD. These are the mechanism used for the BPC and the Brazilian Functionality Index, developed for the social insurance programmes. Brazil formally adopted the International Classification of Functioning, Disability and Health (ICF) as a method for measuring health and disability in 2003, as this was more in-line with social model definitions, and it has been incorporated into the assessment process since 2007. The two mechanisms both present, in many ways, an example of best practice in terms of disability assessment based on the social model of disability. However, they also entail a resource-heavy and time-consuming assessment process. Both mechanisms involve assessments by both a social worker and a medical officer and consider both the impairment and the environment of the applicant. Applicants are scored based on both impairment/illness and functionality, according to a comprehensive questionnaire.
India	The states of Tamil Nadu and Andhra Pradesh, visited for the case study, both use a single assessment for a disability identity, which is a prerequisite for gaining access to all disability benefits. The medical assessment process, using impairment tables, is entirely based on physiological functioning, making no reference at all to the ICF framework. Once the Medical Officer has made the assessment, a percentage impairment will be assigned to the individual. Anyone with 40 per cent or more is then eligible for a disability Identity Card. In Andhra Pradesh, they have introduced a computer-based assessment process (SADAREM) which automatically generates a percentage for the impairment based on the data entered by the Medical Officer. While this may assist the medical professionals, it has done nothing to change the overall experience for persons with disabilities and remains inconsistent with the principles of the CRPD.
Kenya	The current mechanism for identifying disability in the Persons with Severe Cash Transfer Programme (PwSD-CT) scheme is weak. Communities select potential recipient households with support of the county coordinator for the National Council for Persons with Disabilities (NCPWD). Due to the low coverage of the programmes, the key eligibility criterion is the need for 24-hour care and to be, effectively, bed-ridden. There is no assessment of the effectiveness of this selection process but, as the scheme expands, it will be necessary to develop a more robust disability assessment mechanism.
Mauritius	Assessments for the BIP are done by a medical board consisting of two medical officers. The two medical officers (appointed to the role by the government) use a guidance note and impairment table produced by the Ministry of Health to establish the degree of impairment during a short interview with the applicant. It seems that the medical assessment has not been substantively updated since the 1970s and is based on a purely physiological evaluation of the individual's impairment with no account taken of the disabling impact of the external environment.
Rwanda	A medical assessment has been undertaken as a one-off exercise in 2015 by the National Council for Persons with Disabilities, with medical teams visiting each area of the country. The assessment tool used was the Baleme Officiel Belge des Invalidites (BOBI) which was developed in 1973 and it gives people a percentage classification, based on the level of impairment. This is translated into a classification based on percentages of impairment: 90% to 100%; 70% to 89%; 50% to 69% of impairment; 30% to 49% of impairment; and, below 30% of impairment. Those assessed are given disability cards, which specify the level of impairment.

South Africa	The South Africa Social Security Agency (SASSA) employs individual medical officers to undertake a medical assessment, although they are also expected to determine whether the person is employable in the current labour market. The assessment is based on guidelines produced by SASSA and allocates a percentage impairment to each person assessed. However, medical officers have to also ascertain that the person has been optimally treated and that they have been compliant with all treatment. The medical officer recommends whether the person is eligible for the benefit, based on their disability, although the final decision is – nominally – taken by SASSA.
Zambia	A medical assessment is employed on an on-going basis, with medical officers undertaking the assessment based on a form developed by the Zambia Agency for Persons with Disabilities (ZAPD). People's impairments are classified as 'none, mild, moderate, marked and extreme.' The medical officers also need to determine whether the 'medical condition' is likely to limit a person's ability to work '...*in some employment settings*...' Although the assessment is undertaken by the Ministry of Health, the ZAPD is responsible for the final classification. People are given cards which specify whether they have a severe or non-severe disability.

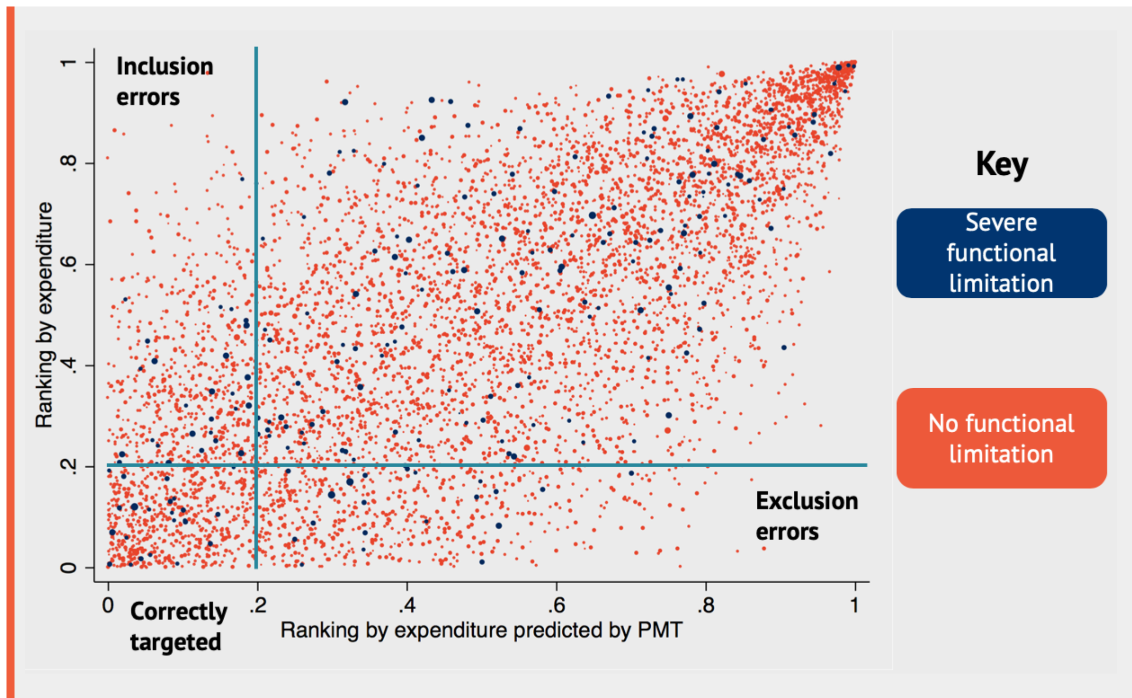
Note: For further information, see Kidd et al (2018); Kidd et al (2019b); Wapling and Schjoedt (2019a); Wapling and Schjoedt (2019b); Wapling and Schjoedt (2019c).

Annex 10 The arbitrary selection generated by the proxy means test

As indicated in the main text, the proxy means test is an inaccurate selection mechanism. Figure A10-1 also indicates that it is arbitrary in its selection. In Figure A10-1, each household without a member with a severe functional limitation in the Third Integrated Household Survey (IHS3) 2010/2011 dataset from Malawi is mapped with a red dot according to its ranking of consumption predicted by the PMT, alongside its actual consumption as recorded in the national household survey for 2010/11.[275] Those households with a member with a severe functional limitation are mapped with blue dots. If the PMT could perfectly predict a household's level of consumption, all households would be lined up along a diagonal from the bottom left corner to the top right. The reality is very different, with households scattered across the graph. The solid lines indicate the situation if a programme were targeted at the poorest 20 per cent of households. All those to the left of the vertical line would be predicted by the PMT to be in the poorest 20 per cent of households and would be included in the programme. However, in reality, the poorest 20 per cent of households are those under the horizontal line. So, the diagram shows which households are the 'inclusion errors' and which are the 'exclusion errors,' as well as the proportion correctly identified. The arbitrariness of the selection of households with a member with a severe functional limitation is evident, with many of those in the poorest 20 per cent excluded by design.

[275] Larger dots indicate multiple households.

Figure A10-1: A scattergraph showing the distribution of households with (blue) and without (red) members with severe functional limitations in Malawi when ranked against actual consumption and consumption predicted by the PMT

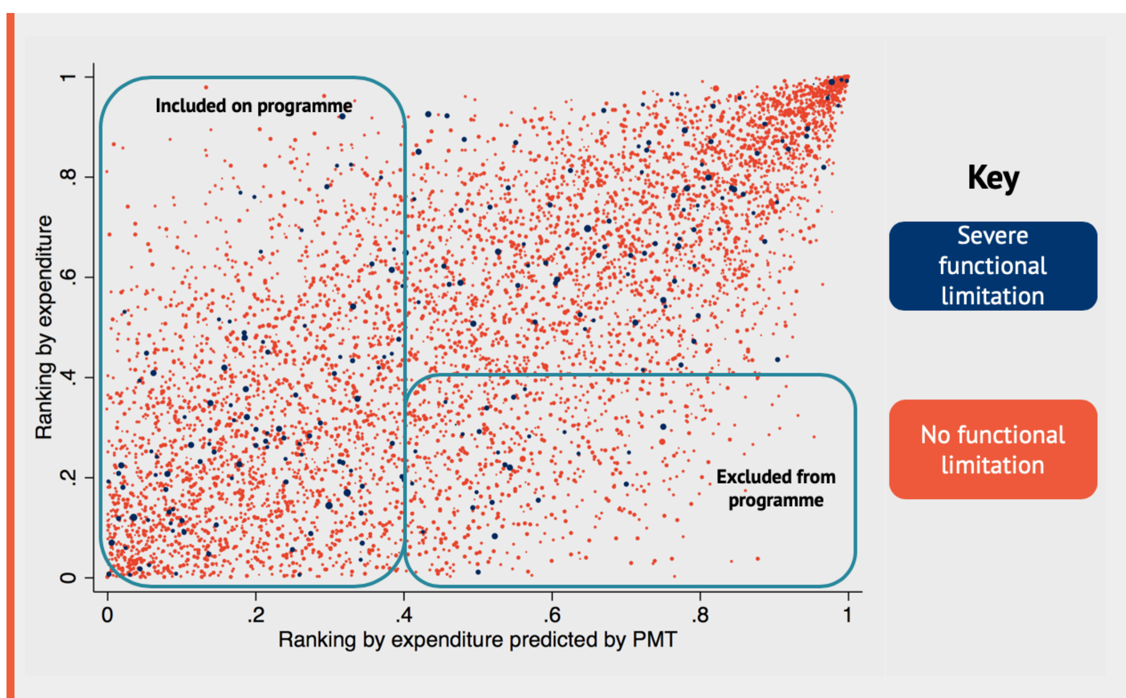


Source: Analysis by Development Pathways of the Malawi HIS 2010/11 dataset.

Annex 11 Adjusting the PMT by increasing the score for households including a person with a disability

As indicated in the main text, in Pakistan the PMT cut-off score for households with members with disabilities – as determined by the national disability assessment mechanism – is increased to facilitate their inclusion. If this method were applied in Malawi, setting the cut-off score at the 40th percentile for persons with disabilities instead of the 20th percentile, it would include many more people with a disability – those in the left-hand box in Figure A11-1 – although many of those included would be in more affluent households. And, many persons with disabilities in the poorest 40 per cent of the population would continue to be excluded (as shown by the right-hand box).

Figure A11-1: A scattergraph showing accuracy of selection of households with a member with a severe functional limitation in Malawi, with a cut-off score at the 40th percentile



Source: Analysis by Development Pathways of the Malawi HIS 2010/11 dataset.

Annex 12 Comparison of social protection programmes in Africa using Proxy Means Tests and the existence of questions on disability

Country	Programme Name	Start year	Combined with other targeting mechanism?	Household survey (acronym)	Year	Disability question?	WG or ADL question?
BOTSWANA	Destitute Persons' Allowance	2003	NO	BCWIS	2009	Yes	No
BURKINA FASO	Nahouri Cash Transfers Pilot Project (NCTPP)	2008	YES	LSMS	2014	Yes	No
CAMEROON	Cameroon Social Safety Nets Project	2014	YES	ECAM	2014	No	No
REBUBLIC OF CONGO	LISUNGI Safety Nets Project	2014	YES	ECOM	2011	Yes	No
DJIBOUTI	Programme National de Solidarité Famille (PNSF)—National Programme of Family Solidarity	2015	YES	EDAM	2012	No	No
EGYPT	Takaful and Karama (Solidarity and Dignity)	2015	YES	HIECS	2010	Yes	No
GHANA	Labour-Intensive Public Works (LIPW) under Ghana Social Opportunities Project (GSOP)	2010	YES	LSMS	2009	Yes	No
	Livelihood Empowerment Against Poverty (LEAP)	2008	YES				
GUINEA	Cash Transfer for Health, Nutrition and Education	2013	YES	ELEP	2012	No	No
KENYA	Cash Transfers for Orphans and Vulnerable Children (CT–OVC)	2007	YES	KIHBS	2016	Yes	No
	Health Insurance Subsidy Programme (HISP)	2014	YES				

Annex 12 Comparison of social protection programmes in Africa using Proxy Means Tests and the existence of questions on disability

	Older Persons' Cash Transfer (OPCT)	2006	YES				
LESOTHO	Child Grants Programme (CGP)	2009	YES	HBS	2010	Yes	No
LIBERIA	Social Cash Transfer Programme (SCT)	2010	YES	HIES	2014	Yes	Yes
MADAGASCAR	Le Transfert Monétaire Conditionnel—Conditional Cash Transfer	2014	YES	EPAM	2005	Yes	No
MALAWI	Social Cash Transfer (SCT)	2006	YES	IHS	2013	Yes	Yes
MOROCCO	Regime for Medical Assistance to the Most Deprived (RAMED)	2011	YES	ENNVM	2006	No	No
MOZAMBIQUE	Labour-Intensive Public Work	2012	YES	IOF	2014	Yes	No
NIGER	Cash Transfers for Food Security and Cash for Work (under the Niger Safety Net Project —*Filet de Protection Sociale*)	2011	YES	ECVMA	2014	No	No
TANZANIA	Tanzania Social Action Fund (TASAF) III / Productive Social Safety Net (PSSN) Programme	2000	YES	HBS	2012	Yes	Yes
ZAMBIA	Social Cash Transfer Programme	2010	YES	LCMS	2010	Yes	No
ZIMBABWE	Harmonised Social Cash Transfer (HSCT)	2011	YES	PICES	2011	No	No

Source: Analysis by Development Pathways based on Cirillo and Tebaldi (2016) and searches through microdata catalogues and national statistical offices.

Annex 13 Additional examples of Proxy Means Test exclusion by design when including proxies for disabilities

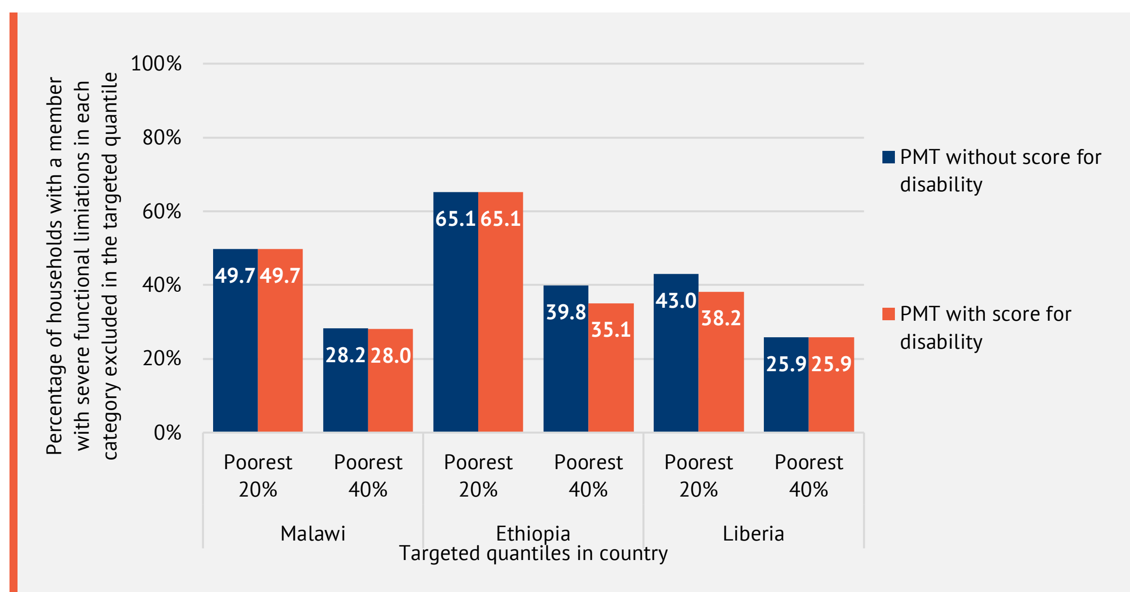
While the main text described experiences of adapting PMTs to be more disability inclusive, there are other options, which are described below.

Option 1: Include functional limitations as a proxy

PMTs could include functional limitations as one of the proxies for household well-being, although this has not yet been undertaken in practice. This could be undertaken, for instance, by using the Washington Group Set of Questions, if this is present in a household survey. Once variables for functional limitations are identified and included in the PMT, a score can be given to households with members with severe functional limitations.

Analysis suggests that by including functional limitations in PMTs, the design errors are likely not to reduce significantly and are variable depending on the country and coverage. Figure A13-1 presents the design errors for households with members with severe functional limitations in three Sub-Saharan countries – Malawi, Ethiopia and Liberia – and for two targeted quantiles – poorest 20 per cent and poorest 40 per cent. In Malawi, the performance of PMTs with scores for functional limitations in correctly identifying households with members with severe functional limitations is just as poor as PMTs without scores for functional limitations. In Ethiopia, PMTs with scores for functional limitations only provide a slight reduction in exclusion errors when targeting larger groups of households. In Liberia, PMTs with scores with functional limitations performed better than PMTs without scores for functional limitations when targeting the poorest 20 per cent of households.

Figure A13-1: Exclusion by design of households with members with severe functional limitations in Malawi, Ethiopia and Liberia, with and without the use of the Washington Group questions as a proxy in PMTs



Source: Analysis by Development Pathways of the following household survey datasets: Malawi HIS 2010/11; Ethiopia ESS 2013/14; Liberia HIES 2014/15.

One reason for PMTs with scores for functional limitations not having significantly lower exclusion of households with persons with severe functional limitations is because these households have lower poverty rates than households without persons with disabilities. This is due to the analysis not taking the additional costs of persons with disabilities into account. It also does not take into account that poverty rates among households without persons with disabilities may be higher than the poverty rates of households with persons with functional limitations, as a result of persons with disabilities living in poverty having higher mortality rates than those without a disability. It does not, therefore, appear to be a good option.

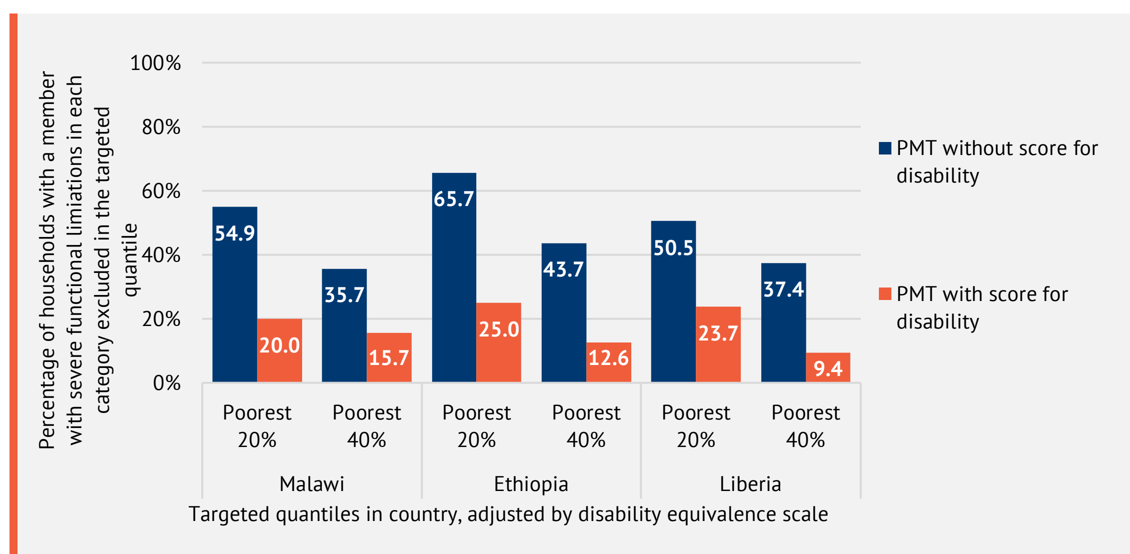
Option 2: Adjusting the expenditure of households with members with a disability

A second option – which, again, has not been attempted – would be to, before estimating the PMT scores, adjust the expenditure of households with members with a disability to reflect the extra cost of disability such that it is equivalent to the expenditure of households without a member with a disability.

Figure A13-2 shows the results of including disability equivalence scales to household expenditure and running PMTs with and without scores for functional limitations across

different countries and adjusted targeted quantiles.[276] The equivalence scale is equal to 40 per cent of the expenditure of households without members with a disability. In other words, the total expenditure of households with members with severe functional limitations is divided by 1.4. The findings suggest that the PMT design errors would only reduce significantly when also including scores for disabilities. If not combined with scores for functional limitations, the exclusion by design errors remains high. By construction, when including a variable in the regressions that explains the imposed variations in expenditure due to the disability equivalence scale, the regressions are better able to correctly identify households with members with severe functional limitations in the targeted groups. However, the results are sensitive to household datasets and the size of target groups. In Malawi, exclusion errors can be as low as 16 per cent when targeting the poorest 40 per cent of households (after adjusting expenditure for extra cost of disabilities). In Ethiopia and Liberia, the simulations also suggest that the performance of PMTs with scores for functional limitations are even better after adjusting household expenditures for the extra cost of disabilities and also exclusion is lower when targeting larger groups.

Figure A13-2: Exclusion by design of households with members with severe functional limitations in Malawi, Ethiopia and Liberia when adjustments to household expenditures are made, with and without the use of the Washington Group questions as a proxy in PMTs



Source: Analysis by Development Pathways of the following household survey datasets: Malawi HIS 2010/11; Ethiopia ESS 2013/14; Liberia HIES 2014/15.

[276] Relative rankings are redefined to reflect adjustments to expenditure because of disability equivalent scales.

Annex 14 Effectiveness of including persons with disabilities in the VUP programme

The Vision 2020 Umurenge Programme (VUP) includes the following schemes:

- The VUP Direct Support programme offers a regular cash transfer to households living in poverty without labour capacity.
- The VUP Public Works offers short-term employment to households living in poverty that have some labour capacity.

Eligibility to these schemes is determined by the Ubudehe targeting mechanism, which uses a simple proxy means test to classify the population into levels of well-being. Disability is determined through community based targeting, without formal guidance. Evidence from the EICV 4 dataset show that both schemes have targeting inaccuracies when assessed in terms of household consumption. This is not surprising given the relative similarities between the majority of the population and the high level of consumption dynamics.[277]

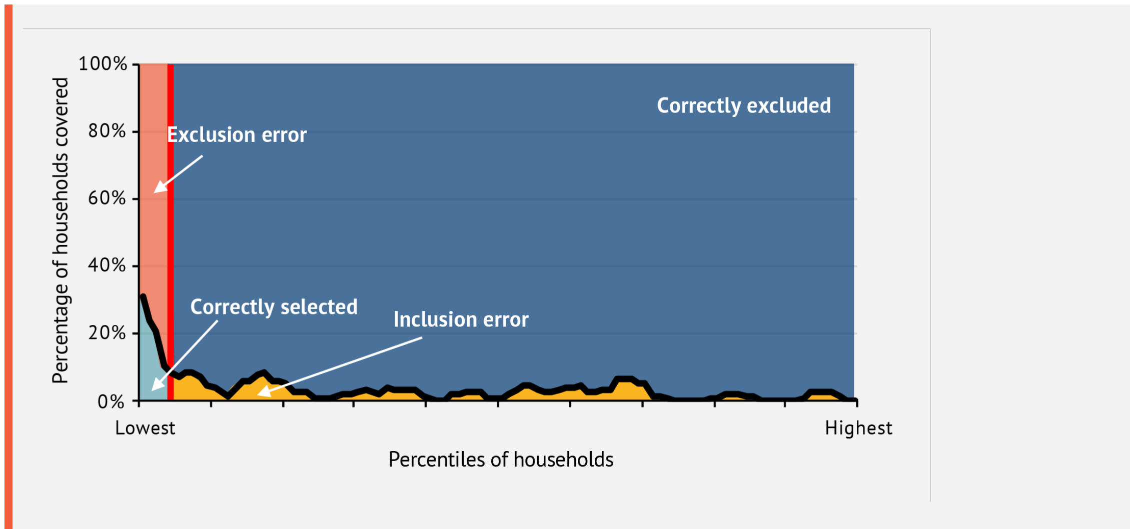
VUP Direct Support

Figure A14-1 visualises the share of households that are receiving the VUP Direct Support cash transfer as a proportion of all households with a person with a disability, below the consumption percentile that represents the total number of actual current beneficiaries. The share of households that receive the benefit is 5 per cent. While more households had been assessed in the lowest consumption percentiles, many recipients are found in more affluent percentiles, indicating both high inclusion and exclusion errors.

In the bottom decile, only 19 per cent of households with a person with a disability receive the transfer. However, 81 per cent of recipient households are found in more affluent deciles, indicating that the targeting mechanism is not closely associated with consumption poverty. Most importantly, the evidence shows that 81 per cent of households with a member with a disability that live in the bottom consumption decile, do not receive the transfer.

[277] Kidd and Kabare (2019)

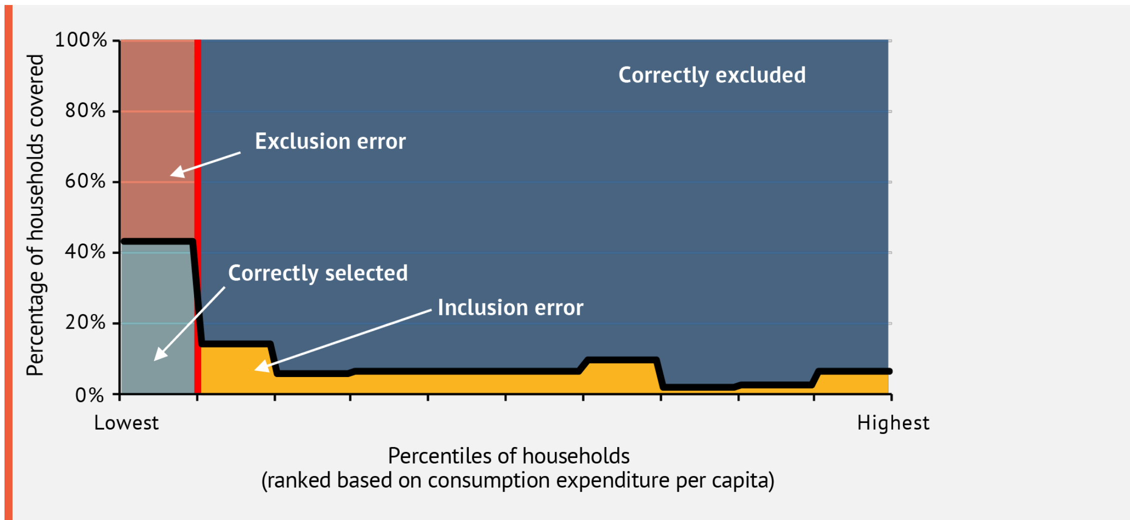
Figure A14-1: Share of households with a person living with a disability receiving VUP Direct Support



Source: Analysis undertaken for this research of the EICV 4 dataset using consumption percentiles excluding VUP benefits, weighted.

Figure A14-2 indicates the share of targeted households receiving the VUP Direct Support benefit across the population of households with no member having 'labour capacity' (the intended target group). Of the total number of households without any labour capacity, 10.2 per cent receive the benefit. Therefore, if the targeting mechanism were accurate in identifying consumption poverty, all households below the 10.2 percentile would receive the benefit. However, many households in the more affluent consumption percentiles can access the benefit while 56.5 per cent of households in the target group – i.e. the poorest 10.2 per cent – are excluded from the scheme.

Figure A14-2: Share of households (without any 'labour capacity') receiving VUP Direct Support by consumption percentile

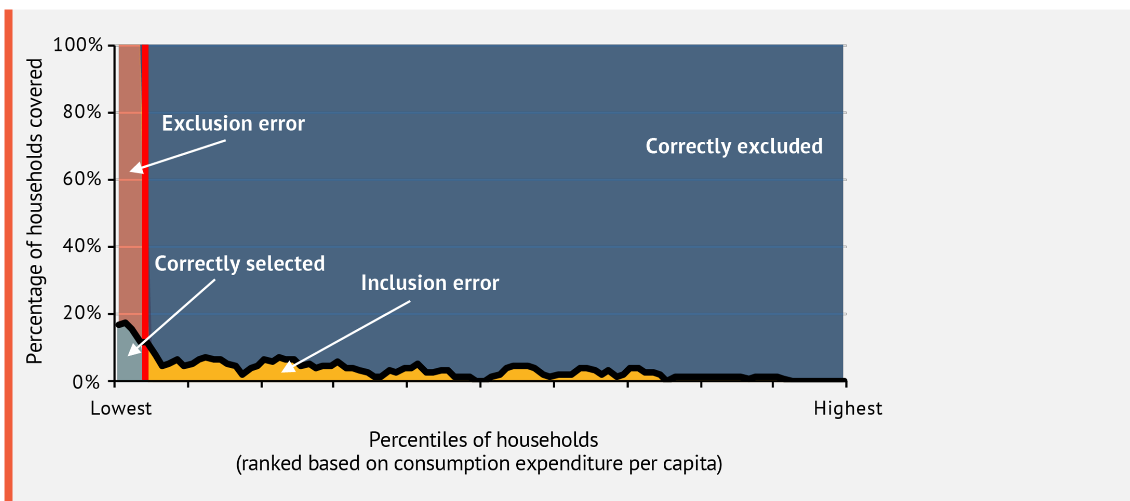


Source: Analysis undertaken for this research of the EICV 4 dataset using consumption percentiles excluding VUP benefits, weighted. "Labour capacity" is defined as being between the ages of 18 and 64 without a disability.

VUP Public Works

5 per cent of households with a person with a severe disability, but also with an 'able-bodied' member of working age, participate in the VUP public works programme, and there is significant exclusion of households with a member with a severe disability from the scheme (see Figure A14-3). Only 17.9 per cent of eligible households in the poorest 5 per cent of eligible households participate in the public works programme.

Figure A14-3: Share of households with a person living with a severe disability and at least one non-disabled working age person participating in VUP Public Works



Source: Analysis undertaken for this research of the EICV 4 dataset using pre-transfer consumption percentiles, weighted.

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