

Series on Disability-Inclusive Development

Inclusion Counts

The Economic Case for
Disability-Inclusive Development





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The Economic Case for Disability-Inclusive Development

02 Series on
Disability-Inclusive Development



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Foreword

CBM is delighted to present this important publication to the international development community, government officials, and non-governmental organisations. The publication presents the research findings of a study conducted by the International Centre for Evidence in Disability at the London School of Hygiene & Tropical Medicine.

By undertaking the largest systematic review of disability and poverty to date, researchers at the London School of Hygiene & Tropical Medicine found a robust empirical basis to support the theorised disability and poverty link, with a focus on economic poverty. This link is important as it provides evidence to the claims made by a number of different actors, including the United Nations, governments, and civil society that persons with disabilities are often among the poorest members of society, facing exclusion from and discrimination in key spheres of life.

Despite the existence of the Convention on the Rights of Persons with Disabilities, persons with disabilities still experience persistent inequalities in almost all indicators of social, political, cultural, and economic participation compared to the rest of the population. From that perspective, this publication also includes evidence from a literature review of how barriers in society exclude persons with disabilities from key areas of life, such as health, education, and work and

livelihood. This publication highlights how this creates costs for persons with disabilities themselves, their families, and for society overall.

Key to the realisation of a post-2015 development framework that is inclusive of persons with disabilities will be how the new goals will be implemented. This publication shows how inclusion can create economic gains at all levels of society together with stories from and interviews with CBM staff working on the frontline of inclusion in health, education, and work and livelihood.

Including persons with disabilities necessitates both investment and vigilance by governments to ensure that women, men, girls, and boys with disabilities can access important services and participate fully in their communities and societies. This requires removing barriers, providing reasonable accommodation, and developing a culture of inclusion. This publication aims to persuade decision-makers to ensure that disability-inclusive development processes, including funding and monitoring mechanisms, are developed so that no one is left behind as the governments of the world take steps to improve the lives of all of their peoples.

Frank Wendt

Vice President and Executive Board Member,
CBM International

Introduction

“Inclusive growth should not be a mere slogan but a fundamental driving force for sustainable development.”

Pranab Mukherjee,
President of India (2013)



The economic case of disability-inclusive development

One billion of the world's population – one out of every seven people on the planet – are women, men, girls, and boys with disabilities.¹ According to the United Nations (UN), at least 80 % of that billion are estimated to live in developing countries,² where they make up a disproportionate percentage of the poorest sections of the community, an important group for development actors. Despite their significance for development, many previous global efforts to reduce poverty, such as the Millennium Development Goals (MDGs), have not explicitly addressed disability.

A commonly-held perception is that disability-inclusive development interventions are financially unfeasible or are too difficult to achieve, particularly in low-income countries. This publication challenges that perception. It asks readers to consider the following questions: can governments afford to continue excluding women, men, girls, and boys with disabilities? How can investment in inclusion benefit persons with disabilities, their families, and societies overall and how can international cooperation support this inclusion?

The full inclusion and participation of women, men, girls, and boys with disabilities in society is not just a development issue – it is also a human rights issue. The human rights obligations for the inclusion and full participation of persons with disabilities have been set out clearly by the Convention on the Rights of Persons with Disabilities (CRPD).

In order to make the case for inclusive societies for persons with disabilities, evidence

needs to be gathered. Research into the economic gains that come from including persons with disabilities in international and national development programmes, as well as looking at the costs of excluding them, has long been lacking. This publication aims to make a contribution to reduce this shortage in available research in a number of ways:

- First, using the findings from an extensive literature review, it demonstrates the close link between disability and poverty.
- Second, it explores the potential pathways through which exclusion of persons with disabilities generate economic costs to individuals, their families, and societies at large.
- Third, it explores how investing in disability-inclusion at the national and international levels by both governments and civil society could lead to potential economic gains.

Based on new empirical evidence and examples from development projects, this publication makes the case that including persons with disabilities in key sectors such as health, education, and work and livelihood from the outset can mean lower costs in the long run and positive returns for both the economy and society overall.

Why and how CBM promotes research for evidence

CBM's engagement in research includes review of existing evidence (through literature reviews) and action-oriented research. CBM's involvement in research is guided by the needs and themes identified by women, men, girls, and boys with disabilities and



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◀ 18-year-old Exhilda Chinyama (centre) is with her school friends in front of the Munali Secondary School in Lusaka, Zambia. Exhilda attends a class for pupils with hearing impairment.

their representative organisations, or other local partners. The evidence generated is intended to be 'actionable', meaning that it is relevant to CBM's work and can be translated into concrete actions.

CBM does not conduct research by itself; instead it partners with research institutions and universities. While CBM staff and implementing partner organisations bring experience in research, the collaboration with academic institutions, such as the International Centre for Evidence in Disability (ICED) at the London School of Hygiene & Tropical Medicine (LSHTM), ensures the ethical aspects of research and ensures that sound methodologies for data collection and analysis are applied. CBM's research partners also contribute to the dissemination of research in academic discourses.

Why CBM is offering this publication

This publication aims to bring the study, 'The Economic Costs of Exclusion and Gains of Inclusion of People with Disabilities', published by ICED in 2014, to a wider audience.³ Using the findings of the study, this publication demonstrates the link between poverty and disability. It also provides evidence of other studies that make the case for including persons with disabilities in the economic and social development of countries.

This evidence is particularly important for building knowledge for the implementation and monitoring of the 2030 Agenda for Sustainable Development. Challenges will arise at the international and national levels regarding how to ensure participation and inclusion of persons with disabilities in the

whole development process. Evidence of innovative solutions and good practices can help governments and development actors to increase their efforts to include women, men, girls, and boys with disabilities in their policies and programmes.

This is the second publication in CBM's 'Series on Disability-Inclusive Development'. The first publication, 'The Future is Inclusive. How to Make International Development Disability-Inclusive', was published in 2015.⁴

What this publication covers

This publication has four parts and six chapters:

Part 1: Why international cooperation needs to be inclusive

Chapter 1 discusses the role of international cooperation in poverty reduction and in support of the inclusion of persons with disabilities. It highlights where previous efforts have failed to include persons with disabilities and where international cooperation needs to ensure that all persons with disabilities will benefit in the future.

Part 2: Presentation of the findings from the LSHTM 2014 review

Chapter 2 provides an overview of how the exclusion of woman, men, girls, and boys with disabilities from participation in society leads to poverty. It highlights the link between poverty and disability by presenting evidence from the most extensive review on the topic to date.

Part 3: Costs of exclusion and gains of inclusion

Chapters 3, 4, and 5 present theoretical findings on the costs of exclusion and the expected gains of inclusion of persons with disabilities in three sectors:

- Health (Chapter 3);
- Education (Chapter 4); and
- Work and Livelihood (Chapter 5).

Each chapter gives an overview of the obligation of governments and development stakeholders under international conventions to include persons with disabilities. Additionally, each chapter highlights the barriers to inclusion along with good practice examples that illustrate how the inclusion of persons with disabilities has made a difference in development activities.

Part 4: Conclusions

Chapter 6 concludes with key learning points, highlighting the importance of including persons with disabilities in the key areas of health, education, and work. It makes the argument that governments cannot afford to exclude persons with disabilities and that investment in inclusion benefits all in society.

What this publication does not do

This publication presents evidence that has come out of a review of previously published studies; therefore, it is not a new study with scientific proof. It also does not present a detailed explanation of why development needs to be disability-inclusive, as this was covered in the first publication of this series.⁵

Furthermore, it does not go into depth about all legal obligations of governments; instead, it provides a brief overview of key international treaties related to health, education, and work and livelihood.

Whom this publication is for

This publication targets audiences in the development and disability sector: development professionals, disability advocates, decision- and policy-makers, fundraisers, as well as current and potential CBM partners. In addition, an interested public will find a comprehensive introduction to the debate on the costs of exclusion and the gains of inclusion.

A note about language and terminology

‘Persons with disabilities’ and ‘disability’: This publication uses the term ‘persons with disabilities’, which is the terminology adopted by the CRPD.⁶ It also uses gender and age differentiated language, such as ‘women, men, girls, and boys with disabilities’. The purpose of this is to highlight that persons with disabilities are not one homogenous group.

Disability occurs when someone with impairment, for example, a spinal cord injury or blindness, interacts with an inaccessible environment. The environment may be inaccessible due to physical barriers (such as steps instead of ramps or the absence of information in accessible formats) or attitudinal barriers (such as prejudices against persons with disabilities).



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‘International cooperation’:

The term ‘international cooperation’ is used in a number of different ways by governments, international agencies, and civil society. For the purpose of this publication, the definition is taken from the Charter of the United Nations as “means to solving international problems of an economic, social, cultural or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all”.⁷

▲ Children queuing for a medical check-up at the paediatric eye and ear camp held on school premises near Lahan, Nepal.

Chapter 1

Effective Development Needs to Be Inclusive



“Removing barriers to participation and ensuring the effective inclusion of women, men, girls, and boys with disabilities in all spheres of life is central to advancing global progress on equality for everyone. This is achieved by countries working together through international cooperation efforts to make positive changes for all persons with disabilities”.

Dave McComiskey,
President of CBM
International (2015)

1.1 Introduction

Much of the evidence and data presented in this publication come from low- and middle-income countries. In these countries, international cooperation, particularly development aid and technical assistance, can play an important role in creating opportunities for persons with disabilities. However, the inclusion of women, men, girls, and boys with disabilities in international cooperation has not been systematic and this has resulted in global development goals, such as the MDGs, not being fully achieved.⁸ The lack of inclusion has also resulted in persons with disabilities missing out on development opportunities and benefits worldwide. The World report on disability, published in 2011, presents compelling evidence of the barriers which persons with disabilities face in realising their rights on an equal basis with others.⁹ The report found that across the whole world women, men, girls, and boys with disabilities have poorer health statuses, lower educational achievements, less economic participation, higher rates of poverty, and face more inequality than persons without disabilities.

The aim of this chapter is to show that, while progress has been made for many people living in poverty, the situation of women, men, girls, and boys with disabilities has received insufficient attention. It highlights how disability-inclusive international cooperation in the areas of health, education, and work and livelihood can change this by supporting the implementation of the rights of persons with disabilities, thereby ensuring their full inclusion and participation in society.

1.2 International cooperation and poverty reduction

The basis for international cooperation is established in international law, and the role it can play was re-iterated by the Millennium Declaration in 2000. The Declaration recognises governments' responsibilities for the development of their own countries. It also highlights the collective responsibility of governments to work together internationally.¹⁰ International cooperation, in all its forms and in particular development aid, has tradition-

▼ Harka Maya is 83 years old and has been diagnosed with cataract. She will undergo surgery at the Biratnagar Eye Hospital, in Nepal.



Box 1: Outcomes of the MDGs¹¹

- The world has reduced extreme poverty by half; in 1990, 47 % of the population in developing regions lived on less than USD \$1.25 a day. This rate dropped to 14 % in 2015—a drop of more than two thirds.
- Global under-five mortality rates have declined by more than half, dropping from 90 to 43 deaths per 1,000 live births between 1990 and 2015.
- Mortality rates from malaria have fallen by an estimated 58 %; between 2000 and 2015, an estimated 6.2 million deaths from malaria were averted due to the substantial expansion of malaria interventions.
- The target of halving the proportion of people without access to an improved drinking water source was achieved in 2010, five years ahead of schedule. In 2015, 91 % of the world's population had access to an improved source, up from 76 % in 1990.
- Disparities in primary school enrolment between girls and boys have been eliminated in all developing regions. The primary school net enrolment rate in developing countries has reached an estimated 91 %, up from 83 % in 2000.

ally been one of the important conduits for richer governments to provide financial and technical support to low- and middle-income countries.¹²

1.2.1 Progress made in reducing poverty

Since the Millennium Declaration and throughout the implementation period of the MDGs, world governments have made progress in

reducing overall poverty rates and in reducing the impact poverty has on people. **Box 1** (page 16) highlights some statistics that reflect this progress.

1.2.2 Progress has not included everyone

Not all targets included in the MDGs have been reached. For example, the 2014 MDG report highlights that one in four children are still affected by chronic undernutrition and that much work still needs to be done to reduce child and maternal mortality.¹³ School dropout rates remain high, particularly in areas of conflict. In addition to not reaching all targets, it has been widely acknowledged that, during the period of the implementation of the MDGs, inequalities between countries and within countries grew.¹⁴

Persons with disabilities were not explicitly included in any of the goals, targets, or reporting mechanisms.¹⁵ This omission means that measuring the progress of the implementation of the MDGs for persons with disabilities was not possible. Also, gaps in key areas, for example, participation rates in education, could not be identified.

1.3 Disability-inclusive international cooperation

The CRPD is the only international treaty to include a unique article on international cooperation, Article 32.¹⁶ It recognises that international cooperation has a role to play in supporting the efforts of countries with limited resources to promote, protect, and

fulfil the rights of persons with disabilities.¹⁷ It also affirms the importance of international cooperation for improving the living conditions of persons with disabilities in every country, particularly developing countries.¹⁸

Box 2 (see page 17) highlights that the approach of the CRPD to international cooperation is much more comprehensive than any previous international treaty. Furthermore, recent concluding observations and a general comment on accessibility issued by the CRPD's committee of experts¹⁹ have expanded what Article 32 means for future international cooperation efforts.²⁰ For example, it asks that all new investments made within the framework of international cooperation encourage the removal of existing barriers to



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◀ Nigerian member of the CRPD committee signing the UN register for committee membership.

Box 2: The CRPD and the role of international cooperation²¹

- The CRPD promotes a rights-based approach to international cooperation and Article 32 obligates governments to ensure that their international cooperation is inclusive of and accessible for all persons with disabilities.
- The CRPD identifies international and regional organisations and civil society, in particular organisations of persons with disabilities, as being responsible for promoting inclusive cooperation.
- The CRPD defines 'disability-inclusive international cooperation' as:
 - accessible and inclusive international development programmes;
 - capacity-building of governments, including sharing and exchanging information and good practices; and
 - cooperation in research and access to scientific and technical knowledge and technical and economic assistance, including access to and sharing of accessible and assistive technologies and technology transfer.

► Ibrahim Wanguey, the owner of a survival yard in south-west Niger, is fetching water from a small reservoir in his garden. He lost his left leg when he was 25 years old.



inclusion of persons with disabilities and prevent the creation of new barriers. Newly developed or built objects, infrastructure, facilities, goods, products, and services must be fully accessible for all persons with disabilities.²²

►► Ishahak Daimari (left) is a client of a community-based rehabilitation programme in India. With the support of the programme, Ishahak established a tea plantation in Assam.

1.4 Inclusion for better development

While there is an overall lack of robust data on how many women, men, girls, and boys with disabilities benefit from international cooperation, it is widely acknowledged that measures for the inclusion of persons with disabilities in development processes need to improve.²³ Excluding persons with disabilities

from key areas of life, such as health, education, and work and other livelihood opportunities, as presented in Chapters 3–5, creates multiple costs to society. It also means that poverty reduction goals are not met and this lessens the overall effectiveness of international cooperation among governments working together.

The debate on how inclusive international cooperation (for example, the 2030 Agenda for Sustainable Development) is implemented continues between governments, international development organisations, and persons with disabilities and their representative organisations. A number of issues have evolved as part of this dialogue and these are discussed further in section 1.4.1.



Box 3: Bringing UN agencies together on disability²⁴



UN Partnership to Promote the Rights of Persons with Disabilities

ILO | OHCHR | UNDESA | UNDP | UNESCO | UNFPA | UNICEF | UN WOMEN | WHO

The goal of the UNPRPD is to develop the capacities of national stakeholders, particularly governments and organisations of persons with disabilities, for the effective implementation of the CRPD by promoting disability-inclusive internationally-agreed development goals.

As the first global UN inter-agency initiative with a programmatic focus on the promotion and protection of the rights of persons with disabilities, the UNPRPD is characterised by four defining features:

1. A one UN approach to disability:

The UNPRPD responds to the complexity of disability by integrating the different competencies of various UN agencies into a common programmatic platform.

2. A focus on partnership building:

The UNPRPD leverages the unique position of the UN at the national level to facilitate partnerships between governments, Disabled People's Organisations (DPOs) and the broader civil society.

3. A focus on joint knowledge creation: The UNPRPD generates cut-

ting-edge knowledge on good practices and ways to mainstream disability in the UN system operational activities.

4. A catalytic approach: The UNPRPD utilises its fund strategically to develop the capacities of partner countries to mobilise additional national and international resources for the promotion of disability rights.

Examples of two projects:

In **Tunisia**, the UNPRPD promoted extensive leadership development, partnership building, and advocacy work in close collaboration with DPOs leading to the adoption of the Tunisian National Charter on the Rights of Persons with Disabilities. The adoption of the Charter represents a significant breakthrough for the Tunisian disability movement, as it has shifted the discourse around disability to a human rights perspective. Additionally, it has initiated setting up necessary institutional mechanisms, for example, a dedicated parliamentary commission. The Charter has been endorsed by 86 % of the newly-elected assembly of representatives and the president. The development of the Charter also resulted in the creation

of a national umbrella organisation of DPOs, the Tunisian League for the Rights of Persons with Disabilities, which will bring together a broad range of representative organisations around a common human rights agenda.

In **Moldova**, the UNPRPD supported the adoption and implementation of the national policy on de-institutionalisation of adults with mental or intellectual disabilities, in consultation with organisations of persons with psychosocial and intellectual disabilities. As a result, there has been a 40 % reduction in the number of beds in psychiatric hospitals and the establishment of community mental health centres in all 26 districts of Moldova. There have also been legal and policy changes leading to improvements in the area of legal capacity. For example, an inter-ministerial working group on legal capacity reform adopted a resolution calling for the abolition of civil law provisions that restrict the legal capacity of persons with mental and intellectual disabilities. The Ministry of Justice has put forward a legislative draft envisaging legal recognition of supported decision-making arrangements, which aims to restore the rights of those who have been declared legally incapable on grounds of disability.

1.4.1 Inclusive international cooperation – key actors

As highlighted in **Box 2** (page 17), Article 32 of the CRPD specifies the responsibilities for a range of actors for implementing disability-inclusive international cooperation:

1. **Donor governments** through their bilateral aid programmes are key actors at the international level. Article 32 obligates state parties to ensure that their international development programmes are accessible and inclusive of women, men, girls, and boys with disabilities. What this means in practice is that development aid should be targeted towards improving the lives of persons with disabilities and removing barriers to their participation in key sectors.
2. **Inter-governmental organisations**, such as the UN and its various agencies, have a key role to play. Some examples include the Inter-Agency Support Group for the implementation of the CRPD, which was set up in 2006 to enhance coordination among UN agencies. In 2011, a Multi-Donor Trust Fund was established to enhance the coordination and implementation of the CRPD in developing countries. **Box 3** (see page 20) highlights this UN mechanism, the UN Partnership to Promote the Rights of Persons with Disabilities (UNPRPD), and provides some examples of the types of projects it supports worldwide.
3. **National governments** that form partnerships with the private sector and civil society to create inclusive opportunities for persons with disabilities are also key actors.



◀ Australia's strategy for strengthening disability-inclusive development.



◀ Germany's 'Action Plan for the Inclusion of Persons with Disabilities' in development cooperation.

Box 4: Disability-inclusive financing²⁵

1. Money from domestic and international resources should be used to realise accessibility for women, men, girls, and boys with disabilities. For example, some of the funds must be invested in making schools, health clinics, and transportation systems accessible.
2. Persons with disabilities should be enabled to participate in the design, implementation, financing, and monitoring of public budgets and fiscal policies. This will ensure that stronger accountability mechanisms are put in place.
3. Both national and international funds should be used to ensure access to necessary disability support services, for example, personal assistance. This might not be possible immediately; however, clear steps must be put in place to show how and when this will happen.
4. Any funds coming into countries from bilateral aid or international cooperation to start-up companies should also create improvements in work and livelihood prospects for persons with disabilities.
5. Census data should be collected, disaggregated by disability, sex, and age. This would allow for the monitoring and evaluation of development aid and would highlight both the progress and the gaps in reaching persons with disabilities.

This is not only related to service provision but also to governance and development of public policy.

1.4.2 The need for disability-inclusive investment

A central question asked by disability advocates during the negotiations for the post-2015 development framework was: how can development funds provided by states support the building of inclusive societies? Ensuring that money spent through international cooperation or through national

funding streams by government does not create new barriers for persons with disabilities, but rather removes them, has been a key issue for international DPOs and disability and development organisations. **Box 4** (page 22) highlights recommendations made by the International Disability Alliance (IDA) and the International Disability and Development Consortium (IDDC) for the post-2015 financing for development negotiations to ensure that international cooperation, particularly financial assistance, is inclusive of persons with disabilities.

Key learning points

- International cooperation has contributed to the reduction of poverty in many of the world's poorest countries, with good progress made towards several of the MDGs.
- Persons with disabilities have experienced some benefits from international cooperation, but their inclusion needs to be scaled up in future development frameworks.
- The exclusion of persons with disabilities, one of the most excluded groups of the population in developing countries, affects the overall effectiveness of international cooperation.
- The CRPD recognises that international cooperation has a role to play in supporting efforts by low- and middle-income countries to create inclusive societies for persons with disabilities.
- Donor governments and inter-governmental organisations are responsible for supporting countries at a national level to leverage opportunities for everyone, including persons with disabilities.
- Donor governments and international organisations, including civil society, can support countries that lack expertise and knowledge to implement the rights of women, men, girls, and boys with disabilities.

Chapter 2

Disability and Poverty – What the Evidence Says



© Paul Jeffrey

“Poverty eradication and the achievement of economic growth can ensure the rights and inclusion of persons with disabilities. As such, the new framework must be people centred, with participation at all levels. We, persons with disabilities, should be recognised as equal partners and work with all of you – governments, the UN system, and civil society – in the post-2015 implementation process”.

Maryanne Diamond,
Chair of IDA (2015)

2.1 Introduction

In order to understand the economic costs of exclusion – and how inclusion of persons with disabilities can lead to economic gains – it is important to look at the relationship between disability and poverty. Chapter 2, therefore, provides an overview of how the exclusion of women, men, girls, and boys with disabilities from social participation contributes to poverty. It also highlights how inclusion is essential, not only from a human rights perspective, but also for promoting economic growth and development. First, the chapter presents new research findings from a systematic review on economic poverty and disability – the most comprehensive investigation on this topic to date – conducted by the London School of Hygiene & Tropical Medicine in 2014.²⁶ Second, it discusses how challenges in collecting accurate and reliable empirical evidence on poverty and disability impede designing, planning, and monitoring development initiatives to ensure inclusiveness. Third, it highlights the impact of poverty on the lives of persons with disabilities, their households, and societies at large. Finally, it introduces findings on how exclusion of persons with disabilities from health, education, and work generates individual and societal costs that contribute to poverty at the individual and societal levels.

2.2 The cycle of poverty and disability

Although robust data has been lacking, it is widely recognised that disability and poverty are closely linked. Researchers and policy-



makers have described this relationship as the ‘cycle of poverty and disability’ and this was extensively discussed in the first publication of CBM’s ‘Series on Disability-Inclusive Development’ (Box 5, page 26).²⁷

2.2.1 Systematic review on disability and poverty

While there is a strong theoretical basis for the cycle of poverty and disability, empirical support has been lacking. Consequently, as part of the original research on the economic costs of exclusion of persons with disabilities that informed this publication, researchers at LSHTM conducted a systematic review to explore the relationship between disability

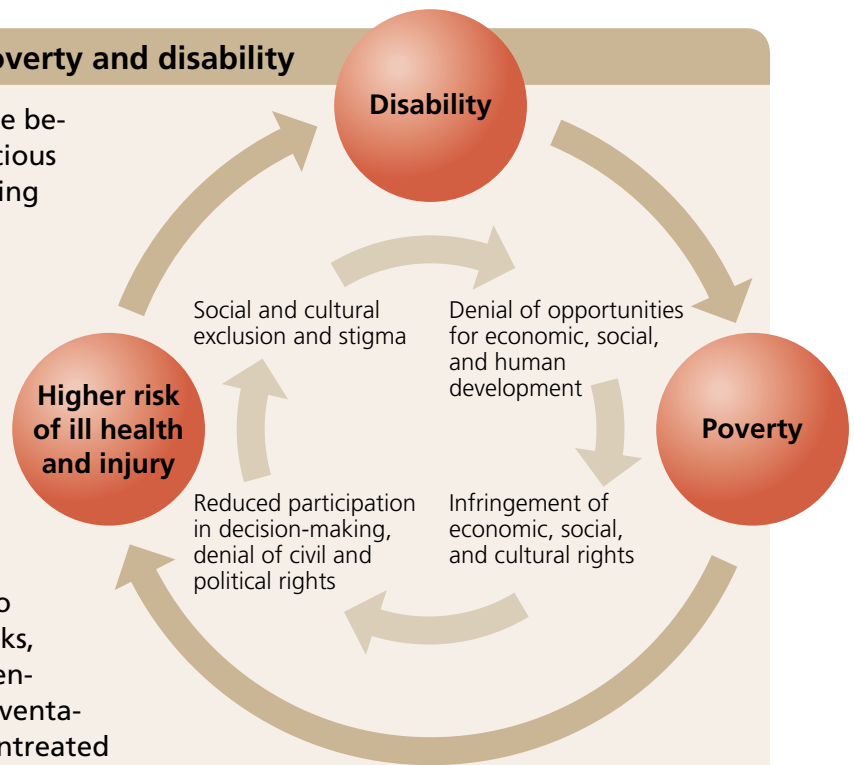
▲ A man is carrying water to his fields in Luzhou, China.

Box 5: The cycle of poverty and disability

Disability and poverty are believed to operate in a vicious cycle, with each reinforcing the other.

To begin, persons living in poverty are more likely to experience ill health and injuries, which may lead to disease or other impairments. For example, a person living in poverty may be likely to develop an injury or illness due to a greater exposure to risks, such as an unsafe work environment or lack of preventative health care. If left untreated – because needed health services are unaffordable, unavailable, or inaccessible – the injury or illness can lead to permanent impairment. By creating safer environments (housing, roads, workplaces), and ensuring access to basic services and necessities, such as health care, adequate food, clean water, and sanitation, some of these impairments could be prevented.

Health problems and impairments can then contribute to or worsen poverty for persons with disabilities, their households, and even the broader communities in which they live. For example, barriers such as negative



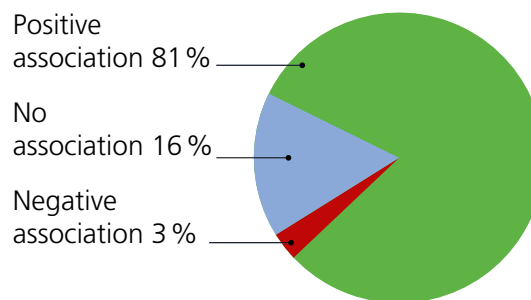
attitudes, inaccessible built environments, and lack of alternative forms of communication can exclude persons with disabilities from fully participating in society. Consequently, persons with disabilities and their households are less likely to access opportunities – in education and training, work, or rehabilitation – that could lead them out of poverty. Additionally, persons with disabilities may face extra costs resulting from disability, such as for assistive devices, transportation, health care, and rehabilitation.

and poverty in low- and middle income countries.²⁸ Systematic reviews are a robust, transparent way of gathering, summarising, and evaluating existing evidence on a given topic. By striving to gather all available research and objectively weighing the findings, systematic reviews provide a complete overview on a topic that can be used to inform policy decisions or highlight areas in need of further research. This systematic review is the most comprehensive study to date to substantiate the link between poverty and disability with empirical evidence.²⁹

After reviewing over 10,000 citations retrieved from eight electronic databases, researchers found 98 studies that explored both directions of the cycle of poverty and disability. Studies were included in the review if they answered one of the following questions:

- Was the disability measured more common among poorer, compared to wealthier, economic groups?
- Were persons with disabilities poorer compared to persons without disabilities?

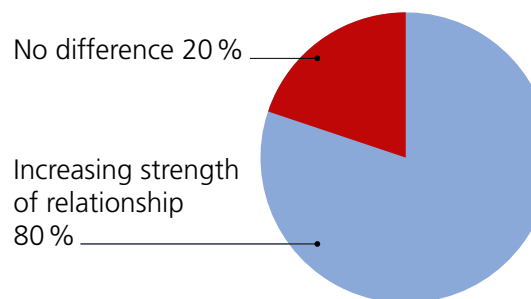
The review found substantial empirical evidence supporting the relationship between poverty and disability, with the vast majority of studies finding that disability and poverty are indeed linked. Even after statistical analyses were performed to determine if the relationship could be due to chance or other factors, 79 of 98 studies (81 %) found that persons with disabilities were poorer compared to persons without disabilities or that disability was more common among people from poorer, compared to wealthier, economic groups (**Figure 1**, page 27). This relationship held when disaggregation was



◀ Figure 1: Relationship between disability and poverty

made by age groups, regions of the world, types of impairments, and study designs.³⁰

Moreover, 80 % of studies that disaggregated data by either level of poverty or severity of disability found the strength of the relationship increased with increasing levels of poverty and increasing severity of disability (**Figure 2**, page 27). This means that persons with greater functional limitations were more likely to be poorer compared to persons with



◀ Figure 2: Strength of relationship between disability and poverty

milder limitations and persons in lower economic groups were more likely to have disabilities compared to persons in middle economic groups.

The following four examples from studies included in the systematic review illustrate

► Diopen Claros is a fisherman and a father of four children, all of whom have hearing impairment. His fishing gear was ravaged during the typhoon Haiyan, which hit the Philippines in 2013. The Claros family was included in relief distribution.



© Paul Jeffrey

the general association found between disability and poverty. They show how different types of disabilities correlate with different parameters of poverty in six countries:

- In Bangladesh, Kenya, and the Philippines, prevalence of visual impairment from cataracts among older adults increased with decreasing socioeconomic status, per capita expenditures, and self-rated wealth.³¹
- In Brazil, prevalence of certain common mental health problems increased as socioeconomic status decreased. Women and men in the poorest group were over three times as likely to experience a common mental health problem, compared to their counterparts in the wealthiest group. Additionally, persons with mental health problems were almost twice as likely to be unemployed as persons without a psychosocial disability.³²
- Risk of having a child with an intellectual disability increased with decreasing household income in China: children with intellectual disabilities were two to three times more likely to live in households belonging to the poorest income groups, compared to the highest income group.³³
- National surveys in Uganda found that households headed by a person with a disability were more likely to be living below

the poverty line, compared to households headed by a person without a disability.³⁴

2.3 The need for comparable disability data

The current lack of comparable data on the situation of persons with disabilities in low- and middle-income countries is a key barrier to designing, implementing, and monitoring disability-inclusive development initiatives. Without statistics on information as basic as the total number of women, men, girls, and boys with disabilities living in a given area, planning, prioritising, and budgeting for appropriate services and policies becomes difficult. Moreover, to determine if persons with disabilities are being included in development actions, it is important to disaggregate indicators of social, cultural, and economic development by disability in order to compare progress relative to the general population. Tracking changes in the situation of persons with disabilities over time is important for highlighting progress and gaps.

Collecting reliable, comparable, and comprehensive data on disability poses a number of challenges. First, as persons with disabilities are often marginalised, they are seldom considered a research priority.³⁵ Even when attempts are made to gather information, the data collected may be poor. For example, social isolation makes it difficult to reach many persons with disabilities, and stigmatisation may make some persons reluctant to identify themselves or family members as having a disability. Additionally, when research methods are not adapted to accom-

modate different modes of communication, persons with certain impairments, such as deafness or intellectual disability, may be excluded.³⁶

Second, there are many different definitions and tools for assessing the situation of persons with disabilities.³⁷ Consequently, the number of persons considered to have a disability can vary substantially, depending on the methodology and definitions that are used in censuses or research projects. This means statistics may not be representative or comparable over time or between locations.

▼ Joyce Simon Kaaya (left) is a farmer who lives in Arumeru, Tanzania. Before her cataract surgery, she was blind and needed someone to guide her to fetch water far from her village.



© CBM/argum/Einberger

Box 6: Washington Group census questions

The following are the Washington Group on Disability Statistics' set of six questions that are recommended by the UN for use in all national censuses. These questions are in line with the WHO's International Classification of Functioning, Disability and Health, which focuses on limitations in functioning (for example, difficulty seeing), rather than simply the presence of impairment (for example, low vision).

Because of a health problem:

1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

Response categories:

- No, no difficulty.
- Yes, a lot of difficulty.
- Yes, some difficulty.
- Cannot do at all.

Finally, as persons with disabilities are not a homogenous group of people, there is a need for disaggregated data on disability. The extent and impact of exclusion is likely to vary significantly by factors such as impairment type, level of support needed, age, sex, ethnicity, income level, and geographic location. However, such figures are rarely

available. By collecting disaggregated disability data, policies and programmes can be tailored to provide more nuanced approaches for creating opportunities for women, men, girls, and boys with disabilities.

The collection of comparable, reliable, and comprehensive disability data has been a key recommendation of the World report on disability and more recently it has been evoked during the post-2015 negotiations, bringing attention to this important issue.³⁸ Furthermore, organisations and entities such as the Washington Group on Disability Statistics, the UN Statistics Division, the United Nations International Children's Fund (UNICEF), and the World Health Organization (WHO) have developed, tested, and promoted tools for measuring disability in national censuses and surveys that are robust and allow for international comparisons.³⁹ Governments as well as researchers are increasingly using the Washington Group on Disability Statistics' questions to collect disability data, representing important progress in this area. **Box 6** (page 30) gives an example of these census questions.

Although data on disability is vital for informing development policy and practice, action should not be delayed until perfect data is available. The evidence from the systematic review by LSHTM presented here, as well as from other reports, shows that persons with disabilities are economically and socially marginalised. Therefore, governments and other key actors should make every effort to ensure full and equal participation of women, men, girls, and boys with disabilities in all development initiatives.

2.4 The impact of poverty

The cycle of poverty and disability explains how disability can lead to or worsen deprivation for persons with disabilities, their households, and the broader communities in which they live (Box 5, page 26). However, everyone is not equally affected by poverty. Other characteristics—such as gender, social and economic status, race or religion, or being a refugee or a migrant—influence how people cope with and are affected by poverty. For example, gender inequality certainly impacts on persons with disabilities' susceptibility to poverty, in the case of women with disabilities. While research on women with disabilities is limited, a small number of studies have found that women with disabilities are more likely to be affected by poverty than men with disabilities.⁴⁰

When individuals and their families are facing extreme poverty, they often must take drastic steps to meet basic needs. For example, children may be taken out of school in order to work and contribute to the household. Productive assets—such as land, livestock, and savings—that could be used to build stronger livelihoods are sold off to buy essentials, such as food and shelter. Health care is put off to avoid additional expenses, leading to worsening health. While in the long-term, these decisions may perpetuate or worsen poverty, they are often necessary in the short-term to ensure survival. This situation is what researchers call 'poverty traps': with dwindling resources available to cover basic needs and make productive investments, individuals and their families become excluded from opportunities that could lead them out of poverty.⁴¹ Poverty



traps often persist over generations unless systematic changes are made to address the drivers of poverty. Sieng Sok Chann's story highlights the challenges persons with disabilities face in overcoming poverty traps.

Sieng Sok Chann's story, Cambodia

My name is Sieng Sok Chann. In the past I used to walk like other people. When I was thirteen years old, Cambodia was still in the war. It was during the Khmer New Year on 16th April 1994. It was raining heavily, and people believed that if they shot guns through the air, the rain would stop. My back got injured—it was a bullet that got into my back bone. It broke my bone in the back.

I realised I was a woman with disability, I could not change anything. Many

▲ Four-year-old Abeston (left), who has a developmental delay, is walking to his preschool, the Anganwadi Centre, with his mother and friends. Thanks to early intervention provided by a community-based rehabilitation programme in India, he can now walk and stand and is able to attend preschool.



©Wahid Adnan/DrikNEWS

▲ Sieng Sok Chann with her six-year old son Sieng Lee. She wants to be a strong model to ensure that others do not disrespect her because of her disability. Her big concern is the education of her son, who wants to become a doctor.

people said to me that the life lived like this is very vulnerable, why don't you go to die? They said words like this and made me feel very bad. I think the outside world really does not understand what the real difficulties are for women with disability like us.

Most women with disability are embarrassed, feel ashamed to go in public and never join in the social life. But for me, I decided that I would forget about the past and must commit myself to be very strong. **So I go to the market, I go to join different events and I make my life change. I can play sport; I can do anything with other people so I am quite happy.** Even though I have had great sorrow and disappointment in the past, now I changed my life to be better for the future. I committed myself that I will help other women with disability, especially to make myself to be a strong model, to make sure people are not looking down on me because of disability. I don't want

people to say my spirit is disabled or my capacity is disabled—I really want to show the world I'm strong.

One day I hope to start an organisation which will help the women with disability who live vulnerable lives like me, to make better life. I believe that women with disability who have a job to do and have good training don't get depressed or feel hopeless in their life. I like teaching in the sewing school because I see that my knowledge could train people with disability, so they have a sustainable life and good job.

I know a lot of problems that women with disabilities face: disability could lead into poverty because you have no job to do, you can be more vulnerable. **Most women with disability in my area are single mothers and with one kid. All of them have been given up or were never cared for by their husband, just like me.**

I repeat again and again, for women with disability it is really hard to live. Please consider disability issues.

My son is called Sieng Lee, he is 6 years old and in grade one. My big concern is his education. I really worry what will happen in the future, because I have no money. His vision is to become a doctor.

Source: www.endthecycle.org.au/stories/siengsok

Poverty traps experienced by women, men, girls, and boys with disabilities impact not only themselves and their families, but also the societies in which they live. With increasing levels of deprivation, people living in poverty are less able to participate in and

contribute to their communities. For example, they might spend less at their local businesses or have less free time to invest in the development of their communities. Furthermore, when children miss out on school, they are at increased risk of poverty as adults. Additionally, since education and training have positive impacts on crime rates, gender empowerment, and citizen participation, entire communities may experience social and financial gains from girls and boys with disabilities being included in education.⁴² Continued social and economic marginalisation consequently robs society of valuable contributions from its members with disabilities.

2.5 Costs of exclusion and gains of inclusion

The exclusion of persons with disabilities in society is a key driver of their increased risk of poverty. Access to health, education, and work and livelihood has been identified as an important pathway for reducing poverty. Failure to include persons with disabilities not only propagates their continued social and economic marginalisation but also can hamper the success of development programmes and policies. Although initiatives to make societies disability-inclusive may carry some initial costs – an excuse that is frequently used to avoid taking decisive action – the costs to individuals with disabilities, their families, and societies at large from exclusion are unsustainable.

Taking an inclusive approach has the potential to reverse these costs and even foster economic gains at the individual, household,

and societal levels. However, to maximise benefits, comprehensive and concerted action to ensure all sectors of society are inclusive is necessary.

The following chapters explore in greater detail how exclusion of persons with disabilities in the key areas of health, education, and work and livelihood leads to economic costs for women, men, girls, and boys with disabilities, their families, and societies as a whole. They also discuss how inclusive approaches can make positive gains by providing some examples.

Key learning points

- Findings from a systematic review conducted by researchers at LSHTM on poverty and disability – the most comprehensive investigation on this topic to date – provide strong evidence that disability and poverty are intimately linked.
- Quality data on the situation of persons with disabilities is needed to inform the planning, implementation, and evaluation of development actions to ensure they are inclusive.
- Exclusion of women, men, girls, and boys with disabilities in areas such as health, education, and work and other livelihood activities propagates poverty and leads to a range of costs to persons with disabilities, their households, and societies.
- Investing in inclusion in turn can have a positive impact and bring long-term economic gains to persons with disabilities, their households, and societies.

Chapter 3

Health



“Better health for people with disability, through improved access to health services, is a crucial enabling factor to participation and positive outcomes in areas such as education, employment, and family, community and public life. Good health will also contribute to the achievement of broader global development goals.”

WHO’s global disability action plan (2014)

3.1 Introduction

Chapter 3 explores the costs of excluding persons with disabilities from health care and health care policies. First, it presents an overview of the obligation of governments and development stakeholders under international conventions to ensure the right to health of persons with disabilities. Second, it reviews some of the barriers that may prevent persons with disabilities from accessing and receiving health care. Third, it discusses how the widespread exclusion of women, men, girls, and boys with disabilities from public health programmes, prevention, care, treatment, and rehabilitation results in a range of economic costs. Fourth, it suggests how inclusion can reverse these costs and lead to gains. Finally, the chapter highlights examples of disability-inclusive health programmes and policies.

3.2 International legal frameworks

The right to health is a human right recognised by a number of international treaties. The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.⁴³

The right to health is further clarified in the:

- Convention on the Rights of the Child, Article 12;
- Convention on the Elimination of All Forms of Discrimination against Women, Article 12; and



- Convention on the Rights of Persons with Disabilities, Article 25. It is, thus, always the obligation of national governments as duty bearers to ensure delivery of and access to good quality health care for all people. International cooperation plays an important role in supporting governments of low- and middle-income countries in creating the infrastructure and developing the necessary capacities. This can include establishing health services in rural areas, developing health management systems, and training medical staff. Section 3.5 highlights some examples of this support.

3.2.1 Key features of the right to health

The right to health is not just about infrastructures and services of a health care system; it also includes a number of determining factors that can impact positively or negatively on a person's health, such as access to clean water, nutritional food, and safe working environments.

▲ This is the main entrance of the Solidariedade Evangelica eye hospital. With the support of CBM, Solidariedade Evangelica is implementing the eye care programme Boa Vista, in Angola.

The right to health includes the following:

- the entitlement to a safe and functioning health care system, including essential medicines and access to treatment such as HIV services, rehabilitation, maternal and child services, sexual and reproductive health;
- the entitlement to services, goods, and facilities that are available, acceptable, and accessible and of good quality;
- the right to give free and informed consent to all medical or therapeutic treatments, including psychotropic medication, electroconvulsive therapy, sterilisation, contraception, abortion, and medical experimentation; and
- the right to give free and informed consent to placement in medical facilities, including psychiatric facilities.⁴⁴

3.2.2. Persons with disabilities and the right to health

Article 25 of the CRPD clarifies the rights of women, men, girls, and boys with disabilities to health and identifies key areas for implementation:

- **Equal access to affordable quality health care programmes:**

Providing persons with disabilities with the same range, quality, and standard of free or affordable health care as is provided to other persons is key. This includes sexual and reproductive health care, population-based public health programmes, as well as private health care. In addition, ensuring that health professionals are properly trained to treat persons with disabilities with respect is important.

- **Disability-specific health services:**

Providing disability-specific health services, which persons with disabilities may need because of their impairments, is essential. This includes early identification and intervention, rehabilitation, and assistive devices, as appropriate.

- **Non-discrimination in insurance:**

Prohibiting discrimination against persons with disabilities in the provision of health insurance, as well as life insurance where such insurance is permitted by national law, is important. Such insurance shall be provided in a fair and reasonable manner.

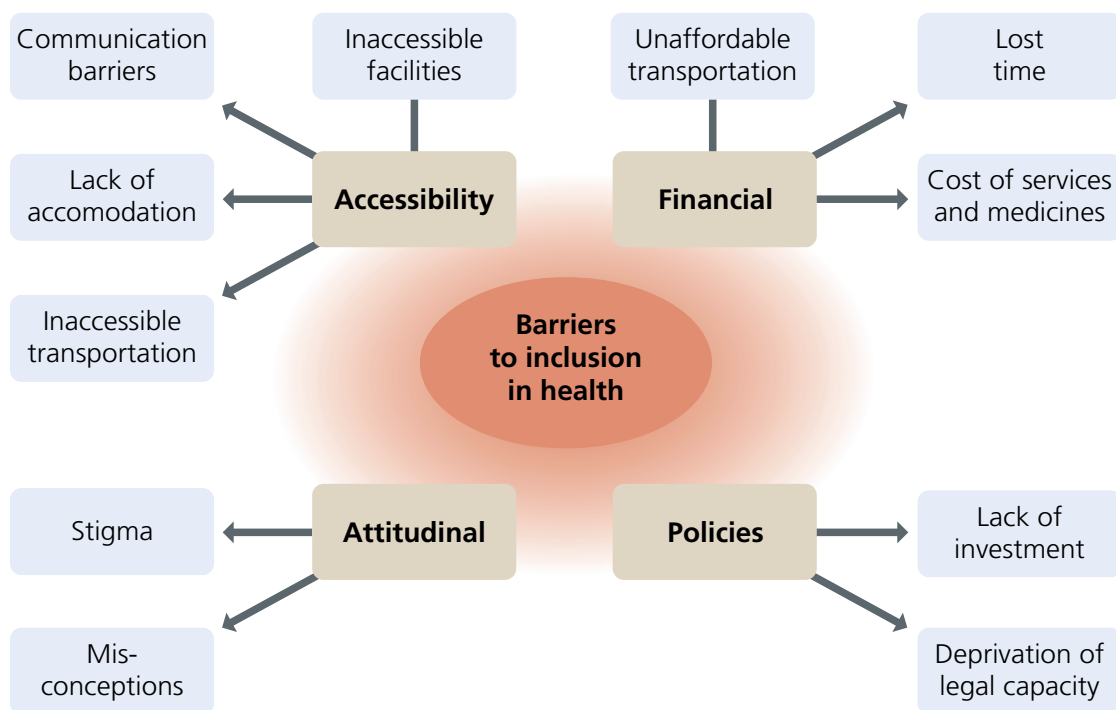
- **Ensuring health care is provided:**

Preventing discriminatory denial of vital health care or food and fluids on the basis of disability is key.

With the aim of providing guidance on the implementation of Article 25 of the CRPD, the World Health Assembly in 2014 adopted the WHO global disability action plan.⁴⁵ This further strengthened the requirements for governments to ensure better access to health and health-related rehabilitation for women, men, girls, and boys with disabilities. **Box 7** (page 37) outlines the action plan's main objectives.

3.3 Barriers to inclusion

Persons with disabilities face many barriers in accessing both mainstream and disability-specific health services. To ensure that health programmes, policies, and planning are disability-inclusive, it is important to understand the barriers leading to unequal access to, and poor quality of, health care for persons with



◀ Figure 3: Interaction of barriers to inclusion in health

disabilities.⁴⁶ **Figure 3** (page 37) illustrates the interaction of some of the barriers that persons with disabilities face in accessing health care.

3.3.1 Inaccessible health care facilities and lack of accommodations

The inaccessibility of health care facilities and lack of accommodations may prevent women, men, girls, and boys with disabilities from seeking or receiving needed health services. Obstacles such as the lack of ramps, internal steps, poor signage, narrow doorways, and inadequate toilet facilities make it difficult for persons with disabilities to access

Box 7: WHO global disability action plan 2014–2021⁴⁷

All member states of the WHO are encouraged to implement the action plan in their national health policies and plans. The key objectives are to:

1. remove barriers and improve access to health services and programmes for persons with disabilities;
2. strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
3. strengthen the collection of relevant and internationally comparable data on disability and support research on disability and related services.

facilities.⁴⁸ Similarly, medical equipment is not always adapted so that it can be used by persons with disabilities; for example, examination tables that are not height-adjustable make it difficult to accommodate those with mobility limitations.

The absence of information provided in alternative formats can hinder the delivery of needed services, particularly for individuals with sensory or intellectual impairments.⁴⁹ Alternative forms of delivering information

include sign language, braille, and audio-visual and pictorial forms. When medical staff and persons with disabilities are unable to discuss important information—such as medical history, explanations of diagnoses, prevention strategies, treatment plans, and recommendations for follow-up—care may not be appropriate, timely, or of high quality.⁵¹

Finally, the lack of affordable and accessible transportation to and from health care facilities may prevent persons with disabilities from seeking treatment.⁵² Since most health facilities in low- and middle-income countries are located in towns or cities,⁵³ persons with disabilities from rural areas face even greater difficulties in accessing services. **Box 8** (page 38) summarises some of these barriers and difficulties.

3.3.2 Attitudinal barriers

Negative attitudes or misconception around disability among local authorities, health managers, health professionals, and family and community members may hinder persons with disabilities from seeking health care. For example, the belief that disability is caused by sin or witchcraft may prevent families from pursuing conventional medical treatment or rehabilitation.⁵⁴ Similarly, signs of an illness may be mistakenly viewed as disability related, leading to potentially life-threatening delays in seeking treatment.⁵⁵ Furthermore, for households living in poverty, spending money on health services for a child with a disability may be considered economically irresponsible, as that child would be seen as unlikely to provide for the family in the future.⁵⁶

Box 8: Inequalities in accessing health care for persons with disabilities

The WHO's World Health Survey of 2002–2004, which drew data from over 50 countries, provides valuable insight into differences in the utilisation of health care between persons with and without disabilities.⁵⁰

The survey found that, although persons with disabilities reported that they needed and attempted to seek care more often than persons without disabilities, they were less likely to receive adequate health services.

The main reason for lack of care was cost, where more than 60 % of persons with disabilities who reported not receiving care responded that they could not afford the cost of the consultation or hospital visit, while 30 % could not afford transport to health facilities. Although individuals without disabilities also reported cost as a barrier, persons with disabilities were significantly more likely to face these challenges.

Compared to persons without disabilities, persons with disabilities were two to four times more likely to report that negative attitudes of health care providers resulted in them not receiving needed health care.

Even when persons with disabilities do seek care, the beliefs and attitudes of health care workers may lead to poor provision of services. Health care providers may incorrectly assume that persons with disabilities do not need certain services; for example, the commonly-held – but erroneous – belief that persons with disabilities are not sexually active or able to procreate leads to the exclusion of women and girls with disabilities from sexual and reproductive health care.⁵⁷

3.3.3 Financial barriers

One of the main reasons persons with disabilities do not access health care is that the services – as well as associated costs such as transportation, medications, and lost income from missed work – are unaffordable.⁵⁸

Some studies suggest that persons with disabilities pay more for services than persons without disabilities. For example, persons with disabilities in low- and middle-income countries may be less likely to access subsidies for health care, compared to persons without disabilities.⁵⁹

In Vietnam, up to 80 % of eligible individuals with disabilities were not enrolled in health insurance programmes.⁶⁰ Furthermore, even when accessing health insurance, plans may not cover all medical needs, such as rehabilitation and specialised health services, which persons with disabilities are more likely to require.⁶¹

3.3.4 Policy barriers

Programmes and services targeted towards the specific health needs of persons with disabilities are often overlooked as policy priori-



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◀ Jan's family could not afford to treat the cataract that he developed as a young child. After the intervention of one of CBM's partners in Cambodia, the boy (centre) is walking home with his family after a successful surgery.

ties. For example, because of the lack of investment in and planning for rehabilitation services, only 5–15 % of persons with disabilities in low- and middle-income countries receive assistive devices that could greatly improve their level of functioning.⁶² Similarly, health service planning and budgeting for mental health conditions is severely lacking relative to need (**Box 9**, page 40).

Additionally, some laws and policies restrict the freedom of persons with disabilities from making decisions about their own health. Laws on legal capacity in many countries

Box 9: Mental health services: An overlooked urgency

Although mental health conditions account for over 10 % of the global burden of disease,⁶³ governments fail to prioritise spending on essential services: on average, national health budgets only allocate approximately 0.5 % in low-income countries, 2 % in middle-income countries, and 5 % in high-income countries for mental health services.⁶⁴

This lack of investment has serious consequences for individuals with psychosocial disabilities. In a study of seven low- and middle-income countries, only 2–15 % of persons with psychosocial disabilities had received treatment in the previous year.⁶⁵ Of the small proportion accessing services, 75 % received treatment that did not meet a standard that was even minimally adequate.⁶⁶

operate under the assumption that persons with certain impairments automatically lack the ability to make their own choices and, thus, transfer that decision-making power to guardians.⁶⁷ Often, there are few or no mechanisms in place for persons with disabilities to appeal this injustice or have supported decision-making to make their own choices and judgments about their health care.⁶⁸

3.4 Costs of exclusion and gains of inclusion

This section explores some of the pathways through which exclusion from the health care can generate economic costs and how more inclusive approaches can lead to potential economic gains.

3.4.1 Spiralling medical costs and the poverty cycle

The World report on disability presents evidence that, as a group, persons with disabilities have poorer overall health statuses and greater health care needs, compared to the general population. This is explained in more depth in **Box 10** (page 41).

With greater health care needs come additional medical expenses: in many low- and middle-income countries, households with a member with a disability spend 15 % of their budget on health care—over one third more than other households.⁶⁹ Given that persons with disabilities are also more likely to live in poverty (see Chapter 2), these expenses can place significant burdens on already constrained household budgets. Challenges in meeting these payments may then prevent or delay persons from seeking health care. Even when care is sought, persons with disabilities may not receive appropriate and comprehensive health assessments, leading to inadequate or delayed treatment and further expenses.⁷⁰

Over the long-term, deteriorating health—including the development of additional health conditions—and the resulting coping strategies may push individuals and their households deeper into poverty. Compared to persons without disabilities, persons with disabilities are more likely to finance their medical treatment by selling assets (for example, land or livestock), taking out loans, or cutting back on consumption of essentials such as food.⁷¹ These decisions, while often the only options, deplete households of important resources that could be used to invest

► Thanks to early intervention, Keo's club-feet will be gently straightened. With regular physiotherapy, provided by CBM's partner in Cambodia, he will be able to walk better.

in education, farming, starting small businesses, and other activities that strengthen livelihoods.⁷²

Access to health insurance has been promoted as part of universal health coverage as a strategy for preventing individuals and



©CBM

Box 10: Health and health care needs of persons with disabilities⁷³

The health and health care needs of persons with disabilities vary widely: some might experience poor health and have high health care needs, while others are in good health with few difficulties and special needs.

Still, as a group, persons with disabilities usually rate their health statuses as being lower, and express greater health care needs, than persons without disabilities. Besides treatment and rehabilitation that may be required for their specific impairments, women, men, girls, and boys with disabilities are often at higher risk of developing additional conditions that may lower functioning and decrease quality of life. For example, depression tends to be more common among persons with disabilities, and individuals with schizophrenia are five times more likely to have diabetes compared to the general population.

Some of these conditions may be linked directly to the impairment while others are less directly

related. For example, persons with disabilities have higher rates of risky behaviours, such as smoking, sedentary lifestyles, or alcohol abuse that can lead to poor health. Additionally, women with disabilities are much more likely to experience violence – particularly sexual violence and abuse – than women without disabilities. This can result in immediate and long-term mental and physical health problems. Persons with disabilities may also experience worse health outcomes due to ‘diagnostic overshadowing’ – the tendency for health professionals to attribute complaints or symptoms of an unrelated illness to a person’s disability.

The combination of these factors often leads to poorer levels of health for persons with disabilities. Often overall health can be improved through proper management of the initial impairment and regular access to health services, including public health programmes and rehabilitation.

Box 11: Costs of prevention versus treatment: The case of HIV

In low- and middle-income countries, treating HIV costs about USD \$ 8,900 per person on medicines alone over the life-course, compared to USD \$ 11 to prevent one case.⁷⁴ However, persons with disabilities are often excluded from sexual and reproductive health programmes.⁷⁵ Furthermore, persons with disabilities – particularly women and girls – are more likely to experience sexual violence.⁷⁶ Consequently, there is some evidence that persons with disabilities are at an increased risk of contracting HIV compared to the general population.⁷⁷ Greater inclusion in preventative programmes could, therefore, produce significant savings, not only from treatment costs but also in lives spared from debilitating disease.

their households from falling into poverty as a result of medical expenses.⁷⁸ While there are some very successful experiences, often failure to consider the health needs of persons with disabilities when designing insurance schemes has created health and wealth inequalities between recipients with and without disabilities. For example, in Vietnam, insurance recipients with disabilities spent four times more on health care, as items such as specialised services or transport were not covered in their plans.⁷⁹ Consequently, insurance recipients with disabilities were at increased risk of poverty compared to other insured groups.⁸⁰ Similarly, in China, health insurance recipients with disabilities reported that only 18 % of their medical expenses were covered, leading to high unmet medi-

cal or rehabilitation needs and out-of-pocket spending.⁸¹

Failure of governments to provide disability-inclusive health care that is affordable for all leads to substantial costs for persons with disabilities and their families. Ultimately, it also brings costs to society as a whole. As health care systems are at least partially financed by governments, some of the rising costs associated with deteriorating health and the development of additional conditions may be felt in health sector budgets.⁸² Additionally, when women, men, girls, and boys with disabilities and their households struggle with overwhelming medical expenses, which can push them into poverty, they may then become reliant on social assistance and other poverty alleviation programmes.

3.4.2 Impact of exclusion on public health interventions

Many public health interventions need widespread participation in order to be successful. Therefore, programmes that do not include persons with disabilities can result in poorer health outcomes for entire communities. For example, disease prevention initiatives – such as vaccinations, clean water, sanitation, and hygiene projects – need high coverage to stop infections from spreading.⁸³ Similarly, when pregnant women with disabilities are not included in nutrition programmes, their babies may experience negative health consequences.⁸⁴

Treating preventable diseases and coping with their long-term consequences bring costs for affected individuals and their households, and for health sector budgets. However, as

spending on prevention is often less than the long-term costs of treatment, significant savings could be realised with greater inclusion of persons with disabilities in public health programmes. **Box 11** (page 42) uses the treatment of HIV to illustrate this point.

Inadequate efforts in considering persons with disabilities in the planning, implementation, and evaluation of public health interventions likely obstructs programme goals and leads to inefficient spending. For all these examples – though adaptations to make programmes accessible will have some additional costs – in the long-term, the savings from improved individual and population health will likely more than offset the initial investment. **Figure 4** (page 44) summarises possible economic gains that inclusive health care can bring to individuals and society.

3.4.3 Impact of inclusive health on society

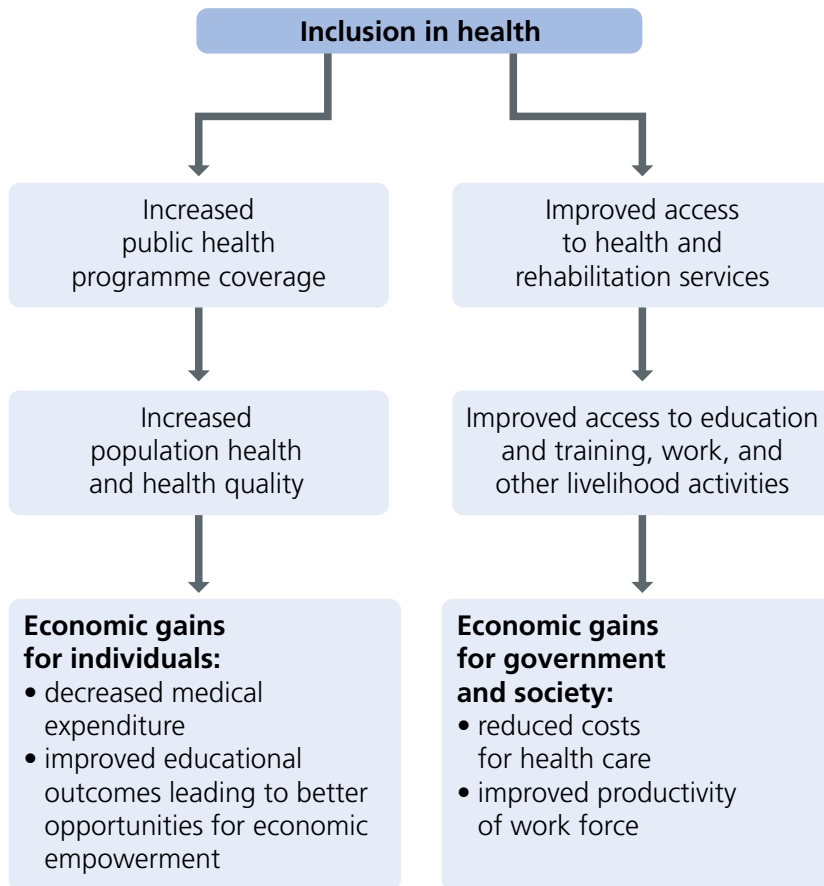
Poor health can be a barrier to participation in social and economic life. By making health policies and services disability-inclusive, improvements in the health of persons with disabilities can increase their participation in training and education and increase opportunities for work. As explained in Chapters 4 (Education) and 5 (Work and Livelihood), greater inclusion of persons with disabilities in these areas could lead to substantial individual and household gains, and even societal economic gains.

Looking first at education, poor health can affect children's access to school and learning.⁸⁵ For example, episodes of illness



and the need for ongoing treatments can cause students to miss school. Frequent absences may then lead to poor performance, grade repetitions, and even dropouts.⁸⁶ Additionally, conditions such as malnutrition, intestinal worms, HIV, and malaria can impact a child's cognitive development and ability to learn.⁸⁷ Since girls and boys with disabilities are more likely to face barriers in receiving timely, appropriate, and affordable care, they may also face inequalities in education due to poor health. As described in Chapter 4, exclusion from education can then lead to a range of individual and societal costs, including limited opportunities for work and livelihood development. However, these costs may be reversed through inclusive

▲ Keder Ejigu (centre, in the back), the district's trachoma officer from the Amhara Trachoma Control Program, conducts health education in a village in the Amhara region in Ethiopia.



▲ Figure 4: Economic gains of inclusion in health care

health: for example, a study based 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 these supports.⁸⁸

Along with the indirect influences of health on education, poor health in adulthood can directly affect work and livelihoods. Illnesses cause absences from work and lower productivity on the job.⁸⁹ If poor

health is persistent, individuals may be fired, forced to cut-down hours, or stop working altogether.⁹⁰ Other household members also often forgo work and earnings in order to care for sick relatives. Finally, as previously mentioned, high costs of health care often cut into household savings, limiting investments in livelihoods that could help households escape poverty.⁹¹

The economic impact of health on work can be substantial. In addition to the influence on individual and household livelihoods, national economies may also be affected. Studies have found that countries with healthier populations have more productive workforces.⁹² Ensuring that persons with disabilities have access to health and rehabilitative services can improve their wellbeing and functioning, leading to increased productivity and economic gains. For example, persons with schizophrenia in China who received individualised family-based interventions (consisting of counselling and drug supervision) worked 2.6 months more annually than those who did not receive such treatments.⁹³ Comparing the costs of providing the intervention to the gains in increased income and reduced hospital costs, this program netted savings of USD \$ 149 per family treated. As the productivity of the workforce is important for economic development, improving the overall health of populations, including persons with disabilities, can promote national level gains.

Grace's story illustrates how appropriate care and treatment leads not only to improved health but also to greater social and economic participation (see following story).

Grace's story, Ghana

My Name is Grace. I am 52 years old, and I am a teacher for nursery level children. I was married and have two children. My children are 18 and 25, the boy is 25 and the girl is 18 years.

I had completed the training college and I was teaching when, in 1992, my husband died. It gave me great frustration and pain, I couldn't bear it.

Sometimes I would reflect about my husband. I would say, "Life is miserable", so at that time, I gave up. Sometimes I didn't even want to dress. I would eat and go to sleep. I was at my father's house, but my father could not approach me, because it was my father who told me that my husband had died.

Whenever I saw my father, all the pain of when I heard of my husband's death would rise up. I even collapsed and fainted. I suffered. **I was miserable for almost a year.** I was beating my father in grief and pain. So they pegged me and they locked me up in my home, in my father's house.

By the grace of God, Sandema CBR people came to me and talked to my brothers and my father. So they released me and they took me to hospital and I was admitted there for seven days. A nurse came and injected me. When I took the drugs it would make me sleepy so that I would not disturb; I would have peace, no problems. I would be weak, but I would be asleep and not have any problem, because I had no control of myself.

After a week they discharged me. So the nurses were giving me medication and I was

OK. The nurses come to our place counseling me. While I am taking the drugs, I feel like [the pain] is calming down, gradually.

I started distance learning for a diploma in basic education. I did pupil teaching, but because of my mental health problem they put me at the nursery level. **I continued studying and I completed a postdiploma degree.**

▼ Grace, surrounded by a group of her pupils. After receiving psycho-social support from the Sandema CBR programme, she is again working as a teacher.



Then I got back to school and they asked me to play with the children. I am now a teacher again. I teach English, maths, creative music and dance, and physical development.

I am managing OK. When I began receiving my salary, I started buying cement to build my house, bit by bit. I rent rooms to

people to increase my income. When my husband died, I only wanted to be in the home. That is how I was. The medication has transformed me. I could feel my senses coming back. **I realised I was not the only person whose husband had died. Now I am better.**

Source: www.endthecycle.org.au/stories/grace

Key learning points

- The right to health for persons with disabilities is protected by a number of international treaties, including Article 25 of the CRPD that clarifies the right to health for women, men, girls, and boys with disabilities and identifies key areas for implementation.
- Persons with disabilities face barriers in seeking and receiving health care, such as inaccessible health care facilities and transportation, lack of adaptations, lack of accessible modes of communication and information, and prejudice and misconceptions. The high cost of quality health care is one of the most important barriers for persons with disabilities.
- When persons with disabilities are not included in health care, they may experience continuously poor or worsening health – including the development of additional impairments. Making health care inclusive can prevent individuals and their households from falling into poverty due to spiralling medical and other costs.
- Treating preventable conditions and their long-term consequences brings costs for affected individuals, their households, and governments. However, as prevention is often substantially less costly than treatment, making public health programmes disability-inclusive can lead to savings.
- Improving the health of persons with disabilities through greater access to both general and disability-specific health care can lead to increased participation in areas such as education and work and livelihood.
- Investing in inclusive health care can bring about economic gains for governments and societies as a whole through improved population health, higher workforce productivity, and more efficient government spending on health care, social assistance, and other programmes.

3.5 Examples of inclusion

This chapter concludes with some examples of how health care has been made accessible and inclusive for persons with disabilities and with an interview with two of CBM's staff members who work on inclusive eye health, some of which is funded by the Australian development cooperation. It also includes an example of the work of one of CBM's partners in Tanzania of providing access to maternal health services for women with disabilities supported by the European Union (EU).

CBM's inclusive eye health programme

Dr Babar Qureshi, CBM's senior adviser for eye health, and David Lewis, strategic programmes director with CBM Australia, discuss why inclusive eye health is important for women, men, girls, and boys with disabilities and how CBM, with donor funding from Australia and other countries, has been supporting it.

Why is inclusive eye health important for persons with disabilities and why is CBM involved?

David: CBM became involved in inclusive eye health care for two reasons. First, persons with disabilities are estimated to make up 20 % of the world's poorest people and eye health care service providers working in many of these countries need to ensure that their services are accessible for and inclusive of everyone. Second, at least 20 % of per-

sons who are blind or have severe vision loss cannot have their sight restored and they have the right to be linked with other services, such as education and community-based rehabilitation. During my years working in the field, I have witnessed on a number of occasions the difficulties persons with disabilities face in accessing eye health services, for example, inaccessible clinics and facilities. Many people with permanent vision loss have not received counselling or referral to wider opportunities, so it was important for us to see how practices could be strengthened.

How did the Australian government become involved in inclusive eye health as a donor?

David: As a result of intensive advocacy by Vision 2020 Australia⁹⁴, of which CBM Australia is a member, the then-parliamentary secretary for international development assistance took up the issue of disability-

► These guidelines on how to set up and implement inclusive eye health programmes are available at www.cbm.org/article/downloads/54741/Inclusion_in_Eye_Health_Guide.pdf



► A patient having a check-up before undergoing cataract surgery at the out-patient eye clinic in Battagram, Pakistan.



© CBM/argum/Einberger

inclusion as an important part of the Australian development aid programme. In the 2008–2009 budget, the Australian government gave AUD \$ 45 million over three years to fight avoidable blindness and put in place a disability-inclusive development strategy. CBM was able to use some of those funds to develop and test practices in inclusive eye health.

Can you give some examples of activities that fall within the inclusive eye health programme?

Babar: There are a number of levels to it, such as working with:

- **Partners.** We sensitised our partners to the fact that eye health services should become inclusive of persons with disabilities. For example, we held workshops to discuss with our health partners how to implement inclusive practices in their projects and programmes.
- **Local and national governments.** We advocated and worked with government officials on inclusive eye health. While sensitising partners is important, it is equally important to combine that work with national actions and policy work, for example, partnering with the Ministry of Health and other high-level officials on eye care. This has a much wider impact, as eye care services will become inclusive across the country and this encourages other sectors in health care to adopt similar actions and policies.
- **Professionals.** CBM is working with the International Council of Ophthalmology to make the curriculum for ophthalmologists

inclusive of disability rights. This will ensure that ophthalmologists are trained to be aware of disability-inclusive eye health practices.

Can you give examples of successes with your work on inclusive eye health?

Babar: In Pakistan, we have been addressing inclusive eye health from two perspectives, working with our partners and focusing on Pakistan's national eye care programme. With our partners, we only have limited reach. However, with the national programme, every single district of Pakistan can be reached. The government may work slowly, but the infrastructure is much bigger and so the impact will be much larger and more sustainable. We engaged in a lot of advocacy with the government of Pakistan and now a national committee has appointed a task force that will work on recommendations for the government to step-by-step ensure that eye health is inclusive of persons with disabilities throughout all districts in Pakistan. As well, the task force will consider the budgetary requirements.

David: Another example to show inclusive eye care in practice is the work at an eye hospital in Cambodia. The staff implemented a 'design for all' approach and looked at ways to reduce not only the physical barriers but also the social and economic barriers for everybody, regardless of age and ability. The hospital now has an accessible building, the staff is trained in disability-inclusion with a broad network of services for two-way referrals, and training resources have been

developed. The hospital has also developed a computerised health information system with data collection on self-reported disabilities. In addition, the eye hospital successfully advocated for a disability-inclusion training module in the curriculum of the national eye health programme.

Inclusive maternal and newborn health care programme in Tanzania

In 2010, CBM's partner, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), in partnership with the regional health management team, planned and implemented a comprehensive, community-based maternal and new-born capacity-building programme to:

- improve the quality of emergency obstetric and new-born care;
- promote friendly care for pregnant women with disabilities;
- prevent obstetric fistula and promote early identification of birth impairments; and
- identify and refer children with birth impairments.

In this interview, Dr Brenda Dmello and Fredrick Msigallah, from CCBRT, discuss the key elements of the programme, which includes awareness raising, providing accessible and inclusive services, and building capacity.

Can you explain the community awareness raising part of the programme?

Brenda: A big part of raising community awareness involved training numerous



▲ A woman is recovering from a fistula operation at the CCBRT hospital.

groups on disability. These groups included 600 community health workers based in different municipalities, including in Dar es Salaam, where there are three municipalities and each one has over 200 community health workers. In addition, 91 community leaders from different villages and sectors of the area participated. The main barrier we found to inclusion was actually the lack of understanding of disability. However, once we started to discuss disability and inclusion with the health care workers, there was no resistance and they were very open to it.

Fredrick: Members of the governing boards of each health care facility and politicians who were responsible for implementing health plans and budgets also received training. It was very important for us to make sure politicians understand the importance

of disability-inclusive maternal health because they make the decisions to allocate budgetary resources. The content of the training included how to use appropriate language on disability-inclusion, how to recognise barriers to inclusion for persons with disabilities, and identifying which laws provide protection. Attitudes were measured at the beginning and the end of the training and an improvement was seen.

Can you outline the steps taken to ensure that women with disabilities were able to access the services?

Brenda: A second aspect of the programme was meeting the maternal health needs of women with disabilities. This meant creating or adapting clinics so women with disabilities could access them, providing communication support and staff training in sign language. A more flexible service was also provided so that women with disabilities were allowed to keep their support persons or family members with them during breastfeeding. Usually the procedures in the clinics are for women who are on their own; for women with disabilities, their support persons are allowed to stay with them if they require assistance.

How important is it to work with government to build capacity?

Brenda: The CCBRT maternal health program works in close partnership with local governments at the regional and municipal levels, from planning to joint implementation of every activity. The program currently offers support to 22 public maternity units.

Chapter 4

Education

“Governments need to recognise that spending large amounts of money initially on system reform such as teacher and staff training, improving infrastructure, and revising curricula, learning materials, and equipment that meet the needs of inclusive education will be the most efficient use of funds, as it has the potential to lead to an improved education for all students”.

UNICEF (2012)



4.1 Introduction

Chapter 4 highlights the costs of excluding persons with disabilities from education and the potential gains of inclusion. First, it presents an overview of the obligation of governments and development stakeholders under international law to ensure the right to education for persons with disabilities. Second, it reviews some of the barriers that may prevent women, men, girls, and boys with disabilities from accessing and progressing through school. Third, it discusses how the widespread exclusion of persons with disabilities from education results in a range of economic costs and how inclusion can reverse these losses and lead to gains. Finally, it explores examples of programmes and policies supporting inclusive education and

▼ Young learners march for the right to inclusive education for all children in Bangladesh.



shows how they are leading to both financial and non-financial benefits for persons with disabilities, their families, and societies as a whole.

4.2 International legal frameworks

The right to education is a human right recognised by a number of international treaties. The ICESCR “recognises the right of everyone to education” and that education “shall be directed to the full development of the human personality and the sense of its dignity”.⁹⁵

The right to education is further clarified in the:

- Convention on the Rights of the Child, Articles 28 and 29;
- Convention on the Elimination of All Forms of Discrimination against Women, Article 10; and
- Convention on the Rights of Persons with Disabilities, Article 24.

It is always the obligation of national governments as duty bearers to ensure that children have access to quality education. International cooperation plays an important role in supporting governments of low- and middle-income countries in creating the infrastructure and developing the capacities needed.⁹⁶ Section 4.5 of this chapter highlights some examples of this support.

4.2.1 Key features of the right to education

The implementation of the right to education can vary among states, depending on the economic and political circumstances.

However, there are a number of essential, interrelated features:

- **Availability:** Governments must ensure that schools and other educational institutions and programmes are available close to where people live. They must also include the relevant services for the schools to function (such as water and sanitation services) and a management structure for the educational system, including the recruitment and continuous training of teachers.
- **Accessibility:** Governments must ensure that educational institutions do not discriminate against potential students; that education is provided within safe physical reach, either at a near location or through modern technology; and that it is economically accessible. Primary education must be available and free to all and secondary and tertiary education must be affordable.
- **Acceptability:** Curriculum and teaching methods must be culturally appropriate and of good quality.
- **Adaptability:** Education must be flexible so that it can be adapted to the needs of changing societies and communities and responsive to students within their diverse social and cultural settings.⁹⁷

4.2.2 Persons with disabilities and the right to education

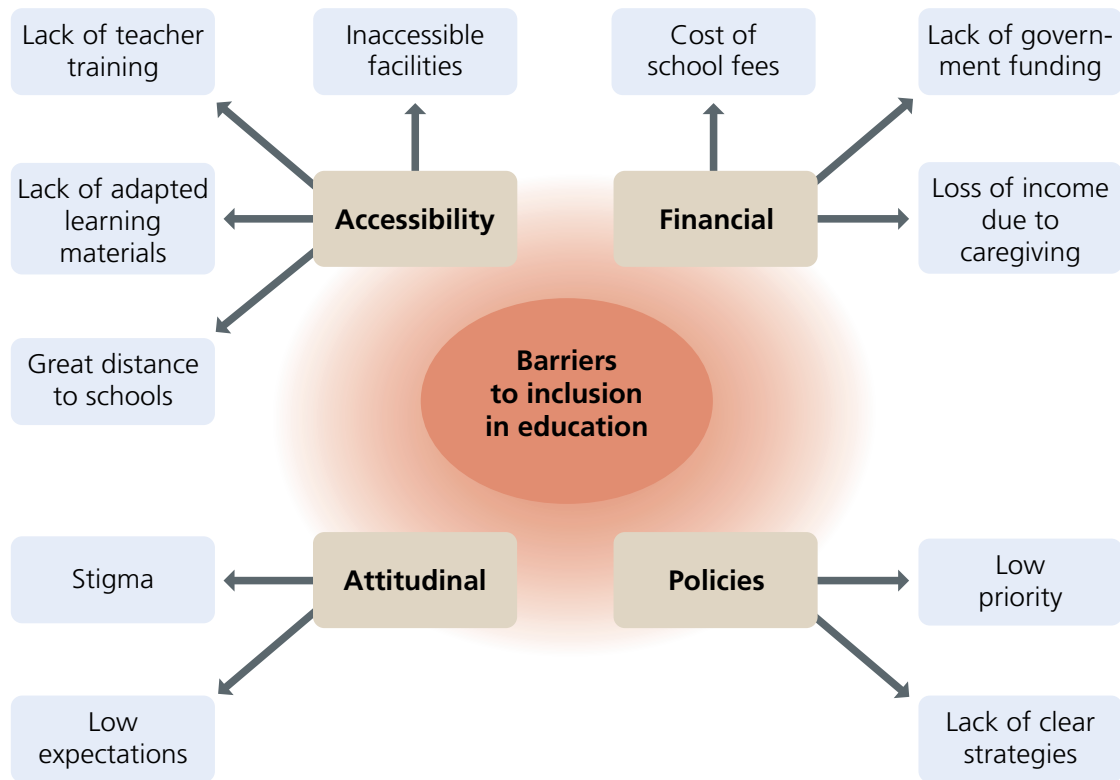
Article 24 of the CRPD further clarifies the rights of women, men, girls, and boys with disabilities to education and identifies a number of areas for implementation:

- **Non-discrimination on the basis of disability:** Children with disabilities must not be excluded from the general education

system. They should be entitled to free and compulsory primary education and to an affordable secondary education. Persons with disabilities should also be able to access general tertiary education, vocational training, adult education, and lifelong learning on an equal basis with others.

- **Accessibility:** Girls and boys with disabilities must be able to access quality and free primary and secondary education on an equal basis with others in the communities in which they live.
- **Reasonable accommodation:** Persons with disabilities might require appropriate adjustments to accommodate their needs so they can access education on an equal basis with others.
- **Individual support:** Persons with disabilities must have access to individualised support to ensure that they are able to maximise their academic and social development. This might include sign language interpreters, having access to the school curriculum and learning material in alternative formats such as braille, and personal assistance during school hours.
- **Development of skills for life and social development:** Persons with disabilities must have access to different forms of communication, skills development, and other support, where needed. This might include braille or accessible computer software; augmentative and alternative modes of learning, communication, and mobility skills; peer support and mentoring; bilingual environments to enable the learning of sign language; and the promotion of the linguistic identity of the deaf community.⁹⁸

► Figure 5: Interaction of barriers to inclusion in education



4.3 Barriers to inclusion

Girls and boys with disabilities are much less likely to attend school compared to children without disabilities and girls with disabilities have even lower participation rates than boys with disabilities.⁹⁹ Figures from the World report on disability show that 50.6 % of boys with disabilities have completed primary school compared to 61.3 % of boys without disabilities. For girls with disabilities, the data shows that only 41.7 % completed primary school compared to 52.9 % of girls without disabilities.¹⁰⁰ Furthermore, even when they do enrol, girls and boys with disabilities com-

plete fewer years of school and have higher dropout rates than their peers without disabilities.¹⁰¹ A variety of barriers (summarised in **Figure 5**, page 54) may prevent children with disabilities from attending and progressing through school. It is important to understand how these barriers interact in order to identify ways to promote inclusion of girls and boys with disabilities in education and training.

While in general data on attendance rates and educational outcomes of girls and boys with disabilities is lacking, **Box 12** (page 55) highlights some of the available statistics.

4.3.1 Inaccessible schools

When schools are not adapted to accommodate the needs of all children, children with disabilities' ability to get to and learn in schools will be limited. A number of elements can make schools inaccessible to children with disabilities:

- **The built environment** of many schools presents difficulties for girls and boys with disabilities to access them and to move around inside. Narrow doorways, lack of ramps, and inadequate toilet facilities are examples of such barriers.
- **The lack of adapted teaching methods and materials** excludes many girls and

boys with disabilities from learning. If they are not taught using methods they can follow and understand – for example, with braille text or sign language instruction – these children will be unable to participate in the learning process. Furthermore, there is a need for adapted curriculum, particularly for children with intellectual impairments, who may learn in different ways or at different paces.

- Even when the built and teaching environments of schools are accessible, if they are **far away from where people live and lack transportation links**, many children with disabilities will be unable to attend.

Box 12: Education statistics for girls and boys with disabilities

- In a study across 30 countries, children with disabilities were on average 10 times less likely to go to school compared to those without disabilities.¹⁰²
- In Malawi, Namibia, Zambia, and Zimbabwe household data shows that between 9–18 % of children five years or older without a disability had never attended school. For girls and boys with disabilities, the rate was between 24–39 %.¹⁰³
- In Bolivia, it is estimated that 95 % of children between six and 11 years old are in school, while only 38 % of children with disabilities of the same age group attend school.¹⁰⁴
- In Bulgaria, Moldova, and Romania enrolment rates for seven- to 15-year-olds were above 90 % in each of the countries. For children with disabilities of the same age group, these rates were 81 %, 58 %, and 59 %, respectively.¹⁰⁵
- In Tanzania, girls and boys with disabilities who attended primary school progressed to higher levels of education at only half the rate of children without disabilities.¹⁰⁶
- In Nepal, almost 6 % of school-aged children are not in school. Of these, an estimated 85 % are girls and boys with disabilities.¹⁰⁷



▲ Eti, who uses a wheelchair, is now attending school thanks to local organisation, GUK, convincing the school to admit her.

Eti, from Bangladesh, tells her story about her struggle to access education.

Eti's story, Bangladesh

My name is Eti. I am 14 years old and I live in Bangladesh. From when I was six years old I have had rheumatoid arthritis in my body. All my joints were swelling.

I had serious pain; no one could touch my legs or joints because they were so painful. We tried treatment in different places but all was in vain. My life changed from that time. For the next year I was just staying at home.

I was supposed to be in school. My parents tried to enrol me but no school would accept me. They said I needed to go to a special school for children with a disability.

That school was far away from home, so it was not possible for me to go there. Staying home was my only option. At that time I was very sad. I felt that everybody else had the opportunity to get an education but it was not possible for me. I cried at my home.

Then I came into contact with the local organisation GUK and they wanted to know my story. They provided me with therapy and a wheelchair, so it is easier for me to get around. They also said that they would try to admit me into the school. At first the school still said it was not possible for me to enrol in school because of my mobility problem. But the GUK people talked with them and convinced them, and that very day they had to admit me.

When I was admitted into primary school there was no ramp. But as I continued, they built a ramp and it was easier for me to access the classroom. Now that I am in high school there is no ramp in the school. My friends carry me with the wheelchair to get onto the landing.

My favourite subject is English. At the moment, I am facing a problem with my education. My primary school was near my home, and it was easy for me to go to school. But now my school is a little bit far away, my parents or my friends have to push me in my wheelchair. If they are not available then I have to take a rickshaw. But this is not always possible, so now I miss my school more than before. I feel bad about this as everybody else is able to attend school but I am not always going.

I am an active member of a Local Ambassador Group. I like the group because once

every month we gather together. We also talk about many topics, especially our rights, and I like this very much. If any of the group members or other people with disabilities face problems, we go together to solve these. For example, if someone is having trouble getting loans or other services provided by the government through the social service department, we go to the officials to discuss. Source: www.endthecycle.org.au/stories/eti

4.3.2 Attitudinal barriers

Misconceptions and negative attitudes may prevent persons with disabilities from accessing their right to equal opportunities for education.

One common barrier is low expectations. Teachers, parents, and peers often underestimate the abilities of persons with disabilities to learn; these attitudes can then be internalised by children with disabilities, leading to low self-esteem about what they can achieve.¹⁰⁸ If families and teachers do not see the benefits of educating girls and boys with disabilities, children may then be discouraged from attending school or progressing through to higher levels of education. Additionally, teachers sometimes feel they lack the time, abilities, and resources to teach students with disabilities and fear that including them in mainstream classrooms will slow down the progress of the rest of the class.¹⁰⁹

Finally, there is increasing evidence that children with disabilities face frequent bullying, mistreatment, and even violence by teachers and peers alike.¹¹⁰ This abuse not

only affects self-esteem, but also hinders learning and can compel children to drop-out.¹¹¹ Parents may also be reluctant to send their children with disabilities to school if they fear they will be mistreated there.¹¹²

4.3.3 Financial barriers

In many low- and middle-income countries, funding for even the most basic education often faces severe shortfalls. Consequently, governments often make the argument that they lack the resources for inclusive education. Additionally, governments may



◀ Converting school material into braille is key for blind students so that they are able to follow along with their classmates.

► Thanks to his tri-cycle, Isa Mohamed (boy sitting at the window) from Nigeria can commute to school.



be reluctant to spend on education for children with disabilities if they do not think it will be a worthwhile investment.¹¹³

If inclusive education is not provided free or at an affordable cost at the national level, the responsibility for payment falls to families. Costs of tuition at special schools or buying accessible teaching materials are prohibitive for most families.¹¹⁴ Additionally, if parents must forgo work to bring their children with disabilities to and from school, it may be financially difficult to keep their children in school.

4.3.4 Policy barriers

In many countries, education for children with disabilities is managed by the Ministry of Social Welfare rather than the Ministry of Education – if seen as a government responsibil-

ity at all.¹¹⁵ This division increases exclusion and de-prioritises educational needs of girls and boys with disabilities.

International and national education policies often have detailed strategies, targets, and incentives for increasing enrolment, attendance, and achievement of all school-aged children. However, plans or measures for promoting the inclusion of children with disabilities in the educational system are seldom explicitly described.¹¹⁶

Additionally, as national figures on education are rarely disaggregated by disability, it is difficult to identify inequalities and track progress over time. Without clear strategies that include measurable and monitored aims and objectives, quality inclusive education for girls and boys with disabilities is likely to be neglected.

4.4 Costs of exclusion and gains of inclusion

The exclusion of children with disabilities from education has negative impacts on their families, communities, and even societies as a whole. This section explores some of the pathways through which disability-inclusive approaches can lead to economic gains.

4.4.1 Impact on work and livelihoods

Education is not only a right guaranteed to all children, but is also one of the greatest tools for reducing poverty and promoting sustainable development.¹¹⁷ Though education can produce a wide range of benefits, its impact on work and livelihood is the most widely recognised.

First, at an individual level, education and training can increase opportunities for employment, higher wages, and more sustainable livelihoods. In addition to teaching important technical skills, such as literacy and numeracy, schools are important settings where children can develop social skills, create networks, and learn to work with others. The creation of these social and practical skills can in turn lead to greater engagement in and productivity at work or other income-generating activities. Across countries, adults who attended school are more likely to be employed and to have higher incomes than those who did not. Estimates from general population studies indicate that each additional year of schooling increases a person's earnings by 10%.¹¹⁸

Second, improving access to education for persons with disabilities may reduce pov-

erty for their households. With increased opportunities for employment and other income-generating activities, persons with disabilities may become increasingly economically self-sufficient and may be able to contribute more financially to the household economy. **Box 13** (page 60) presents evidence from studies on the poverty alleviation potential of education among persons with disabilities.

Third, excluding persons with disabilities from education may perpetuate low education and poverty for future generations. One study in Vietnam found that children of parents with disabilities were less likely to attend school compared to children of parents without disabilities.¹¹⁹ One explanation

▼ 22-year-old Amjad Hossain lost both his lower legs when the Rana Plaza building collapsed in Dhaka, Bangladesh. He was forced to stop working as a mechanic and is now doing an apprenticeship as an electronic technician at the Centre for Rehabilitation of the Paralyzed.



© CBM/argum/Emberger

for this difference was the lower education and income levels of the parents with disabilities.

Fourth, many social assistance and welfare programmes – particularly cash transfers – increasingly require that recipients fulfil certain conditions in order to receive benefits. As these conditions are meant to tackle the drivers of poverty, enrolment of children in primary school is a common requirement for participation. However, if schools are not inclusive, families with children with disabilities may be excluded from programmes that have proven successful in reducing poverty.

Finally, other family members may have to forgo opportunities for employment or schooling to take care of a child with a dis-

ability. Often, the responsibility for caregiving falls to women and girls, which may contribute to gender inequalities in both school and work.

4.4.2 Impact of inclusive education on society

Education can also have a range of positive impacts in areas such as public health, empowerment of women, and social participation. These impacts not only have positive social impacts, but also economic gains, as illustrated in **Figure 6** (page 61).

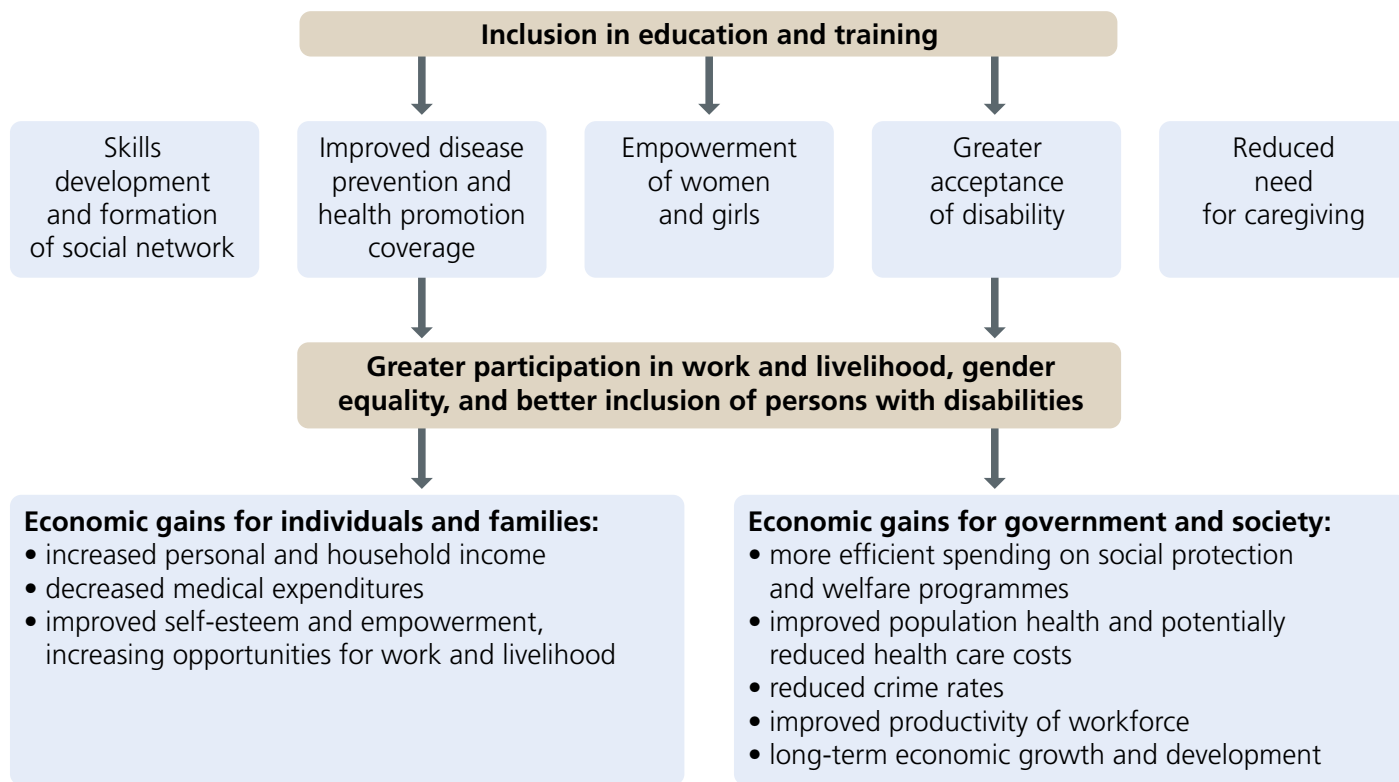
First, public health campaigns and other development initiatives often use schools as their point of delivery, especially if children are the target population. Some examples of programmes commonly implemented in schools include treatment campaigns for intestinal worms, nutritional supplementation, bed net provision for malaria prevention, and sexual and reproductive health education. By excluding girls and boys with disabilities from school, they are less likely to benefit from these interventions, which can lead to worse health outcomes, including the development of additional disabilities. Poor health can then lead to an array of costs, as discussed in Chapter 3.

Second, education of girls and boys promotes gender empowerment and equality. When women and girls stay in school and have opportunities for work, they have greater economic independence as well as knowledge and skills that can improve their lives and those of their families. Empowering women and girls has been linked to many benefits, including lower child and maternal

Box 13: Increased wages as a result of education

Some studies have shown that promoting the inclusion of children with disabilities in education can generate economic development:

- In a study across 13 low- and middle-income countries, households with an adult with a disability were more likely to live in poverty; however, this poverty gap was reduced for each additional year of schooling that the adult with a disability received.¹²⁰
- In China, for every extra year of school that children with disabilities completed, their wages as adults increased by 5–8%.¹²¹
- Studies in the Philippines and Nepal found an even greater impact of education on wages, with estimates of over 20% increases for each additional year of education that children with disabilities completed.¹²²



mortality, decreased transmission of HIV, increased autonomy, greater protection against abuse and violence, and improved health and educational outcomes for children.¹²³ While the social impact of any of these benefits merits greater investment in education for women and girls, there are also economic gains. For example, women with more education are more likely to delay or reduce childbearing and the declining birth rates in low-income countries have been linked to national economic growth and increased household savings.¹²⁴ Similarly, preventing HIV averts some of the higher

costs for care and treatment from the public health budget.¹²⁵ As women and girls with disabilities are at higher risk of domestic violence, abuse, and other forms of marginalisation, promoting empowerment through education is fundamental.¹²⁶

Third, education plays an important role in preventing crime. In addition to contributing to suffering and loss of human life, crime is financially costly for society. Spending on legal and medical fees, policing, prisons, reduced revenues for businesses, and the losses in potential earnings for both the victims and perpetrators can cause substantial costs for

▲ Figure 6: Economic gains of inclusion in education and training



▲ Rassi (left) is training Tahiratou to become a seamstress. After bone surgery, supported by a CBM partner in Niger, Tahiratou is now in a position to learn a trade.

individuals, families, and societies at large. Inclusive education, by providing avenues for more productive lifestyles as well as promoting community values, may, therefore, lead to economic gains through crime reduction.

Finally, inclusive education promotes participation of persons with disabilities, leading to economic and social benefits for societies as a whole. For example, schooling increases individuals' skills and knowledge, which creates a better-equipped, more efficient workforce. Educated workers are better able to innovate and adapt to new technologies and are more attractive to outside investors. Furthermore, when girls and boys with disabilities can interact with their peers without disabilities from a young age, misconceptions and stigma of disability can be tackled. This

can help overcome barriers to participation in other domains and lead to the formation of more tolerant, equitable, and cohesive societies. Evidence highlighting some of these economic gains of investing in education is presented in **Box 14** (page 62).

Box 14: Benefits of investing in education for children with disabilities

- The education level of the general population is the most significant factor explaining long-term economic growth for countries across the globe.¹²⁷
- A study from Bangladesh indicated that USD \$ 26 million per year was lost due to the reduced earnings attributable to lower education levels among persons with disabilities. Losses were even higher when accounting for reduced employment and school opportunities among other family members involved in caregiving.¹²⁸
- In a study of nine Caribbean countries, increasing school attendance has been shown to have the greatest impact on crime rates, reducing violent activity in young people by 55–60%. Additionally, school attendance significantly reduced risky health behaviours, such as alcohol consumption, drug use, and smoking.¹²⁹

Key learning points

- The right to education for persons with disabilities is protected by a number of international treaties. Article 24 of the CRPD further clarifies the rights of women, men, girls, and boys with disabilities to education and identifies a number of key areas for implementation.
- In accessing education, persons with disabilities face a number of barriers, such as inaccessible schools, high costs, negative attitudes, and low expectations. The lack of national policies with measurable targets for inclusive education is also a major barrier.
- Including persons with disabilities in education increases opportunities for employment, higher wages, and more sustainable livelihoods.
- Education has positive impacts in areas such as crime reduction, empowerment of women, health, and citizen participation. Ensuring that education is disability-inclusive maximises the financial and social gains resulting from these positive impacts.
- Investing in inclusive education supports the development of a more skilled and productive workforce, which is a key element for promoting national economic growth and social cohesion.

4.5 Examples of inclusion

This chapter concludes with an interview with one of CBM's senior education advisors on the opportunities for and challenges of inclusive education. Also presented is an example of how international cooperation funding from Finland has contributed to enhancing the inclusive education capacity of the teacher education and resource centres in Ethiopia.

Interview with CBM's senior education advisor

Sian Tesni is senior education adviser at CBM. In this interview, Sian reflects upon the progress made on inclusive education and highlights remaining gaps.

Have you witnessed an increase in support for inclusive education?

Sian: During my years of work in this area, I have witnessed increased support for disability-inclusive education. There are a number of contributing factors related to this. First, there has been an increased collaboration between government and NGOs and donors, particularly in recent years. Second, the enthusiasm and the will to work together have increased (although sometimes the eagerness to bring about change quickly has led to lower quality inclusive education). Third, increasing opportunities have been created at universities and training institutions to develop capacities of teachers, so they are well-equipped to teach in inclusive settings.



© CBM/Telemans

▲ Eight-year-old Yeny (left) attends a public primary school in Canas, Peru. An education specialist supports Yeny in her learning.

How have governments progressed inclusive education?

Sian: Governments are slowly making progress on inclusive education. For example:

- In Nicaragua, a community-based approach to inclusion is being developed, with the close involvement of the government. This approach was piloted in one region and is now becoming a national programme.
- In Burkina Faso, the Ministry of Education is working to strengthen an existing inclusive education programme with capacity-building opportunities and early years provision for all children with a focus on ensuring equal access for boys and girls with disabilities. Early years provision is a

combination of early learning, care, and development for a young child.

- In Ethiopia, there is a new initiative from the Norwegian Agency for Development Cooperation, working with the Ministry of Education, to develop a countrywide comprehensive approach to inclusive education. The emphasis is on teacher preparation, infrastructure, and bringing specialists and mainstream educational provisions together.

How important is institutional learning for inclusive education?

Sian: Documenting learning and demonstrating evidence on intervention that works, or does not work, is important for developing inclusive educational systems. Countries' educational systems differ in their approaches and, therefore, reforms to make education inclusive also vary. In some countries, inclusive education has been introduced with a project cycle management approach, which monitors and evaluates progress based on lessons learned, including feedback from users and their families. In other countries, the emphasis is more on providing modules on inclusive education to regular teacher training and courses. The amount of dedicated time varies, with some providing 30-hour modules to others providing full time post-graduate studies in inclusive education with the opportunity to specialise. The challenge is always that there tends to be a strong emphasis on theoretical learning with courses often taught by college lecturers who themselves do not have experience or backgrounds in disability and education or inclusive education.

What do you think are the challenges for implementing inclusive education?

Sian: There are many challenges, but I would highlight four:

1. The first challenge is the need for early identification of children with disabilities and referrals to accessible, community-based services. This can be difficult because medical and rehabilitative services are sometimes miles away from where the person who needs the service lives.
2. Providing accommodation and adjustments at school for all according to their individual learning needs is a challenge. For example, deaf learners may require sign language interpretation to facilitate their education.
3. Another challenge is the lack of state involvement in preschool education. The private and NGO sectors often run preschools with limited input from state departments. This can result in preschool education being costly or dependent on external donor funding and this is particularly challenging for children with disabilities.
4. Accessing the specialised knowledge and support from teachers and pedagogues who have worked within the specialised education sector and who can provide skills and resources for inclusion in mainstream education is yet another challenge.

What do you think are the opportunities for implementing inclusive education?

Sian: Again, I will highlight four:

1. The potential for ministries working together with NGOs to deliver inclusive education;

2. Increases in promising practice examples, which can be used to build inclusive programmes and increase the coverage (the lessons learned need to be documented and widely shared);
3. The initiatives and development of information and communication technology as well as increased availability of assistive devices; and
4. The importance of initiatives such as Global Partnership for Education¹³⁰ and Global Campaign for Education¹³¹ to create awareness and support the inclusion of girls and boys with disabilities in national and international plans for education.

▼ 18-year-old Exhilda Chinyama at school in Lusaka, Zambia. After graduation, she wants to become a nurse and have a family.



© CBM/argum/Emberger



▲ Oumou (left) with her best friend Bissara doing their homework for school. Oumou had her right leg amputated due to a deformity. Now, she walks with a prosthesis and is completely included and attends secondary school.

Inclusive adult education in Mozambique

Thousands of Mozambican families, including families of persons with disabilities, have in recent years improved their quality of life as a result of adult and youth literacy projects implemented in the country by Deutscher Volkshochschul-Verband International (DVV International) and its partners.¹³²

Since April 2012, DVV International in Mozambique has implemented a three-year programme on inclusive adult education supported by the EU with 25 % co-funding from the German Federal Ministry for Economic Cooperation and Development (BMZ). The project, known as 'Inclusive adult edu-

cation in Mozambique', was designed to address a gap in the educational system in Mozambique in relation to the learning needs of persons with disabilities. The principal components of this project included the establishment of an inclusive curriculum, the strengthening of NGOs in the development and implementation of inclusive literacy courses, and the proffering of advice to the Ministry of Education in relation to the integration of persons with disabilities into adult education. Speaking about the inclusion of persons with disabilities, the project supervisor commented:

"All this time, it was our conviction that, to work on literacy, we were giving a second chance to all young people and adults who, for some reason, had not learned to read and write when younger. It was enough to see that young people and adults in our literacy program believed that our mission was to be fulfilled. We never noticed the absence of persons with disabilities or were concerned about their absence. Now, we see how wrong we were to ignore them. Therefore, the objective of this project continues to be very important even today and will continue for a much longer time."

One of the main objectives of the project was to improve the literacy skills of 2,000 people who lacked literacy skills and include women and men with disabilities in this group. An evaluation of the project highlighted that approximately 350 people with disabilities participated in the programme, helping them develop literacy skills and improve their opportunities for the future.

Chapter 5

Work and Livelihood

“We must ensure that growth is inclusive and leaves no one behind. Actions are needed so that men, women, and youth have access to decent work and social protection floors. Labour market policies should put a special focus on young people, women and people with disabilities.”

Ban Ki-moon,
Secretary-General
of the UN (2013)



5.1 Introduction

Chapter 5 highlights the costs of excluding women and men with disabilities from work and other livelihood development activities and programmes. First, it presents an overview of the obligation of governments and development stakeholders under international conventions to protect the right to work and to sustainable livelihoods for persons with disabilities. Second, it reviews some of the barriers that prevent many persons with disabilities from participating in work. Third, it discusses how the widespread exclusion of persons with disabilities from work results in a range of economic costs and how inclusion can reverse these losses and lead to gains. Finally, it presents examples of disability-inclusive work and livelihood development programmes and policies and shows how they are leading to both financial and non-

financial benefits for women and men with disabilities, their families, and societies as a whole.

5.2 International legal frameworks

The right to work is a human right recognised by a number of international treaties. The ICESCR recognises “the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts”.¹³³

The right to work is further clarified in the:

- International Covenant on Civil and Political Rights, Article 8;
- International Convention on the Elimination of All Forms of Racial Discrimination, Article 5;
- Convention on the Elimination of All Forms of Discrimination against Women, Article 11;
- Convention on the Rights of the Child, Article 32;
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Article 11; and
- Convention on the Rights of Persons with Disabilities, Article 27.

It is always the obligation of national governments to create conditions for decent work and to ensure livelihood opportunities. International cooperation plays an important role in supporting governments of low- and middle-income countries in creating employment and protection from discrimination. Section 5.5 highlights some examples of this support.

Box 15: A note on work, employment and livelihood

‘Work’ and ‘employment’ are used in this publication to refer to any activities that contribute to an individual’s or household’s livelihood.

A **‘livelihood’** is the means by which individuals or households are able to meet their basic needs, such as food, water, shelter, and essential medicines. For a livelihood to be **‘sustainable’**, households must be able to meet these needs even in times of stress and shock, for example, drought, famine, or war. Additionally, there must be opportunities for livelihood improvement, such as through education and investments, so that individuals can move beyond the subsistence level, toward long-term poverty alleviation.



◀ Chaka Suma uses a wheelchair as a result of an accident in 1998. Since receiving his first loan in 2002, his business has improved and he met his wife, who now also works with him in his grocery store in Mombasa, Kenya.

5.2.1 Key features of the right to work

The right to work is recognised as being an essential human right; work forms an inseparable and inherent part of human dignity.¹³⁴ There is no standardised way of implementing the right to work, as the economic and political circumstances vary from country to country. However, there are a number of essential principles with which governments are bound to comply:

- **Free choice:** A person must be free to choose to participate in employment opportunities without being forced into certain types of work.
- **Open labour market:** There must be no discrimination in access to or participation in the labour market.

- **Decent work:** A person must be treated fairly in terms of payment, length of working hours, and freedom to join trade unions.
- **Safe working environment:** A person must be able to work without being at risk of injury or death.

5.2.2 The right to work for persons with disabilities

Article 27 of the CRPD clarifies the right of women and men with disabilities to work and further outlines the following obligations governments must meet with respect to providing equal opportunities in employment:

- **Non-discrimination:** Persons with disabilities have the right to work on an equal basis with others.

- **Accessibility:** The right of persons with disabilities to work includes the opportunity to earn a living in a work environment that is accessible to persons with disabilities. Accessibility in the workplace involves identifying and removing barriers that hinder women and men with disabilities from carrying out their work on an equal basis with others.
- **Reasonable accommodation:** With a view to facilitating access to work on an equal basis with others, governments must ensure that reasonable accommodation is provided to persons with disabilities. See **Box 16** (page 70) for details of reasonable accommodation.¹³⁵
- **Positive measures:** Besides a duty to impose obligations on private sector employ-

ers, governments should adopt positive measures to promote employment opportunities for persons with disabilities. One example of such positive measures is the quota system.

In addition to the specific rights stipulated in the CRPD, there are a number of global recommendations and guidelines supporting the rights of women and men with disabilities to work. For example, the International Labour Organization (ILO) has a range of standards on measures to promote the inclusion of women and men with disabilities in employment. These include the 2002 code of practice for managing disability in the workplace and a number of conventions on rehabilitation and vocational training.¹³⁶

Box 16: Reasonable accommodation and employment¹³⁷

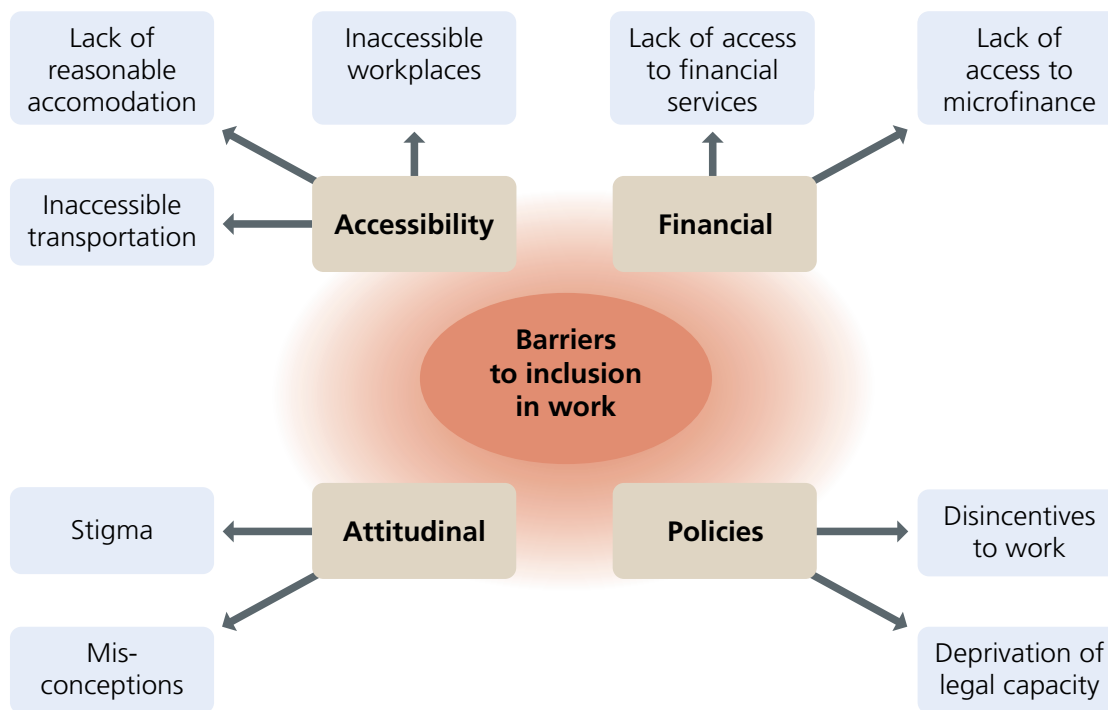
Article 2 of the CRPD defines reasonable accommodation as “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms”.

For governments and employers this means:

- They have a legal obligation to provide reasonable accommodation to persons with disabilities. This extends

to both public and private sector employees and should be provided at a proportionate cost to employers.

- They must develop policies that promote and regulate flexible and alternative work arrangements that reasonably accommodate the individual needs of employees with disabilities. Policy measures can include adjustment and modification of machinery and equipment; modification of job content, working time, and work organisation; and physical adaptation of the work environment to provide access to the workplace.



◀ Figure 7: Interaction of barriers to inclusion in work and livelihood

5.3 Barriers to inclusion

Persons with disabilities are less likely to work, compared to persons without disabilities.¹³⁸ Even when persons with disabilities do find work, they tend to have longer hours, lower wages, less job security, and fewer opportunities for promotion.¹³⁹ Women with disabilities face even greater disadvantage; compared to men with disabilities, not only are they half as likely to work, but, when they are employed, they earn half the income for similar jobs.¹⁴⁰ Global data highlights that employment rates for women with disabilities are 19.6 %, while they are 52.8 % for men with disabilities and 29.9 % for women without disabilities.¹⁴¹

Exclusion from work is often the result of exclusion in other areas, such as health and education. For example, when women and men with disabilities are in poor health, they are more likely to miss work, be less productive on the job, or not work at all. Similarly, when excluded from education and training, persons with disabilities are less likely to have the qualifications needed for many jobs.

Figure 7 (page 71) summarises some of the barriers to inclusion in work and livelihood.

Numerous barriers limit persons with disabilities' access to all types of work in both the formal and informal labour market. See **Box 17** (page 72). Understanding how these barriers limit participation can help identify

Box 17: Participation of persons with disabilities in different types of work

Work in the **formal sector** is taxed, monitored, and regulated by the government and is included in estimates of a country's overall economic activity. In contrast, work in the **informal sector** is usually unregulated and often outside of insurance systems and labour protections.¹⁴²

There are many types of work in which persons with disabilities may be engaged, in either the formal or informal sector. These can include **employment by a company or self-employment**, where

individuals earn their livings through direct transactions with customers. For both, wages may be earned in cash or in kind. In low- and middle-income countries, some estimates suggest that up to 80 % of persons with disabilities who are working are self-employed, almost entirely in the informal sector.¹⁴³

Additionally, persons with disabilities may be involved in **unpaid productive activities**, such as domestic work or farming for consumption, that contribute to the livelihood of the household.

ways of promoting greater inclusion in work and sustainable, gainful livelihoods for persons with disabilities.

5.3.1 Inaccessible work environments

Inaccessible work environments exclude many persons with disabilities from work. For example, physical and communication barriers in vocational services, during job interviews, in the workplace, or at social events with colleagues may prevent women and men with disabilities from getting jobs or reaching their maximum potential once hired. These challenges may be overcome with reasonable accommodation (previously explained in **Box 16**, page 70), many of which can be provided at a modest cost.

Individuals who are self-employed or engaged in unpaid productive activities might also require specific supports and accommodations in order to succeed, such as assistive devices, vocational rehabilitation, or other accessibility measures. However, these supports are often difficult to access for individuals living in poverty if not publically provided.¹⁴⁴

5.3.2 Attitudinal barriers

Misconceptions and discriminatory attitudes towards persons with disabilities frequently limit their opportunities for employment. For example, many employers believe that an employee with a disability would be less productive and less qualified than an employee without a disability, even if they both have

the necessary skills for the job.¹⁴⁵ Furthermore, employers often worry that implementing reasonable accommodations will be too expensive or they do not know where to find information on what measures are suitable and how to put them in place.

Additionally, the stigma towards persons with disabilities limits the development of networks, which is often crucial to finding jobs and career advancement. Persons with disabilities themselves and their families may also have low expectations of their capabilities and employability, discouraging them from even seeking work.¹⁴⁶

5.3.3 Financial barriers

Financial services—such as personal or business banking, insurance, savings schemes, and loans—are essential resources for successful entrepreneurship and for protecting and improving livelihoods. As many persons with disabilities are self-employed,¹⁴⁷ access to these services is key for starting and growing businesses. Even for individuals who are not self-employed, financial services can help in coping with unforeseen expenses and can encourage investments (for example, in education) that may lead to better livelihoods. However, persons with disabilities are often excluded from services offered by financial institutions. As persons with disabilities in low- and middle-income countries are at higher risk of living in poverty (see Chapter 2), they might lack requirements such as collateral, guarantors, or records of past financial transactions, and so financial institutions are often reluctant to take them on as clients.¹⁴⁸ Although the purpose of microfinance pro-



◀ Mourine Yilamonyuy regained her self-confidence by joining a local DPO in Kumbo, Cameroon. She now raises pigs and has started to become self-sufficient.

grammes offered by NGOs is to extend financial services to individuals living in poverty, persons with disabilities are often excluded from these programmes. In a multicountry study of over 100 microfinance organisations, persons with disabilities were hardly even represented; only 0–0.5% of the clientele were persons with disabilities, indicating that they are severely underrepresented from an avenue that has proved effective in reducing poverty.¹⁴⁹ Barriers to participation included negative attitudes of staff, inaccessible facilities, and low levels of awareness about eligibility for microcredit programmes among both microfinance institutions and persons with disabilities themselves.¹⁵⁰



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▲ Field worker, Salou Bonkaney, teaches Hamadou Abdou (right) and his father, Moumoni, how to take care of their survival yard in Niger. The yard has a well that supplies water to all of the families in the surrounding area.

5.3.4 Policy barriers

Certain legislation and policies limit opportunities for work for persons with disabilities. Sometimes legislation openly discriminates against them. For example, in Cambodia, people with any type of chronic impairment are prohibited from becoming teachers.¹⁵¹

Even when policies are well meaning, they can create disincentives to work. For example, governments are increasingly adopting social protection programmes as a strategy to prevent and reduce poverty among the poorest and most vulnerable in their population. Given the high level of poverty and marginalisation, persons with disabilities are often specifically targeted as key beneficiaries in certain programmes – usually in the form of cash transfer, such as ‘disability

grants’. If these grants have conditions that the beneficiary be unemployed, persons with disabilities and other marginalised groups may choose not to work in order to maintain this source of steady income – particularly when the employment opportunities available to them are scarce and/or poorly paid.¹⁵² Attaching these conditions to social protection programmes, therefore, hinders their goal of developing stronger, sustainable livelihoods (see **Box 18**, page 78).

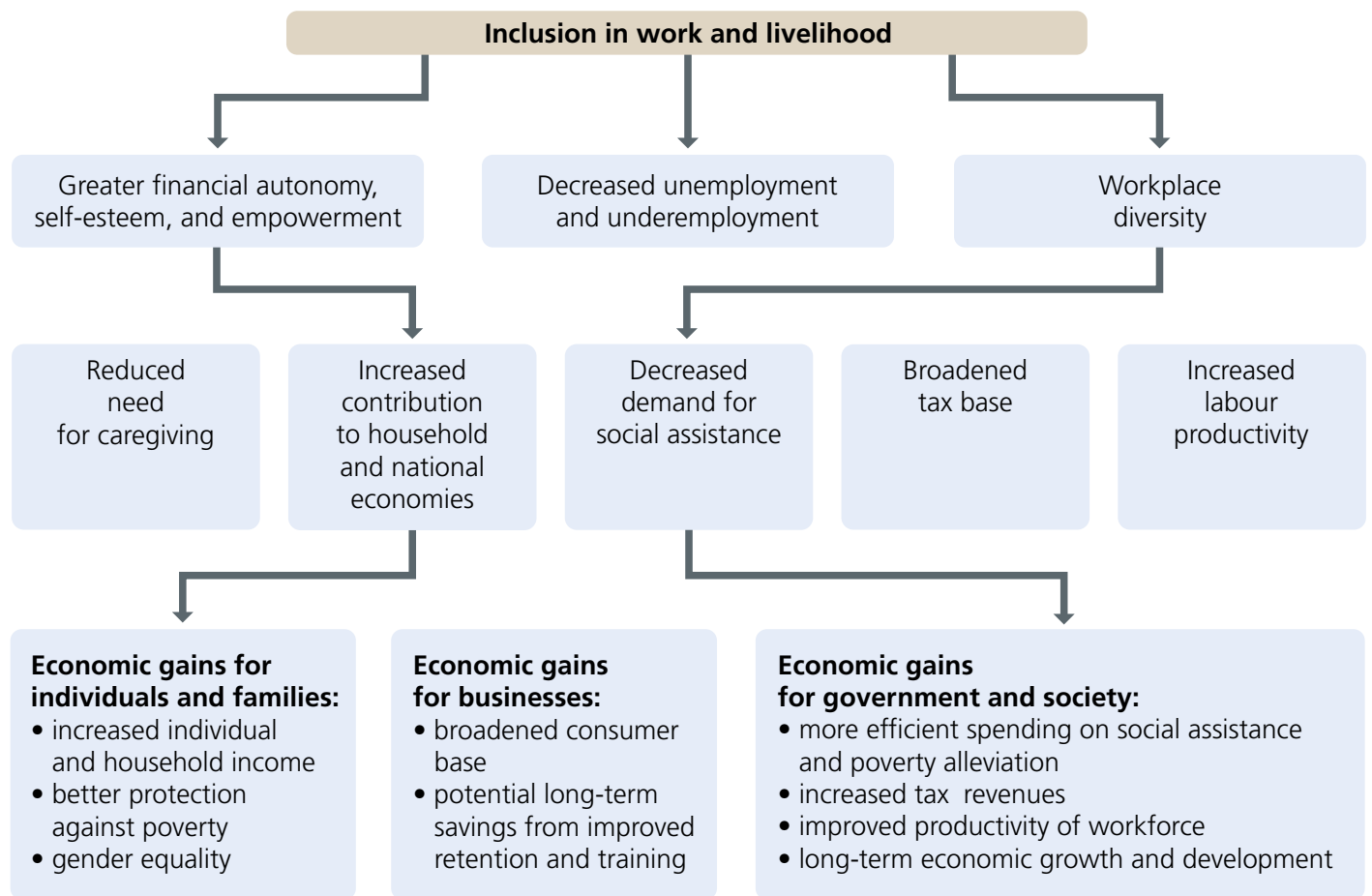
Finally, as many persons with disabilities in low- and middle-income countries are working in the informal sector, they are often ineligible for social insurance programs, such as pension schemes, health insurance, or vocational training and support.¹⁵³

5.4 Costs of exclusion and gains of inclusion

Exclusion from work not only has a negative impact on persons with disabilities, but also on their families, communities, and even nations as a whole. This section explores some of the pathways through which exclusion from work may generate economic costs and how more inclusive approaches may lead to economic gains. An illustration of the different economic gains is provided in **Figure 8** (page 75).

5.4.1 Impact on livelihoods

Work is key to building a sustainable livelihood. Although the vast majority of persons with disabilities has the capacity to work, the barriers explained in the previous section prevent equal participation.



First, when persons with disabilities are excluded from work, the lost wages affect their and their households' abilities to earn sustainable livelihoods. Some studies have measured the costs associated with lost income among persons with disabilities due to exclusion in employment. A study in South Africa, for example, found that, on average, persons with severe depression or anxiety disorders lost USD \$ 4,798 per year in earn-

ings—meaning they only received about half the average income level.¹⁵⁴ When totalled for all individuals with severe depression or anxiety disorders in South Africa, it was found that USD \$ 3.6 billion was lost annually.¹⁵⁵

When women and men with disabilities are included in work, however, some of those losses may be avoided. For example, in Pakistan, providing rehabilitation to persons who are blind was estimated to lead to total

▲ Figure 8: Economic gains of inclusion in work and livelihood

gains of USD \$ 71.8 million per year in household earnings.¹⁵⁶ Ensuring persons with disabilities have the supports they need to engage in work, therefore, may produce long-term individual and household financial gains.¹⁵⁷ While there are many adaptations and accessibility measures that can be provided at low or no cost,¹⁵⁸ public subsidies may be required to address systemic barriers or help small-scale employers cover costs.

Second, in addition to work for wages, women and men with disabilities often engage in activities that, although unpaid, are nonetheless essential contributions to their households' livelihoods.¹⁵⁹ For example, many households in low- and middle-income countries rely on subsistence farming to meet basic food needs.¹⁶⁰ As low yield can leave households living in poverty at risk of hunger and financial ruin, any increases in participation or productivity help ensure that at least basic needs are met and may even move households beyond the subsistence level. Similarly, engaging in domestic work and caregiving allows other family members to engage in activities that contribute more directly to the household's economy. Though the economic value of these activities is difficult to quantify, they are nonetheless crucial to a household's economy and livelihood. Finding ways to increase the participation of persons with disabilities in these types of activities can also be an important mechanism for strengthening livelihoods.

Third, caregivers may forgo work to assist family members with disabilities.¹⁶¹ For example, in Bangladesh, lost income from adult caregivers amounted to USD \$ 234 million

per year.¹⁶² These losses could be minimised if greater supports that encourage independent living were provided to persons with disabilities and their households, such as rehabilitation, vocational training, personal assistance, and assistive devices.

Finally, access to work and other livelihood opportunities for women and men with disabilities may strengthen the economy of their communities. Higher incomes often mean greater spending, which helps support local businesses. Furthermore, if persons with disabilities are able to start or grow their own businesses, these enterprises could spread resources throughout the community, for example, by hiring workers or buying materials and other inputs from local businesses.

5.4.2 Impact on national economic growth and development

When women and men with disabilities face systematic barriers to work, national economies are affected. As the number of people who are working and the productivity of those workers are key determinants of the strength of a country's economy, excluding a significant part of the population reduces contributions to the national economy. Furthermore, lost earnings from persons with disabilities and their households decrease disposable income – meaning they will have less to spend and invest in businesses in their communities – which also affects economic growth.

The story of Charles shows the positive impact of work not only on economic independence but also on dignity and respect (see following story).



© 2014 CBR Sandema/CBM Australia

◀ Charles, who is blind, joined a DPO and received training in weaving through the Sandema CBR Programme. He is now independent and taking care of his wife and son. He feels respected by his community.

Charles' story, Ghana

My name is Charles. I was not born with disability, but I fell ill with measles when I was three years old. At that time the availability of nurses was a problem and my parents did not know about the hospital.

There were rashes all over my body and later on I got blind. I became blind at the age of three years and four months. When my parents realised that I was blind, they did not say anything. My mother was crying when she realised that I am blind. I was still having friends, going out with them, but not all the time.

I did not have access to education because of my disability. I wanted to go to school but my parents did not know about education, or even who to contact to get to the visually

impaired school. After realising that I could not access education, my future plans were to become a farmer.

My relationship with my father was great because he taught me how to farm and how to weave local baskets. The only unfortunate thing is that my father did not help me to have access to education because of ignorance.

I became self-reliant after receiving vocational training through the local organisation Sandema CBR. I heard an announcement on the radio that there was an opportunity for people with a disability to go and learn handy work.

I left my community and came to Sandema where I stayed with my sister. I joined the Disabled Persons Organisation (DPO) in 2003 and I received three years training on how to

weave tables, doormats and beds. After I joined the group I became happy and felt better.

We have been encouraging one another not to sit idle but to work hard, to gain a living so that we can get food to eat, soap to wash.

I learned an important thing from my colleagues. Most of my colleagues were married, so I also put an effort in to get married. I never believed I could get married because of my blindness. I thought I could not afford to take care of a wife, like clothing her or providing shelter. But I got married.

I'm now independent. Having a companion that is my wife, gaining income for living

through my weaving, this training has helped me a lot. I am excited because I have work and am self-employed; I am now getting an income. I am married, and I have a child: a young boy who is four years old. In the future when I have grown old, he can take care of me.

I am happy because people respect and value me with regards to my achievement. They realise that they have wives—I also have a wife. They gain income for living—I also gain a living. They have a child—I also have a child. I am also the local leader for the Blind Union, so my colleagues realise that we are all the same, so they respect me a lot.

Source: www.endthecycle.org.au/stories/charles

Box 18: Social protection

Social protection programmes are designed to help individuals, households, and communities to prevent, mitigate, or cope with risks that can temporarily or permanently lead to or worsen poverty.

The main role of social protection has been to protect minimum living standards so that all people can meet their basic needs. However, with the right design and investment, social protection is increasingly being promoted as having a 'spring-board' effect. By helping men and women living in poverty move beyond the subsistence level, they are then able to spend time on activities (for example, education and training) or make investments (such as starting small businesses, or buying land or fertiliser for more productive farming) that lead to stronger livelihoods.

In low- and middle-income countries, **social assistance**, such as transfers in cash or in kind, to individuals living in poverty has been the dominant type of social protection programme. Other forms of social protection include forms of **social insurance**, for example, health insurance, old-age pensions, unemployment benefits, access to **social services**, and **policy reforms** to protect the rights of vulnerable groups.

Social protection programmes, thus, often target individuals or groups living in or at risk of poverty. As it is well-documented that, as a group, persons with disabilities are significantly more likely to be living in poverty (see Chapter 2), many social protection schemes either indirectly or directly include them in their eligibility criteria.

Some studies have attempted to calculate the losses to national economies from exclusion of persons with disabilities in work:

- A study from 1996 estimated that low- and middle-income countries lost between USD \$ 473.9–672.2 billion from their annual economies due to the failure to maximise the potential of persons with disabilities in work.¹⁶³ At the national level, losses in Gross Domestic Product (GDP) reached as high as 45 % for some countries.
- Estimates on global economic losses from unemployment and lower productivity of men and women with visual impairments ranged from USD \$ 42 – 168 billion annually.¹⁶⁴ When the costs from lost productivity among caregivers were included, these estimates increased still further.
- In Bangladesh, up to USD \$ 891 million has been estimated to be lost from the country's GDP due to the exclusion of women and men with disabilities from work in 2008 alone.¹⁶⁵
- In Morocco, a study in 2011 indicated that USD \$ 1.1 billion, or 2 % of the country's GDP, was lost due to lower salaries and levels of employment among persons with disabilities.¹⁶⁶ Men with disabilities living in urban areas accounted for almost half of the reported losses.

By removing barriers that limit participation in and productivity at work, countries may be able to reverse these losses and even experience economic growth. In one multi-country study, it was estimated that the economy of a country could grow by 1–7 % by removing barriers that hinder inclusion in work.¹⁶⁷



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5.4.3 Impact on social protection and tax revenues

The financial autonomy of persons with disabilities included in work or other livelihood strengthening opportunities may in turn lead to savings for governments through more effective spending on social protection and welfare programmes and increased tax revenues. **Box 18** (page 78) describes social protection mechanisms more in detail.

Social protection – mainly in the form of social assistance – is increasingly being adopted across low- and middle-income countries as an effective tool for economic and social development.¹⁶⁸ In addition to mainstream schemes offered to the general population, several countries, such as Brazil, South Africa, and Liberia, have implemented social protection programmes specifically targeting persons with disabilities.¹⁶⁹

While social protection programmes should always be available to safeguard against

▲ Nuh Cletus Fung is a graduate of an apprenticeship programme in office work, training that enabled him to find a job as a hospital secretary and cashier in Fungdong, Cameroon.



© CBM

◀ Ernest Nyah (right) from Kumbo, Cameroon, has an intellectual disability. He graduated from an apprenticeship programme and now works as a cobbler, repairing shoes. He has gained a lot of respect within his own family due to this programme.

economic shocks and alleviate extreme poverty and inequality, poor design and the absence of other ways of earning sustainable livelihoods can lead to long-term dependence. Through accessing work, persons with disabilities become more economically self-sufficient, resulting in reduced need for these programmes. With fewer individuals in need of assistance to meet basic needs, savings can be used to improve these programmes or reallocated to other programmes in need of funding. In order to capture these benefits, however, as previously mentioned, it is important to ensure that social assistance programmes do not create disincentives to work. For example, there is some evidence that decreases in employment of persons with disabilities in South Africa were driven in large part by stipulations of disability grants that recipients be unable to work.¹⁷⁰

Additionally, increasing inclusion of both persons with disabilities and their caregivers in work increases a country's potential tax base. For example, in the Philippines, in a study exploring the financial impacts of unrepaired cleft lip and palate, it was found that excess unemployment among individuals with this condition was responsible for USD \$ 8–9.8 million dollars in lost tax revenue.¹⁷¹

In high-income countries, investing in programmes that promote the employment of persons with disabilities has been shown to lead to net economic gains from reduced social assistance spending and increased tax revenue. While social assistance and tax systems are certainly much more extensive in high-income countries, low- and middle-income countries may also experience returns in these areas from investments in inclusive employment. At the present, this may be more relevant to middle-income countries, as many low-income countries are allocating very limited budgetary resources to social assistance and have weak mechanisms for tax collection, especially from the informal sector.

5.4.4 Gains for disability-inclusive employers

As previously mentioned, employers are often reluctant to hire persons with disabilities out of fear that it will be expensive and will produce limited returns.¹⁷² However, there is evidence that inclusion of persons with disabilities is a smart business decision: with proper job matching and reasonable accommodations, employees with disabilities are just as productive as other workers and their inclusion can lead to economic gains.¹⁷³

Some employers in high-income countries have found that employees with disabilities have greater retention rates, better attendance, and fewer workplace accidents than those without disabilities.¹⁷⁴ Moreover, their performance is rated as being on par with their colleagues without disabilities.¹⁷⁵ Experiences from several companies indicate significant savings from the reduced need for recruitment, hiring, training, lower absenteeism, and decreased insurance pay-outs.¹⁷⁶ Although employers worry about the costs of providing reasonable accommodations, these savings could more than offset the initial expenses.¹⁷⁷

Additionally, inclusion of persons with disabilities may improve diversity and the general work environment.¹⁷⁸ Studies have shown that employing women and men with disabilities can increase morale and teamwork among all staff, which in turn may increase productivity.¹⁷⁹ Also, creating structures and systems to accommodate women and men with disabilities can facilitate the retention and return-to-work of employees who have had accidents or developed impairments during the course of their employment—a growing concern with aging workforces.¹⁸⁰

Finally, as persons with disabilities make up almost one fifth of the population, they represent a largely untapped group of consumers. Employing persons with disabilities brings an improved understanding of the needs and wants of these potential consumers, allowing businesses to tailor their products and services appropriately as well as to adapt strategies to better compete in a diverse marketplace.¹⁸¹ Hiring persons with dis-

abilities can also improve a company's corporate responsibility image, which may then attract customers and promote brand loyalty.¹⁸²

Though there is a lack of evidence quantifying the business advantages of hiring persons with disabilities in all countries, let alone low- and middle-income countries, similar gains may be attainable if investments are made to create inclusive workplaces. **Box 19** (page 81) features three examples of demonstrated gains for employers.

Box 19: Gains of inclusive employment in high-income countries

Although limited, evidence from high-income countries has quantified some of the economic benefits described above.

In the United States, when major companies Walgreens and Verizon employed significant numbers of persons with disabilities—while ensuring appropriate accommodations and an inclusive workplace—they saw such gains as a 20 % increase in productivity and a 67 % return on investment, respectively.¹⁸³ Furthermore, a cost-benefit analysis of 30 supported employment programs in the United States for persons with autism and Asperger's Syndrome indicated a net gain, primarily due to reductions in benefit spending.¹⁸⁴

In Australia, the total cost of absences due to illness for workers with disabilities was less than half and the number of workers' compensation pay-outs was one quarter of that accrued by employees without disabilities.¹⁸⁵

An analysis of a Scotland-based supported employment project for persons with disabilities found that every GBP £ 1 spent on the programme led to a savings of GBP £ 5.87, due in large part to decreased need for disability or welfare benefits and increased tax revenue.¹⁸⁶

Key learning points

- The right to employment for persons with disabilities is protected by a number of international treaties. Article 27 of the CRPD clarifies the right of women and men with disabilities to work and identifies key areas for implementation.
- Persons with disabilities face many barriers to participating in work, such as inaccessible work environments, lack of reasonable accommodations, and exclusion from financial and microfinance services and from policies that are either discriminatory or create disincentives to work.
- When barriers to participation lead to unemployment and lost wages, opportunities for persons with disabilities and their households to earn a sustainable livelihood will be limited. Communities and nations as a whole can also be affected due to the decreased economic activity of persons with disabilities.
- Social protection plays an important role in preventing poverty but proper design is needed to ensure that these programmes promote long-term livelihood development for persons with disabilities and their households.
- Including persons with disabilities in work can lead to financial autonomy, resulting in savings for governments through more effective spending on social protection and welfare programmes and increased tax revenues.
- Evidence from high-income countries presents a business case for hiring persons with disabilities. With reasonable accommodation and accessible workplaces, employees with disabilities can be just as productive as other workers and their inclusion may even increase overall profit margins. Higher retention rates, lower absenteeism, and equal performance to employees without disabilities can be sources of economic gain.

5.5 Examples of inclusion

This chapter concludes with an interview with CBM's senior livelihood adviser on the impact of inclusive work and livelihoods for persons with disabilities. Also included are examples and stories from inclusive employment and livelihoods projects in Georgia and Kenya. Another example highlights how inter-

national cooperation from the EU increased vocational training and employment opportunities for women and men with disabilities. Someone Otieno (see Someone's story on page 84) also tells his story on how he succeeded in starting his own business in Kenya, with the support of a microcredit from a CBM partner.

Interview with CBM's livelihood adviser

Hubert Seifert is senior livelihood adviser at CBM. In this interview, Hubert reflects on the progress made and the gaps remaining for persons with disabilities accessing livelihood opportunities.

What benefits have you seen from investment in inclusive livelihoods?

Hubert: Earning a wage means an entire transformation of the self-esteem of women and men with disabilities and it leads to acceptance and integration within their communities and, of course, transforms society at large. Over the years, I have seen many examples of how earning a livelihood increases respect for persons with disabilities.

One example is a group in a town near Mombasa, Kenya, where I am based, which has shown how women and men with disabilities can make a difference in their community. The group started a project where they rented farmland and CBM supported them with a loan for seed and fertiliser and, as a result, they had a good harvest. They saved the profits and borrowed more funds and purchased the land. They also started a wholesale shop in their small town, selling seeds, fertiliser, and other products. They now provide valuable services to the community and are integrated and respected. As a result of the group's hard work, the community now realises that persons with disabilities can be self-reliant and successful businesspersons.

Has the perception that persons with disabilities are not 'credit worthy' impacted on measures to create inclusive livelihoods?

Hubert: Yes, we are beginning to overcome this challenge by working with the commercial banking sector to improve access to financial services. We lobbied Equity Bank to promote inclusion; Equity Bank started as a microcredit institution in Kenya many years ago and is now the largest bank in Kenya, with about eight million account holders targeting low- and middle-income groups. They now have a policy of including persons with disabilities as equal customers, which has promoted mainstreaming.

Has technology a role to play in creating inclusive livelihoods?

Hubert: Yes, technology has simplified banking, particularly through the use of mobile phones. M-Pesa is a mobile phone-based money transfer and microfinancing service launched by Vodafone that operates the largest mobile network in Kenya with about 22 million users. This simple and cost-effective technology has reduced the costs of opening bank accounts, travelling to the banks in towns, and has resulted in easy access to financial services for persons with disabilities.

How receptive has the private sector been to including persons with disabilities?

Hubert: As highlighted earlier, there has been progress with banks, such as Equity Bank. We have also had success with the private sector in Kenya with regard to employment. For example, the Association for the

Physically Disabled of Kenya (APDK) lobbied Safaricom (the largest mobile phone company in the country) to employ persons with disabilities. Subsequently, Safaricom allowed APDK, with support from CBM, to do the pre-interviewing and pre-selection of suitable candidates for employment in their call centre. Safaricom has now hired over 50 employees with disabilities. Safaricom has also become the first company in Kenya to redesign its website to be accessible for blind and visually-impaired persons.

Inclusive employment project in Georgia

The EU funded a project in the Imereti region in Georgia called 'A Pilot Program to Educate, Employ, Advocate and Legislate for Equal Opportunities for People with Disabilities' (APPEAL). The main goal of the project was to increase access to vocational education and employment for persons with disabilities by:

- ensuring that the national policy in Georgia promoting the employment of persons with disabilities was in line with international standards, for example, the CRPD;
- creating a system of employment services—including vocational and/or on-the-job training and support for securing job opportunities—for persons with disabilities and local employers wishing to hire persons with disabilities; and
- reducing the stigma and discrimination towards persons with disabilities by providing jobs and policy changes that allow them to better integrate with the general public

and to promote their abilities as opposed to their disabilities.

APPEAL's activities included working with:

- decision-makers in the Ministry of Economy and Development; the Ministry of Labour, Health and Social Affairs; and the Ministry of Education and Science to ensure Georgia's laws on employment were compliant with international law and respected the human rights of persons with disabilities;
- private sector employers to assess realistic incentives necessary for hiring persons with disabilities; and
- media to change public attitudes on the capabilities of persons with disabilities.

The project recorded a number of positive outcomes:

- 24 persons with disabilities were employed within the framework of the project.
- 134 entrepreneurs with disabilities were registered in the database of potential employers.
- 64 persons with disabilities and 43 employers attended a job fair, which was organised as part of the project.
- 22 TV shows, 4 radio talk shows, and 13 articles were devoted to presenting and promoting APPEAL's activities and goals.

Someone Otieno's story, Kenya¹⁸⁷

Someone works in Mombasa. He is a person with mobility impairment as a result of polio. He has a family of seven to support. In 2002,

CBM's partner, the APDK offered Someone a microcredit, which he used to start his first battery charging business.

Developing his own business

After Someone repaid the initial loan, he again borrowed, this time for a welding machine. Someone, when he was younger, attended a technical school where he learned how to weld. As he did not have money to buy material for welding, he bought cheap scrap metal from the waste dump. He paid others to collect the scrap metal and bring it to the shop, as it was difficult for him to do that work. He used the scrap metal to make grills and frames for doors and windows. The welding business went very well, however, after a while, Someone realised that welding is a physically hard job and he began to develop bigger plans.

Getting access to mainstream credit to grow his business

Someone always wanted to open a hardware shop for general building materials. He went back to APDK looking for much larger credit. At this stage, APDK referred him to a local bank and went with him to apply. He was successful in getting the credit and was then able to pay an employee to do the welding so he could focus on building his hardware business. Commenting on how gaining access to credit made a difference for him, Someone says, **"My life has changed, because my business is now big. I have four transporters, two welders, four people to collect scrap metal, three people making ventilation"**.



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Someone has a strong business sense and has made a success of every venture he has taken on. He gives thanks to APDK for the initial support they gave him in getting access to credit and securing a business licence, as these are not always easy for persons with disabilities. He says, **"I am praising APDK so much. Without them, I couldn't start and grow my business. I can now support my family"**.

▲ Someone Otieno had polio. In 2002, he received his first microcredit. He started out with a one-person business but is now the employer of about 13 workers.

Chapter 6

Conclusions

"A world that recognizes the rights of the disabled, ensures that people with disabilities can be productive members of their communities and nations, and provides an inclusive and accessible environment, is a world that will benefit all of us— with or without disabilities."

Ban Ki-moon,
Secretary-General
of the UN (2013)





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◀ Six-year-old Najmna has cerebral palsy. Thanks to the support of APDK, she received occupational therapy and physiotherapy and is now attending school in Mombasa, Kenya.

Given the fact that persons with disabilities have been left behind in the development processes of many countries, this publication has sought answers to two important questions:

- Can governments afford to continue excluding women, men, girls, and boys with disabilities?
- How can investment in inclusion benefit persons with disabilities, their families, and societies overall and how can international cooperation support this inclusion?

By using the findings from the LSHTM study and noting the legal and policy obligations of governments and development stake-

holders, both of these questions have been addressed. The study presents findings that show that the inclusion of women, men, girls, and boys with disabilities can generate economic gains for both individuals and governments. Societies that are not inclusive can create costs for persons with disabilities and their families and, very often, missed opportunities in areas such as health, education, and work and livelihood. In addition, some findings showed that exclusion from one area of life, such as health, can negatively impact on others, for example, work and livelihood. In many cases, exclusion of persons with disabilities leads to their perpetuated or

even increased poverty and this makes it an important policy consideration for governments.

Despite challenges in finding robust evidence on how investment in disability-inclusion generates positive outcomes for everyone, there are several good examples and national level studies which indicate that disability-inclusive health, education, and work and livelihood can trigger economic gains for entire societies. It also means that governments comply with their obligations to ensure equal opportunities and

respect for the human rights of women, men, girls, and boys with disabilities.

This publication addresses a number of issues that governments and other development stakeholders, such as the private sector and civil societies, should take into account in the implementation of the 2030 Agenda for Sustainable Development. These issues are summarised in the following key learning points, which illustrate that action taken for sustainable development must be inclusive of and accessible to women, men, girls, and boys with disabilities.

► Harka Maya at her home after cataract surgery on both of her eyes at the Biratnagar Eye Hospital, in Nepal.



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Key learning points

- Findings from the LSHTM systematic review on the relationship between poverty and disability report show evidence that disability and poverty are intimately linked.
- Excluding women, men, girls, and boys with disabilities in one area, such as education, can lead to exclusion in others, for example, employment, resulting in a snowballing of costs and the persistence of poverty traps.
- Ensuring persons with disabilities have access to health and education improves their lives and increases their opportunities and participation in their communities.
- International cooperation efforts by governments and development stakeholders to reduce poverty and improve the lives of women, men, girls, and boys with disabilities need to be scaled up.
- Human rights normative frameworks underpin the obligations of governments to provide health, education, and opportunities for work and livelihood for persons with disabilities on an equal basis with others.
- Quality data on the situations of women, men, girls, and boys with disabilities is needed to inform the planning, implementation and evaluation of development actions on health, education, and work and livelihood opportunities to ensure they are inclusive.

About the authors of the ICED research report

Lena Morgon Banks and Sarah Polack at ICED compiled the research report, 'Economic Costs of Exclusion and Gains of Inclusion of People with Disabilities'. ICED is an international centre at LSHTM with expertise in disability research and teaching in the context of public health and development. ICED is committed to developing tools, techniques, and evidence about disability and translating research findings into practice.¹⁸⁸



Lena Morgon Banks

is a researcher at LSHTM and a member of ICED. Some of the research projects on disability in which she has been involved include: access of children

with disabilities to education and health services in Nepal and Malawi, inclusion of children with disabilities in child protection programmes, and access to and impact of social protection amongst persons with disabilities in low- and middle-income countries. In 2015, she will begin her PhD, focusing on interventions to increase uptake of health and rehabilitative services among persons with disabilities.



Sarah Polack is a senior lecturer at LSHTM and a member of ICED. Her recent research has focused on methodological issues in the assessment of disability within surveys. As well, she has

explored access to health and education services and quality of life of people with disabilities in low- and middle-income settings. Sarah also teaches epidemiology and research methods to Master's students at LSHTM.

CBM's 'Series on Disability-Inclusive Development'

In April 2015, CBM launched its '**Series on Disability-Inclusive Development**'. In this series, CBM has committed to publish a number of publications over the coming years as part of a dialogue on key issues in disability-inclusive development.

The opening publication 'The Future is Inclusive. How to Make International Development Disability-Inclusive' covered key facts and figures on the situation of women, men, girls, and boys with disabilities living in low- and middle-income countries and presented the reasons that development and humanitarian actions must be disability-inclusive. As well, it showed how CBM has endeavoured to implement disability-inclusive development, and what was learned along the way.

'The Future is Inclusive' can be ordered via www.epubli.com (ISBN 978-3-7375-3923-4) and is available at www.cbm.org/didseries1_the_future_is_inclusive_pdf

A German version is also available („Zukunft inklusiv(e)! Entwicklungszusammenarbeit mit und für Menschen mit Behinderungen gestalten“, ISBN 978-3-7375-3922-7).

Upcoming publications

Future publications in this series will cover inclusive development topics, such as education, health, livelihood, and humanitarian assistance.

Accessibility

All publications in this series will be available as accessible PDFs on CBM's website:

www.cbm.org

Feedback

We are interested in hearing your views about our publications and welcome your comments, suggestions, and questions.

Please E-mail us at didseries@cbm.org



Who is CBM

Who we are and what we want to achieve

CBM is an international Christian development organisation, committed to improving the quality of life of persons with disabilities in the poorest communities of the world. With more than 100 years of expertise, CBM aims to promote inclusion and to make comprehensive health care, education, and livelihood services available and accessible to persons with disabilities living in low- and middle-income countries.

CBM, together with its partners, is also engaged in initiatives that aim at strengthening the participation and self-determination of persons with disabilities, their families, and communities. Over the past years, CBM has increasingly emphasised working with mainstream development organisations, governments, and international bodies, such as the UN and the EU, to advocate for disability-inclusive policies and programmes. CBM is in official relations with the WHO and has consultative status with the UN Economic and Social Council (UN ECOSOC).

How we work

CBM works in partnership with civil society organisations, including DPOs and faith-based organisations, as well as with government departments and UN organisations, at the national, regional, and international levels.

CBM works with a global network of professionals and experts, supporting partners in developing and implementing projects and programmes in the following areas of work:

- comprehensive health and rehabilitation services in the areas of eye health, ear and hearing care, and physical disability;
- community-based rehabilitation;
- community mental health;
- inclusive education;
- livelihood;
- accessibility; and
- disaster risk reduction and emergency response.

Training and capacity development of local professionals is a key component of our work. CBM also strives to adhere to gender sensitive programme planning and implementation and has started to implement measures to adhere to environmental standards and to promote environmental sustainability.

Organisational set up

CBM's global programme and global advocacy work is managed by the International Office, located in Bensheim, Germany. The direct work with our partners in low- and middle-income countries is managed by Regional Offices in Latin America, Africa, Europe, and Asia.



▲ Worldmap of support. CBM is helping worldwide – together with its local partners.



CBM has member associations which provide a vital link between people with disabilities in the poorest places of the world and those that have the interest, capacity, and resources to help.

Based in Europe, North America, Africa, and Australasia, Member Associations support CBM's programmes worldwide, mobilise

resources from individuals and institutions, and carry out national advocacy and awareness-raising campaigns to ensure that the rights and needs of persons with disabilities in poor communities are not forgotten.

More information is available at www.cbm.org

Abbreviations

| | |
|-------------------|--|
| APDK | Association for the Physically Disabled of Kenya |
| APPEAL | A Pilot Program to Educate, Employ, Advocate and Legislate for Equal Opportunities for People with Disabilities |
| BMZ | German Federal Ministry for Economic Cooperation and Development |
| CBR | Community Based Rehabilitation |
| CCBRT | Comprehensive Community Based Rehabilitation in Tanzania |
| CRPD | Convention on the Rights of Persons with Disabilities |
| DPO | Disabled People's Organisation |
| DVV International | Deutscher Volkshochschul-Verband International (Institute for International Cooperation of the German Adult Education Association) |
| EU | European Union |
| GIZ | Deutsche Gesellschaft für Internationale Zusammenarbeit |
| GDP | Gross Domestic Product |
| GUK | Gono Unnayan Kendra |
| ICED | International Centre for Evidence in Disability |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| IDA | International Disability Alliance |
| IDDC | International Disability and Development Consortium |
| ILO | International Labour Organization |
| LSHTM | London School of Hygiene & Tropical Medicine |
| MDG | Millennium Development Goals |
| NGO | Non-Governmental Organisation |
| OECD | Organisation for Economic Co-operation and Development |
| OHCHR | Office of the High Commissioner for Human Rights |
| UN | United Nations |
| UNDESA | United Nations Department of Economic and Social Affairs |
| UNDP | United Nations Development Programme |
| UN ECOSOC | United Nations Economic and Social Council |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNODC | United Nations Office on Drugs and Crime |
| UNPRPD | United Nations Partnership to Promote the Rights of Persons with Disabilities |
| WHO | World Health Organization |

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With the landmark passing of the Convention on the Rights of Persons with Disabilities, ratifying countries pledged to promote the full inclusion of persons with disabilities in all areas of society. Yet in many countries persons with disabilities continue to be excluded from key areas of life such as health, education, and work. This publication explores how excluding persons with disabilities has a negative impact on the economy and society. It also highlights that inclusive practices can generate economic gains at individual and societal level.

“This book provides us with convincing evidence that the international community will not be able to achieve sustainable development without breaking the vicious circle of poverty and the exclusion of persons with disabilities. This is in line with the Convention on the Rights of Persons with Disabilities, which emphasizes the importance of mainstreaming disability issues as an integral component of sustainable development strategies.”

Oh Joon, President of the Conference of States Parties to the Convention on the Rights of Persons with Disabilities and Ambassador and Permanent Representative of the Republic of Korea to the United Nations (2015)

“When we take actions to improve the lives of all people, we need to remember to include everyone. Persons with disabilities are particularly vulnerable and often forgotten, but have a lot to offer. To utilize the abilities of all is important for both the people and the economy of every country.”

Eric Solheim, Chair of the OECD Development Assistance Committee (2015)

“This important new CBM publication is both timely and relevant to the recent adoption of the 2030 Agenda for Sustainable Development. The research highlights how disability-inclusive development not only benefits persons with disabilities, but all of society, and truly embraces the concept of ‘leave no one behind’. This publication is highly recommended for those working in the fields of human rights, development, education, and social sciences.”

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