Disability inclusion

Topic guide
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About this Topic Guide

This guide summarises some of the most rigorous available evidence on the key debates and challenges of disability inclusion in development and humanitarian response.

GSDRC Topic Guides aim to provide a clear, concise and objective report on findings from rigorous research on critical areas of development policy. Their purpose is to inform policymakers and practitioners of the key debates and evidence on the topic of focus, to support informed decision-making.

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Disability prevalence

Disability is not rare. An estimated **one billion people** or around 15 per cent of the world's population have some form of disability (WHO & World Bank, 2011). Disability is more common in low- and middle-income countries than in high-income countries, and among older age groups (WHO & World Bank, 2011; Mitra & Sambamoorthi, 2014). Disability is something everyone is likely to experience, either permanently or temporarily, at some point in their life (WHO & World Bank, 2011). People with disabilities are diverse and not defined by their disability.

The current situation of people with disabilities

Disability does not necessary imply limited well-being and poverty. Yet, there is growing evidence that **disability and poverty are highly correlated**, especially multi-dimensional poverty (Groce et al., 2011; Mitra et al., 2013). Disability is both a **cause and consequence of poverty**, and poverty and disability reinforce each other, contributing to increased vulnerability and exclusion (DFID, 2000; Trani & Loeb, 2012).

Data show that people with disabilities in low- and middle-income countries are poorer than their nondisabled peers in terms of access to education, healthcare, employment, income, justice, social support and civic involvement (Groce et al., 2011; WHO & World Bank, 2011; Heymann et al., 2014; Mitra, 2014; Morgon Banks & Polack, 2014; Brooks et al., 2013), and are more likely to experience **multiple deprivations** (Mitra et al., 2013).They encounter inaccessible transport, infrastructure and digital technology (WHO & World Bank, 2011; DESA, 2013). Children and adults with disabilities are at **higher risk of physical, sexual and other forms of violence** (Hughes et al., 2012; UNICEF, 2013; Ortoleva & Lewis, 2012). People with disabilities are often **excluded from disaster management and risk reduction processes** (UNISDR, 2014; Smith et al., 2012), and are **disproportionately affected by conflicts and disasters** (Mitchell & Karr, 2014; Smith et al., 2012; WRC, 2015). Humanitarian response is often inaccessible (UNISDR, 2014, p. 4; Kett & Twigg, 2007; WRC, 2008; Mitchell & Karr, 2014).

The exclusion of people with disabilities has significant economic as well as social costs, caused by **losses in productivity and human potential** (DFID, 2000; Morgon Banks & Polack, 2014).

Diverse experiences of disability

Intersecting inequalities and personal factors may influence the experience of disability, and not all people with disabilities are equally disadvantaged (WHO & World Bank, 2011):

- **Women with disabilities** often experience double discrimination that can extend to all areas of life (DESA, 2011; DFID, 2000; Morgon Banks & Polack, 2014; Ortoleva & Lewis, 2012; WHO & World Bank, 2011; HRW, 2012).

- **Children with disabilities** are amongst the most marginalised and discriminated against children in the world (HI & STC, 2011; Trani et al., 2013; Trani & Cannings, 2013).

- **Older people with disabilities** are disproportionately poor (Masset & White, 2004).

- People who experience **mental health conditions or intellectual impairments** appear to be more disadvantaged in many settings than those who experience physical or sensory impairments (WHO & World Bank, 2011; Inclusion Intl., 2006).

- **People with invisible disabilities** often face significant discrimination (Yeo & Moore, 2003).

Barriers to disability inclusion

The evidence makes it clear that these **inequalities are a result of barriers**, rather than any inherent limitations of people with disabilities (Heymann et al., 2014; Groce et al., 2011; Morgon Banks & Polack, 2014; Groce & Kett, 2014; Groce & Bakhshi, 2011; Bruijn et al., 2012; WHO & World Bank, 2011). Barriers to disability inclusion include: attitudinal barriers; environmental barriers; institutional barriers; 'internalised' barriers; lack of participation; inadequate data, statistics and evidence on what works, and inaccurate concerns over cost/difficulty of disability inclusion. **Attitudinal barriers** are one of the greatest obstacles to achieving equality of opportunity and social integration (Wapling & Downie, 2012; UNICEF, 2013; Heymann et al., 2014; Bruijn et al., 2012). The lack of rigorous and comparable data, combined with lack of evidence on programmes that work, often impedes understanding and action on disability inclusion (WHO & World Bank, 2011).

The impact of disability inclusion

Some evidence and estimates indicate that disability inclusion could lead to increased earnings and labour productivity; increased tax revenues; improved individual and family well-being; and wider societal benefits through a **more inclusive and accessible society for all** (Lamicchane, 2015; Morgon Banks & Polack, 2014; Heyman et al., 2014; Grider & Wydick, 2015; WRC, 2015; WHO & World Bank, 2011).

Disability inclusive development / humanitarian response approaches

Disability inclusive development/humanitarian response approaches need not be costly or complicated. They include:

- **mainstreaming** (DESA, 2011; Coe & Wapling, 2010; Bruijn et al., 2012);
- the **'twin track approach'** (DFID, 2000; Al Ju'beh, 2015);
- **raising awareness and changing attitudes/behaviours** (Coe & Wapling, 2010; Coe, 2012; UNICEF, 2013; Bruijn et al., 2012);
- **comprehensive accessibility** and **Universal Design** (DESA, 2013; WHO & World Bank, 2011);
- **reasonable accommodation** (UNCRPD, 2006);
- **participation** (DESA, 2011; Al Ju'beh, 2015; Coe & Wapling, 2010; Bruijn et al., 2012; CBM, 2012; Smith et al., 2012; NCG, 2012; DSEA, 2011);
- **rights-based initiatives** (DESA, 2011; Wapling & Downie, 2012; Al Ju'beh, 2015; NCG, 2012);
- **community-based rehabilitation (CBR)** (Mauro et al., 2014; Biggeri et al., 2014);
- **inclusive education** (Bakhshi et al., 2013; WHO & World Bank, 2011);
- **inclusive livelihood approaches** (Mont, 2014; Mitra, 2014); and
- **'Building back better' after emergencies** (Mitchell & Karr, 2014).

Organisational change is needed for the successful inclusion of people with disabilities in development/humanitarian projects (Bruijn et al., 2012; Wapling & Downie, 2011; Coe & Wapling, 2010).

Inclusive approaches are **more cost-effective** than piecemeal disability interventions (Walton, 2012; Bruijn et al., 2012). The costs associated with including people with disabilities are far outweighed by the long-term financial benefits to individuals, families and society (CBM, 2012).

Tools to monitor and evaluate the impact of disability inclusion include the UN-endorsed Washington Group Short Set of Questions. People with disabilities can participate in the collection and analysis of data.

Most work on disability inclusion is framed around the **UN Convention on the Rights of Persons with Disabilities**. Looking towards the future, the new **Sustainable Development Goals** pledge to leave no one behind and directly mention people with disabilities under five of the 17 goals.

However, it is still rare for international development initiatives to systematically include disability in all aspects of all programmes (Groce et al., 2011).

State of the evidence

Lack of definitional clarity and robust statistics and little attention to, or funding for, disability research in international development has resulted in a limited evidence base and evidence gaps in all sectors (Groce et al., 2011, p. 1495). There is growing evidence on the association between disability and multidimensional poverty and inequalities. However, more research is needed, especially into the exact nature of this relationship, its dynamics and causalities, and the impact of intersectionality. The evidence is often nuanced and context dependent. There is often strong anecdotal evidence available, but few randomised control trials, or rigorous quantitative or qualitative evidence-based studies. There is more evidence on the impact of exclusion than inclusion, as exclusion is often still the default position. While there are many examples of best practice, there are very few rigorous or external evaluations of what works (and what does not) in disability inclusive development/humanitarian response approaches. More practical tools are needed, and appropriate and effective benchmarks and indicators for evaluating disability inclusion.

1 Background: definitions, concepts and history

Disability is part of the human condition. Everyone is likely to experience it, either permanently or temporarily, at some point in their life (WHO & World Bank, 2011, p. 3). **People with disabilities are diverse** and not defined by their disability (Al Ju'beh, 2015, p. 14; WHO & World Bank, 2011, p. 7). Disabilities may be visible or invisible, and onset can be at birth, or during childhood, working age years or old age.

This guide is designed to bring development and humanitarian professionals up to date on disability inclusion. It highlights key concepts and debates and covers: the current situation of people with disabilities in various sectors development and humanitarian professionals may be interested in; barriers to disability inclusion that have contributed to the current situation and need to be overcome; the impact of disability inclusion; best practice disability inclusive development/humanitarian response approaches that can be applied across the board; and disability inclusion policies, frameworks and tools, including for specific sectors.

Definition of disability

There is no single definition of disability (Mitra, 2006, p. 236). Defining disability is complicated as it is 'complex, dynamic, multidimensional and contested' (WHO & World Bank, 2011, p. 3).

The **UN Convention on the Rights of Persons with Disabilities** (UNCRPD) recognises that 'disability is an evolving concept' (UNCRPD, 2006, p. 1):

> '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' (UNCRPD, 2006, p. 4).

This fluid definition accommodates different understandings of disability or impairment (Schulze, 2010, p. 27, pp. 35-36), but by defining disability as an interaction, makes clear that disability is not an attribute of the person (WHO & World Bank, 2011, p. 5). As Al Ju'beh notes (2015, p. 13), 'An impairment on its own would not lead to disability should there be a completely inclusive and comprehensively accessible environment', which includes addressing attitudinal barriers such as stereotypes, prejudices and other forms of paternalistic and patronising treatment (Schulze, 2010, p. 27). UNCRPD's definition enshrines the social model of disability (Schulze, 2010, p. 27).

Different **models of disability** inform how disability is understood and acted upon, and can be categorised as follows.

Charity model

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

Medical model

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). It assumes that addressing the medical ailment will solve the 'problem' – that disability needs to be fixed or cured (Al Ju'beh, 2015, p. 20). This model is widely criticised on different grounds, including for not considering the important roles of environmental and social barriers (Mitra, 2006, p. 237; 82; Rimmerman, 2013, p. 27).

Medical and charity models of disability have led to 'development interventions based largely on impairment needs assessed by "expert" personnel, involving specialist services that are often severely limited in geographical, age, and impairment reach, as well as generally being expensive to run' (Coe, 2012, p. 402).

Social model

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, practice 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).

Human rights model

This model of disability is based on the social model and also seeks to transform unjust systems and practices. It takes the UNCRPD 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).

The social and human rights models form the basis of many disability policies and practices (Kett & Twigg, 2007, p. 88). As development professionals may identify with the individual models of disability, it is important not to alienate them when introducing them to disability as a human rights issue, but to 'help [them] to see that barriers are a more helpful and respectful lens with which to view disability' (Al Ju'beh, 2015, p. 23).

Interactional models

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; 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 is disabled 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).

Disability inclusion

A meta-analysis of the use of social inclusion in disability studies found it to mean: i) being accepted and recognised as an individual beyond the disability; ii) having personal relationships with family, friends and acquaintances; iii) being involved in recreation and social activities; iv) having appropriate living accommodation; v) having employment; and vi) having appropriate formal and informal support (Rimmerman, 2013, p. 1).

Disability inclusive development 'seeks to ensure the full participation of people with disabilities as empowered self-advocates in development processes and emergency responses and works to address the barriers which hinder their access and participation' (Al Ju'beh, 2015, p. 49).

Note on the use of language

The language used to describe people with disabilities is important as it is about fundamental respect for the integrity and dignity of people with disabilities (Al Ju'beh, 2015, p. 24).

The use of 'people/persons with disabilities' is known as 'people first' language. It is based on the need 'to affirm and define the person first, before the impairment or disability' (Al Ju'beh, 2015, p. 25). It is the preference in many developing countries and the language used by the UNCRPD (Al Ju'beh, 2015, p. 25).

In the UK, however, the preferred term is 'disabled people', as 'people do not have disabilities, but rather impairments which become disabling, due to society not being comprehensively accessible and inclusive' (Al Ju'beh, 2015, p. 25). This guide uses the term people with disabilities and disabled people interchangeably.

Table 1: Appropriate use of language (for English speakers)

Do Use	Don't Use
Person with an impairment; person with disability, people with disabilities	The disabled, handicapped, PWD
Person without a disability, non-disabled person, sighted person	Normal person
Person with a psychosocial disability, or psychiatric impairment or person with mental illness	'Mental' or 'mad'
Person with intellectual disabilities or persons with learning disabilities	Mental handicap or retarded
Person who is blind, person who has low vision; partially sighted person	The blind; the visually impaired
Person who is deaf, person who is hard of hearing; a deaf person	Suffers from hearing loss, the deaf, deaf and dumb, deaf-mute
Person who uses a wheelchair, wheelchair-user	Confined or restricted to a wheelchair, wheelchair bound
Person with a physical disability	Invalid; handicapped person; cripple, crippled, lame
Unable to speak, uses synthetic speech	Dumb, mute
Lives with / has / experiences a disability / impairment	Suffers from
Accessible toilet / parking for persons with disabilities	Disabled toilet/handicapped parking

Source: adapted from Al Ju'beh, 2015, pp. 28-29.

Disability prevalence

Disability is not rare, however it is hard to obtain an estimate of the number of people with disabilities. There are big differences in the ways countries define and measure disability; the quality and methods of data collection; the reliability of sources; and disclosure rates as families may fear stigma and isolation (Al Ju'beh, 2015, p. 12; WHO & World Bank, 2011, pp. 21-24). In low-income countries prevalence is often recorded as very low as a result of the use of weak methodologies. The Washington Group Short Set of Questions has been designed to measure disability consistently worldwide and is beginning to be used more widely.

The World Report on Disability, 2011, is seen as the most reliable source to date on disability data and statistics (Al Ju'beh, 2015, p. 12). It finds that there are over a billion people, **about 15 per cent of the world's population**, who have some form of disability (WHO & World Bank, 2011; p. 44). A similar global figure of 14 per cent is found by Mitra & Sambamoorthi (2014, p. 940) using a different methodology but the same data. They also find that disability prevalence is higher: in low- and middle-income countries than in high-income countries; among people aged 65 and above (39 per cent) than among working age adults (12 per cent); and among women (18.5 per cent) than men (12.1 per cent) (Mitra & Sambamoorthi, 2014, p. 940, 944).

Disability prevalence is likely to rise as a result of 'ageing populations and the higher risk of disability in older people as well as the global increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders' (WHO & World Bank, 2011, p. xi).

Table 2: Age-sex standardised disability prevalence (per cent) among adults for all countries and by country income group

	At least two severe or extreme limitations (a)	One severe or extreme limitation (b)	At least two moderate limitations (c)	One moderate limitation (d)	No limitation (e)	Disability (a)+(b)
All 54 countries	4.9	9.1	5.1	11.5	69.4	14.0
High income countries	1.7	4.8	3.0	10.1	80.3	6.5
Upper middle income countries	4.2	9.2	4.2	13.0	69.4	13.4
Lower middle income countries	7.8	12.1	6.8	10.9	62.3	19.9
Low income countries	4.8	7.8	5.0	10.8	71.6	12.6

Source: Mitra & Sambamoorthi, 2014, p. 944

Table 3: Prevalence of limitations and disability (per cent) for all countries by demographic characteristic

	At least two severe or extreme limitations (a)	One severe or extreme limitation (b)	At least two moderate limitations (c)	One moderate limitation (d)	No limitation (e)	Disability (a)+(b)
Adults aged 18+						
Women	7.0	11.5	6.3	13.5	61.8	18.5
Men	4.0	8.1	4.7	10.5	72.7	12.1
Working age adults (18-64)						
All	3.6	8.4	4.7	11.6	71.6	12.0
Women	4.8	9.9	5.4	13.3	66.6	14.7
Men	2.4	6.7	3.9	9.8	77.1	9.1
Older adults (65+)						
All	19.1	20.3	11.0	15.1	34.5	39.4
Women	22.2	22.0	11.9	14.7	29.3	44.2
Men	15.6	18.3	9.8	15.6	40.7	33.9

Source: Mitra & Sambamoorthi, 2014, p. 944

The evolving disability rights movement

Historically, people with disabilities have largely been provided for through solutions that segregate them, such as residential institutions and special schools (WHO & World Bank, 2011, p. 3; Schulze, 2010, 16; Rimmerman, 2013, p. 22). However, responses to disability began to change in the 1970s, driven by the self-organisation of people with disabilities across the world and by the growing tendency to see disability as a human rights issue (WHO & World Bank, 2011, p. 3; Rimmerman, 2013, pp. 20-22). This has resulted in policies shifting 'towards community and educational inclusion, and medically-focused solutions have given way to more interactive approaches recognizing that people are disabled by environmental factors as well as by their bodies' (WHO & World Bank, 2011, p. 3).

Disabled people's organisations (DPOs)

These were set up with a rights-based approach to empowerment: people with disabilities represented themselves rather than being represented by others (Barron & Amerena, 2007, p. 14). Their common slogan is '**nothing about us, without us**'.

DPOs emerged from civil rights movements, including in former colonial countries, and exist at local, regional and national levels across the world, offering support and the opportunity to raise awareness and advocate for rights (Barron & Amerena, 2007, pp. 14-15; Rimmerman, 2013, pp. 20-21; Irvine, 2014, p. 162). They may require institutional strengthening and organisational capacity building to help them to increase the visibility of disability issues, promote inclusive development, and support rights advancement (Barron & Amerena, 2007, p. 7; Wapling & Downie, 2012, p. 39). Sometimes it is important to keep in mind that DPOs may only represent one type of disability, or they may represent the views of an elite: they may not speak for women, rural dwellers, or people with disabilities who are not members of the DPO (Bruijn et al., 2012, p. 59; Trani et al., 2011, p. 1192).

Contributions of civil society actors to disability rights

DPOs and national and international NGOs helped draft the UNCRPD, and this marked a paradigm shift in the way civil society interacts with multilateral institutions (Woodburn, 2013, pp. 75-76; Schulze, 2010, p. 19). An International Disability Caucus of DPOs and NGOs was created to present a cohesive agenda that would be both applicable and beneficial to all with disabilities (Woodburn, 2013, p. 82). The involvement of DPOs and NGOs led to the human-rights based focus of the UNCRPD, a definition of disability, and the inclusion of women's rights – an article on disabled women and gendered language (Woodburn, 2013, pp. 85-89; Schulze, 2010). Through its adoption of a social model of disability, the UNCRPD is viewed as a landmark in the history of the disability rights movement (Meekosha & Soldatic, 2011, p. 1384). There are some concerns however that marginalised groups were not adequately represented in the discussions; for instance, fewer southern NGOs were involved (Woodburn, 2013, p. 90; Meekosha & Soldatic, 2011, p. 1383).

United Nations Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) affirms the dignity and human rights of all people with disabilities and rejects the link between ability and impairment (Wapling & Downie, 2012, p. 12). It does not create any new rights but clearly states that 'persons with disabilities have equal access and a right to full and effective enjoyment of all human rights' (Schulze, 2010, p. 7, 13; WHO & World Bank, 2011, p. 9). The principles of the UNCRPD are: inherent dignity, non-discrimination, effective inclusion, respect for differences, equal opportunity, accessibility, gender

equality and respect for the evolving capacities of children with disabilities (Wapling & Downie, 2012, pp. 18-19; Schulze, 2010, pp. 44-49).

Article 32 on international cooperation and Article 11 on humanitarian emergencies are unique, and require state parties and other actors in international cooperation to respect, promote and fulfil the rights and dignity of people with disabilities (Wapling & Downie, 2012, p. 22).

The **Optional Protocol** is a side-agreement to the UNCRPD. It establishes an individual complaints mechanism for the Convention, with a complaints body in the form of the UNCRPD Committee.

As of October 2015, there are 160 signatories and 160 ratifications to the Convention; and 92 signatories and 88 ratifications to the Optional Protocol. State parties to the UNCRPD are required to adopt legislation and other measures to promote and protect the human rights of people with disabilities, and can be held accountable to the UNCRPD Committee. States that have ratified the UNCRPD have the option of 'progressive implementation', whereby they are allowed to implement the Convention over a number of years (Groce et al., 2011, p. 1495).

UNCRPD as an advocacy and accountability tool

The UNCRPD is a powerful tool with which to measure the fulfilment of rights. It acts as a rallying point for lobbying activities, as it analyses barriers and provides a clearly defined and easily understood set of rights that are linked to common development themes (Wapling & Downie, 2012, p. 17, 22; Groce et al., 2011, p. 1495; Meekosha & Soldatic, 2011, p. 1386). It has helped raise the political profile of disability issues within international development (Groce et al., 2011, p. 1495). People with disabilities and NGOs have also used the UNCRPD to hold their national governments to account. Even in states that are not signatories to the UNCRPD – such as Somalia, South Sudan and Tajikistan – disability activists encourage their government to sign and ratify it (Aldersey, 2013).

However, despite commitments to the UNCRPD on paper, in many countries there are still problems with its effective implementation and enforcement (Groce et al., 2011, p. 1495).

Putting disability on the international development agenda

Lack of disability in the Millennium Development Goals (MDGs)

The MDGs did not mention people with disabilities, and this is felt to have been 'a lost opportunity to address the pressing social, educational, health and economic concerns of millions of the world's most marginalized citizens' (Groce, 2011, p. viii). The MDGs' focus on national averages concealed whether processes were inclusive or equitable (Vandemoortele, 2011, p. 19). They have been criticised for incentivising the pursuit of the 'low hanging fruit' (i.e. providing for the easy to reach rather than those most in need) (Save the Children, 2012). Lack of explicit mention of people with disabilities resulted in the lack of systematic inclusion of people with disabilities in programmes and policies, and lack of monitoring of disability-related statistics (Groce, 2011, p. x).

Disability inclusion in the Sustainable Development Goals (SDGs)

Local, regional and national DPOs and NGOs led the calls for disability to be included in the MDGs and SDGs (Groce, 2011, p. ix; Mitra, 2013, p. e178; Al Ju'beh, 2015, p. 34). The final outcome document of the post-2015 agenda, Transforming our world: The 2030 agenda for sustainable development, is disability inclusive and pledges to leave no one behind, with eleven explicit references to people with disabilities. It notes that more than 80 per cent of people with disabilities live in poverty, which puts people with disabilities at the centre of poverty eradication throughout the agenda (Lockwood, 2015). It directly

references people with disabilities under five of the seventeen goals, in relation to education, growth and employment, reducing inequality, safe and inclusive human settlements, and data collection and monitoring of the SDGs. It commits to using data which is disaggregated by disability. People with disabilities are also included wherever vulnerable is referenced (18 times), in line with paragraph 23.

The SDGS are described as 'a powerful tool that people with disabilities can use nation by nation to argue for their inclusion' (Haslam, 2015). The strong focus on disability in 'so many national policy areas within this document, such as employment, education and transport, gives clear direction for development planners and thinkers' (Haslam, 2015). However, there are some concerns about the lack of explicit references to people with disabilities in relation to health and gender (Lockwood, 2015). In addition, it is considered very important that the indicators for the SDGs contain explicit references to people with disabilities.

2 The situation of people with disabilities: the current state of affairs

Disability does not necessarily imply limited well-being and poverty. Many people with disabilities live fulfilling lives, have families, earn a living, and are successful. However, a growing body of evidence indicates that they also face attitudinal, physical and institutional barriers and intersecting inequalities, which can result in multi-dimensional poverty, exclusion, and marginalisation. Exclusion in one area of life can have negative repercussions in other areas.

This section looks at the current situation for people with disabilities in various sectors. For general best practice development/humanitarian response disability inclusion approaches to the challenges faced by people with disabilities in the different sectors see Section 5; for toolkits see Section 6.

Intersecting inequalities

People with disabilities are diverse, and not all people with disabilities are equally disadvantaged (WHO & World Bank, 2011, p. 8). **Multiple and intersectional discrimination** is slowly being recognised as a social barrier for people with disabilities (Schulze, 2010, p. 30).

- **Gender:** Women and girls with disabilities commonly experience double discrimination that can extend to all areas of life, including legislation and policies (DESA, 2011, p. 12; DFID, 2000, p. 5; Morgon Banks & Polack, 2014, p. 36; Ortoleva & Lewis, 2012; WHO & World Bank, 2011, p. 8; HRW, 2012, p. 3). Women with disabilities from minority groups or rural areas and other marginalised identities face additional disadvantages (Ortoleva & Lewis, 2012, p. 28).

- **Age:** Children with disabilities are amongst the most marginalised and discriminated against children in the world (HI & STC, 2011, p. viii; Trani et al., 2013, p. 404; UNICEF, 2013, p. 41; Trani & Cannings, 2013, p. 58). Very little is known about young people with disabilities, and programmes often overlook them (Groce & Kett, 2014, p. 3; Meyers et al., 2014). Older people with disabilities are disproportionately poor (Masset & White, 2004, p. 291).

Inequalities and the diversity of disability

People with different forms of impairment or acquirement can experience inequalities differently. The World Report on Disability finds that 'people who experience mental health conditions or intellectual impairments appear to be more disadvantaged in many settings than those who experience physical or sensory impairments' (WHO & World Bank, 2011, p. 8; Inclusion Intl., 2006). People with other invisible disabilities (such as debilitating pain or fatigue), often face significant discrimination (Yeo & Moore, 2003, p. 579). In some countries, people who have been disabled as a result of conflict enjoy higher status than those whose disabilities have another cause, as a result of the value placed on them as 'war heroes' or 'innocent victims' (Mitchell & Karr, 2014, p. 228; Kett & Twigg, 2007, p. 95; Meyers, 2014, p. 200).

The association between poverty and disability

While not all people with disabilities are poor, it is increasingly recognised that 'disability is an important issue in poverty reduction and poverty alleviation efforts' (Groce et al., 2011, p. 1493). A small but growing body of evidence is providing specific information about the association between disability and poverty, especially multi-dimensional poverty (Groce et al., 2011, p. 1496, 1502; Mitra et al., 2013, p. 3). Data are showing that people with disabilities in low- and middle-income countries are 'poorer than their nondisabled peers in terms of access to education, access to healthcare, employment, income, social support and civic involvement' (Groce et al., 2011, p. 1496). For example, a study using internationally

comparable data from fifteen developing countries found that in most countries, disability is '**significantly associated with higher multidimensional poverty** as well as lower educational attainment, lower employment rates, and higher medical expenditures'[1] (Mitra et al., 2013, p. 1). A recent systematic review of the relationship between disability and poverty in low- and middle-income countries also noted that 'the majority of studies (78 of 97 - 80 per cent) found a positive, statistically significant association between disability and economic poverty' (Morgon Banks & Polack, 2014, p. ii). A study of poverty and disability in Afghanistan and Zambia found 'evidence of lower access to healthcare, education and labour market for people with disabilities, whatever is the disability status, but poverty measured by an asset index is not statistically different between people with and without disabilities' (Trani & Loeb, 2012, p. S19). It should be noted, however, that most families in these countries own very few assets (Trani & Loeb, 2012, p. S31). Other studies find similarly inconclusive results on the association between disability and household income or household consumption expenditures (Rischewski et al., 2008; WHO & World Bank, 2011, p. 40; Mitra et al., 2013).

The links between poverty and disability

Where does the association between poverty and disability come from? It is often stated that disability is 'both a cause and consequence of poverty' and poverty and disability 'reinforce each other, contributing to increased vulnerability and exclusion' (DFID, 2000, p. 1, 2; Trani & Loeb, 2012, p. S19). However, the dynamics among the causal factors driving this disability–poverty nexus are under-researched (Groce et al., 2011, p. 1493, 1495; Mitra et al., 2013, pp. 1-3; Morgon Banks & Polack, 2014, p. i; Mont, 2014, p. 24). This is partly the result of the lack of a consistent measure of disability (Groce et al., 2011, p. 1494, 1500; Mitra et al., 2013, p. 1).

Disability → poverty

Disability accentuates poverty because the systemic institutional, environmental and attitudinal barriers that people with disabilities encounter in their daily lives result in their entrenched social exclusion and lack of participation in society (Groce et al., 2011, p. 1497). This leads to:

- discrimination, social marginalisation and isolation;
- insufficient access to education, adequate housing, nutritious food, clean water, basic sanitation, healthcare and credit;
- lack of ability to participate fully in legal and political processes; and
- lack of preparation for and meaningful inclusion in the workforce
  (Woodburn, 2013, p. 80; Groce et al., 2011, p. 1497).

Additional costs of disability

Disability can reduce people's earning potential. Yet someone with a disability 'might need a higher income to achieve the same level of functioning as a nondisabled person' to pay for assistive devices or personal support (Groce et al., 2011, p. 1502; Mitra et al., 2013, p. 2; WHO & World Bank, 2011, p. 10, 43). Very few studies estimate the direct costs of disability. Direct costs may be low due to the unavailability of services and goods (e.g. medical care, assistive devices), which may in turn limit opportunities and well-being. Poor people with disabilities are less likely to earn their way out of poverty as a result of the work and education related barriers they face (Heymann et al., 2014, p. 3).

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[1] Multidimensional poverty refers to the experience of simultaneous multiple deprivations.

Poverty → disability

Poverty increases the likelihood of disability: chronically poor people are often at risk of ill health and injuries, which may lead to disability (Groce et al., 2011, p. 1498; Mitra et al., 2013, p. 2). Poverty is associated with malnutrition, inadequate access to public health services (e.g. immunisation), poor living conditions (e.g. lack of safe water), and environmental exposures (e.g. unsafe work environments), which can lead to health conditions which result in disability (Mitra et al., 2013, p. 2). The poor who become disabled are likely to descend further into poverty, with a significant effect on their entire household (Groce et al., 2011, p. 1498).

Diverse economic experiences

People with disabilities live in environments and have individual compounding characteristics that influence their economic experiences (Groce et al., 2011, p. 1502; Mitra et al., 2013, p. 2).

Environmental factors

Evidence from different countries is diverse, as the particular education facilities, labour market, and social protection available in a given context can influence whether disability leads to poverty (Mitra et al., 2013, p. 2; WHO & World Bank, 2011, p. 40).

Where persons with disabilities face social marginalisation and lack of access to education, employment, healthcare, legal representation and credit, they may be more marginalised if improving economic conditions allow others to improve their quality of life (Groce et al., 2011, p. 1507). One study found that the difference in economic well-being across disability status appears to be more often significant in middle-income than low-income countries (Mitra et al., 2013, p. 7). Another study also found that the disability gap in employment (people with disabilities have lower employment rates than people without disabilities) is more common in middle-income than low-income countries (Mizunoya & Mitra, 2013, p. 38).

Differences can also be found within countries. In Vietnam, 'districts with better healthcare and infrastructure, such as roads and health services, show less of a link between disability and poverty' (Mont & Nguyen, 2013). Some argue that the political ideology of a country can affect people with disabilities' experience of poverty (Gill & Schlund-Vials, 2014).

Personal/individual factors

Different types of impairments, age of acquisition, gender, ethnicity and rural or urban location all affect how people with disabilities experience poverty (Groce et al., 2011, pp. 1502-1503). For instance, a study using internationally comparable data of fifteen developing countries found that among people with disabilities, 'persons aged 40 and above and persons with multiple disabilities were more likely to be multi-dimensionally poor' (Mitra et al., 2013, p. 1). Children with disabilities are disproportionally likely to live in poverty (HI & STC, 2011, p. viii; Trani et al., 2013, p. 404; Trani & Cannings, 2013, p. 58). A study in Afghanistan found that girls with disabilities were more deprived on all dimensions of multidimensional poverty than boys with disabilities (Groce et al., 2011, p. 1503). People with mental illness face higher levels and intensity of poverty, partly as a result of stigma and prejudice (CCDRP, 2013, p. 1; Trani & Loeb, 2012, p. S32).

Studies indicate that 'women with disabilities are more likely to be affected by poverty than men with disabilities, and that unmarried women are the most vulnerable to poverty' (Groce et al., 2011a, p. 17). In contrast, in some countries, men who have been disabled by war are considered heroes and 'often escape poverty through privileged access to land, employment and public facilities' (Trani & Loeb, 2012, p. S32).

Family and household poverty

Some studies have found that households with disabled family members had a lower mean income and fewer assets than households without, although the evidence is mixed (Groce et al., 2011, p. 1501, 1503; Mitra et al., 2013, p. 3; Woodburn, 2013, p. 80; WHO & World Bank, 2011, p. 10). Three types of cost are associated with disability at the household level:

- **direct costs** – including medical treatment and travel costs;
- **opportunity costs** as a result of lost income; and
- **indirect costs** relating to the provision of 'care' provided by family or community members (Groce et al., 2011, p. 1503; UNICEF, 2013, p. 14).

Those caring for children or adults with disabilities are generally female, and they often give up income-generating activities to do so (Cordier, 2014, p. 554; Groce & Kett, 2014, p. 6; ESCAP, 2012, p. 15). A study in Asia and the Pacific also finds that in households where people with disabilities support dependents, they are unable to earn enough to fulfil those support responsibilities (ESCAP, 2012, p. 6). These studies establish that '**the root cause of the problem is not the person with a disability**, but the social marginalisation, and lack of access to basic resources such as education, employment, healthcare and social support systems that link disability and poverty at the household level' (Groce et al., 2011, pp. 1503-1504).

Access to jobs, livelihoods, and social protection programmes

A large majority of people with disabilities are either **not employed, under-employed or earn lower wages** (Groce et al., 2011, p. 1499; WHO & World Bank, 2011, p. 235; Heymann et al., 2014, pp. 4-5; Mitra, 2014, p. 269). A study of 15 developing countries found that in nine of them there was a statistically significant disability gap showing lower employment rates for people with disabilities (Mizunoya & Mitra, 2013, p. 32).

- **Gender:** The study of 15 developing countries also found that employment differences across disability status are more pronounced among males than females (Mizunoya & Mitra, 2013, p. 38). However, other studies suggest that women with disabilities have worse employment rates and wages than men with disabilities (Heymann et al., 2014, p. 5; ESCAP, 2012, p. 19; Lamicchane, 2015, p. 248). A survey of 51 countries found that men with disabilities have an employment rate of 52.8 per cent compared with 64.9 per cent for men without; and for women the figures were 19.6 per cent and 29.9 per cent respectively (Mont, 2014, p. 23).

- **Disability type:** People with intellectual disabilities, mental illnesses or multiple disabilities have been found to be less likely than people with other disabilities to access the labour market (Groce et al., 2011, p. 1499; Morgon Banks & Polack, 2014, pp. 35-36; Mizunoya & Mitra, 2013, p. 16; WHO & World Bank, 2011, p. 8). A study of Nepal, Cambodia and Bangladesh found that people with physical impairments were less likely to find jobs than people with hearing and visual impairments, even when they had longer periods of schooling (Lamicchane, 2015, p. 248).

The economic crisis

A study of 55 countries found that during the economic crisis many people with disabilities lost their jobs and funding for employment support was cut, and recent evidence indicates that the disability employment gap has been widening (Fembek et al., 2013, p. 15, 90; Heymann et al., 2014, p. 4).

Improving the livelihoods of people with disabilities

Attempts to improve the livelihoods of people with disabilities have involved efforts to include them in social protection programmes and in the labour market (Rimmerman, 2013, pp. 82-82).

Formal employment

Barriers to participation in education and training place people with disabilities at a **disadvantage in the job market** (Morgon Banks & Polack, 2014, p. 36; Fembek et al., 2013, p. 128; Mont, 2014, p. 25; Mitra, 2014, p. 275). In South Africa for example, the formal employment rate for people with disabilities is less than a third of that of people without disabilities (Morgon Banks & Polack, 2014, p. 35). Young people with disabilities find it particularly hard to get apprenticeships or training (Groce & Kett, 2014, pp. 7-8).

Even when people with disabilities have the required skills, additional **barriers** may include: their social isolation limiting the development of networks; discriminatory attitudes and misconceptions by employers; workplace harassment; low expectations of their capabilities by individuals with disabilities and their families; inaccessible work environments and lack of accommodations; and discriminatory legislation (Morgon Banks & Polack, 2014, pp. 36-37; Mizunoya & Mitra, 2013, p. 29; WHO & World Bank, 2011, p.236, 239-240, 250; Heymann et al., 2014, p. 6; Mont, 2014, p. 25; Mitra, 2014, pp. 276-280; ESCAP, 2012, pp. 16-18). A study of disability and equity at work attributes much of the employment and income disadvantages faced by people with disabilities to **discrimination, both explicit and implicit** (Heymann et al., 2014, p. 6).

Box 1: Tackling barriers to employment

Overcoming the labour market barriers experienced by people with disabilities requires a range of approaches, addressing constraints outside and inside the labour market (Heymann et al., 2014, p. 9; Mitra, 2014, p. 280). Labour market interventions include: anti-discrimination laws, hiring quotas, wage subsidies, vocational rehabilitation and accommodation in the workplace (Rimmerman, 2013, pp. 84-92; Fembek et al., 2013, p. 144; WHO & World Bank, 2011, p.235, 240-246; Mont, 2014, pp. 27-29; Mitra, 2014, pp. 284-293). The aim is to change attitudes in the workplace and amongst people with disabilities and their families (WHO & World Bank, 2011, p.235; Mont, 2014, p. 32).

In developed countries, evidence shows that disability discrimination legislation has resulted in the most significant progress in workplace accommodations for people with disabilities, although they continue to experience disproportionly high rates of unemployment (Rimmerman, 2013, p. 92, 125). The size of the informal economy and limited legal implementation capacity in some developing countries may limit the effectiveness of disability discrimination legislation there (Heymann et al., 2014, p. 12).

There has been a lack of rigorous impact evaluations of employment programmes for people with disabilities in low- and middle-income countries (Mont, 2014, p. 26). However, programmes targeting the context-specific employment challenges of people with disabilities are more likely to be successful in improving employment rates (Mitra, 2014). This would include making sure training fulfilled market demands (Mont, 2014, p. 30). Separate employment programmes for people with disabilities are less efficient and sustainable than including them in mainstream efforts (Mont, 2014, p. 36). It is recommended that employment policies consider issues such as awareness raising, inclusive education, inclusive healthcare, and accessible transport, and recognise that most livelihood generating activities are not in the formal sector (Mont, 2014, pp. 37-38; Mitra, 2014, p. 294). Programmes that address multiple constraints to employment are promising, although there is little available evidence on these (Mitra, 2014, p. 294). Social assistance can also have positive effects on employment for people with disabilities (WHO & World Bank, 2011, p.248).

Informal employment

An estimated 80 per cent of economically active people with disabilities in developing countries are self-employed, as this is often their only option (Leymat, 2012, p. 26; Groce et al., 2011, p. 1504; Morgon Banks & Polack, 2014, p. 37; Mizunoya & Mitra, 2013, p. 35). Self-employment is associated with job insecurity, and lack of pensions and other welfare benefits, while lack of education, skills training and access to finance schemes creates further challenges (Groce et al., 2011, p. 1504; Morgon Banks & Polack, 2014, p. iii, 37; Leymat, 2012, p. 26). In addition, stigma and prejudice towards people with disabilities may prevent customers using their service (e.g. in Southern Africa customers will not buy food from women with epilepsy, fearing that it is an infectious condition) (Groce et al., 2011, p. 1504).

Access to microfinance

Many microfinance institutions (MFIs) avoid clients with disabilities, who constitute less than one per cent of clients for most MFIs (Groce et al., 2011, p. 1505; Leymat, 2012, p. 28). This is often as a result of incorrect assumptions that people with disabilities will be unable to pay back the money borrowed (Groce et al., 2011, p. 1505; Morgon Banks & Polack, 2014, p. 37; Leymat, 2012, p. 29; Mont, 2014, p. 33). While some organisations of and for people with disabilities provide microfinance, they are often only able to reach relatively small numbers of people, and their programmes are often not self-sustainable (Leymat, 2012, pp. 33-34). People with disabilities may also feel they lack the financial skills to access these services (Leymat, 2012, p. 29).

Box 2: Facilitating access to mainstream financial provision

A global survey looking at access to financial services for people with disabilities found that if they are given the opportunity to access financial services, 'many are capable of successfully managing loans and businesses' (Leymat, 2012, p. 25). It also found that the 'most cost-efficient and sustainable way of providing financial services for disabled people is to facilitate their access to mainstream financial provision' (Leymat, 2012, p. 30).

This has been done by: raising awareness among microfinance staff; establishing partnerships for cooperation between organisations of/for people with disabilities and microfinance institutions; promoting reasonable accommodation by adapting methodologies, product design, and accessibility; or simply by supporting people with disabilities to submit their loan applications (Leymat, 2012, pp. 30-33). Sensitisation of staff and outreach in a Ugandan microfinance institution doubled the number of clients with disabilities, for example (Heymann et al., 2014, p. 11). Savings schemes are currently one of the most effective ways people with disabilities can access microfinance (Groce et al., 2011, p. 1505; Leymat, 2012, p. 35).

It should be noted that microfinance is not the only or best solution for all (Leymat, 2012, p. 35; Burns et al., 2014, p. 31).

Begging

The strong links between disability and poverty also increase the likelihood of turning to begging, to earn all or part of a living, in urban areas (Groce et al., 2014, pp. 1-3; Burns et al., 2014, p. 29, 31). In some cultures begging is often considered 'an acceptable way, and in some cases the only way, for people with disabilities to make a living outside the home' (Groce et al., 2014, p. 1, 4). A literature review found that people with disabilities decide to beg as a result of a lack of social networks; internalised social stigma; education and skills levels; limited employment prospects; social protection floors; and a downward spiral of poverty (Groce et al., 2014, pp. 4-7).

People with disabilities often **contribute to their households** by doing unpaid labour (Groce et al., 2011, p. 1504).

Social protection

A growing number of countries have social protection programmes that either target people with disabilities or mainstream disability. Yet statistical and anecdotal evidence shows that many people with disabilities are not reached by social protection programmes, because of varied barriers (Rohwerder, 2014, p. 5). Much work is needed to address these (Mitra, 2005, p. 18; Palmer, 2013, p. 148). Begging by people with disabilities appears to be far less common in countries with established social protection systems (Groce et al., 2014, p. 7).

Social protection programmes risk strengthening dependency and segregation, and reducing incentives to work (Rimmerman, 2013, pp. 3-4; WHO & World Bank, 2011, p.248), although evidence supporting this in low- and middle-income countries is lacking so far (Mitra, 2009, p. 516). In addition, social protection programmes on their own will not eliminate the vulnerabilities people with disabilities face: complementary programmes are needed to create an enabling environment (Rohwerder, 2014, p. 9). Evidence on how safety nets affect people with disabilities is limited: more research is needed (WHO & World Bank, 2011, p. 11).

Support and participation in society

Children and adults with disabilities are often **isolated from mainstream social, cultural, and political opportunities** (WHO & World Bank, 2011, p.263; HI & STC, 2011, p. v; Trani & Cannings, 2013, p. 58). Stigmatisation can lead to lack of registration of the birth of children with disabilities, which is a fundamental barrier to their participation in society and increases their invisibility and vulnerability to exploitation (UNICEF, 2013, p. 41). The World Report on Disability finds that people with disabilities often have unmet needs for support services, personal care, access to aids and equipment, participation in education, employment, and social activities, and modifications to the home or workplace (WHO & World Bank, 2011, p. 40, 137). Lack of support prevents many people with disabilities from achieving a good quality of life and participating in social and economic life on an equal basis with others (WHO & World Bank, 2011, p. 137).

Provision of assistance and support

People's need for assistance and support will depend on 'environmental factors, the stage of life, the underlying health conditions, and the level of individual functioning' (WHO & World Bank, 2011, p.138). Formal services are inadequate (WHO & World Bank, 2011, p.157). Due to the lack of investment in rehabilitation, only 5-15 per cent of people with disabilities in low- and middle-income countries receive assistive devices (Morgon Banks & Polack, 2014, p. 47). In addition, as children and adolescents grow, their assistive devices need to be replaced every year or two (Groce & Kett, 2014, p. 7). They are often expensive, yet ill-fitting devices reduce the young people's confidence and ability to participate (Groce & Kett, 2014, p. 7; UNICEF, 2013, p.18).

People with disabilities often rely on informal care from family and friends, but this is sometimes unavailable, inadequate or insufficient (WHO & World Bank, 2011, p. 139, 157; Burns et al., 2014, p. 39).

Barriers to assistance and support include: lack of awareness and funding; lack of adequate human resources; inappropriate policies and institutional frameworks; inadequate and unresponsive services; poor service coordination; and attitudes and abuse (WHO & World Bank, 2011, pp. 144-147).

Exclusion from society

People with disabilities often encounter **negative attitudes** held by government officials, policy makers, community members – and even family members – which results in their exclusion from society (Groce et al., 2011, p. 1499; Groce & Kett, 2014, pp. 10-11; Burns et al., 2014, pp. 39-41). Negative social attitudes can result in disabled people's families keeping them hidden at home or sending them to institutions (Groce & Kett, 2014, p. 5). Hundreds of thousands of children with disabilities continue to live in institutions, as do many adults with intellectual disabilities (Groce & Kett, 2014, p. 12; UNICEF, 2013, pp. 46-47; Scior et al., 2015, p. 60). People with disabilities are sometimes denied the right to marry or have families of their own (Groce & Kett, 2014, p. 10; Ortoleva & Lewis, 2012, p. 75; Fembek et al., 2013, p. 69). In addition, a study in Afghanistan and Zambia shows a 'significant relationship between disability, unemployment and being single', which excludes people with disabilities, as marriage is often considered a 'major step in the process of gaining a rightful place within society' (Trani & Loeb, 2012, p. S33).

Impact on families

Family members can also face discrimination by association (PPUA Penca, 2013, p. 15; Burns et al., 2014, pp. 43-44). This sometimes results in them developing a negative attitude towards their relative with disabilities (PPUA Penca, 2013, p. 15; Burns et al., 2014, p. 39). Negative attitudes about disability especially disadvantage mothers, who are 'blamed' in some cultures for having a child with a disability (Inclusion Intl., 2006, p. 63). This, combined with mothers generally bearing the majority of the care giving responsibilities, often devalues and isolates them (Inclusion Intl., 2006, p. 63).

Political participation

People with disabilities have often been **excluded from playing an active part in the political process** in their own countries and wider international development processes (Groce et al., 2011, p. 1499; Balmas et al., 2015, p. 11). They face challenges in exercising their fundamental right as a citizen to vote in elections (PPUA Penca, 2013, p. 8). Existing laws can confuse and discriminate against the political rights of people with disabilities (PPUA Penca, 2013, p. 11; Balmas et al., 2015, p. 13; WHO & World Bank, 2011, p. 171). People with intellectual disabilities are often prevented from voting as they are perceived as having 'limited capacity to vote' (Balmas et al., 2015, p. 13). Polling stations are often located in inaccessible places and their staff do not have training to assist people with disabilities (PPUA Penca, 2013, p. 8; WHO & World Bank, 2011, p. 171). People with disabilities also face difficulties in accessing information about voter registration and the candidates, and many are even prevented from registering as voters (PPUA Penca, 2013, p. 8; WHO & World Bank, 2011, p. 171).

In addition, people with disabilities may be prevented from standing as candidates (PPUA Penca, 2013, p. 12). For example, in Indonesia, candidates are required to be literate to stand for legislative election, but it is unclear whether the ability to read braille is acceptable as a test of literacy (PPUA Penca, 2013, p. 12).

Education

Studies across the world have found that children with disabilities are **less likely to go to school** than children without disabilities and are **more likely to drop out** (Groce et al., 2011, p. 1498; Morgon Banks & Polack, 2014, p. 26; Groce & Kett, 2014, p. 8; EFA, 2015, p. 101; WHO & World Bank, 2011, p. 206; UNICEF, 2013, p. 27; HRW, 2012, p. 10; Trani et al., 2011, p. 1198). For example, a study in Afghanistan found that the proportion of non-disabled children accessing school is almost twice as high as the proportion of children with disabilities (Trani et al., 2012, p. 352).

- **Gender:** Girls with disabilities are even less likely to receive an education than boys with disabilities (Trani & Loeb, 2012, p. S32; EFA, 2015, p. 101; WHO & World Bank, 2011, p. 206; Trani et al., 2011, p. 1198).
- **Disability type:** Children with physical impairments are generally more likely to be enrolled than those with intellectual or sensory impairments (WHO & World Bank, 2011, p. 207; Inclusion Intl., 2006, pp. 32-35; Trani et al., 2012, p. 355).

Some parents of children with disabilities say that without school, they have no choice but to lock up or tie up their children while they go to work or complete daily chores (HRW, 2012, P. 10). Scarce data about children with disabilities means the 'scale of the challenge is likely underestimated' (EFA, 2015, p. 78).

Barriers to education
The reasons for the low educational levels of children with disabilities can include:
- inaccessible school buildings (e.g. multi-storey with no lifts, inaccessible toilets);
- limited communication modes (e.g. no materials in Braille);
- location, combined with lack of transport links;
- stigmatisation and bullying;
- lack of teacher confidence and training;
- low expectations of children with disabilities;
- prohibitive costs and inadequate resources; and
- policies that prevent inclusive education – e.g. special education is under the jurisdiction of ministries for health or social welfare rather than the ministry of education (Morgon Banks & Polack, 2014, pp. 27-28; Srivastava et al., 2015, p. 189 Groce & Kett, 2014, p. 7; Groce & Bakhshi, 2011, p. 1155; WHO & World Bank, 2011, pp. 212-216; UNICEF, 2013, p. 26, 32, 36; HRW, 2012, p. 10; Bruijn et al., 2012, p. 52; HRW, 2012, p. 13; Trani et al., 2011, p. 1190; Burns et al., 2014, pp. 26-28).

Long-term implications
Lack of access to education for children with disabilities has repercussions throughout their lives. The well-established links between **illiteracy or marginal literacy and poverty** significantly increase the likelihood that they will raise their own children in poverty (Groce et al., 2011, p. 1498; Groce & Bakhshi, 2011, p. 1161; WHO & World Bank, 2011, p. 10; Barron & Ncube, 2010, pp. 12-13). Some estimate that literacy rates for adults with disabilities in developing countries are possibly as low as three per cent overall and one per cent for women with disabilities, although little attention is paid to this issue in the literature and the methodology is unclear (Groce & Bakhshi, 2011, p. 1153, 1158-1159). Fifty per cent of people in India with mild to moderate disabilities are thought to be illiterate, which is still significantly low (Groce & Bakhshi, 2011, p. 1158). Despite these low literacy rates, some experts in development 'clearly stated that the literacy needs of disabled adults were low priority – to be addressed only after literacy rates in the general population improved' (Groce & Bakhshi, 2011, p. 1161). These adults with disabilities will find it difficult to break the links between disability and poverty (Groce & Bakhshi, 2011, p. 1154, 1161).

In addition, exclusion from schools denies children with disabilities an opportunity for social networking and community participation, as well as all sorts of medical, social, nutritional and developmental resources, which can lead to **isolation, decreased autonomy, and lower quality of life** (Morgon Banks & Polack, 2014, p. 34; Trani et al., 2011, p. 1200; WHO & World Bank, 2011, p. 205). Caregivers have a

heightened risk of depression and limits on their own independence as a result of the increased dependency burden (Morgon Banks & Polack, 2014, p. 34). Exclusion from mainstream education also **helps propagate discriminatory attitudes at the societal level**, creating further barriers to participation in other domains (Morgon Banks & Polack, 2014, p. 34; UNICEF, 2013, p. 27).

Debates over the type of education
There is debate about whether children with certain types of disabilities learn best in specialised schools or general classrooms (Groce & Bakhshi, 2011, p. 1154; WHO & World Bank, 2011, pp. 211-212). A systematic review found a lack of evidence about the effectiveness and cost-effectiveness of approaches to increasing inclusive education (Bakhshi et al., 2013, p.10, 34). However, the World Report on Disability noted that it is generally agreed that inclusive schools are more cost-effective than special schools (WHO & World Bank, 2011, p.220).

Inclusive education
Inclusive education has become part of the international agenda, partly running parallel to the objective of Education for All (EFA) (Srivastava et al., 2015, p. 179). It entails 'providing meaningful learning opportunities for all students within the regular school system' (UNICEF, 2013, p. 28). Strong and continuous leadership at the national and school levels is identified as one of the most important elements in an inclusive education system (WHO & World Bank, 2011, p.216). However, there is no universal definition of inclusive education, which causes difficulties in implementing coherent and sustainable programmes (EFA, 2015, p. 101; Bakhshi et al., 2013, p.7; WHO & World Bank, 2011, p. 209).

Issues with implementation
Inclusive education is more than the presence of students with disabilities in schools, which will not automatically lead to positive academic or social outcomes (Srivastava et al., 2015, p. 190; WHO & World Bank, 2011, p. 233; Bakhshi et al., 2013, p. 6). However, many programmes have ended up at this minimum standard as a result of 'lack of resources, teacher training and expectations, and expertise, as well as persistence of negative social attitudes leading to discrimination and exclusion' (Bakhshi et al., 2013, p. 7). Inclusive education manuals to support teacher training should be grounded in the educational realities in low-income countries (Le Fanu, 2015, p. 273).

Lack of projects
In addition, one study found few projects on inclusion of students with disabilities (Srivastava et al., 2015, p. 189). Many estimates also indicate that inclusive education efforts are still not reaching 90 per cent of all children with disabilities in developing countries (Groce & Bakhshi, 2011, p. 1156; Srivastava et al., 2015, p. 189). There are concerns that the factors that helped implement inclusive education in Western countries may not be applicable in developing countries (Srivastava et al., 2015, p. 181; Le Fanu, 2015, p. 273).

Health

Having a disability is not synonymous with having a health problem: many persons with disabilities live healthy lives. People with disabilities often have a diverse range of health needs (WHO & World Bank, 2011).

However, there is some evidence that, collectively, they **experience poorer levels of health** and require more healthcare than the general population (WHO & World Bank, 2011, p. 57; Morgon Banks & Polack, 2014, p. 50). Increasing evidence also indicates that exclusion from care and treatment for both general

and disability-specific health needs leads to poorer health outcomes among people with disabilities (WHO & World Bank, 2011, p.57; Morgon Banks & Polack, 2014, p. 48). **Mortality rates** for children with disabilities are estimated to be as high as 80 per cent in countries where under-five mortality as a whole has decreased to below 20 per cent – this cannot solely be ascribed to genetic or bio-medical factors (Inclusion Intl., 2006, p. 39).

Healthcare challenges

People with disabilities may face inequities in access, quality and delivery of care in mainstream health services, leading to poorer overall treatment outcomes (Morgon Banks & Polack, 2014, p. 47). Health facilities are often inaccessible; information is often not communicated appropriately; transport is often not accessible or affordable; health services are often not affordable; misconceptions and stigma around disability may prevent families seeking healthcare; and discrimination by healthcare providers may limit provision of appropriate services (Morgon Banks & Polack, 2014, pp. 48-49; Fembek et al., 2013, p. 81; WHO & World Bank, 2011, pp.62-63, 70-72, 77; Burns et al., 2014, p. 34). For example, the incorrect but common assumption that people with disabilities are sexually inactive limits provision of sexual and reproductive healthcare, and women with disabilities may experience 'forced and/or coerced sterilisation, forced contraception and/or limited or no contraceptive choices, a focus on menstrual and sexual suppression, poorly managed pregnancy and birth, [and] forced or coerced abortion' (Frohmader & Ortoleva, 2013, p. 2; see also: Morgon Banks & Polack, 2014, p. 49; Ortoleva & Lewis, 2012, p. 41; HRW, 2012, p. 9).

In addition, healthcare workers are often unfamiliar with people with disabilities. They hesitate to take on routine care in the mistaken belief that specialist care is always needed (Groce & Kett, 2014, p. 6; WHO & World Bank, 2011, p.77).

Healthcare costs and poverty

A study in Vietnam found that the economic burden of healthcare, especially in relation to medication and travel costs, was greatest for people with disabilities, around 12 per cent of whom experience catastrophic expenditure (40 per cent non-food expenditure) (Palmer, 2014, p. 389, 392). Such high out-of-pocket medical costs for people with disabilities can **exacerbate poverty** (Morgon Banks & Polack, 2014, pp. 49-51).

Lack of access to, or delay in, appropriate healthcare may lead to higher medical and productivity costs in the long term as a result of continuously poor or worsening levels of functioning, with associated **costs for wider society** (Morgon Banks & Polack, 2014, p. 51).

Public health campaigns

Failure to include people with disabilities in public heath interventions may impede the effectiveness and efficiency of these programmes (Morgon Banks & Polack, 2014, p. iv, 48, 52; WHO & World Bank, 2011, pp.60-61). There is increasing evidence that people with disabilities, especially women, are at increased risk of contracting HIV. This is partly because of sexual violence due to the persistence of the myth that sex with a virgin can cure AIDS (Morgon Banks & Polack, 2014, p. 52; Ortoleva & Lewis, 2012, p. 14; HRW, 2012, pp. 8-9). However, they are frequently overlooked in preventative measures, which could lead to **very high individual and societal costs** (Morgon Banks & Polack, 2014, p. 52; HRW, 2012, p. 8). Many children with disabilities are not included in immunisation efforts, although they are at the same risk of childhood diseases (UNICEF, 2013, p.23). A growing body of research indicates that young people with disabilities are at equal or greater risk for smoking, alcohol consumption and unsafe sex, yet public heath campaigns are often inaccessible to them (Groce & Kett, 2014, p. 6, 11; UNICEF, 2013, p. 26).

Nutrition

The nutritional needs of children and adults with disabilities are rarely addressed, as a result of:

- less access to health and social services;
- lack of awareness and ineffective communication on the part of health and development professionals; and
- public health campaigns that do not consider the special needs of people with disabilities (Groce et al., 2013, p. e180).

People with disabilities are sometimes deliberately omitted from nutrition outreach efforts as their lives are less valued (Groce et al., 2013, p. e180). Poor knowledge and stigma among caregivers can result in some children and adults with disabilities, such as severe cerebral palsy, suffering from undernutrition and failure to thrive as a result of inadequate feeding (Groce et al., 2013, p. e180-e181; UNICEF, 2013, p.25). People with disabilities can be denied food or offered less food than other household members (Groce et al., 2013, p. e181).

Water and sanitation

Lack of access to safe water and basic sanitation can **exacerbate impairments and poverty** for people with disabilities (Wilbur et al., 2013, p. 1). The extent to which people with disabilities lack access to safe water and sanitation is unknown (Wilbur et al., 2013, p. 1). However, studies show that people with disabilities face difficulties collecting water due to the distance to travel to the water pump, and heavy pump handles and water containers (Wilbur et al., 2013, p. 2; UNICEF, 2013, p. 25). In addition, they are sometimes discouraged from using water sources or forced to wait longer in line as a result of being considered unclean (Wilbur et al., 2013, p. 2; UNICEF, 2013, p. 25).

Having to use other WASH facilities, or use them at different times, **increases the risk of accidents and physical attacks**, including rape, especially for girls (UNICEF, 2013, p. 25). Toilets are often inaccessible and there have been cases where people have soiled themselves as a result (Wilbur et al., 2013, p. 2). Lack of accessible toilets can prevent children with disabilities from attending school (UNICEF, 2013, p. 26). Being viewed as 'dirty' can **negatively affect people's dignity and ability or desire to take part in the community**, as well as lowering their self-esteem and willingness to assert their rights (Wilbur et al., 2013, p. 3). Communities are often unaware of how to make facilities accessible for people with disabilities (Wilbur et al., 2013, p. 3).

Accessibility: Transport, infrastructure and digital technology

Lack of accessibility of the physical environment, information and public services prevents people with disabilities from living independently and participating fully in all aspects of life (DESA, 2013, p. 4; Al Ju'beh, 2015, p. 54). See also environmental barriers.

Transport

Inaccessible transport has been cited in a number of studies as a key barrier to people with disabilities accessing healthcare and employment, especially those living in rural areas (Morgon Banks & Polack, 2014, p. 48; WHO & World Bank, 2011, p.66; Mont, 2014, p. 25). A recent survey by the Zero Project of 150 countries found that only three per cent of respondents believe that the public transport system in the capital is accessible for all (Balmas et al., 2015, p. 11). Barriers to accessible transport include: lack of effective programmes; obstacles to special transport services and accessible taxis; physical and informational barriers; lack of continuity in the travel chain; lack of pedestrian access; and lack of staff awareness and negative attitudes (WHO & World Bank, 2011, pp. 178-179). Without accessible transport, people with disabilities are more likely to be **excluded from services and social contact** (WHO & World Bank, 2011, p. 170).

Infrastructure

In many countries accessibility requirements have yet to be integrated into all aspects of the planning and design of buildings. This has led to inaccessible or separate – and generally inequitable – services (DESA, 2013, p. 13; WHO & World Bank, 2011, pp. 173-174).

Experience shows that mandatory minimum standards are necessary, as voluntary efforts on accessibility are not sufficient to remove barriers (WHO & World Bank, 2011, p. 173).

Retrofitting for accessibility is more expensive – by up to 20 per cent of the original cost – than integrating accessibility into new buildings (WHO & World Bank, 2011, p. 173; UNICEF, 2013, p. 19). It is generally feasible to meet accessibility requirements at one per cent of the total cost (WHO & World Bank, 2011, p. 173).

Digital technology

Lack of accessibility in the 'design, development and production of telecommunication services and products and digital literacy can prevent a substantial number of people with disabilities from achieving social inclusion' (Rimmerman, 2013, p. 3, 76; see also WHO & World Bank, 2011, pp. 170-172). The Zero Project finds that it is not only cost that prevents people with disabilities from accessing digital technology, but lack of political will to define standards for software and hardware (Fembek et al., 2014, p. 33; WHO & World Bank, 2011, p. 185). In addition, mainstream devices may be incompatible with assistive devices, especially given the rapid pace of technological change (WHO & World Bank, 2011, p. 184, 186).

> **Box 3: Implementing accessibility**
>
> Increased opportunities for successful implementation of accessibility are suggested to arise from a combination of a top-down approach, with nationally legislated minimum requirements (the most common approach), and a participatory, bottom-up approach, as well as applying the principle of universal design (DESA, 2013, p. 12, 18). Technological developments can also contribute to a more accessible environment (WHO & World Bank, 2011, p. 4). There are suggestions that an incremental approach, which creates a 'culture of accessibility', makes it easier to raise standards (WHO & World Bank, 2011, p. 169).
>
> Accessibility approaches need to take into account constraints including affordability, competing priorities, availability of technology and knowledge, and cultural differences; as well as being based on evidence of what works (WHO & World Bank, 2011, p. 169, 174). Attitudinal barriers need to be tackled as much as physical barriers, through education and awareness raising (WHO & World Bank, 2011, p. 169).
>
> *Standards*
>
> The World Programme of Action concerning Disabled Persons, The United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities and The Convention on the Rights of Persons with Disabilities, require that governments and the international community to recognise the importance of accessibility in ensuring the equalization of opportunities for persons with disabilities by empowering them to 'live independently and participate fully in all aspects of life' (DESA, 2013, pp. 3-4). Individual states can have their own accessibility standards. See also the Toolkits in Section 6.

An evaluation of disability inclusion programmes found that it is important to remember that 'access by and inclusion of disabled people are not the same thing – each require a different strategy' (Coe, 2012, p. 400). Sometimes the provision of ramps is felt to be all that is needed for disability inclusion, when in fact is just enables access for physically impaired people (Coe, 2012, p. 406).

> **Box 4: Universal design**
>
> Universal design is an approach to design based on the 'premise that design processes must be inclusive, produce equitable benefits and be appropriate to human functioning, gender, demographic group and social, economic and cultural setting and historical development experience' (DESA, 2013, p. 18). Its seven principles are: equitable use; flexibility in use; simple and intuitive use; perceptible information; tolerance for error; low physical effort; and size and space for approach and use' (UNICEF, 2013, p. 19). It is practical and affordable, even in developing countries (WHO & World Bank, 2011, p. 177).
>
> 'Building accessibility and the principle of universal design into the international development agenda would ensure that every environment, space, product or service, whether physical or virtual, could be easily approached, reached, entered, exited, interacted with, understood or otherwise used by persons of varying capabilities' (DESA, 2013, p. 25).

Rates of violence

A systematic review found that adults with disabilities were 'at a **higher risk of violence** than are non-disabled adults, and those with mental illnesses could be particularly vulnerable', although robust studies are absent and there are large gaps in knowledge about the prevalence and risk of violence against adults and children with disabilities (Hughes et al., 2012, p. 2, 8, 9; Mikton & Shakespeare, 2014, p. 3056). Children with disabilities are estimated to be three to four times more likely to be victims of violence (UNICEF, 2013, p. 44). Some studies also show that people with intellectual disabilities had the 'highest population rates of violence compared with both the general population and individuals with other disability types' (Hughes et al., 2012, p. 8; Inclusion Intl., 2006, p. 45). In addition, there are reports of hate crimes against people with disabilities, and physical violence and sexual abuse against people with disabilities in homes, institutions, communities and other settings (Hughes et al., 2012, p. 3).

Contributing factors to increased risk

People with disabilities are at increased risk of interpersonal violence because of: 'exclusion from education and employment, the need for personal assistance with daily living, reduced physical and emotional defences, communication barriers that hamper the reporting of violence, societal stigma, and discrimination' (Hughes at al., 2012, p. 1621; see also Ortoleva & Lewis, 2012, p. 42, 79-83 and HRW, 2012, p. 5). Residential care is also a major risk factor for sexual and physical abuse (UNICEF, 2013, pp. 45-47; HRW, 2012, p. 14). Stigma and stereotyping may result in their complaints not being taken seriously or believed, while the justice system is often inaccessible to them (Ortoleva & Lewis, 2012, p. 38, 59-74, 85-88).

Both children and young women and men with disabilities are 'especially vulnerable as a result of entrenched social and structural discrimination against them', which results in children being 'uninformed about their rights, finding themselves in environments where they are vulnerable to sexual violence and, if they are violated, with little opportunity to receive medical, legal or psychosocial support' (HI & STC, 2011, p. vi). Many abusers believe that these young people will be unable to report the abuse or will not be believed (Groce & Kett, 2014, p. 12; UNICEF, 2013, p. 41, 44; HI & STC, 2011, p. viii). Unfortunately this is often the case as people in authority may have little knowledge about people with disabilities (Groce et al., 2014, p. 12). The perpetrators enjoy almost total impunity (HI & STC, 2011, p. 5).

Women and girls

Women and girls with disabilities are at **heightened risk of 'physical, psychological, sexual or financial violence**, neglect, social isolation, entrapment, degradation, detention, denial of health care and forced sterilization and psychiatric treatment', at home, in the community, and in refugee camps (Ortoleva & Lewis, 2012, p. 16, 38-59; HRW, 2012, p. 5; WRC, 2015, p. 1; Barriga and Kwon, 2010; Burns et al., 2014, p. 52). In addition, they are especially vulnerable to trafficking (Ortoleva & Lewis, 2012, pp. 77-78). Women with disabilities are at least 'twice as likely to experience domestic violence and other forms of gender-based and sexual violence as non-disabled women, and are likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence' (Ortoleva & Lewis, 2012, p. 16; HRW, 2012, p. 5; Astbury & Walji, 2013, p. 22).

People with intellectual and mental disabilities are at particular risk of sexual abuse, especially girls and women (Morgon Banks & Polack, 2014, p. 50; WRC, 2015, p. 1; 45; Astbury & Walji, 2013, 8).

There is a long history of 'socially – and even legally – sanctioned **forced and non-consensual sterilization**' of women and girls with disabilities, particularly of women with intellectual disabilities

(Ortoleva & Lewis, 2012, pp. 42-43; Fembek et al., 2013, p. 69; UNICEF, 2013, p. 41; HRW, 2012, p. 6; Frohmader & Ortoleva, 2013, pp. 4-5).

Impact

Lack of access to gender-based violence prevention activities and response services can result in limited access to food, shelter, healthcare, safe working environments, marriage and social integration for people with disabilities (WRC, 2015, pp. 1-2; Ortoleva & Lewis, 2012, p. 91). Women with disabilities who have experienced violence are at increased risk of homelessness, poverty and unemployment, increased disability and ill-health (Ortoleva & Lewis, 2012, pp. 90-91).

Access to justice

A study of access to justice for people with disabilities found that while there are often laws in place to prevent discrimination against people with disabilities, they are not effectively implemented; and professionals feel that **access to justice is sometimes or usually harder** for people with disabilities (Brooks et al., 2013, p. 15, 29). A study in Sri Lanka found that women with disabilities have little legal literacy, while laws are not freely available in accessible forms (Samararatne & Soldatic, 2015, pp. 764-764).

This exclusion can be caused by various factors in all institutions of the justice system, including discrimination, poverty, low institutional trust or confidence in the process, lack of capacity (both staff in the judicial system and people with disabilities), communication barriers, weak access to information, or living in remote areas with a lack of judicial facilities (Brooks et al., 2013, p. 9, 17; Ortoleva & Lewis, 2012, p. 59). There is reported to be a systematic failure of the court system to acknowledge women with disabilities as competent witnesses (Ortoleva & Lewis, 2012, p. 71). As a result of problems with access to justice, there is said to be 'an **atmosphere of impunity** surrounding abuses committed against people with disabilities' (Brooks et al., 2013, p. 9).

Disaster risk reduction

People with disabilities are often **excluded from disaster management and risk reduction processes** (UNISDR, 2014; Smith et al., 2012, p. 5). A survey of people with disabilities by the UN Office of Disaster Risk Reduction (UNISDR) found that 85.57 per cent of respondents from 137 countries had not participated in community disaster management and risk reduction processes currently in place in their communities. However, only 20.6 per cent of respondents believe they can evacuate immediately without difficulty in the event of a sudden disaster event (UNISDR, 2014, p. 2). Most rely on the support of family (UNISDR, 2014). In addition, the Zero Project found that many countries surveyed did not have early warning systems accessible to all people with disabilities (Fembek et al., 2013, p. 51; Kett & Twigg, 2007, p. 99; Smith et al., 2012, p. 6).

However, the new **Sendai Framework for Disaster Risk Reduction** 2015-2030 (para 11 & target 11b) now includes five references to persons with disabilities and an additional two references to universal design (Stough & Kang, 2015).

Risk and mortality

Wide neglect of the needs of people with disabilities in official planning processes has increased death rates of people with disabilities and reduced their inclusion in disaster response (UNISDR, 2014, p. 4, 12; Smith et al., 2012, p. 4). People in wheelchairs or with other mobility impairments have died as a result of inaccessible evacuation procedures in events such as tsunamis and floods (Osamu, 2014, p. 144). People

with sensory disabilities have been unable to escape on time as warnings were not provided in accessible formats (Osamu, 2014, p. 144).

Conflict and emergencies

Disasters and conflicts **exacerbate existing disabilities and create new ones** (Mitchell & Karr, 2014, p. 226). It is generally agreed they have a **disproportionate impact** on people with disabilities, although there is little available evidence of the pathways leading to this increased vulnerability (Mitchell & Karr, 2014, p. 228; Smith et al., 2012, p. 2). People with disabilities are particularly at risk of marginalisation and discrimination as a result of exclusionary policies and practices by communities and humanitarian agencies (Kett & Twigg, 2007, p. 87, 91).

Natural disasters

According to emergency management statistics, people with disabilities die in far higher percentages of the population than other people in natural disasters (Mitchell & Karr, 2014, p. 1). In the 2011 Japanese earthquake and tsunami, for instance, people with disabilities were twice as likely to die as other people in the population (Osamu, 2014, p. 143).

Conflict

People with disabilities have also been reported to be directly targeted during conflict (Rohwerder, 2013, pp. 773-774). In Iraq, there were reports of people with Down's syndrome being used as suicide bombers (Rohwerder, 2013, p. 774). In conflict, people with disabilities are also at increased risk of death and injury as a result of mobility challenges and communication problems, which may make it harder to flee violence (Rohwerder, 2013, p. 774). The disruption and destruction of services and social safety nets caused by conflict can reduce the quality of life of people with disabilities (Rohwerder, 2013, pp. 774-775; Kett, 2010, p. 345). It can be assumed that people with disabilities will experience poverty in conflict contexts, as conflict exacerbates prior conditions of poverty, discrimination and social exclusion, although more research is needed on the casual links between disability and poverty in countries affected by conflict (Kett, 2010, p. 342, 355, 364).

Flight and refugees

Refugees with disabilities are 'among the most isolated, socially excluded and marginalized of all displaced populations' (WRC, 2008, p. 1). People with disabilities may be abandoned by their families as they flee conflict or disaster (Kett & Twigg, 2007, p. 97). When they are taken along, people with disabilities have sometimes been denied access to shelters, or have felt they should leave because of discrimination they faced in the shelter (UNISDR, 2014, p. 4; Kett & Twigg, 2007, pp. 92-93, 101).

People with disabilities can become more dependent and isolated as a result of the loss of their assistive and mobility devices, services, and support structures (Kett & Twigg, 2007, p. 100; Kett, 2010, p. 346; WRC, 2008, p. 2). Attitudinal, physical and social barriers means they are excluded from or unable to access mainstream assistance programmes (WRC, 2008, p. 2). Services provided in camps such as toilets and schools may not be built to be accessible (Mitchell & Karr, 2014, p. 1; WRC, 2008, p. 3; Smith et al., 2012, p. 6). Food distribution procedures are often inaccessible, especially for those with physical or visual impairments, or put people with disabilities at risk (Mitchell & Karr, 2014, p. 1; WRC, 2008, p. 3; Smith et al., 2012, p. 7). There is a lack of specialised healthcare and accessible healthcare facilities (WRC, 2008, p. 3). Access to vocational and skills training, income-generation and employment opportunities for refugees with disabilities varies considerably (WRC, 2008, p. 3).

There are few opportunities for formal participation of refugees with disabilities in camp management and programme planning, implementation and management (WRC, 2008, p. 4). People with disabilities, especially women and girls, are also at increased risk of physical and sexual violence, discrimination and harassment (WRC, 2015; Mitchell & Karr, 2014, p. 1; Kett & Twigg, 2007, p. 91; WRC, 2008, p. 4; Barriga and Kwon, 2010).

Vulnerability and capability

Research has shown that people with disabilities face acute vulnerability to economic crises and political upheavals, but are less likely than non-disabled community members to benefit from interventions or humanitarian assistance put in place in response to these shocks (Groce et al., 2011, p. 1499). However, it is also important to note that **people with disabilities are disproportionately vulnerable 'primarily as a consequence of social disadvantage, poverty and structural exclusion'** rather than because of any inherent vulnerability (Hemingway and Priestley, 2006, p. 64). Many people with disabilities have skills, experience and other capabilities that can assist them in disasters, and which can be used more widely in disaster risk reduction or emergency response (Kett & Twigg, 2007, p. 103). People with disabilities have been actively involved in disaster risk reduction or emergency response across the world (Kett & Twigg, 2007, pp. 102-105).

Humanitarian response

Often data on people in need in humanitarian responses are not disaggregated and people with disabilities are not accounted for, which marginalises them further (UNISDR, 2014, p. 14; Mitchell & Karr, 2014, p. 1; Kett & Twigg, 2007, p. 95; WRC, 2008, p. 2; Smith et al., 2012, p. 4). Humanitarian agencies often refer people with disabilities to specialist agencies, rather than making their own services accessible, which perpetuates discrimination and exclusion (Kett & Twigg, 2007, p. 94). People with disabilities have many of the same needs as everyone else in an emergency (food, shelter, WASH), but it is how they are provided that matters (Kett & Twigg, 2007, p. 94). Perceived expense can also contribute to the exclusion of people with disabilities, despite evidence suggesting accessible facilities involve only minimal extra costs (Kett & Twigg, 2007, p. 94).

Diverse needs

People with disabilities have diverse needs, which may be overlooked in humanitarian response (Mitchell & Karr, 2014, p. 227). For instance, a focus on people who have become physically impaired as a result of emergencies may lead to neglect of those already living with disabilities (Rohwerder, 2013, p. 779). Children with disabilities also face particular challenges in emergencies (UNICEF, 2013, pp. 49-53; Mitchell & Karr, 2014, pp. 228-229).

Post-conflict reconstruction

The long-term effects of conflict and emergencies on people with disabilities is under-researched, but they are **often left out of the reconstruction process** (Kett, 2010, p. 343; Samararatne & Soldatic, 2015, p. 763). Women with disabilities have been found to be at risk of being left behind during repatriation efforts (Barriga and Kwon, 2010, p. 6), and disabled women living in rural post-conflict areas 'face the greatest of difficulties in the peace-building process, and are more vulnerable to forms of physical and sexual violence, exploitation and extreme forms of abject poverty' (Samararatne & Soldatic, 2015, p. 759).

People with disabilities may face difficulties in taking advantage of the distribution of food and rebuilding materials in the recovery phase (Kett, 2010, p. 346). Immediate post-conflict support for people with

disabilities may not be designed in a sustainable way; for example, the camps for amputees in Sierra Leone were located too far from urban centres, which reduced opportunities for integration, schooling, shopping and employment (Kett, 2010, p. 358). A World Bank assessment in Sierra Leone also found that people with physical and psychological disabilities were amongst the poorest segments of the population in the post-conflict period (Kett, 2010, p. 356). Until recently, children with disabilities were rarely considered in post-conflict education strategies or reconstruction and development programmes (Trani et al., 2011, p. 1190).

Opportunities for people with disabilities
Some emergencies have resulted in unexpected opportunities, such as the formation of disabled people's organisations which lobby to get disability issues on the government agenda, as in post-conflict Sierra Leone and Liberia (Kett & Twigg, 2007, p. 94; Kett, 2010, p. 348, 360-361). Disabled veterans may have political power as 'war heroes', which can be used to raise awareness and make disability a priority within the post-conflict reconstruction process (Irvine, 2014, p. 163). However, some governments do not automatically extend rights and benefits given to war victims and disabled ex-combatants to all people with disabilities: it took almost 30 years for Nicaragua to do so (Meyers, 2014, p. 197).

Box 5: 'Build back better' after emergencies
Experiences from post-emergency situations also suggest that crises can advance disability-inclusive development goals. They can provide opportunities to challenge prejudice and discrimination and 'build back better' by ensuring comprehensive accessibility in post-emergency reconstruction (Mitchell & Karr, 2014, pp. 3-4). South Africa's progressive disability policy, for instance, was introduced post-apartheid with the strong influence of South Africa's disability movement (Irvine, 2014). The influx of organisations and services after an emergency can improve services for some people with disabilities (Kett & Twigg, 2007, p. 95).

Macro-economic costs of disability exclusion

The exclusion of people with disabilities involves **losses in productivity and human potential** (DFID, 2000, p. 4), which have economic costs for societies (Buckup, 2010). One study in Bangladesh found that, 'reductions in wage earnings attributed to lower levels of education among people with disabilities and their child caregivers were estimated to cost the economy USD 54 million per year' (Morgon Banks & Polack, 2014, p. ii). In addition, the 'exclusion of people with disabilities from the labour market results in a total loss of USD 891 million/year; income losses among adult caregivers adds an additional loss of USD 234 million/year' (Morgon Banks & Polack, 2014, p. iii). In Morocco, the lost income due to exclusion from work was estimated to result in national level losses of as high as approximately USD 1.1 billion (Morgon Banks & Polack, 2014, p. iii).

A study in 2000 calculated that the **economic losses** from lower productivity among people with disabilities across all low- and middle-income countries amounted to between USD 473.9-672.2 billion a year (Morgon Banks & Polack, 2014, p. iii, 42). A 2009 study of 10 low- and middle-income countries estimated that costs from lower labour productivity and exclusion of people with disabilities amounted to approximately 3-7 per cent of GDP, which is lower than the earlier study but still significant (Buckup, 2009, p. 51; Morgon Banks & Polack, 2014, p. iv, 42). It makes clear that 'people with disabilities are less productive not because they are "disabled" but because they live and work in environments that are "disabling"' (Buckup, 2009, p. 51).

In addition, public spending on disability programmes can be significant. This has encouraged some countries to foster the inclusion of people with disabilities in the labour market (WHO & World Bank, 2011, p. 43; Heymann et al., 2014, p. 4).

Implications

These studies indicate that policy makers should frame the exclusion of people with disabilities not only as a social but also as an economic concern (Buckup, 2010). It makes economic sense to create an environment that is supportive for people with disabilities (Buckup, 2009, p. 51). This is particularly important, as in times of crisis governments may cut spending and rethink budget allocations. However, 'promoting the inclusion of people with disabilities in the world of work is not only a matter of rights and social justice but also contributes to sustainable growth and development' (Buckup, 2010).

More research needed

While the Buckup study indicates that it is possible to generate country level data on the costs of exclusion, there is still a lack of evidence looking at the macro-economic costs of excluding people with disabilities. In addition, Walton (2012, p. 19) finds that few in-depth studies explore the links between inclusive growth and disability inclusive development, despite acknowledgement that people with disabilities will form a critical part of any inclusive growth strategy.

Lack of data and the invisibility of people with disabilities

The invisibility of people with disabilities in international development

Disability is still largely absent from data collection and monitoring mechanisms in international development (Mitra, 2013, p. e178). The invisibility of people with disabilities in the mainstream development narrative has 'resulted in development interventions unintentionally leaving out people with disabilities from their target groups' (Al Ju'beh, 2015, p. 50; Bruijn et al., 2012, p. 20). Lack of data about disability means that policy makers and practitioners are more likely to put disability aside (Groce et al., 2011, p. 1501). It has contributed to the false impression that people with disabilities are a 'very small group, reserved for the specialist attention of health or rehabilitation professionals and beyond the scope of development studies' (Mitra et al., 2013, p. 1).

The UN Expert Group on Disability Data and Statistics, Monitoring and Evaluation finds that 'data disaggregated by disability in all areas will be essential to ensure progress is measured and persons with disabilities are not left behind in future mainstream development programmes' (UN, 2014, p. 9).

Difficulties in measuring disability

Disability is complex and therefore difficult to measure: 'no gold standard measure exists, different measures exist for different purposes, and the use of different measures in different countries makes international comparison of prevalence or outcomes difficult' (Mitra, 2013, p. e178; Madans et al., 2011, p. 3; Wissenbach, 2014, p. 4). Measuring child disability is particularly difficult as children develop at different speeds, which makes it difficult to assess function and distinguish significant limitations from variations in normal development (UNICEF, 2013, p. 63). In addition, people with disabilities may not be willing to identify themselves for fear of becoming labelled and marginalised (Kett & Twigg, 2007, p. 97). Developing global indicators for the monitoring and evaluation of disability policies and programmes is very challenging (Groce et al., 2011, p. 1508).

Box 6: Frameworks and indicators for monitoring and evaluating disability inclusion

The Washington Group questions

The UN recommends using the **Washington Group questions** to gather disability data consistently across the world. There are many other recommendations for the inclusion of the Washington Group questions in censuses, and government, UN, and NGO data collection (UN, 2014, p. 10), and global household surveys such as the Demographic and Health Survey (DHS) (Mitra, 2013, e178). For example, DFID has made a commitment (2013) to advocate for the use of the UN's Washington Group questions on disability in DFID-supported surveys and censuses, and is encouraging bilateral and multilateral partners to do the same (DFID, 2014, p. 9). The questions can be used to monitor the impact and implementation of the UNCPRD and other disability inclusion efforts by donors and NGOs (Madans et al., 2011, pp. 1-2, 5; Mitra, 2013, p. e178; UN, 2014, p. 6).

The Washington Group on Disability Statistics is a voluntary working group made up of representatives of over 100 National Statistical Offices and international, non-governmental and disability organisations. Its members work towards disability definition and measurement that is culturally neutral and reasonably standardised (Madans et al., 2011, p. 1).

Washington Group short set of questions

The Group has produced a shortlist of questions to measure disability consistently worldwide, mainly through use in censuses and household surveys (Madans et al., 2011, p. 1). The shortlist includes **six questions** – five on functional limitation (limitations in seeing, hearing, walking or climbing steps, concentrating, and communicating) and one on self-care (limitation in showering or dressing). They use a severity scale to capture the full spectrum of functioning (Madans et al., 2011, p. 4).

The Washington Group short set of questions can be used for disaggregating data to track SDG indicators (UN, 2014, P. 19). The questions, in combination with general well-being questions on, for instance, employment or education, can also be used to assess participation and equal opportunities. This is an alternative to identifying needs for rehabilitation or barriers in the environment, which require a longer set of questions or a dedicated disability survey (Mitra, 2013, p. e178; Madans et al., 2011, p. 3).

Washington Group extended sets

The Washington Group has also developed extended set questions on functioning. In addition, to 'accurately assess disability in children, care must be taken to use questionnaires specifically designed for the purpose', and UNICEF is working with the Washington Group to develop a screening tool specifically for children (UNICEF, 2013, pp. 67-68).

Complementary methodologies

Other complementary methodologies are also being developed that provide more detail than the short set of questions (UN, 2014, p. 7; Wissenbach, 2014, pp. 4-5). For example, a Model Disability Survey is being developed by WHO & World Bank, with the aim of providing data on all aspects of disability (impairments, activity limitations, participation restrictions, related health conditions), as well as environmental factors (UN, 2014, pp. 7-8). It is a general population survey designed to address Article 31 of the Convention on the Rights of Persons with Disabilities by collecting data to compare the participation and inclusion rates of people with disabilities and those without.

3 Barriers to disability inclusion

The previous section highlights the various barriers in different sectors that result in the exclusion of people with disabilities from society. Similar barriers also mean that people with disabilities are excluded from, or unable to access, mainstream development and humanitarian assistance programmes – there are estimates that only around four per cent of people with disabilities benefit from international cooperation programmes (Schulze, 2010, p. 173).

These barriers to disability inclusion can be categorised as attitudinal, environmental, and institutional. People with disabilities may also internalise barriers which prevent their inclusion. Further barriers to inclusion in development and humanitarian response are: lack of participation of people with disabilities; inadequate data, statistics and evidence of what works; and inaccurate concerns over the cost/difficulty of disability inclusion.

Disability inclusive responses aim to remove these barriers through various means outlined in Section 5.

Attitudinal barriers

Attitudinal barriers, which result in stigmatisation and discrimination, deny people with disabilities their dignity and potential and are one of the greatest obstacles to achieving equality of opportunity and social integration (Wapling & Downie, 2012, p. 21; UNICEF, 2013, p. 11; Heymann et al., 2014, p. 6; Bruijn et al., 2012, pp. 21-22). Negative attitudes create a disabling environment across all domains (WHO & World Bank, 2011, p. 193, 262). They are often expressed through: the inability of non-disabled to see past the impairment; discrimination; fear; bullying; and low expectations of people with disabilities (DFID, 2000, p. 8; WHO & World Bank, 2011, p. 6, 262; UNICEF, 2013, p. 11).

Attitudes towards people with disabilities in low- and middle-income countries can be more extreme and the degree of stigma and shame can be higher than in high-income contexts (Mont, 2014, p. 24). These attitudes can arise as a result of 'misconceptions, stereotypes and folklore linking disability to punishment for past sins, misfortune or witchcraft' (Groce & Kett, 2014, p. 5; Rimmerman, 2013; Burns et al., 2014, pp. 43-44). Multiple and intersectional discrimination can intensify attitudinal barriers. Development organisations' staff may also have negative attitudes towards people with disabilities (Bruijn et al., 2012, p. 22).

Environmental barriers

Inaccessible environments create disability by creating barriers to participation and inclusion (WHO & World Bank, 2011, p. 263; Bruijn et al., 2012, pp. 22-23). Physical barriers in the natural or built environment 'prevent access and affect opportunities for participation' (Wapling & Downie, 2012, p. 21; DFID, 2000, p. 8; WHO & World Bank, 2011, p. 4). Inaccessible communication systems prevent access to information, knowledge and opportunities to participate (Wapling & Downie, 2012, p. 21; PPUA Penca, 2013, p. 5, 11; WHO & World Bank, 2011, p. 4). Lack of services or problems with service delivery also restrict participation of people with disabilities (WHO & World Bank, 2011, p.262).

Institutional barriers

Institutional barriers include many laws, policies, strategies or practices that discriminate against people with disabilities (Wapling & Downie, 2012, p. 21; DFID, 2000, p. 8; WHO & World Bank, 2011, p. 6, 262; Bruijn et al., 2012, p. 23). For example, a study of five Southeast Asian countries found that electoral laws do not specially protect the political rights of persons with disabilities, while 'some banks do not allow visually impaired people to open accounts, and HIV testing centers often refuse to accept sign language

interpreters due to confidentiality policies' (PPUA Penca, 2013, p. 5, 11; Wapling & Downie, 2012, p. 21; Al Ju'beh, 2015, p. 87). Many countries still have restrictive laws, particularly affecting people with psychosocial or intellectual disabilities (Al Ju'beh, 2015, p. 87). Discrimination may not be intended but systems can indirectly exclude people with disabilities by not taking their needs into account (WHO & World Bank, 2011, p. 6).

Lack of enforcement and political support for policies can also limit the inclusion of people with disabilities (NCG, 2012, p. 85). For example, an evaluation of Norway's work on disability inclusion in development and humanitarian action found that its disability inclusion policy documents have been ignored, or at best forgotten, and disability has not been a priority theme for the government. This has resulted in ineffective mainstreaming and lack of coordination (NCG, 2012, pp. 85-87).

'Internalised' barriers

Sometimes internalised barriers can severely affect the participation and functioning of people with disabilities in society (Bruijn et al., 2012, p. 16). Stigma relating to people with disabilities results in their exclusion from societal interactions, which in turn can result in their 'lack of pro-active behaviour in expressing their opinions and claiming their rights', leading to further exclusion (PPUA Penca, 2013, p. 12, 14-15). Low expectations of people with disabilities can undermine their confidence and aspirations (DFID, 2000, p. 8; WHO & World Bank, 2011, p. 6; Mont, 2014, p. 25).

Lack of participation

The lack of consultation and involvement of people with disabilities is a barrier to their inclusion in society (WHO & World Bank, 2011, p.263; DESA, 2011, p. 10).

Inadequate data and statistics

The lack of rigorous and comparable data and statistics, combined with lack of evidence on programmes that work, often impedes understanding and action on disability inclusion (WHO & World Bank, 2011, p.263).

Inaccurate concerns over cost/difficulty of disability inclusion

One of the most common reasons given for not including people with disabilities is perceived cost (Coe & Wapling, 2010, p. 884). Inadequate funding and allocations for implementing policies and plans can prevent the inclusion of people with disabilities (WHO & World Bank, 2011, p. 262). Other excuses relate to concerns that disability inclusion is too difficult and requires specialist knowledge, or that people with disabilities require special programmes (Bruijn et al., 2012, p. 22). Staff may also feel that they are overloaded and 'don't have time for an additional issue' (Bruijn et al., 2012, p. 22), or that it is an issue that is only relevant in high-income countries.

Experience from various development organisations shows that these excuses have to be tackled to establish commitment to disability inclusion (Bruijn et al., 2012, pp. 72-75).

Box 7: Tackling misconceptions about the cost of disability inclusion

Including people with disabilities in mainstream programmes is not as costly as sometimes perceived, although reliable figures are not available (Bruijn et al., 2012, p. 47). A **budget allocation of 2-7 per cent** is recommended for development organisations to raise awareness and to make buildings, communication, and transport accessible (Bruijn et al., 2012, p. 47). This should be included at the design stage so it is not regarded as 'additional' costs (Coe & Wapling, 2010, p. 884). However, **low/no-cost adjustments** to how programme activities are carried out can also be made (Coe & Wapling, 2010, p. 884).

Cost-effective and with wider long-term financial benefits
Several studies argue that inclusive approaches are more cost-effective than separate piecemeal disability interventions, which do not remove all the barriers people with disabilities face (Walton, 2012, p. 4; Bruijn et al., 2012, p. 73). The costs of including people with disabilities 'are far outweighed by the long-term financial benefits to individuals, families and society' (CBM, 2012, p. 10).

4 Impact of disability inclusion

Much more evidence is available about the impact of the exclusion of people with disabilities (see Section 2) than of their inclusion, as exclusion is still so common. In addition, it should be noted that decisions on how to include people with disabilities can be inherently political.

However, some evidence and estimates indicate that disability inclusion leads to the following outcomes.

Increased earnings and labour productivity

The economic benefits of adopting a disability inclusive approach to development are complex and difficult to quantify as a result of a lack of data (Walton, 2012, p. 1, 2). One study in Nepal finds that wage returns to education for people with disabilities are very high, ranging from 19.3 to 25.6 per cent (Lamicchane & Sawadea, 2009; Lamicchane, 2015, p. 249). However, 'at least 10 years of schooling are necessary for returns on the investment in education to turn positive' (Lamicchane, 2015, p. 249). Further work in Nepal, the Philippines, and Cambodia, found that 'people with disabilities who enjoy longer years of schooling tend to be engaged in full-time or white-collar jobs which are usually associated with greater income stability' (Lamicchane, 2015, p. 247). In addition, a study across 13 low- and middle-income countries found that 'each additional year of schooling completed by an adult with a disability reduced the probability by 2-5 per cent that his/her household belonged to the poorest two quintiles' (Morgon Banks & Polack, 2014, p. iii). It is estimated that in Pakistan, 'rehabilitating people with incurable blindness would lead to gross aggregate gains in household earnings of USD 71.8 million per year' (Morgon Banks & Polack, 2014, p. iii).

The inclusion of people with disabilities in work/employment can lead to greater economic self-sufficiency, which decreases demands on social assistance, although evidence from low- and middle-income counties is lacking (Morgon Banks & Polack, 2014, p. iv, 44). Evidence from high-income countries also indicates that 'with the proper job matching and the right accommodations, employees with disabilities can be just as productive as other workers and their inclusion may even increase overall profit margins' (Morgon Banks & Polack, 2014, p. 45).

Increased tax revenue

It is anticipated that increasing labour force participation of both people with disabilities and their caregivers will increase a country's potential tax base (Morgon Banks & Polack, 2014, p. iv, 44). In the Philippines for example, excess unemployment among individuals with unrepaired cleft lips and palates is calculated to have cost the government between USD 8-9.8 million dollars in lost tax revenue (Morgon Banks & Polack, 2014, p. iv, 44). More evidence is available from high-income countries. In Scotland, evidence indicates that every £1 spent on a supported employment project led to a savings of £5.87, due in large part to decreased need for disability/welfare benefits and increased tax income (Morgon Banks & Polack, 2014, p. 44).

Improved individual and family well-being

Education can provide individuals with the skills, experience and empowerment to vocalise their opinions, and therefore 'inclusion in education can be a first step towards increasing political participation and social justice for people with disabilities' (Morgon Banks & Polack, 2014, p. 34). A study of disability and equity at work finds that 'work provides the material means through which to acquire adequate food, clothing, and shelter; access education, health care, and support services; and

participate in the cultural, recreational, and social life of one's community' (Heymann et al., 2014, p. 2). Including people with disabilities in the labour market also reduces stigma and promotes inclusion (Heymann et al., 2014, p. 2). Gainful employment can have a significant positive impact on feelings of worth, ability, and self-determination for individuals with disabilities, as well as increasing their social and civic interaction (Morgon Banks & Polack, 2014, p. 46; Heymann et al., 2014, p. 2-3; Lamicchane, 2015, p. 247; Burns et al., 2014, p. 30).

A quasi-randomised control trial in India found that community-based rehabilitation (CBR) programmes significantly improved the well-being and access to services of people with disabilities (Mauro et al., 2014). Compared to the control group, access to pensions and allowances, aid appliances, access to paid jobs and personal-practical autonomy for the people with disabilities involved in the CBR programmes increased by 29.7 per cent, 9.4 per cent, 12.3 per cent and 36.2 per cent respectively after seven years (Mauro et al., 2014).

A randomised control trial in China found that people with schizophrenia who received individualised family-based interventions worked 2.6 months more per year than those who did not receive the treatment (Morgon Banks & Polack, 2014, p. v). A study in Bangladesh found that 'children who were provided with assistive devices (hearing aids or wheelchairs) were more likely to have completed primary school compared to those who did not receive any supports' (Morgon Banks & Polack, 2014, p. v). A small study in Ethiopia found that the provision of wheelchairs led to a 'significant time reallocation away from begging (1.40 fewer hours per day) and toward income-generating activity (1.75 more hours per day) and 77.5 per cent higher income' (Grider & Wydick, 2015, p. 2).

Little evidence is available, but recent research on disability inclusion in gender-based violence activities in refugee camps found that including women and girls with disabilities, and their caregivers, fostered relationship building and trust among women and girls with disabilities, as well as with others in the community (WRC, 2015, p. 2). Inclusion also led to information exchange, skills building, and improved self-esteem. It enabled women and girls with disabilities to be recognised, not for their impairment, but for their roles as leaders, friends and neighbours, making positive contributions to their communities (WRC, 2015, p. 2). Women with disabilities and caregivers in the VSLAs also reported 'increased independence and decision-making and greater respect and status within the family and community as a result of their newfound access to income-earning opportunities' (WRC, 2015, p. 2).

More inclusive and accessible societies for all

Creating an accessible environment has benefits for a broad range of people, including older adults, pregnant women, parents with small children, people with less education or speakers of a second language (WHO & World Bank, 2011, p. 169). Efforts to increase the quality of education to ensure effective learning for children with disabilities arguably has the potential to improve teaching abilities overall (Morgon Banks & Polack, 2014, p. 34). Inclusive education and employment could encourage 'greater acceptance of diversity and the formation of more tolerant, equitable and cohesive societies' (Morgon Banks & Polack, 2014, p. 34, 46). Inclusive humanitarian responses would also be automatically accessible to older adults, children, pregnant women and people suffering from debilitating illness (Kett & Twigg, 2007, p. 93).

5 Disability inclusive development / humanitarian response approaches

Best practice approaches to ensuring that international development/humanitarian programmes are inclusive of and accessible to people with disabilities need not be costly or complicated. They can be applied across all international development sectors, and they include the following.

Mainstreaming

Mainstreaming disability in development and humanitarian response is broadly defined as the inclusion of people with disabilities in all aspects of development and humanitarian efforts (DESA, 2011, p. 5). It means that disability should be considered in all programming (although disability-specific actions and programming may also be required) (DESA, 2011, p. 5).

Mainstreaming is simultaneously a method, a policy and a tool for achieving social inclusion, which involves the practical pursuit of non-discrimination and equality of opportunity (DESA, 2011, p. 5). Mainstreaming disability is about 'recognizing persons with disabilities as rights-holding, equal members of society who must be actively engaged in the development process irrespective of their impairment or other status, such as race; colour; sex; sexual orientation; language; religion; political or other opinion; national, ethnic, indigenous or social origin; property; birth or age' (DESA, 2011, p. 5).

People with disabilities share most basic needs with other people in society, and so mainstreaming has been recognised as the most cost-effective and efficient way to achieve equality for persons with disabilities (DESA, 2011, p. 5; Coe & Wapling, 2010, pp. 884-885; Bruijn et al., 2012, p. 25). Experience suggests that an estimated 80 per cent of people with disabilities can be included without any specific additional intervention, or with low-cost and simple community-based interventions that do not require specific expertise (Bruijn et al., 2012, p. 26, 73).

It is important that efforts to mainstream disability begin with analysis of barriers and careful planning (Coe & Wapling, 2010, p. 884). An evaluation of Norwegian efforts to mainstream disability, for example, found that such efforts were poorly designed and insufficient (NCG, 2012, pp. 76-77). Mainstreaming risks 'token involvement of disabled people and the neglect of their self-determination and equality' if not carried out well (Meekosha & Soldatic, 2011, p. 1394).

'Twin-track' approach

The 'twin-track approach' combines mainstreaming with disability-specific projects needed to achieve the full inclusion and participation of people with disabilities (DFID, 2000, p. 11; DESA, 2011, p. 5; CBM, 2012, p. 15). It is the 'most commonly referenced approach by UN agencies, bilateral development agencies and NGOs for including people with disabilities in development' and humanitarian response (Al Ju'beh, 2015, p. 55).

Successful outcomes require emphasis on both tracks, as they complement each other (Al Ju'beh, 2015, p. 55). Often the balance is tipped towards disability-specific services in international development, rather than mainstreaming (Al Ju'beh, 2015, pp. 55-56).

Raising awareness and changing attitudes/behaviours

Evaluations of disability inclusion in mainstream development NGOs' programmes found that 'challenging staff and community attitudes is *the* key first step to seeing positive change towards the inclusion of disabled people in development work' (Coe & Wapling, 2010, pp. 881-882; Coe, 2012, pp. 404-405; UNICEF, 2013, p. 12; Bruijn et al., 2012, p. 90). Interacting with people with disabilities can result in a positive change in the attitudes and behaviour of those implementing programmes and enable them to better tailor their services to meet the needs of people with disabilities (WRC, 2015, p. 2). Evaluations of disability inclusion efforts by a mainstream development NGO found that positive attitudinal change towards children and adults with disabilities is possible in a relatively short period (Coe, 2012, p. 404).

Bringing disability into the political and social discourse can create awareness and understanding of it at organisational, community and institutional levels, which can promote positive attitudes towards it (DESA, 2011, p. 8; Al Ju'beh, 2015, p. 50; UNICEF, 2013, p. 12; CBM, 2012, p. 15). Greater awareness encourages identification of incidence, type and impact of disability (CBM, 2012, p. 15). This awareness should encompass recognition of the diverse experiences of people with disabilities, and an understanding of the social model and the different barriers people with disabilities face (Al Ju'beh, 2015, p. 50; Coe, 2012, p. 403). It is important to reinforce inclusion messages regularly with all stakeholders (Coe, 2012, p. 405).

Comprehensive accessibility

Comprehensive accessibility 'ensures that physical, communication, policy and attitudinal barriers are both identified and addressed' (CBM, 2012, p. 17). Providing comprehensive accessibility is thought to be 'an enabler of an improved, participative economic and social environment for all members of society' (DESA, 2013, p. i, 6; CBM, 2012, p. 15).

See also information on accessibility and universal design in Section 2.

Reasonable accommodation

Reasonable accommodation is defined by the UNCRPD as 'necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms' (UNCRPD, 2006, p. 4). It is an important strategy in mainstreaming (WHO & World Bank, 2011, p. 264). It can include:

- structural modifications to facilities;
- use of equipment with universal design features;
- communication in appropriate formats;
- modification of working times or arrangements; and
- alternative models of service delivery (WHO & World Bank, 2011, p. 74).

Requirements for reasonable accommodation can be voluntary or mandatory (WHO & World Bank, 2011, p. 241). In some circumstances, for example where employers bear the cost of providing reasonable accommodations, they may be less likely to hire people with disabilities, although various financial incentives can be offered to counter these obstacles (WHO & World Bank, 2011, p. 242). While accessibility can be realised progressively, reasonable accommodation has potential to be realised more immediately (Schulze, 2010, pp. 55, 62).

Participation

Best practices for disability inclusion in development and humanitarian work are 'participatory, actively and meaningfully involving people with disability in all matters concerning them in the process of forming policies and programmes' (DESA, 2011, p. 7; see also: Al Ju'beh, 2015, p. 51; Coe & Wapling, 2010, p. 883; Bruijn et al., 2012, p. 38-40; CBM, 2012, p. 15; Smith et al., 2012, p. 11; NCG, 2012, p. 76).

Include all impairment groups

Participation needs to involve all impairment groups, and also consider intersectionalities with gender, age, ethnicity and other factors that can contribute to discrimination or exclusion (Al Ju'beh, 2015, p. 51; Coe & Wapling, 2010, p. 883; DSEA, 2011, p. 7). It is 'especially important to ensure the inclusion of the most marginalized groups of persons with disabilities, such as persons with psychosocial disabilities and persons with intellectual disabilities' (DESA, 2011, p. 7). Not doing so can result in programmes' impact being substantially reduced as a result of too much emphasis being placed on a 'small selection of the most articulate and least isolated disabled people' (Coe & Wapling, 2010, p. 883; Bruijn et al., 2012, p. 38). For example, Norwegian aid was found to focus primarily on people with physical/mobility disabilities, with less relevance for other disability groups (NCG, 2012, p. 76).

Involve DPOs

The mantra of the disability movement, '**nothing about us, without us**', highlights that organisations should provide services *with* people with disabilities, rather than *for* them (Al Ju'beh, 2015, p. 52; Kett & Twigg, 2007, p. 103). DPOs can play an important role in this process: donors should consider helping to address DPOs' capacity gaps, which are sometimes large (DESA, 2011, p. 7; Wapling & Downie, 2012, pp. 39-47; Kett & Twigg, 2007, p. 104; Bruijn et al., 2012, p. 57; NCG, 2012, p. xviii). For example, an evaluation of Norway's work on disability inclusion in development found that the most relevant and effective interventions were those supporting advocacy and capacity building of DPOs (NCG, 2012, p. 76). It is also important to be accountable to people with disabilities (DESA, 2011, p. 7).

The involvement and leadership of people with disabilities in community institutions and activities can lead to better attention to their concerns in organisations and programmes, and greater appreciation by other community members of their skills and capacities (WRC, 2015, p. 2; CBM, 2012, p. 15).

Participatory research

People with disabilities can help collect and analyse data. An example of participatory research carried out with people with disabilities is the 'Voices of the Marginalised' project, piloted in Bangladesh, which identifies the issues people with disabilities feel are most critical (Burns et al., 2014). The research modelled the process of empowerment itself (Burns et al., 2014, p. 68). However, there is a 'lack of knowledge of the use of this approach in disability research in non-Western countries' (Katsui and Koistinen, 2008, p. 747). A review of the literature on the monitoring and evaluation of CBR programmes also found no standard approach to the inclusion of people with disabilities in M&E (Lukersmith et al., 2013).

Rights-based approach

Best practices for disability inclusion adopt a rights-based approach (DESA, 2011, p. 7; Wapling & Downie, 2012, p. 27; Al Ju'beh, 2015, pp. 86-97; NCG, 2012, p. 77). This means that 'each mainstreaming initiative should contribute systematically to the implementation of the UNCRPD, which aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (DESA, 2011, p. 7; see also: Al Ju'beh,

2015, p. 93). A rights-based approach promotes barrier removal and inclusion in all sectors, including health, rehabilitation, assistance and support, environments, education and employment (DESA, 2011, p. 7). Evaluations of disability mainstreaming in World Vision programmes found that the UNCRPD offered opportunities for good progress because of governments' adoption of it (Coe, 2012, p. 407).

Legislation plays an important role in enforcing rights, creating minimum standards in accessibility, and ensuring participation (WHO & World Bank, 2011). Technical assistance can build governments' capacity to put in place or strengthen such legislation (WHO & World Bank, 2011, p.269).

Community-based rehabilitation

Community-based rehabilitation (CBR) has evolved to become a strategy for rehabilitation, equalisation of opportunities, poverty reduction, and the social inclusion of people with disabilities (WHO & World Bank, 2011, p. 13; UNICEF, 2013, p. 17; CBM, 2012, p. 15). It is increasingly being implemented through the combined efforts of people with disabilities, their families, organisations and communities, and government and non-governmental services (WHO & World Bank, 2011, p. 13).

There is limited but growing evidence that CBR can improve well-being for persons with disabilities and their families (Mauro et al., 2014; Biggeri et al., 2014). Evaluation of CBR programmes supported by Norwegian aid found that local ownership and buy-in made them effective and sustainable (NCG, 2012, pp. 79-80). CBR is said to have great potential, but 'WHO estimates that CBR still only reaches a small number of all persons with disability' (Groce & Bakhshi, 2011, p. 1159).

Organisational change

Experience from a number of development NGOs shows that successful disability inclusion requires organisational change (Bruijn et al., 2012, p. 8, 64). It is important that donors emphasise the issue's importance and NGOs recognise it as an organisational priority to ensure that the appropriate resources are provided (DESA, 2011, p. 8; Coe & Wapling, 2010, p. 884).

Evaluations of attempts to mainstream disability inclusion in a development NGO's programming found that 'early effective training on social model principles is crucial' (Coe, 2012, p. 403). Training carried out by people with disabilities themselves was found to be particularly helpful (Bruijn et al., 2012, p. 34).

Wapling and Downie's report on donors and disability inclusion finds that:
> 'experience shows the most substantial gains are made when donors and development agencies change the way disability is internally defined and understood, when they commit to approaching disability from a human rights-based perspective rather than an impairment-based one, and when the empowerment and support of disabled people's organizations is central to their strategy' (2011, p. 13).

It is important to: secure commitments from senior staff; set concrete organisational targets for disability inclusion; design inclusive budgets; and collaborate with others (Wapling & Downie, 2012, pp. 27-29; Coe, 2012, pp. 406-407).

Inclusion messages need to be regularly reinforced, as there can be a 'tendency to drift from socially inclusive principles back towards medical/charity model approaches when implementation starts' (Coe, 2012, p. 403).

Mainstreaming disability takes time, commitment and resources. Donors can benefit from:

- appointing disability champions;
- involving people with disabilities in decision making and as advisors;
- including disability in baseline surveys and situational analyses;
- disaggregating data to include numbers of people with disabilities; and
- supporting research linked to disability
(Wapling & Downie, 2012, pp. 29-31; Coe, 2012, p. 400; Bruijn et al., 2012, p. 68, 91).

Adapting existing programming tools to be disability inclusive has been found to be more effective than providing generic checklists (Coe, 2012, pp. 405-406).

Evaluations of attempts to mainstream disability inclusion in a development NGO's programming found creating a disability inclusive environment in the organisation itself was essential (Coe & Wapling, 2010, p. 883; Bruijn et al., 2012, p. 69). A more disability-friendly organisation can be created by:

- conducting regular disability awareness training sessions and including it in staff induction programmes;
- hiring more staff, volunteers or consultants with disabilities;
- adapting communication and information systems;
- making offices, workshops and conferences accessible; and
- creating a sense of shared commitment by using access as a starting point for wider discussions
(Wapling & Downie, 2012, pp. 33-35; Al Ju'beh, 2015, pp. 63-68).

Resources: case studies of successful disability inclusion

Intentional efforts can quickly achieve a ten-fold increase in the disabled people being included in a mainstream NGO's programmes: this was one of the findings of a synthesis of the externally evaluated lessons from World Vision's disability inclusion work (Coe, 2012, p. 404).

Box 8: Case study resources

- The World Report on Disability identifies different strategies for inclusion in various sectors (WHO & World Bank, 2011).

- A UN Department of Economic and Social Affairs (DESA) report outlines case studies that illustrate best practices at international, regional, sub-regional and national levels for including persons with disabilities in all aspects of development efforts (DESA, 2011).

- An ILO-Irish Aid report outlines case studies of organisations working toward the inclusion of people with disabilities in all spheres of life (ILO, 2011).

- The Zero Project reports collect and profile innovative practises in disability inclusion from around the world. They include information on impact and effectiveness, as well as transferability, scalability, and cost-efficiency (e.g. Balmas et al., 2015; Fembek et al., 2014; Fembek et al., 2013).

- The CBM guide to 'Inclusion made easy', provides case studies and lessons learned in various sectors (CBM, 2012).

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6 Policies, frameworks and tools

A mapping of the disability inclusion policies and practices of major multilateral and bilateral agencies (Lord et al., 2010) finds that disability inclusion is increasingly part of international cooperation and development aid. Policies often combine several approaches to the inclusion of disability in development, including human rights and participation, and disability is included through both specific and mainstreamed programmes (Lord el al., 2010, p. iii). However, Groce et al. (2011, p. 1508) find that systematic disability inclusion in all aspects of all development programmes is still rare.

Overarching frameworks

Most work on disability inclusion is framed around the **UN Convention on the Rights of Persons with Disabilities**. The new **Sustainable Development Goals (SDGs)** mention people with disabilities under five of the seventeen goals: on education (SDG4); growth and employment (8); inequality (10); accessibility of human settlements (11); and data collection and monitoring (17). (See Section 1.)

Approaches of UN agencies and other multilateral organisations – selected examples

- The UN Enable website provides information on disability and the *UN organisations* that promote disability inclusion. Among these are:
    - UNICEF
    - UNHCR – see also UNHCR manual on Working with persons with disabilities in forced displacement
    - UNESCAP – Incheon strategy to 'Make the Right Real' for persons with disabilities in Asia and the Pacific and ESCAP guide on disability indicators for the Incheon strategy.

- *World Bank* – see also Social analysis and disability: A guidance note – Incorporating disability-inclusive development into Bank-supported projects

- *WHO* – see also the WHO global disability action plan 2014–2021: Better health for all people with disability

- *ILO* – see also the ILO's Disability inclusion strategy and action plan 2014-17

- *Global Partnership for Education*

- *European Union/European Commission* – see also the European Disability Strategy (2010-2020), which resolves to promote the rights of people with disabilities at international level, and the Guidance note on disability inclusive development cooperation for EU staff.

Approaches of bilateral development agencies – selected examples

- *UK*: Disability framework: Leaving no one behind

- *Australia*: Development for all 2015-2020: Strategy for strengthening disability-inclusive development in Australia's aid program

- *Germany*: Action plan for the inclusion of persons with disabilities (2013-2015)

- *Japan*: JICA thematic guidelines on disability

- *USA*: USAID disability policy paper and Disability inclusive development introductory course (for USAID staff and development partners).

Toolkits for disability inclusion – selected examples

General

Many of these toolkits contain sections relevant to various sectors.

- Inclusion made easy: A quick program guide to disability in development (CBM)
- Count me in: Include people with disabilities in development projects – A practical guide for organisations in North and South (LIGHT FOR THE WORLD)
- Make development inclusive: How to include the perspectives of persons with disabilities in the project cycle management guidelines of the EC (CBM)
- Community-based rehabilitation guidelines (WHO)
- Disability, equality and human rights – A training manual for development and humanitarian organisations (Oxfam – with Action on Disability and Development)
- Disability inclusive development toolkit (CBM)
- Making inclusion a reality in development organisations: A manual for advisors in disability mainstreaming (IDDC)
- Making it work: Good practices for disability inclusive development (Handicap Intl.)
- Human rights. Yes! action and advocacy on the rights of persons with disabilities (One Billion Strong & University of Minnesota Human Rights Center)
- Travelling together: How to include disabled people on the main road to development (World Vision)
- Mainstreaming disability in development: Lessons from gender mainstreaming (Disability KaR)
- A handbook on mainstreaming disability (VSO)

Poverty and livelihoods

- Making national poverty reduction strategies inclusive (GTZ, Handicap Intl. & CBM)
- Good practices for the economic inclusion of people with disabilities in developing countries: Funding mechanisms for self-employment (Handicap Intl.)
- Achieving equal employment opportunities for people with disabilities through legislation (ILO)
- Inclusive employment (Handicap Intl.)
- Count us in! – How to make sure that women with disabilities can participate effectively in mainstream women's entrepreneurship development activities (ILO)
- Inclusive social protection: Tools and guidance (GIZ)

Participation and governance

- Equal access: How to include persons with disabilities in elections and political processes (USAID, IFES & NDI)
- A guidance paper for an inclusive local development policy (Handicap Intl., shia & HSO)
- Rights in action: Good practices for inclusive local governance in West Africa (Handicap Intl.)
- Inclusive civic engagement: An information toolkit for families and people with intellectual disabilities (Inclusion Intl.)
- My voice matters! Plain language guide on inclusive civic engagement (Inclusion Intl.)

Education

- Inclusive education (Handicap Intl.)
- Inclusive learning: Children with disabilities and difficulties in learning (HEART)
- Education for children with disabilities – Improving access and quality: Guidance note (DFID)
- INEE pocket guide to supporting learners with disabilities (INEE)

Health

- Promoting sexual and reproductive health for persons with disabilities (WHO & UNFPA)

WASH

- Compendium of accessible WASH technologies (WEDC, WaterAid & share)
- Casting the net further: Disability inclusive WASH (World Vision)
- Disability: Making CLTS fully inclusive (Institute of Development Studies)

Accessibility

- Accessibility and development: Environmental accessibility and its implications for inclusive, sustainable and equitable development for all (DESA)
- Accessibility design guide: Universal design principles for Australia's aid program (DFAT)
- International best practices in universal design: A global review (Cornell University ILR School)
- Guide to improve accessibility for persons with disabilities: Inclusive meetings (Handicap Intl.)
- Accessibility of Housing. A Handbook of Inclusive Affordable Housing Solutions for Persons with Disabilities and Older Persons (UN-Habitat)

Disaster Risk Reduction

- Mainstreaming disability into disaster risk reduction: A training manual (Handicap Intl. & ECHO)
- Disability inclusive disaster risk management: Voices from the field & good practices (CBM & DiDRR)
- Major hazards and people with disabilities (Council of Europe)

Humanitarian response

- Disability inclusion: Translating policy into practice in humanitarian action (WRC)
- Ageing & disability in humanitarian response: A resource book of inclusive practices (Ageing and Disability Task Force)
- Humanitarian aid: All inclusive! How to include people with disabilities in humanitarian action (LIGHT FOR THE WORLD & Diakonie Eine Welt)
- The Sphere handbook: Humanitarian charter and minimum standards in humanitarian response (The Sphere Project)
- 'I see that it is possible' Building capacity for disability inclusion in gender-based violence programming in humanitarian settings (WRC)

Gender

- Disability rights, gender, and development: A resource tool for action (Secretariat for the UN Convention on the Rights of Persons with Disabilities, UNFPA & Wellesley Centers for Women)
- Mainstreaming disability and gender in development cooperation (IDDC, MDI & DCDD)
- Guide to gender mainstreaming in public disability policies (CERMI)
- Gender and disability mainstreaming: Training manual (GIZ & DIWA)

Human rights

- Monitoring the Convention on the Rights of Persons with Disabilities (OHCHR)
- Disability rights advocacy: An advocacy manual for disability rights activists (ADD Zambia)

Monitoring and evaluation

- Monitoring the UN Convention on the Rights of Persons with Disability (Washington Group on Disability Statistics)
- Module on child functioning and disability (Washington Group on Disability Statistics/UNICEF)
- Training manual on disability statistics (WHO/ESCAP)

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