Disability Care and Support Systems

Country Assesment Tool

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Global Disability Fund

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Foreword

Caring for each other is a fundamental human value, a foundation for social and economic development, and an important aspect of upholding human rights. Comprehensive care and support systems are therefore essential to realizing the human rights of all and ensuring no one is left behind. They are the backbone of disability-inclusive societies, enabling autonomy, dignity, and participation for all.

This publication provides a road map for action grounded in international human rights standards, and drawing upon the lived experiences of people with disabilities. It complements previous work developed by civil society organizations by integrating a disability rights perspective and ensuring that care and support systems advance gender equality, economic justice, and autonomy for all.

This is a practical instrument to help Governments, policymakers and organizations of persons with disabilities to evaluate and strengthen their national policies, and to build care and support systems that are inclusive, rights-based and transformative. I encourage all stakeholders – States, civil society and international partners – to use it as a tool for change.

Together, we can dismantle outdated paradigms and build human rights-based systems that recognize care and support as a shared social responsibility and a pillar of equitable economies that deliver for all. Let us work collectively to create societies where every person can live independently, participate fully and thrive.

Volker Türk
United Nations High Commissioner for Human Rights

I. Introduction

Background

Ongoing crises and changing demographics around the world underline the need for actions to improve care and support systems. The coronavirus disease (COVID-19) pandemic highlighted the centrality of national comprehensive care and support systems that include everyone, especially persons with disabilities in all their diversity, including women, children and older persons. This was also highlighted by the Secretary-General of the United Nations in Our Common Agenda. It is now increasingly recognised that care and support systems should involve the sharing of unpaid care and support, while alleviating the burden of labour-intensive unpaid care and support for those bearing primary responsibility for providing it.

In a growing number of countries, comprehensive national care and support systems are now being created to bolster the recovery from the pandemic, but discussions often overlook the rights of persons with disabilities and those providing care and support.[1] This oversight could lead to systems failing to consider gender-, disability- and age-related rights and needs. The Human Rights Council mandated the Office of the United Nations High Commissioner for Human Rights (OHCHR) to conduct work on care and support systems through five reports, on a conceptual framework, good practices and policy priorities,[2] digital and assistive technologies, housing and transportation, and international standards.[3] Disability reports are available on the OHCHR thematic page on the rights of persons with disabilities, while the report on standards can be accessed from the OHCHR gender equality page.

The work of OHCHR on care and support is aimed at contributing to gender mainstreaming in disability rights work and to disability rights mainstreaming in gender equality, thereby supporting women's autonomy, in particular through economic empowerment and by ensuring that persons with disabilities enjoy the right to live independently and be included in the community. The comprehensive mandate of OHCHR allows for cross-movement action and multisectoral engagement to encourage conversations on care and support systems.

In 2023 OHCHR published an advocacy toolkit entitled "Time to transform care and support systems".[4] The toolkit includes resources to provide enhanced advocacy for the measures needed to transform care and support systems, and to broaden the scope of these measures.

This publication draws from and complements the OHCHR publication *Promoting the Rights of Persons with Disabilities through the Sustainable Development Goals: A Resource Package (SDG-CRPD Resource Package),* which developed policy guidance, human rights indicators and guidance on data sources compatible with both the Sustainable Development Goals (SDGs) and the Convention on the Rights of Persons with Disabilities (CRPD).[5]

The *SDG-CRPD Resource Package* addresses sector-specific issues. Its policy guidance booklets focus on policy areas of care and support systems, such as social protection, as contained in the Sustainable Development Goals. The *Human Rights Indicators* booklets contain indicators to measure compliance with the Convention, and the *Data Sources Guidance* booklets suggest sources that are commonly used to inform the indicators. These materials are useful for evaluating compliance with the Convention.

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[1] Julio Bango and Patricia Cossani, *Towards the Construction of Comprehensive Care Systems in Latin America and the Caribbean: Elements for Implementation* (Santiago, United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and the Economic Commission for Latin America and the Caribbean (ECLAC), 2021), pp. 10–11.

[2] A/HRC/RES/49/12.

[3] A/HRC/RES/55/8.

[4] To receive a copy of these materials, please contact ohchr-disability@un.org.

[5] The present publication draws its analysis from OHCHR, *Promoting the Rights of Persons with Disabilities through the Sustainable Development Goals: A Resource Package* (Geneva, 2024). To avoid excessive referencing, the *Resource Package* will be referenced only when material is used verbatim.

Care and support in the *SDG-CRPD Resource Package*	
Care and support disability priority areas	Examples of components of the *Resource Package* addressing priority areas
A. Social protection	
Cash transfers	**Policy guidance on SDG 1**
	Section 4: "Inclusive social protection" Subsection 4.5 on "Tailoring benefits to the diversity of persons with disabilities".
	Human Rights Indicators
	Article 28 (Social protection)
	Data Sources Guidance
	Article 28 (Social protection)
Assistive technology	**Policy guidance on foundations for inclusive SDGs**
	Part I: "Key concepts from the Convention on the Rights of Persons with Disabilities" Section 2: "Core pillars for all policies" Subsection 2.3: "Support for persons with disabilities: assistive technology and support services"
	Policy guidance on SDG 3
	Section 5: "Other actions by target" Subsection 5.1.2: "Increase access to quality health services, including rehabilitation services, medicines, health products and assistive technology."
	Thematic brief on "Research and innovation"
	Assistive technology
	Human Rights Indicators
	Articles 4 (General obligations) and 20 (Personal mobility)
	Data Sources Guidance
	Articles 4 (General obligations) and 20 (Personal mobility)
B. Human support	
Paid support	**Policy guidance on foundations for inclusive SDGs**
	Part I: "Key concepts from the Convention on the Rights of Persons with Disabilities" Section 2: "Core pillars for all policies" Subsection 2.3: "Support for persons with disabilities: assistive technology and support services"
	Policy guidance on SDG 1
	Community services and support: including access to basic general services and disability-specific services (target 1.3)
	Policy guidance on SDG 5
	Economic empowerment of women with disabilities (targets 5.4, 5.a and 5.b)

	Human Rights Indicators
	Article 19 (Living independently and being included in the community)
	Data Sources Guidance
	Article 19 (Living independently and being included in the community)
C. Infrastructure	
Transport	**Policy guidance on SDG 11**
	Section 5.2: "Transportation systems inclusive of persons with disabilities" (target 11.2)
	Human Rights Indicators
	Article 20 (Personal mobility)
	Data Sources Guidance
	Article 20 (Personal mobility)
Housing	**Policy guidance on SDG 11**
	Section 5.1: "Accessible housing, slums and homelessness" (target 11.1)
	Human Rights Indicators
	Article 28 (Adequate standard of living and social protection)
	Data Sources Guidance
	Article 28 (Adequate standard of living and social protection)
D. Cross-sectoral	
I. Governance	**Policy guidance on foundations for inclusive SDGs**
	Part II: "Structural requirements to create an enabling legal, policy and programming environment: implementing SDGs 10, 16 and 17" Section 1: "Governance" Subsection 1.1: "Institutional framework for good governance inclusive of persons with disabilities" Section 2: "Participation of persons with disabilities in public life" Subsection 2.1: "Ensure responsive, inclusive, participatory and representative decision making at all levels" Subsection 2.2: "Ensuring the right to vote of persons with disabilities"
	Human Rights Indicators
	Article 29 (Participation in political and public life)
	Data Sources Guidance
	Article 29 (Participation in political and public life)

II. Measuring needs	**Policy guidance on foundations for inclusive SDGs**
	Part II: "Structural requirements to create an enabling legal, policy and programming environment: implementing SDGs 10, 16 and 17" Section 1: "Governance" Subsection 1.2: "Results-based strategic planning for policy implementation" 1.2.2: "Disability assessment and determination as a tool for policymaking" Subsection 1.5: "Data collection and disaggregation by disability"
	Human Rights Indicators
	Article 31 (Statistics and data collection)
	Data Sources Guidance
	Article 31 (Statistics and data collection)
III. Financing	**Policy guidance on foundations for inclusive SDGs**
	Part II: "Structural requirements to create an enabling legal, policy and programming environment: implementing SDGs 10, 16 and 17" Section 1. "Governance" Subsection 1.3: "Finance and budgeting": 1.3.1: "Rights-based budgeting" 1.3.2: "Disability markers"
	Human Rights Indicators
	Article 5 (Equality and non-discrimination), Article 31 (Statistics and data collection)
	Data Sources Guidance
	Article 5 (Equality and non-discrimination), Article 31 (Statistics and data collection)
IV. Awareness and education	**Human Rights Indicators**
	Article 8 (Awareness-raising)
	Data Sources Guidance
	Article 8 (Awareness-raising)

One concept that is applied in the *SDG-CRPD Resource Package* that is also highly relevant for disability-inclusive policymaking is the twin-track approach. A twin-track approach to disability-inclusive policymaking advocates for mainstreaming the rights of persons with disabilities into all policies while also implementing targeted measures for their needs and requirements. The balance between mainstreaming and a targeted approach should be adjusted to address diverse community needs, with the overarching aim of inclusivity across development initiatives.

Objective

The *Country Assessment Tool* has been designed to enable a self-evaluation of the readiness of a given country's policy environment to implement comprehensive care and support systems that are aligned with the Convention, working to advance gender and economic justice, while addressing disability-specific policy priorities.[6] It is intended to inform policymakers and support the advocacy efforts of organizations of persons with disabilities to help them shape emerging care and support policies.

The *Country Assessment Tool* complements the *Care Policy Scorecard* developed by Oxfam.[7]

	CARE POLICY SCORECARD	COUNTRY ASSESSMENT TOOL
WHAT IS IT?	A practical tool to measure and rack a Government's progress and commitments on policies that have a direct impact on care (unpaid and paid).	A practical self-evaluation tool for the policy readiness of countries to implement comprehensive care and support systems that are aligned with the Convention and informed by the conceptual framework in the *Care Policy Scorecard*.
OBJECTIVES	Provide policymakers with evidence and information to make informed decisions on these policies.	Inform policymakers and support the advocacy efforts of organizations of persons with disabilities and non-governmental organizations (NGOs) to shape disability-inclusive care and support policies.
HOW DOES IT WORK?	The *Scorecard* consists of a set of policy indicators and questions to assess progress systematically and holistically across relevant public policy areas for unpaid and paid care work.[8]	The *Country Assessment Tool* enhances some of the elements of the *Scorecard* and contains additional indicators on disability rights. It can be used as a complement to the *Scorecard* or as a standalone tool.

Methodology

The *Country Assessment Tool* follows the methodology of and complements the *Care Policy Scorecard*. It is intended to serve as a stand-alone tool that can be used independently or as an add-on to the *Scorecard*, and it sets out the preconditions required to implement disability-inclusive comprehensive care and support systems. For a comprehensive assessment, it is recommended to use the *Scorecard* along with the *Country Assessment Tool*. The *Scorecard* offers a practical instrument for care and support advocates to use in assessing and monitoring government progress and commitments relating to gender equality.[9] It also supplies policymakers with evidence and information to make informed decisions on these policies.

[6] Feminist movements have long championed the recognition of care work, advocating for its economic and social value to address systemic gender inequities. They have emphasized that care work, often unpaid and performed predominantly by women, is crucial for societal well-being and economic sustainability. Examples of care economy frameworks are referenced throughout this publication, and the Oxfam *Care Policy Scorecard* is a reflection of such work.

[7] Anam Parvez Butt and others, *Care Policy Scorecard – A Tool for Assessing Country Progress Towards an Enabling Policy Environment on Care* (Oxfam, Oxford, United Kingdom, 2021).

[8] Ibid., p. 9.

[9] Ibid.

As is set out in the following sections, the frameworks adopted by the *Scorecard* and the *Country Assessment Tool* are compatible and complementary. The *Country Assessment Tool* enhances some of the elements of the *Scorecard*, it contributes to various different policy areas, indicators and data sources, and it provides examples relating to disability rights, thereby providing a disability lens. The following tables show the indicators that were reworked from the *Scorecard* for the *Country Assessment Tool*. Sections, policy areas and indicators with changes are highlighted.

SECTION 1: Unpaid care and support giving policy framework		
Policy areas	*Care Policy Scorecard* indicators	Disability-specific policy priorities in the Country Assessment Tool
1.1 Care-supporting physical infrastructure	1.1.1 Piped water	
	1.1.2 Household electricity	
	1.1.3 Sanitation services and facilities	
	1.1.4 Public transport	Inclusive public transport requires flexible point-to-point transport connections, and accessibility should be prioritized.
	1.1.6 Time- and energy-saving equipment and technologies	
	1.1.5 Assistive technology [NEW]	Assistive technology enables independence and autonomy and reduces the need for unpaid care and support.
	1.1.7 Housing [NEW]	Accessible housing allows persons with disabilities to decrease their need for support and reduces the risk of institutionalization.
1.2 Care services	1.2.1 Public healthcare services	
	1.2.2 Early Childhood Care and Development (ECCD) services	ECCD is a comprehensive concept that includes programmes, services and interventions providing care and support for children with disabilities and their families.
	1.2.3 Human support – paid support work [NEW]	Persons with disabilities may need personal assistance and individual support to perform activities of daily living. A generalized lack of support services leads to this being provided by families without compensation.

1.3 Care-related social protection benefits	1.3.1 Public pension	
	1.3.2 Cash transfer policies related to care and support	Social protection schemes with cash transfers must account for disability-related extra costs in contributory and non-contributory schemes.
	1.3.3 School meals or food vouchers	
	1.3.4 Care-sensitive public works programmes	
	1.3.5 Concessions and discounts [NEW]	Concessions improve support for persons with disabilities by enhancing their access to essential resources and services.
1.4 Care-supporting workplaces	1.4.1 Paid sick leave	
	1.4.2 Equal paid parental leave	
	1.4.3 Flexible working	
	1.4.4 On-site childcare	
	1.4.5 Breastfeeding at work	

SECTION 2: Paid care and support work		
Policy areas	*Care Policy Scorecard* indicators	Disability-specific policy priorities
2.1. Labour conditions	2.1.1 Living wages for paid care workers 2.1.2 Compatibility between wages, education and specialization 2.1.3 Working hours conditions and regulations 2.1.4 Formal contract and access to social benefits for care and domestic workers 2.1.5 Guaranteed child rights and labour protection	
2.2. Workplace regulations	2.2.1 Health and safety in the workplace 2.2.2 Prevention of workplace sexual abuse and harassment 2.2.3 Workplace inspections and grievance mechanisms ensuring decent work	
2.3. Migrant care workers' protections	2.3.1 Equal rights and protections for migrant domestic workers	
2.4. Right to organize	2.4.1 Right to representation and negotiation, freedom of association and right to strike	

SECTION 3: Cross-cutting		
Policy areas	Scorecard indicators	Disability-specific policy priorities
3.1. Data collection	3.1.1 Advertising standards prohibiting gender stereotypes	
	3.1.2 Awareness-raising campaigns on valuing caregiving and reproductive work and shifting gendered norms on care work	Campaigns on care and support work should emphasize its value, challenge rigid gender roles and promote the autonomy of persons with disabilities, ensuring they participate in all aspects of care on their own terms. Such campaigns should provide accessible information about rights and dismantle stereotypes that create discriminatory perceptions.
	3.1.3 Education to promote a more equitable distribution of care	
3.2. Social norms interventions	3.2.1 Measurement frameworks	Mainstream data collection frameworks have significant gaps when it comes to including disability, which must be addressed by using a twin-track, functional approach to identifying persons with disabilities.
	3.2.2 Time-use data	
	3.2.3 Disability assessment and certification [NEW]	Governments should develop disability assessment and certification mechanisms to identify persons with disabilities and provide adequate care and support.
3.3. Legal capacity and deinstitutionalization [NEW]	3.3.1 Legal capacity [NEW]	By centring their will and preferences, recognition of legal capacity and supported decision-making are core to the autonomy and agency of persons with disabilities.
	3.3.2 Deinstitutionalization [NEW]	Institutionalization is incompatible with care and support. Deinstitutionalization requires the closure of all institutions and the creation of inclusive community-based support systems that promote autonomy.

II. Care and support

Defining care and support

Everyone needs care and support at some point in their lives and in different circumstances, and everyone provides care and support to others in turn. These needs and roles change throughout our lives, depending on our circumstances. Care and support systems must be dynamic and flexible, recognizing not only the varying intensity levels of care and support needs but also the potential of persons with disabilities to develop skills and competencies for care and self-care, in line with article 19 of the Convention.

The terms "care" and "support" are used in different ways in the care and support agenda, reflecting different levels.

"Care" can be used to refer to care for people and the planet, care systems, the care economy or care work, among other usages.

"Support" is an integral part of the right to live independently and be included in the community (article 19 of the Convention), and it is referred to in the Convention as a cross-cutting concept. It also used in the concepts of "support systems" and "support work".

Care	Support
Care for people and the planet	The right to live independently and be included in the community (article 19)
Care sustains life and ensures well-being, involving self-care, care for others and care for the planet. It supports dignity, autonomy and equal participation, recognizing that everyone needs care and support at some point.	The right to live independently ensures that everyone can choose how and where to live, participate in daily life and access support to thrive in their community, rather than living in isolation or in an institution.
Care systems	Support systems
Care systems integrate policies, services and norms to reorganize care, promote shared responsibility and value care work through a rights-based, intersectional lens.	Support systems enable persons with disabilities to live and participate through human support, technology, financial aid, housing and community-based support for autonomy. This needs cross-sectoral policies.
Care economy	Support economy
The care economy encompasses all paid and unpaid work supporting caregiving, which is crucial for health, jobs, education and society. Care systems highlight care's broader, essential role in life.	There is no agreed definition, yet one can be inferred from parallel definitions, with a shift to the material conditions for delivering on support systems, including both human and non-human support.
Care work	Support work
Care work, both paid and unpaid, is skilled but undervalued. Paid services complement unpaid care, enhance quality and prevent burn-out.	Assistance enabling individuals, especially persons with disabilities, to live autonomously and participate in society, and upholding their dignity beyond basic needs.
Care and support work in the Convention on the Rights of Persons with Disabilities	
Children transition from care dependency to autonomy, while adults with disabilities require support, not care-based approaches. The Convention limits the use of the word "care", applying it to children or using it in terms such as "healthcare" and "respite care".	

Non-rights-based care systems have guided the design of modern social protection systems, but they have been criticized by the disability rights movement, as such systems[10] have overlooked the agency and autonomy of persons with disabilities.[11] Concerns have been raised about how a narrow understanding of "care" might lead to welfare policies that are overly caregiver- and service provider-centred, thus perpetuating existing care systems and their associated human rights violations.

Within the disability rights movement, the provision of support is seen as distinct from the provision of "care". Under the Convention, "care" only applies to children, as capacity to make decisions evolves from childhood to adulthood. Adults with disabilities may need support, hence the construction of "care and support" that is used in international documents, which can reflect all perspectives on the matter.[12]

Demographic changes

Demographic shifts require a reassessment of non-rights-based care systems to prevent future crises, and this is already happening in several regions.[13] In some countries, declining birth rates and increasing life expectancy are altering the age structure of the population, and more robust and adaptable support systems are required for ageing populations. The rise in youth unemployment and a global decrease in the younger population presents challenges for intergenerational care and support dynamics.[14]

Unpaid care and support giving, which is greatly prevalent in contexts where there is limited availability of care and support services, is mostly provided by women. This acts as a barrier to the formal participation of women in the labour force, with 606 million women worldwide being outside the formal labour force due to care responsibilities, as compared with 41 million men who are inactive on the labour market for the same reason. Women are increasingly participating in the formal labour market, however, and non-rights-based care systems must adapt to demographic changes and ensure that care and support mechanisms are universal, equitable, affordable, accessible and of high quality.[15]

Austerity measures, which affect 85 per cent of the global population, strain resources that are critical for maintaining effective care and support systems.[16] Combined with the increasing pressures of climate change, which exacerbates water scarcity, droughts and related health issues, such factors require a re-evaluation and strengthening of policy frameworks. If no policy response is devised in response to ongoing trends, social outcomes will deteriorate, potentially leading to the complete abandonment of those requiring support.

Persons with disabilities constitute at least 16 per cent of the world population, and at least 20 per cent of them have high support requirements.[17] Around 80 per cent of persons with disabilities live in

[10] The phrase "non-rights-based care systems", also called "conventional care systems", refers to systems based on outdated paradigms that, as described in A/HRC/52/52, para. 6, "are characterized as carer-centred, and commonly place care receivers as passive recipients of care, with no agency to control and direct the care that they receive, leading to a loss of autonomy, economic disempowerment, and segregation and isolation from the rest of the community in institutions or in 'family homes.'" Care and support systems are human rights-based, transformative, gender-responsive, disability inclusive and age appropriate. As described in A/HRC/55/34 at para. 4, care and support systems are necessary preconditions for persons with disabilities to live independently in their communities with autonomy, choice and control. These systems include a network of services, people and products that enable persons with disabilities to carry out activities of daily living and to actively participate in their communities.

[11] Bango and Cossani, *Towards the Construction of Comprehensive Care Systems*, p. 10.

[12] References to care as an obligation are found in article 7 of the Convention. Other references to care are found in the context of healthcare (article 25) or respite care (article 28). Obligations for adults with disabilities are framed in terms of support.

[13] A/HRC/55/34.

[14] Laura Addati, Umberto Cattaneo and Emanuela Pozzan, *Care at Work: Investing in Care Leave and Services for a More Gender Equal World of Work* (Geneva, International Labour Organization (ILO), 2022).

[15] Ibid.

[16] Oxfam, "The assault of austerity: how prevailing economic policy choices are a form of gender-based violence", 22 November 2022, p. 5.

[17] World Health Organization (WHO) and World Bank, *World Report on Disability* (Geneva, 2011), p. 27.

developing countries,[18] where most of them do not have access to care and support systems.[19] Data collection and analysis may ultimately allow for better policies.[20] Present trends underscore the urgent need for systems to be flexible, inclusive and responsive to changes in the fabric of society.

Impact of COVID-19

The COVID-19 pandemic has placed unprecedented stress on non-rights-based care systems, exacerbating the challenges faced by both paid and unpaid care and support givers.[21] The strain on those systems that was caused by the pandemic significantly worsened working conditions, increasing the pressure on those providing these essential services.[22]

Research indicates that persons with disabilities were disproportionately affected during this time. In particular, they often faced greater barriers to accessing support.[23] During the COVID-19 lockdowns, persons with disabilities faced severe challenges. Those who relied on support for daily living activities struggled with isolation and concerns around their survival, while those living in institutions were at high risk, as shown by the many deaths in care homes and psychiatric facilities.[24] Access to healthcare and information became more difficult, and discrimination persisted, restricting opportunities to obtain income support or to participate in online education, and making it more difficult to seek protection from violence. The disruption to services that persons with disabilities rely on further highlighted pre-existing inequalities within non-rights-based care systems. This evidence has led to calls for systemic reform to tackle the crises that are faced and to safeguard the rights of care and support workers and of persons with disabilities.[25]

Care and support economy

> "The care economy comprises care work, both paid and unpaid, and direct and indirect care, its provision within and outside the household, as well as the people who provide and receive care and the employers and institutions that offer care. Care work consists of, among others, activities and relations that pursue sustainability and quality of life; nurture human capabilities; foster agency, autonomy and dignity; develop the opportunities and resilience of those who provide and receive care; address the diverse needs of individuals across different life stages; and meet the physical, psychological, cognitive, mental health and developmental needs for care and support of people including children, adolescents, youth, adults, older persons, persons with disabilities and all caregivers."
>
> *Source:* Resolution concerning decent work and the care economy, paragraph 9. International Labour Conference, 112th session, Geneva, 2024.

[18] United Nations, Department of Economic and Social Affairs, "Factsheet on persons with disabilities", www.un.org/development/desa/disabilities/resources/factsheet-on-persons-with-disabilities.html.
[19] Department of Economic and Social Affairs (2018), *Disability and Development Report: Realizing the Sustainable Development Goals by, for and with Persons with Disabilities – 2018* (New York, 2019), p. 41.
[20] Resolution V of the 112th session of the International Labour Conference, held in Geneva in 2024, states: "Collecting data disaggregated by all forms of care work and measuring the scope and value of unpaid care are critical to understanding the care economy and informing policy design. These data should be disaggregated by income, sex, age, race, ethnic origin, migration status, disability, geographical location and other relevant characteristics, in line with national context." (para. 28).
[21] UN Women and ECLAC, *Care in Latin America and the Caribbean During the COVID-19: Towards Comprehensive Systems to Strengthen Response and Recovery* (Santiago, 2020).
[22] Ibid., p. 1.
[23] OHCHR, "COVID-19 and the rights of persons with disabilities: guidance", 29 April 2020, p. 1.
[24] Ibid.
[25] ILO, *Care Work and Care Jobs for the Future of Decent Work* (Geneva, 2018), p. 25.

Reforms to the care and support economy have long been demanded by feminist movements and care worker groups. Their advocacy extends beyond the redefinition of care and support work, pushing for a fair valuation of such work, with a just redistribution of responsibilities between genders, and within and between households, communities, the private sector and the state. Such calls have been fuelled by an understanding that care and support work is foundational to the sustained functioning of societies and to the growth and stability of the economy. The challenge involves confronting non-rights-based care systems that have long marginalized the contributions of those who do most of the care and support work. This particularly affects women's well-being, economic security and political participation. Some recent efforts at reimagining care and support policies have recognized the need to include the representation of persons with disabilities.[26]

Empowerment and autonomy

The disability rights movement has been a driving force for autonomy, working to ensure that persons with disabilities of all ages and genders are able to live independently within their communities, and that adults can exercise their legal capacity. Support systems are crucial for the liberty of persons with disabilities in preventing practices that may lead to their isolation in institutions or at home. They enable persons with disabilities to make autonomous decisions in all aspects of their life, particularly on the type of support they receive and who provides it. This empowerment allows them to participate in decisions such as where to live, study, work, spend time with friends and engage in social life.

Reimagining care and support systems

Non-rights-based care systems are based on outdated paradigms, they are carer-centred, and they remove agency from persons with disabilities. Based on patriarchal norms, they impose a "duty of care" on women and girls, who take on most unpaid care and support roles, which undermines their agency and choices and has a structural impact on their human rights. Furthermore, non-rights-based care systems undervalue care and support work and workers and can render them invisible.

[26] Bango and Cossani, *Towards the Construction of Comprehensive Care Systems*, pp. 10, 23 and 37.

NEGATIVE IMPACTS OF NON-RIGHTS-BASED CARE SYSTEMS	
Area of impact	Explanation
Institutionalization and segregation	Non-rights-based care systems often rely on institutional care, where individuals are placed in large or small (and often overcrowded) segregated facilities, isolating them from their communities. Institutionalization is a human rights violation that leads to social exclusion, a risk of violence and loss of autonomy.
Violation of autonomy and dignity	A lack of respect for individuals' autonomy and choices regarding how they receive care and support results in practices where care is provided without informed consent, disregarding personal preferences and failing to provide the tools necessary to exercise choice and control.
Perpetuation of stigma and discrimination	Reinforcement of negative stereotypes and stigma associated with disability, ageing or illness. Non-rights-based care systems view individuals as passive recipients of care rather than as active participants with rights and capabilities. They also perpetuate gender-biased roles and stereotypes.
Barriers to community inclusion	Scarcity of services and outdated systems can create barriers to community living and integration. Such factors limit participation in society and access to education, recreation, employment and independent living.
Economic inefficiency	Piecemeal solutions and institutional "care" are often more expensive and less efficient than community-based alternatives. Resources are spent on maintaining large facilities rather than investing in community support services that can enhance the quality of life for individuals and are sustainable in the long term.
Systems that operate contrary to human rights obligations	Many non-rights-based care systems do not align with international human rights frameworks such as the Convention on the Rights of Persons with Disabilities. They fail to uphold the principles of equality, non-discrimination, the right to live independently in the community and respect for autonomy.
Undervaluing of care and support work and workers	Non-rights-based care systems rely on unpaid labour, mainly from women, with poor working conditions for care and support workers, and on patriarchal norms that socially undervalue their work.

Care and support systems must be human rights-based, transformative and gender-, disability- and age-responsive. Care and support systems provide the means, through a network of services, people and products, for persons with disabilities to live independently in their communities with autonomy, choice and control.[27] They must be universally accessible to all, regardless of race, class, caste, ethnicity, migration status, sexual orientation, gender identity or geographical location, among other factors.

A transformative care and support framework recognizes the contributions of the feminist and disability movements. It acknowledges the link between gender equality, disability rights and intersecting systems of discrimination, ensuring inclusive benefits across diverse populations. Without this approach, non-rights-based care systems risk creating conflict and exclusion, and leaving certain populations behind.

[27] A/HRC/55/34, paras. 4–6.

International and national action

Care and support systems are gradually being enhanced by States, resulting in increased action at the international level. Intergovernmental documents related to care and support have been adopted at the General Assembly,[28] the Human Rights Council,[29] the Economic and Social Council,[30] the Commission on the Status of Women,[31] the Regional Conference on Women in Latin America and the Caribbean[32] and the International Labour Conference.[33] The Sustainable Development Goals address the care agenda and unpaid care work in particular in target 5.4, which directly contributes to the transformation of care and support systems and calls upon States to address gaps on the way to a post-2030 agenda.

There are other initiatives at the international level that also reflect the momentum of engagement on care and support systems. The Global Alliance for Care was created in 2021, following the Generation Equality Forum, and it has explicitly included persons with disabilities in its strategic framework; the Association of Southeast Asian Nations (ASEAN) held a conference on the topic in 2023;[34] and the 2024 Pact for the Future includes a commitment to invest in the care and support economy.[35]

At the national level, many countries are in the process of creating new care and support systems, as well as reforming existing systems that operate under outdated paradigms. In Chile, Mexico, Panama, Paraguay and Peru, proposals have been discussed for adopting new care and support systems.[36] Information on support needs has been collected as part of the process to start a new system in Kenya.[37] A system was adopted in Uruguay in 2015,[38] and systems were adopted more recently in Colombia and Costa Rica.[39] Positive policy programmes on personal assistance have been adopted in countries such as Armenia, the Republic of Moldova, Serbia and Thailand, while non-medical disability assessment processes have been adopted in Fiji, Nepal and Viet Nam.[40]

[28] See, for example, General Assembly resolution 77/317, proclaiming an International Day of Care and Support; see also UN Women, "Member States agree on International Day of Care and Support: a milestone for gender equality and sustainable societies", 9 August 2023, www.unwomen.org/en/news-stories/news/2023/08/member-states-agree-on-international-day-of-care-and-support-a-milestone-for-gender-equality-and-sustainable-societies.

[29] See, for example, A/HRC/RES/49/12, A/HRC/RES/54/6 and A/HRC/RES/55/8.

[30] See, for example, E/CN.5/2024/L.5 on "Promoting care and support systems for social development".

[31] See, for example, Commission on the Status of Women, sixty-first session, 13–24 March 2017, Agreed conclusions; sixty-eighth session, 11–22 March 2024 (E/CN.6/2024/L.3), Agreed conclusions, paras. 32 and 54 (ii).

[32] The Buenos Aires Commitment was adopted at the Regional Conference on Women in Latin America and the Caribbean. It addresses the transformative path for a care society and recognizes care as a right.

[33] See Resolution V of the 112th session.

[34] Economic and Social Commission for Asia and the Pacific (ESCAP), "Report on the Regional Forum on Care Work for ASEAN Countries", www.unescap.org/sites/default/d8files/event-documents/Report%20on%20the%20Regional%20Forum%20on%20Care%20Work%20for%20ASEAN%20Countries%20%283%29.pdf.

[35] *Summit of the Future Outcome Documents, September 2024: Pact for the Future, Global Digital Compact and Declaration on Future Generations* (United Nations publication, 2024), pp. 7–8.

[36] Alberto Vásquez Encalada and María Antonella Pereira, *Autonomía: Un Desafío Regional – Construyendo Sistemas de Apoyos para la Vida en Comunidad de las Personas con Discapacidad en América Latina y el Caribe* (Caracas, Center for Inclusive Policy and CAF-Development Bank of Latin America and the Caribbean, 2023).

[37] A/HRC/55/34, para 51.

[38] ECLAC, *El Desafío de un Sistema Nacional de Cuidados en Uruguay* (2011).

[39] Vásquez and Pereira, *Autonomía: Un Desafío Regional*.

[40] A/HRC/55/34, paras. 20 and 50.

III. Legal foundations

Legal framework for support

The Convention on the Rights of Persons with Disabilities is the main human rights treaty that has a coherent body of obligations related to support and to the care of children with disabilities. It contains all the core human rights standards for persons with disabilities. Compliance with the Convention prevents human rights violations and offers guidance for designing disability-responsive policies. The Convention upholds the rights of persons with disabilities to autonomy, inclusion and participation in all aspects of life, supporting the establishment of a stronger legal framework for care and support systems. It also provides a solid framework for accountability and redress of disability rights violations.

The Convention has a strong intersectional framework that recognizes intersectional discrimination. Articles 6 and 7 include provisions to address discrimination against women with disabilities and children with disabilities, respectively, based on their gender, age and disability. The Committee on the Rights of Persons with Disabilities has explained that these examples of intersectionality are illustrative and not exhaustive, recognizing that intersectional analysis includes all forms of discrimination.[41] As a result, the Convention provides States with a set of obligations that are comprehensive and are aimed at ensuring the rights of all persons involved in care and support systems.[42]

Community-based solutions and deinstitutionalization

The Committee on the Rights of Persons with Disabilities recognizes institutionalization as a form of violence against persons with disabilities.[43] Deinstitutionalization is a State obligation and a tool against violence. However, persons with disabilities also experience violence related to care outside institutions. Hence, although deinstitutionalization is an important step, further measures and policies must be in place to prevent and respond to violence in the community.

Community-based solutions aligned with the Convention have successfully led to deinstitutionalization and the promotion of community living for persons with disabilities. These solutions prioritize services that enable individuals to live in the community, providing them with choices equal to those of others and shifting away from long-term institutional care. Policies must seek to promote equal outcomes for persons with disabilities in work, participation in society, and health and well-being.

Persons with disabilities overcome barriers by creating their own community-based solutions that align with the Convention, often with support from their families in the absence of or in combination with public policies that systematically recognize their human rights. Services, particularly those that promote their autonomy, are in most cases non-existent. Even in the best cases they tend not to be comprehensive.

Persons with disabilities know what they need and have experience in developing solutions for varying support arrangements. Systems must incorporate their perspective and promote solutions where they guide service providers, and the quality of services should be measured against human rights standards. As stated by the Special Rapporteur on the rights of persons with disabilities, transitioning to any new service paradigm requires co-design from the outset and requires diverse voices around the table.[44]

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[41] General comment No. 6 (2018) on equality and non-discrimination (CRPD/C/GC/6), para. 36.
[42] The provisions in the Convention on the right to work and general comment No. 8 (2022) of the Committee on the Rights of Persons with Disabilities on the right of persons with disabilities to work and employment are essential for taking the perspective of care and support workers into account.
[43] CRPD/C/5, para. 6.
[44] A/HRC/52/32, para. 62.

In developing care and support systems, meaningful participation of persons with disabilities and their representative organizations must be ensured.[45] Their insights and experiences are necessary for transitioning to rights-based service paradigms. Data must be collected and disaggregated to understand challenges and ensure effective services.

Disability-inclusive policies

Policy efforts on the care and support economy tend to target persons with disabilities mainly as recipients of care, while the roles of caregivers and providers of support are largely overlooked. Their representation in the co-design of care and support systems is central to the effectiveness and efficiency of the support that they provide. As has been stated by the Committee on the Rights of Persons with Disabilities, all aspects of policy and system design that affect persons with disabilities must involve their participation.[46] This ensures that the systems that are created are responsive to their needs while respecting their rights and agency in providing and receiving care and support and empowering them in their self-care. This represents a commitment to co-design, recognizing that the insights and contributions of persons with disabilities are valuable and necessary in creating systems that truly support their independence and well-being.[47]

The Special Rapporteur on the rights of persons with disabilities issued a report on disability-inclusive policies, highlighting that disability-inclusive policy frameworks require a twin-track approach covering participation, monitoring, budgeting, data collection and disability awareness.[48]

Aspects of disability-inclusive policy frameworks

Benefits of care and support, risks of inaction

There are significant economic benefits to transforming and improving care and support systems. Care and support systems create a stronger social protection floor, securing income that helps prevent financial crises. They can also operate as a pacifying factor, preventing crises. Feminist literature has identified many benefits to adopting equitable care and support systems, including the so-called triple dividend of care and support investment:

1. Directly contributing to people's well-being;
2. Creating high-quality jobs;
3. Increasing women's participation in the formal labour force by reducing the time spent providing unpaid care and support.[49]

[45] Committee on the Rights of Persons with Disabilities, general comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention (CRPD/C/GC/7).
[46] Ibid.
[47] United Nations, "Transforming care systems in the context of the Sustainable Development Goals and Our Common Agenda – UN system policy paper", July 2024. The policy paper identifies participation and decision-making by the groups most likely to be overlooked as a means to secure "representation and meaningful participation of caregivers and care recipients and their organizations" (p. 19).
[48] See A/71/314, section IV.
[49] Bango and Cossani, *Towards the Construction of Comprehensive Care Systems*, p. 17.

Investing in care and support sectors can substantially diminish poverty rates, advance gender equality and contribute positively to growth in gross domestic product.[50]

Continuing with business as usual risks reinforcing systems that have long been challenged by women, persons with disabilities and older persons. Doing so perpetuates gender inequality and the institutionalization of persons with disabilities, potentially leading to serious human rights violations. It can also generate a vicious circle of care, poverty and inequality, where unpaid care and support givers cannot enter the labour force and care and support receivers cannot access the services they need.[51] Worsening working conditions contribute to keeping workers in poverty and can be directly linked with violence and the abandonment or neglect of those receiving care and support. Seen as a pillar of social protection systems, the provision of care and support affects the proper performance of the other pillars.[52]

[50] See, for example, Rachel Connelly and Ebru Kongar, eds., *Gender and Time Use in a Global Context* (Palgrave Macmillan, 2017); Ana Güezmes García and María-Noel Vaeza, coordinators, "Advances in care policies in Latin America and the Caribbean: towards a care society with gender equality", ECLAC, 2021, pp. 15–16; ILO, "The benefits of investing in transformative childcare policy packages towards gender equality and social justice", ILO brief, October 2023.

[51] ILO, "The benefits of investing in transformative childcare policy packages", p. 14.

[52] See, for example, Mignon Duffy, "Why improving low-wage health care jobs is critical for health equity", *AMA Journal of Ethics,* vol. 24, No. 9 (September 2022).

IV. Policy dimensions and objectives

Proposals to transform non-rights-based care systems have engaged with how care and support work is unequally distributed. The 5Rs+[53] framework calls for recognizing, reducing and redistributing unpaid care and support giving, rewarding paid care and support work and ensuring representation, social dialogue and collective bargaining for care and support workers.[54]

There are three dimensions to care and support:[55]

- Providing care and support, acknowledging the social interrelationship inherent in the need for both giving and receiving care and support
- Receiving care and support, recognizing individuals as active rights holders with autonomy over the care and support they receive
- Self-care, emphasizing the importance of having the means and time to exercise and manage personal care and support.

The transformation of care and support systems encompasses three policy objectives aimed at tackling the unequal distribution of unpaid care and support giving, which disproportionately falls on women. These policy objectives are referred to as follows:

- Time for care and support, which requires the release of available time to provide high-quality care and support (if a person works too much, they cannot care for or support others)[56]
- Cash for care and support, which requires (primarily public) financial resources to pay adequately for the provision of care and support (noting that cash transfer programmes can cover care and support services)[57]
- Service provision, with the aim of reducing unpaid care and support giving – that is, funding the demand for care and support services.[58]

5Rs+ framework	Care and support actions considering the rights of persons with disabilities
Recognize	Implies recognizing the human rights of persons with disabilities and measuring time use in all dimensions of care and support.
Reduce	Implies reducing labour-intensive unpaid care and support giving that persons with disabilities and their families provide for others, and self-care.
Redistribute	Implies reallocating time invested in labour-intensive unpaid care and support giving through human rights-based services and community networks, including services provided by the private sector and by the State. These systems should address the needs of persons with disabilities, allowing them to manage their own support arrangements.
Reward	Provides rewarding care and support for workers by improving their working conditions and ensuring access to social protection programmes, improving the quality of care and support provided.

[53] To find a common framework that can be easily expanded, professionals working on care and support have started to use 5Rs+ informally, progressively including further "Rs" that have been proposed. For example, UN Women's toolkit on paid and unpaid work recommends resilience as a new "R". The UN system policy paper produced in July 2024 includes resources. See UN Women, "A toolkit on paid and unpaid care work: from 3Rs to 5Rs", June 2022, p. 4; United Nations, "Transforming care systems", p. 25.
[54] ILO, *Care Work and Care Jobs*, p. xliv.
[55] A/HRC/52/52, para. 27.
[56] ILO, *Care Work and Care Jobs*, pp. 126–133.
[57] Ibid., pp. 145–150.
[58] Ibid., pp. 133–145.

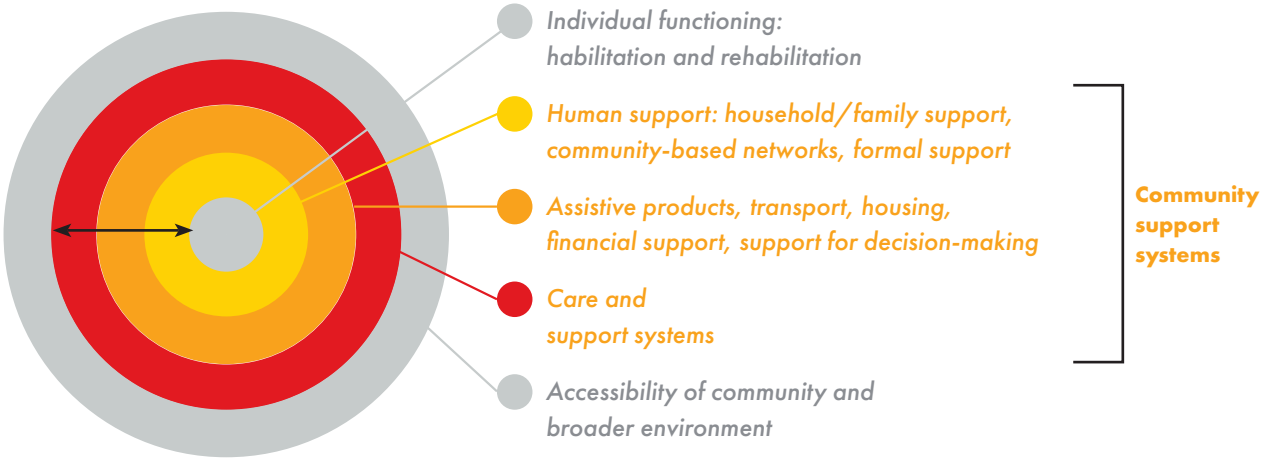
Represent	Implies the representation of care and support workers and persons with disabilities and their organizations by including their views in social dialogue and collective bargaining, formalizing care and support work.
Resources	Implies costing and tracking care investments, developing care and support-responsive budgeting and expanding the available fiscal space for financing inclusive and thriving economies.[59]

Overlap between the Scorecard and disability-inclusive policies

The policy areas included in the *Scorecard* follow a rights-based approach in responding to care and support providers and receivers, with the aim to "shift the gender norms, power relations and racial discrimination that underlie the undervaluing of care work."[60] They are aligned with the 5Rs+ framework and the policy objectives. The *Scorecard* has three sections that thematically group care policies and indicators:

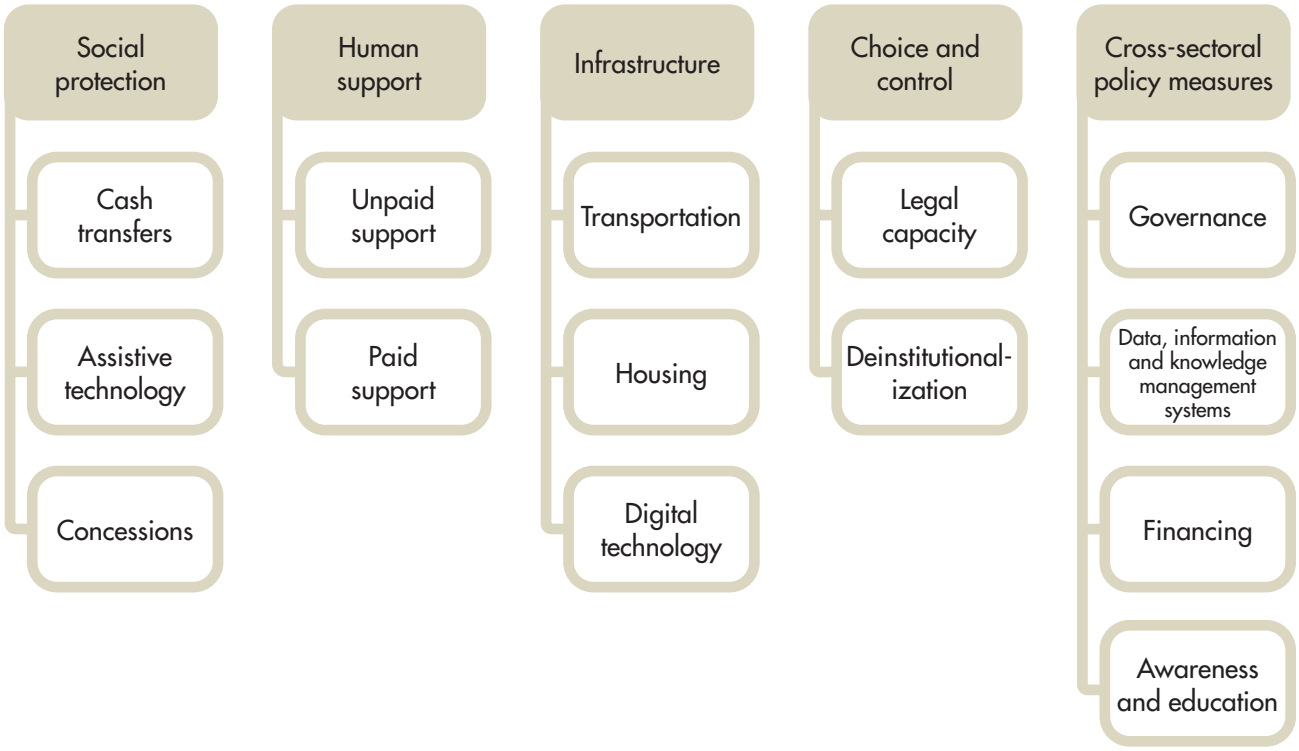
There are policy areas that are related and that can overlap with the objectives and dimensions of care and support systems. There is an interdependence between care and support systems, the improvement of individual functioning, and the accessibility and inclusiveness of the environment. Maximizing individual functioning and improving broader environmental accessibility can reduce the need for human support services. However, such measures are not considered part of the care and support systems in this *Country Assessment Tool*.

Figure i
Interdependence among community support systems, improvement of individual functioning and accessibility of the community and broader environment.[61]



[59] United Nations, "Transforming care systems", p. 20.
[60] Butt and others, *Care Policy Scorecard*, p. 17.
[61] Department of Economic and Social Affairs, *Disability and Development Report 2024: Accelerating the Realization of the Sustainable Development Goals by, for and with Persons with Disabilities* (New York, 2024).

OHCHR has identified several indicators and policy areas in the *Scorecard* that could be enhanced with a disability rights perspective. These disability-specific policy priority areas are:



All changes to the policy areas and indicators of the *Scorecard* are aimed at incorporating a disability rights approach and are explained in section 3.

How do care and support systems coordinate with other sectors?

The aims of care and support systems are to redistribute the responsibilities and time invested in care and support across society, to promote gender equality and shared responsibility and to ensure that care and support are provided with dignity and fairness and in line with human rights principles. This paradigm has been shaped and driven by feminist movements, organizations of persons with disabilities and movements of older persons, which have long highlighted both the unequal burden placed on women and the systemic exclusion of those who require care and support.

In practice, the typical entry point into care and support systems involves individuals who provide care and support in their families or communities, and who seek assistance from the State to reorganize their time and access services that enable them to fully exercise their rights. While care and support providers come from all backgrounds – including women with disabilities, older persons and men – the available data consistently show that it is primarily women who perform this work on a daily basis, reflecting deep-rooted gender inequality in the social organization of care and support.

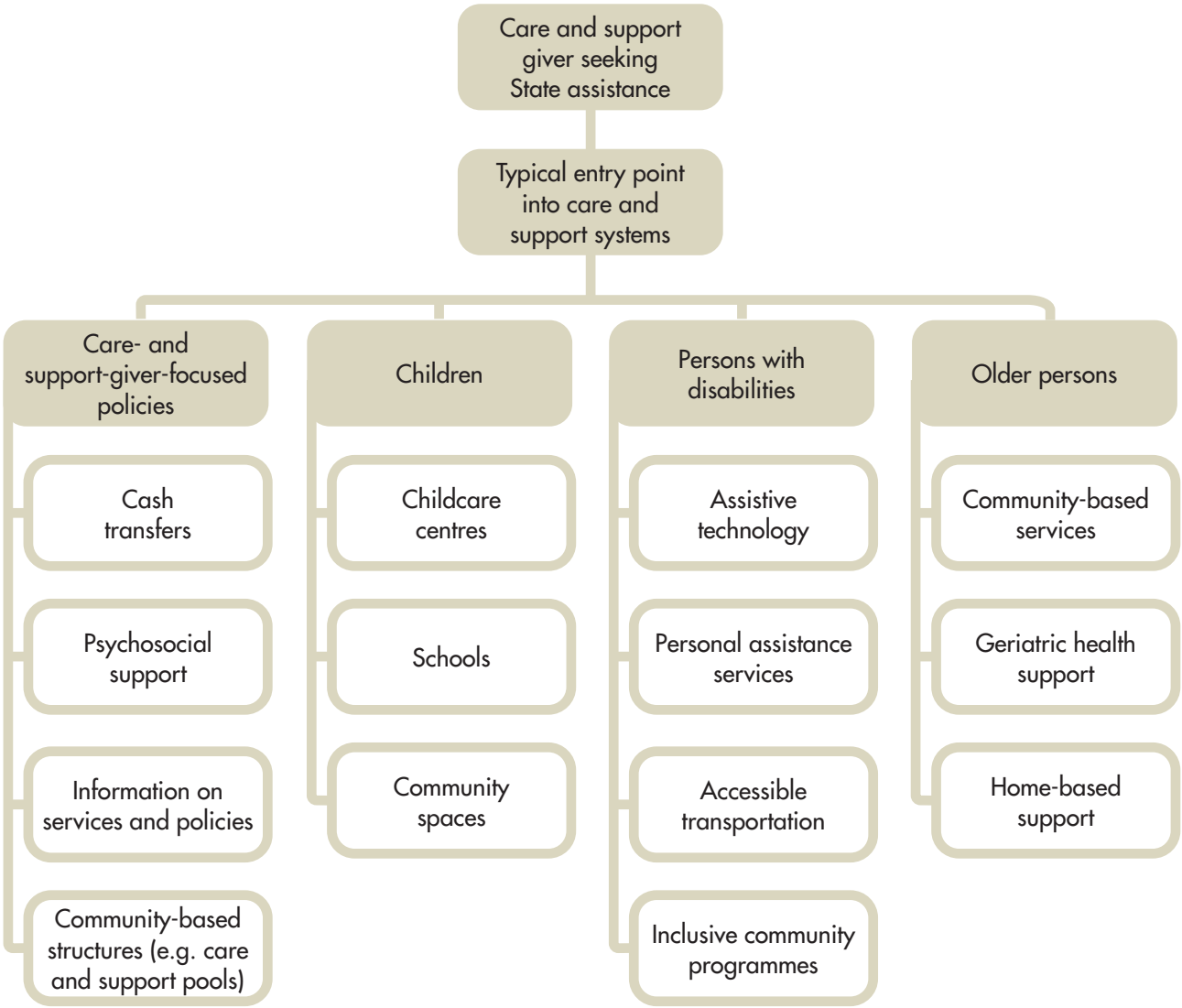
Once a request is made, there should be coordination between the care and support system and other social sectors covering ageing, disability and childhood. In particular:

- A person providing care and support to a father (an older person), a partner (a person with disability) and a child (without disabilities), for instance, may require different responses for each
- Those responses are typically managed by distinct sectors, covering ageing (social protection, healthcare, community-based services), disability (personal assistance, measures to increase accessibility, assistive technology), and childhood (education, community activities).

Many of the services available in these sectors at the time of writing still fall short of international human rights standards, particularly those of the Convention on the Rights of Persons with Disabilities. In some cases, systems continue to rely on institutional or segregated responses, such as residential homes, day-care centres or special schools, which fail to promote autonomy, independent living or inclusion in the community.

Care and support systems must not serve as automatic referral mechanisms into traditional service structures. Instead, they should act as coordinating platforms that direct public and community-based services towards rights-aligned responses. These systems must support both the fair reorganization of time for those who provide care and support, and the autonomy and meaningful participation of those who receive them.

Figure ii
Coordination of care and support systems



V. Policy areas and indicators

Based on the definition of transformative care policies devised by the International Labour Organization, the *Scorecard* determines which policies have transformative potential and organizes them into its three sections. Given the compatibility of the conceptual frameworks produced by Oxfam and OHCHR, this publication expands, redefines and specifies those areas that are in accordance with the priorities under the Convention.

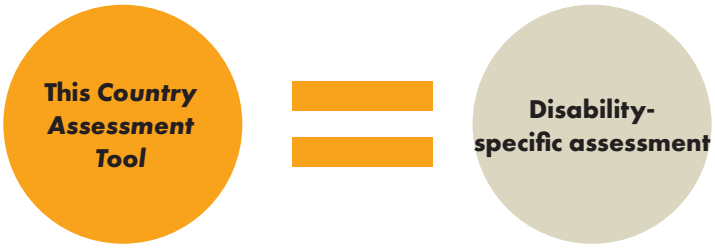
The *Scorecard* is a comprehensive tool for assessing the configurations of care systems. Efforts were made to include disability rights in the *Scorecard*, but further enhancement is needed to meet the standards of the Convention. OHCHR identified indicators that:

The sources of verification included in this *Country Assessment Tool* complement those mentioned in the *Care Policy Scorecard*, except when indicators are completely replaced.

Instructions

For a full assessment, use all the *Scorecard* indicators, including the modifications and new indicators proposed in this *Country Assessment Tool*. To do this, first review the *Scorecard* narrative in detail, followed by this *Country Assessment Tool* narrative in the indicators in this publication, and finally use the accompanying spreadsheets for scoring.

You may wish to conduct a stand-alone assessment focused exclusively on disability, in which case you should complete only the indicators presented below when using the spreadsheets.



This *Tool* is designed to be applicable in a wide range of contexts. However, it may not fit all situations perfectly. Before starting, review all indicators and their relevance in detail and make any necessary modifications. For example, in countries with federal systems, it may be desirable to add an assessment criterion (a scoreline) to each indicator to account for differences in public policy at the federal and state or provincial levels.

Impact on people: Indicators and sources of verification

The indicator tables in this *Country Assessment Tool* are designed to assess the policy environment, not the impact of policy on people. Nevertheless, they are also designed to be flexible and can be adjusted during the implementation planning phase to better suit national or local contexts. When revising the indicator tables, it is possible to add scorelines that focus on specific aspects of disability-inclusive policy, with the aim of measuring other relevant factors in the policy framework or their impact on people.

The *SDG-CRPD Resource Package* produced by OHCHR includes a set of structural, process and outcome indicators, corresponding with various articles of the Convention on the Rights of Persons with Disabilities, that address all dimensions of care and support systems. Structural indicators assess a State's commitment to human rights by reflecting its ratification of legal instruments and the development of the necessary institutional mechanisms for promoting and protecting human rights. Process indicators evaluate how a State implements policy measures and programmes to turn its human rights commitments into tangible actions. These indicators focus on the policies created and the steps taken to implement the commitments made. Outcome indicators measure the results of these efforts, capturing the level of enjoyment of human rights in a given context. Over time, they consolidate the impact of the actions and measures taken by States to fulfil their commitments.

See the *SDG-CRPD Resource Package*, "Frequently asked questions on the human rights indicators on the Convention on the Rights of Persons with Disabilities", pages 6 to 7, for more information.

The *Resource Package* also offers guidance on how to use data sources to assess outcome indicators. These suggested data sources can feed in new scorelines based on the indicators. They can also serve as a valuable reference for those conducting the assessment, who may not have previous experience in all policy areas. Indeed, some sources of verifications suggested in the indicators below come from the *Resource Package*.

At the beginning of the self-evaluation, decisions need to be made regarding data collection methodology and how to score each line. The *Care Policy Scorecard* includes a section on scoring that provides guidance on deciding how to score criteria.[62] The accompanying spreadsheets include a formula that automatically calculates scores and a table that assesses the transformative impact of a policy based on the score obtained.

In certain contexts, there might not be a formal policy enacted in law or under administrative regulations. However, some aspects of the policy area might be addressed by specific programmes or policies pertaining to other policy areas. In such cases, the assessment criterion for the existence of a policy might be given a score of 0.5 or even 0, and the remaining criteria can still be scored if they are addressed through other programmes or regulations.

The integration lab of the Keough School of Global Affairs at the University of Notre Dame, Oxfam America, the National Women's Law Center and the National Partnership for Women & Families used the Scorecard to develop an assessment of the care policy environment in the United States of America and issued a report.[63] The resulting documents are a useful example of what an assessment can look

[62] Butt and others, *Care Policy Scorecard*, pp. 26–28.

[63] Nicolas Chehade and others, "US Care Policy Scorecard: Assessing federal unpaid and underpaid care policies in the US", Keough School of Global Affairs (University of Notre Dame), Oxfam America, National Women's Law Center and National Partnership for Women & Families, 19 July 2023, available at www.oxfamamerica.org/explore/research-publications/uscarescorecard/.

like. The overall scores and self-evaluation of the indicator on migrant workers' protections in the United States are shown in the table below.

TABLE 1. **OVERALL SCORING AND GENERAL TRENDS**

Section 1: Unpaid care work	**Average score**
Policy area 1.1: Care-supporting physical infrastructure	61%
Policy area 1.2: Care services	59%
Policy area 1.3: Social protection benefits related to care	52%
Policy area 1.4: Care-supporting workplaces	7%
Section 1 total score:	45%
Section 2: Paid care work	**Average score**
Policy area 2.1: Labor conditions and wage policies	51%
Policy area 2.2: Workplace environment regulations	47%
Policy area 2.3: Migrant care workers' protections	24%
Policy area 2.4: Right to organize	43%
Section 2 total score:	41%
TOTAL COUNTRY SCORE	43%

The assessment of each indicator is available in the raw data file accompanying the Oxfam America report. There follows an excerpt of the indicator table for *Scorecard* indicator 2.3.1 on equal rights and protections for migrant workers.

INDICATOR 2.3.1: EQUAL RIGHTS AND PROTECTIONS FOR MIGRANT CARE WORKERS[64]			
ASSESSMENT CRITERIA	SCORE	SCORE EXPLANATION	SOURCE
There is a national policy to ensure equal rights and protections for different migrant workers (e.g. internal migrants, migrants returning to country of origin, international migrants)	Partial: 0.5	The Immigration and Nationality Act prohibits employers (when hiring, discharging, or recruiting or referring for a fee) from discriminating because of national origin against U.S. citizens, U.S. nationals, and authorized aliens or discriminating because of citizenship status against U.S. citizens, U.S. nationals, and the following classes of aliens with work authorization: permanent residents, temporary residents (that is, individuals who have gone through the legalization program), refugees, and asylees.	Link 1 Link 2 Link 3 Link 4 Link 5

[64] The material **"US Care Policy Scorecard: Assessing federal unpaid and underpaid care policies in the US" – Chehade, Nicolas; Fahmy, Nourhan; Holmstrom, Alina; Iyer, Prithvi; Rewald, Rebecca; Castro Bernardini, María del Rosario – 19/7/23** (Table 4, p. 16) has been reproduced in Table 1 and adapted in the Indicator 2.3.1 table (from the raw data spreadsheet accompanying the Scorecard) by the publisher, with the permission of Oxfam, Oxfam House, John Smith Drive, Cowley, Oxford OX4 2JY, United Kingdom, www.oxfam.org.uk. Oxfam does not necessarily endorse any text or activities that accompany the material, nor has it approved the adapted text.

		No anti-discrimination law has been found related to undocumented workers with no work authorization status. Occupational Safety and Health Administration workplace protections and minimum wage, overtime and related laws under the Fair Labor Standards Act are enforced regardless of a person's immigration or migration status. Finally, as set out by the Department of Labor of the United States, "the Migrant and Seasonal Agricultural Worker Protection Act (MSPA) protects migrant and seasonal agricultural workers by establishing employment standards related to wages, housing, transportation, disclosures and recordkeeping", but it does not apply to independent contract workers.	
Legislation and ratification			
There is legislation to ensure access to equal rights and protections for migrant care workers	No: 0	Migrant care workers are only protected to the extent that the laws listed above cover workers generally, but no law specifically protecting migrant care workers was found. For example, migrant care workers are protected from discrimination through the Immigration and Nationality Act only if they have work authorization, and they are covered by the "wage and hour laws" of the Fair Labor Standards Act. If they are self-employed, an independent contractor or a domestic worker, however, they will not be covered by the Fair Labor Standards Act or Occupational Safety and Health Administration laws on workplace safety. What is more, access to and interpretation of those protections vary widely. For example, increasingly aggressive immigration law enforcement (by Immigration and Customs Enforcement (ICE) at the time of writing) has curtailed undocumented workers' access to these protections in many cases. Experts consulted for the scorecard assessment in the United States have expressed the view that, although there are some protections, access to and enforcement of these protections varies widely and the separation of immigration enforcement from labour or employment law enforcement is not consistently upheld, making protections much more tenuous in practice for undocumented workers. Additionally, there are limits to protections for migrant care workers under the National Labor Relations Act, and court decisions have curtailed undocumented workers' ability to be awarded back-pay or other remedies if they are fired for trade union organizing.	Link 1 Link 2
The relevant convention/s (ILO Convention 189) have been ratified	No: 0	The Domestic Workers Convention, 2011 (No. 189) has not been ratified by the United States.	Link 1

Accessibility and inclusivity			
The policy extends to all workers, occupations and population groups and those most likely to be marginalized, including informally employed migrant workers	No: 0	The Immigration and Nationality Act applies only to temporary residents, refugees and asylees who have work authorization. The Fair Labor Standards Act and Occupational Safety and Health Administration laws do not apply to independent contract workers.	Link 1
TOTAL SCORE FOR INDICATOR 2.3.1: __4 /17	**24%**		

As a result of the assessment based on the indicator, the report includes a narrative summary of the results:

Policy area 2.3: Migrant care workers' protections

This policy area includes only one policy indicator, focused on equal rights and protections for migrant care workers. Many household care workers in the US are migrants, so analyzing policies that protect migrant workers is integral to understanding whether the care landscape is equitable. The sole policy indicator in this section, 2.3.1: Equal rights and protections for migrant care workers, received a score of 24 per cent. This indicator is associated with the Immigration and Nationality Act, OSHA, FLSA, and the DOL Migrant and Seasonal Agricultural Worker Protection Act (MSPA). This policy indicator scored the best in regulation and monitoring and the worst in accessibility and inclusivity, and legislation and ratification. No credit was given for any of the indicators under the latter two assessment criteria. This is in part because the Immigration and Nationality Act doesn't have special language for migrant care workers, and OSHA and FLSA do not apply to informal or self-employed migrant care workers. Additionally, work authorization under the Immigration and Nationality Act is issued pursuant to an individual's immigration status; workers whose immigration status is work-related must often depend on individual employers for their work permits. This policy indicator also scored very low among design and impact, and budget and administration assessment criteria. Recent requests by the Biden administration for funding for caseload and backlog reductions indicate that funding thus far to implement this policy has been insufficient. The scores for this policy indicator show that no policies exist that provide adequate protection for migrant care workers.

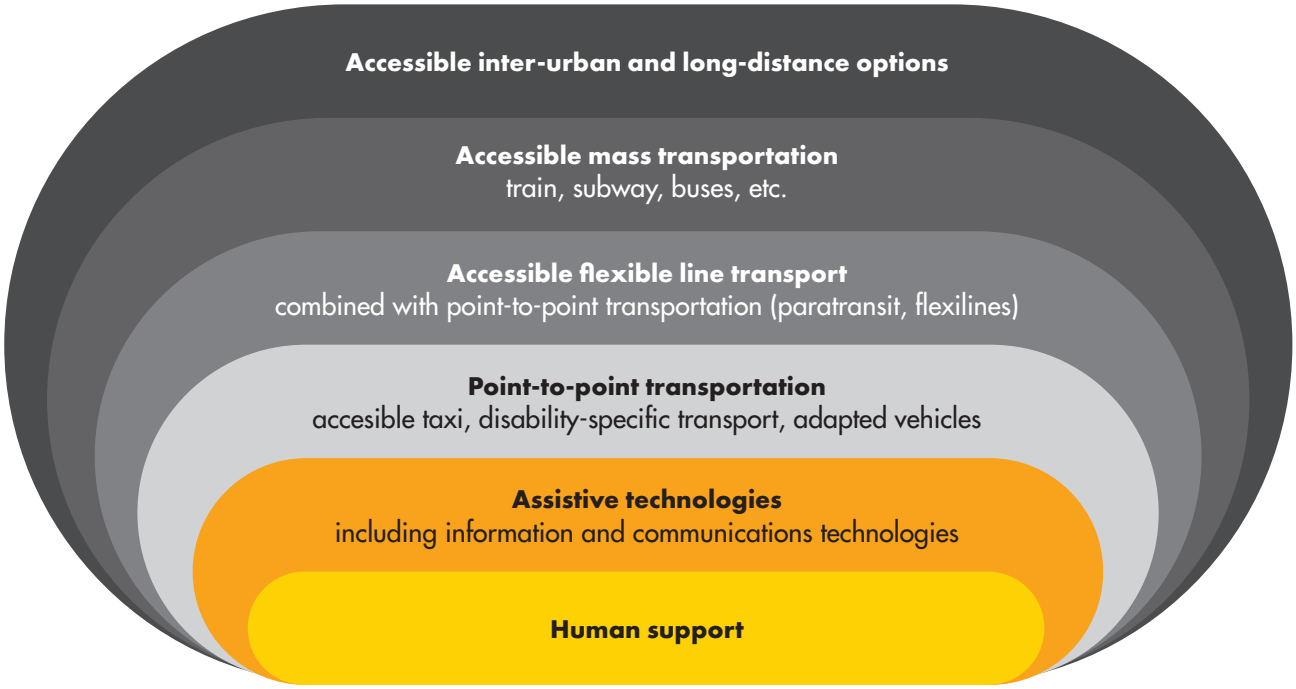
Source: Nicolas Chehade and others, "US Care Policy Scorecard: Assessing federal unpaid and underpaid care policies in the US", Keough School of Global Affairs (University of Notre Dame), Oxfam America, National Women's Law Center and National Partnership for Women & Families, 19 July 2023, p. 24, available at www.oxfamamerica.org/explore/research-publications/uscarescorecard/.
Abbreviations: DOL, Department of Labor; FLSA, Fair Labor Standards Act; OSHA, Occupational Safety and Health Administration

1. Indicator 1.1.4: Public transport[65]

Relevance:

Transportation is part of a care-related infrastructure that can reduce the amount of time dedicated to unpaid care and support giving, if it is accessible, and it can facilitate access to services.[66] Public transportation for persons with disabilities is essential for their participation in society and for their access to healthcare, education, employment and leisure activities.

Figure iii
Integrating individual mobility at different levels



Source: OHCHR, *SDG-CRPD Resource Package*, 2024.

For personal mobility, persons with disabilities may require human support, although this requirement can often be reduced by the provision of assistive technology. With assistive technology, the baseline for transport services for most persons with disabilities is point-to-point transport (such as private cars, accessible taxis or disability-specific transport). As the volume of commuters increases during a period of economic growth in a given jurisdiction, mass transport must be made accessible, including by covering costs for personal assistants. In that scenario, paratransit and accessible public transit complement, rather than substitute for, each other.[67] Persons with disabilities who cannot fully benefit from mass public transportation use paratransit or new shared mobility services.[68] Flexible transport or paratransit lines are more affordable and more immediate solutions than fully accessible mass transportation. Such services complement mass transportation options and are necessary to improve access for persons with disabilities, in both urban and interurban areas.

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[65] The material **"Care Policy Scorecard – A tool for assessing country progress towards an enabling policy environment on care – Butt, Anam Parvez; Parkes, Amber; Castro Bernandini, Maria Del Rosario; Paz Arauco, Veronica; Sharmishtha, Nanda; Seghaier, Roula – 20/09/2021"** (Indicator 1.1.4 on Public transport; Indicator 1.2.2 on Early Childhood Care and Development (ECCD) services; and Indicator 1.3.2 on Cash transfer policies related to care and support) has been adapted by the publisher, with the permission of Oxfam, Oxfam House, John Smith Drive, Cowley, Oxford OX4 2JY, United Kingdom, www.oxfam.org.uk. Oxfam does not necessarily endorse any text or activities that accompany the material, nor has it approved the adapted text.

[66] ILO, Care work and care jobs, pp. 113-114.

[67] A/HRC/55/34, para. 36.

[68] On new mobility services, see Anne Goralzik, Alexandra König, Laura Alciauskaite and Tally Hatzakis, "Shared mobility services: an accessibility assessment from the perspective of people with disabilities", *European Transport Research Review*, vol. 14 (2022), p. 2.

The assessment criteria that have been included are aimed at assessing access to transport and the provision of services for those who cannot fully benefit from mass public transport. An additional criterion has been added to measure access to public transport disaggregated by sex, age and disability.

Indicator 1.1.4 Assessment criteria	Score		
	Yes	Partial	No
There is a national policy for the provision of public transport	1	0.5	0
There is a national accessibility strategy and/or plan to identify and eliminate all existing barriers to accessibility in transportation infrastructure	1	0.5	0
Accessibility and reach			
The policy is targeted towards underserved and marginalized populations	1	0.5	0
The policy is aimed at ensuring that public transport services are affordable	1	0.5	0
The policy considers all transportation modes, including point-to-point transport[69]	1	0.5	0
Measures such as tax exemptions, fee waivers, discounts and subsidies are in place to promote and ensure access to accessible transportation services for persons with disabilities	1	0.5	0
Transportation services and programmes under this policy are aimed at reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0
Public transport services under this policy are safe, reliable and well networked	1	0.5	0
Budgeting and administration			
The budget allocation for this policy has risen (in real terms) since the previous budget cycle	1	0.5	0
The budget allocation is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect personnel and administrative costs)	1	0.5	0
The budget allocation for public transport services is being sufficiently (≥ 80%) spent on both personnel costs and actual delivery/implementation	1	0.5	0
There is adequate government human resource and technical capacity for implementation of the policy	1	0.5	0
Public transport services are primarily (≥ 80%) government funded or administered	1	0.5	0
Private transport services are regulated to meet equivalent affordability and accessibility requirements	1	0.5	0

[69] Other services and measures include paratransit services, incentives for persons with disabilities to access alternative accessible transportation and incentives to create such services.

Indicator 1.1.4 Assessment criteria	Score		
	Yes	Partial	No
Regulation and monitoring			
There is a government department/unit/agency responsible for implementing the policy	1	0.5	0
The policy includes provisions for the oversight and regulation of the quality, accessibility, reliability and affordability of public transport services	1	0.5	0
The Government collects and publishes disaggregated data on implementation of the policy, with indicators and targets	1	0.5	0
An operation feedback and grievance mechanism is available and accessible	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on unpaid care and support giving	1	0.5	0
Design and impact			
The policy was developed through consultation with women and persons with disabilities from diverse backgrounds and their organizations	1	0.5	0
There is an explicit intention to address issues around unpaid care and support giving in the policy objectives or purpose (to reduce time, costs and labour for caregivers and/or to improve the quality of care received)	1	0.5	0
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0
There is evidence of positive impact on the reduction or redistribution of unpaid care and support giving as a result of the policy	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for public transport services	1	0.5	0
Persons with disabilities are equally (≥ 20%) represented in management and governance structures for public transport services	1	0.5	0
The proportion of the population that has convenient access to public transport, by sex, age and disability, is in line with demographic composition	1	0.5	0
Score for indicator 1.1.4: (out of 26)		**___%**	
Degree to which policy is transformative (0-5)		**___**	

Sources of verification:

At the global level, data on public transport convenience and service quality will be gathered and managed by the United Nations Human Settlements Programme (UN-Habitat) and other partners for international comparison. The data includes:

- Data on locations of public transport stops in cities, from the city administration, service providers and geographic information system (GIS) data
- Information on dwelling units within 500 m of public transport stops, from census or GIS data
- Number of residents per dwelling unit, from census data or household surveys
- Household surveys with information on the proportion of households that declare that they have access to public transport within 0.5 km, and on the quality of the transport service.

Efforts will focus on capacity-building to ensure consistent standards for data generation, reporting and analysis across countries and regions. At the time of writing, there is no internationally agreed methodology for measuring public transport convenience and service quality, nor are there global or local databases on urban transport systems. Data harmonization and comparability at the global level are lacking. Data collection is required at the local level, where there are deficiencies, especially regarding mass transit and transport infrastructure data. To address these challenges, an open-source software platform called the OpenTripPlanner accessibility tool has been developed by the World Bank and Conveyal. This tool makes it easy for government officials and urban transport providers to calculate accessibility for various transportation opportunities and scenarios using standardized data.

Policy examples in action || Practical policy implementation

Pakistan: In Karachi, the Rickshaw Project develops autorickshaws with hand controls for drivers with disabilities and space for passengers with disabilities. The prototype was crowdfunded and the design was shared with a local rickshaw manufacturer, with plans to integrate these accessible rickshaws into the Careem ride-hailing fleet.

South Africa: The City of Cape Town leads the Dial-a-Ride initiative, a dedicated curb-to-curb transport service for persons with disabilities who cannot use mainstream public transport. The project integrates with MyCiTi bus services and provides regular and ad hoc transport for 350 regular users and 2,270 occasional passengers – although, unfortunately, it requires applicants to undergo an occupational assessment for eligibility. The service offers accessible transportation for work, school, medical visits and social activities.[70]

Spain: Eurotaxis are vehicles with a taxi licence that are adapted so that wheelchair users can get in without having to get out of their wheelchair. Drivers can apply for funding to buy and adapt the vehicles. Decree 1544/2007 requires 5 per cent of licences to be granted to adapted taxis.[71]

[70] See www.myciti.org.za/en/routes-stops/dial-a-ride/.
[71] City Council of Madrid, "¿Qué es un Eurotaxi?".

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 20.25, 20.26.

Data Sources Guidance: Article 20 of the CRPD

2. Indicator 1.1.6: Assistive technology [new indicator]

Relevance:

Assistive technology is essential for the inclusion of persons with disabilities. It facilitates access to healthcare, education, work and other important parts of life. Assistive technology is vital in care and support systems because it enables independence and autonomy and reduces the need for unpaid care and support giving.[72] For example, adequate wheelchairs enable their users to move on their own without the need for additional human support, and screen readers allow blind persons to read documents and navigate websites without human assistance.

Digital technologies are increasingly being used as assistive technologies to enhance accessibility and independence for persons with disabilities. These tools include software applications, mobile devices and wearable technology to support communication, mobility and daily activities. Screen readers provide a common example of digital technology that serves as assistive technology.

In 2022 the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) published the *Global Report on Assistive Technology*, which contains specific recommendations to improve access. According to the report, the main barriers to the provision of assistive devices in many countries are cost, lack of support and lack of availability.[73] The Committee on the Rights of Persons with Disabilities has outlined other barriers in its recommendations to States, such as absence of information,[74] lack of quality,[75] lack of training in mobility,[76] lack of distribution mechanisms,[77] lack of protection or assistance to persons with disabilities in humanitarian emergencies,[78] lack of adequate public procurement policies,[79] administrative barriers, not using universal design,[80] and the absence of guarantees of non-discrimination.[81]

Market-related barriers to assistive technologies include monopoly market power, trade barriers, high costs, logistics and distribution problems, and a lack of essential market information.[82] These failures result in limited access to affordable, high-quality assistive products, particularly in low- and middle-income countries, where levels of access can be as low as 3 per cent among those in need, compared with 90 per cent in high-income countries.[83]

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[72] See, for example, ATScale, *The Case for Investing in Assistive Technology* (2020), pp. 8 and 61; WHO and UNICEF, *Global Report on Assistive Technology* (Geneva, 2022), p. 13.
[73] WHO and UNICEF, *Global Report on Assistive Technology*, p. 33.
[74] CRPD/C/AZE/CO/2-3, para. 45.
[75] CRPD/C/MNG/CO/2-3, para. 41.
[76] The Committee has referred to training for persons with disabilities in how to use mobility devices (see, for example, CRPD/C/ALB/CO/1, paras. 35–36) and training on quality standards for assistive technology (see, for example, CRPD/C/IND/CO/1, paras. 42–43).
[77] CRPD/C/BHR/CO/1-2, para. 40; CRPD/C/DEU/CO/2-3, para. 45.
[78] CRPD/C/ISR/CO/1, para. 24 (a).
[79] CRPD/C/MWI/CO/1-2, paras. 41–42; CRPD/C/TGO/CO/1, paras. 41–42.
[80] CRPD/C/MWI/CO/1-2, paras. 41–42.
[81] CRPD/C/ALB/CO/1, paras. 35–36.
[82] ATScale, *Assistive Products Market Report 2024* (2024), pp. ii and 1.
[83] Ibid.

WHO has a Priority Assistive Products List, which identifies assistive products that are essential for improving the lives of persons with disabilities. The list includes a range of products such as mobility devices, prostheses, hearing aids and communication aids. These products are categorized based on their priority level, which indicates their importance and impact on the user's life. The list aims to guide countries in prioritizing the provision of assistive products and services to meet the needs of their populations.

Indicator 1.1.6 Assessment criteria	Score		
	Yes	Partial	No
The policy is aimed at ensuring that assistive technologies are universally available and accessible to everyone	1	0.5	0
The policy is aimed at ensuring that assistive technologies are affordable	1	0.5	0
Assistive technologies from the Priority Assistive Products List are immediately available	1	0.5	0
Assistive technology programmes under this policy are reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0
Assistive technology is integrated throughout health systems, with access points in education, social welfare and other sectors[84]	1	0.5	0
Budgeting and administration			
The budget allocation for this policy has risen (in real terms) since the previous budget cycle	1	0.5	0
The budget allocation is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect personnel and administrative costs)	1	0.5	0
The budget allocation for assistive technology programmes is being sufficiently (≥ 80%) spent on both personnel costs and actual delivery/implementation	1	0.5	0
Assistive technology services have an adequate number of trained staff at all levels of health and social service delivery	1	0.5	0
Assistive technology programmes are primarily (≥ 80%) government administered	1	0.5	0
Access to assistive technology is facilitated through several funding sources[85] and incentives[86] that improve access and correct market failures	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for implementing the policy	1	0.5	0

[84] WHO and UNICEF, *Global Report on Assistive Technology*, p. 33.

[85] WHO lists a number of measures to cover the costs of accessing assistive technology, including public insurance schemes, compulsory private insurance schemes, voluntary private insurance schemes and a list of safe and effective assistive products that are subsidized or provided free to people who are eligible.

[86] Examples of incentives promoting accessibility include tax exemptions for accessibility modifications of devices or for the import/export of appropriate assistive technology, devices, vehicles, and financial assistance for the purchase of assistive devices, communication devices or home modifications.

Indicator 1.1.6 Assessment criteria	Score		
	Yes	Partial	No
The policy includes provisions for the oversight and regulation of the quality, accessibility, reliability and affordability of assistive technology programmes	1	0.5	0
The Government collects and publishes disaggregated data on implementation of the policy, with indicators and targets	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on unpaid care and support giving	1	0.5	0
Design and impact			
Consultation processes are undertaken to ensure active involvement of persons with disabilities, including through their organizations, in the design, implementation and monitoring of policies for the provision of assistive technology	1	0.5	0
There is an increasing number of persons with disabilities who are accessing publicly funded assistive technology, disaggregated by sex, age, disability and geographical location	1	0.5	0
There is an explicit intention to address issues around unpaid care and support giving in policy objectives (to reduce time, costs and labour for caregivers and/or to improve the quality of care received)	1	0.5	0
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0
There is evidence of a positive impact through the reduction or redistribution of unpaid care and support giving as a result of the policy	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for the provision of assistive technology	1	0.5	0
Persons with disabilities are equitably (≥ 20%) represented in management and governance structures for the provision of assistive technology	1	0.5	0
Score for indicator 1.1.5: (out of 24)	**___%**		
Degree to which policy is transformative (0-5)	**___**		

Sources of verification:

- Administrative data can be obtained from programmes that provide specific measures. Many government institutions exist to design and/or produce assistive technology services. However, when different measures are provided through different systems, further coordination might be needed, for instance in the form of a unique personal identifier to avoid double-counting beneficiaries.
- In accordance with resolution WHA71.8 of 26 May 2018 on improving access to assistive technology, the WHO created a set of progress indicators for access to assistive technology. The WHO secretariat must submit progress reports in 2022, 2026 and 2030, and the progress indicators can be consulted online via the Global Health Observatory.

- The Rapid Assistive Technology Assessment devised by WHO is a population-based household survey that measures need, demand, supply, user satisfaction and barriers to accessing assistive technology. It asks people using assistive technology about who paid for their products. Respondents can choose options such as government support, but the survey does not cover the specific government measures involved.
- Another tool from WHO, called assistive technology capacity assessment or ATA-C, evaluates a country's capacity to finance, regulate, procure and provide assistive technology. It is used to assess funding schemes and to determine who is covered by each scheme and what proportion of the population is covered by it.
- In 2001, the Rehabilitation Engineering and Assistive Technology Society of North America conducted a national survey on the "Use and need of assistive technology and information technology by persons with disabilities in the United States", which included data on sources of expenditure on assistive technology.

Policy examples in action || Practical policy implementation

Singapore: SG Enable, an NGO in Singapore, launched the Enabling Village and Tech Able initiatives in 2015 to enhance support for persons with disabilities through assistive devices. Tech Able provides a showcase for assistive technologies, offering assessments and training, as well as collaboration with innovators and government agencies to improve accessibility. Since its inception, Tech Able has served over 800 individuals, significantly raising awareness and improving access to assistive devices and training for persons with disabilities.[87]

Kenya: The National Development Fund for Persons with Disabilities supports the provision of assistive devices and services to persons with disabilities in Kenya. The fund prioritizes those requiring assistance to function in a learning, training or work environment.[88]

Colombia: The Relay Centre (Centro de Relevo) facilitates communication between deaf and hearing people through a technological platform with online Colombian sign language interpreters. The centre is a public initiative by the Ministry of Information Technologies and Communications and the National Federation of the Deaf of Colombia. The Relay Centre is a technology solution that allows access to services from any computer or mobile device, 24 hours a day and free of charge.[89]

Rwanda: The Supply Division of UNICEF negotiated better terms with key suppliers for the inclusion of hearing aids in its product catalogue. As a result, with funding from ATscale, the Government of Rwanda and UNICEF were able to buy hearing aids for $118 per product – in contrast with prices exceeding $2,000, at which they were often previously sold in the country. This represents a reduction of over 94 per cent. The Ear and Hearing Care (EHC)–Winsiga Ndumva Program on Disability Inclusive (DI) primary healthcare services will be scaled up to eight districts and should provide about 1,200 hearing aids as well as other ear care services to children with hearing impairments.[90]

[87] Zero Project, "Learn, try, and test assistive technology", https://zeroproject.org/view/project/373f3c1b-9717-eb11-a813-0022489b3a6d.
[88] Kenya National Commission on Human Rights, "Information on the rights of persons with disabilities and digital technologies", 1 September 2024, pp. 6–7.
[89] Government of Colombia, Ministry of Information Technologies and Communications Technologies, "Centro de Relevo", https://colombiatic.mintic.gov.co/679/w3-propertyvalue-198256.html.
[90] UNICEF, "UNICEF supplies hundreds of children with life-changing hearing aids", 24 June 2022.

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 1/4.25, 19.31, 20.19, 20.20, 20.21, 20.22, 26.14, 26.16, 32.16

Data Sources Guidance: Articles 1–4, 19, 20, 26 and 32 of the Convention

3. Indicator 1.1.7: Housing [new indicator]

Relevance:

Accessible housing allows persons with disabilities to decrease their need for support. Without accessible housing, persons with disabilities require more support and face a greater risk of institutionalization or remission to day-care centres. Institutionalization limits autonomy and increases the risk of abuse. Accessible housing is a critical component of community support systems, alongside services such as transportation, and it enables the use of assistive technology in the home. Furthermore, having one's own home fosters greater independence from the family, allowing persons with disabilities to live more autonomously and reducing barriers to living in accordance with their preferences.

Persons with disabilities face barriers in accessing adequate housing, reinforcing a cycle of poverty and exclusion. Even in the case of those who can afford to live in adequate housing, urban planning often fails to meet accessibility requirements, further limiting access to such housing. Discrimination, poverty and financial overreliance on the family all contribute to difficulties in finding suitable housing. Women generally face greater challenges than men in accessing housing due to gender stereotypes resulting in wage discrimination and disproportionate access to informal work, giving men better resources and limiting women's access to well-located housing, particularly in developing countries.[91] Women and girls with disabilities often struggle to access accessible housing or shelters when fleeing gender-based violence.[92]

Making housing accessible for persons with disabilities is a long-term effort. New construction, in particular public housing, should follow accessibility standards and universal design principles. In the meantime, targeted measures must be planned to adjust existing housing in accordance with the accessibility criteria of visitability, adaptability and feasibility.[93] This can be done through direct cash transfers or by offering services to make modifications. Digital technologies, such as smart home systems, app-controlled locks and voice-activated assistants can enhance home accessibility for persons with disabilities by allowing them to control various aspects of their home with ease.

[91] Nora Libertun de Duren and others, *Gender Inequalities in Cities* (Inter-American Development Bank, CAF-Development Bank of Latin America and the Caribbean and UN-Habitat, 2020), pp. 21–25.
[92] A/HRC/55/34.
[93] OHCHR, Policy guidance on Sustainable Development Goal 11 (advance version), 2021, p. 22, "Criteria for improving the accessibility of existing buildings: visitability, adaptability and feasibility".

Indicator 1.1.7 Assessment criteria	Score		
	Yes	Partial	No
Accessibility of housing is included in national housing policy, construction codes and urban planning legislation	1	0.5	0
Accessibility of housing involves the adjustment of existing homes to meet accessibility standards through targeted measures and modifications	1	0.5	0
Accessibility and reach			
The policy is targeted towards underserved and marginalized populations	1	0.5	0
The policy is aimed at ensuring that housing is universally available and accessible to everyone	1	0.5	0
National comprehensive accessibility standards are adopted and applied to public and private housing[94]	1	0.5	0
The policy is aimed at ensuring that housing is affordable	1	0.5	0
Housing programmes under this policy are reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0
Measures such as financial support and services are directed towards and available to persons with disabilities so that existing buildings can be adapted, including through the use of assistive technology	1	0.5	0
Budgeting and administration			
The budget allocation for this policy has risen (in real terms) since the previous budget cycle	1	0.5	0
The budget allocation is sufficient to implement the policy (consider direct implementation and maintenance costs, and indirect personnel and administrative costs)	1	0.5	0
The budget allocation for housing programmes is being sufficiently (≥ 80%) spent on both personnel costs and actual delivery/ implementation	1	0.5	0
There is adequate government human resource and technical capacity for implementation and monitoring of the policy	1	0.5	0
Housing programmes are primarily (≥ 80%) government administered or funded	1	0.5	0
Access to public housing programmes is prioritized for persons with disabilities	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for monitoring and enforcing accessibility standards at the design and final stages of construction or housing modification	1	0.5	0
The policy includes provisions for the oversight and regulation of the affordability of accessible housing	1	0.5	0

[94] OHCHR, Policy guidance on Sustainable Development Goal 11, p. 23.

Indicator 1.1.7 Assessment criteria	Score		
	Yes	Partial	No
The Government collects and publishes disaggregated data on implementation of the policy, with indicators and targets	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on unpaid care and support giving	1	0.5	0
Design and impact			
The policy was developed through consultation with persons with disabilities from diverse backgrounds and their organizations	1	0.5	0
There is an explicit intention to address issues around unpaid care and support giving in the policy objectives or purpose (to reduce time, costs and labour for caregivers and/or to improve the quality of care received)	1	0.5	0
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0
There is evidence of a positive impact through the reduction or redistribution of unpaid care and support giving as a result of the policy	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for the provision of housing	1	0.5	0
Persons with disabilities are equitably (≥ 20%) represented in management and governance structures for the provision of housing	1	0.5	0
The number and proportion of beneficiaries of public housing programmes, disaggregated by sex, age, disability and geographical location, are in line with the targeted estimates	1	0.5	0
Score for indicator 1.1.7: (out of 25)	**___%**		
Degree to which policy is transformative (0-5)	**___**		

Sources of verification:

In many countries, the authorities estimate the number of homeless persons or those living in slums, informal settlements or inadequate housing. In fact, some already collect such data for reporting on target 11.1.1 of the Sustainable Development Goals. However, data on disability are not directly collected for these sources. Since the data have not been disaggregated by disability, surveys are needed to produce reliable estimates. General household surveys may not have adequate samples to achieve this end, so targeted samples will likely be necessary.

Where support programmes are in place to fund or provide adaptations to existing housing, these programmes should have information available on expenditure and the kind of services provided. In other instances, data from household surveys or disability surveys can provide information on accessible housing. The National Study of the Profile of Persons with Disabilities in Argentina that was carried out in 2018 shows that approximately 13.2 per cent of households with persons with disabilities indicated that their homes needed adaptations.[95] A study from Spain included a microdata

[95] Vásquez and Pereira, *Autonomía: Un Desafío Regional*, p. 13.

analysis of the Spanish survey on disability to identify personal expenditure to cover accessibility requirements.[96] This type of data can help to identify the demand for financial support for adaptations.

Countries working on deinstitutionalization strategies usually collect and analyse data on housing. For example, the Government of Spain recently commissioned a series of documents related to the strategy in that country.[97] One document on homelessness states that 20.5 per cent of the homeless persons surveyed had a recognized disability, although the actual percentage is probably higher.[98] The document on persons with disabilities found that only 0.6 per cent of Spanish homes are fully accessible, and that 34 per cent of persons with disabilities have problems moving around at home or in their building.[99]

Policy examples in action || Practical policy implementation

China: The barrier-free access and retrofitting of facilities programme of the Government of Hong Kong Special Administrative Region covers housing estates and is aimed at creating a barrier-free environment by enhancing accessibility. A key part of this initiative is the access coordinator and access officer scheme, which is modelled on existing gender focal points. This scheme establishes dedicated roles within each department to manage and improve accessibility, including in housing. With US$167 million invested, the programme has retrofitted 3,500 government premises and 240 public housing estates, ensuring greater accessibility for persons with disabilities.[100]

Indonesia: In 2015, Puspadi Bali, an NGO, launched an accessible housing project in partnership with Warmadewa University and Journeyman International. This initiative led to the building or improvement of 12 accessible homes and one public library and addressed individual needs. The project is targeted towards individuals with disabilities living in poverty who lack affordable housing. It involves designing homes, raising funds and overseeing construction with community involvement. The project is funded by various donors, including the Hands Up Community and the Australian Consulate-General. Puspadi Bali aims to build at least two accessible houses annually and to expand the project across Bali from 2024 to 2026.[101]

Spain: The Ecom Foundation, an organization for persons with disabilities, led a project advocating for accessible and affordable housing, which is essential for independent living and preventing institutionalization. With NextGenerationEU funding from the European Union, Ecom developed a housing adaptation service providing personalized advice through a multidisciplinary team using a person-centred approach, whereby the adaptations were directly funded. With the end of the European funding, Ecom now provides advice on how to apply for local funding from the city of Barcelona, the metropolitan authority and the generalitat (regional government), which covers up to 45 per cent of the cost of adaptations.

[96] Fernando Alonso-López, "Filling the gaps of housing adaptation in Spain: Is private expenditure an alternative to public support?" *Journal of Aging and Environment*, vol. 34, No. 2 (March 2020), pp. 141–155.
[97] Government of Spain, Ministry of Social Rights, Consumer Affairs and Agenda 2030, Estudio DesInstitucionalización, Proyecto EDI web pages, https://estudiodesinstitucionalizacion.gob.es.
[98] Government of Spain, Ministry of Social Rights, Consumer Affairs and Agenda 2030, *Estudio DesInstitucionalización, Estudio sobre los Procesos de Desinstitucionalización y Transición Hacia Modelos de Apoyo Personalizados y Comunitarios: Personas En Situación de Sinhogarismo* (Madrid, 2023), p. 37.
[99] Government of Spain, Ministry of Social Rights, Consumer Affairs and Agenda 2030, *Estudio DesInstitucionalización, Estudio sobre los Procesos de Desinstitucionalización y Transición Hacia Modelos de Apoyo Personalizados y Comunitarios: Personas con Discapacidad* (Madrid, 2024), p. 64.
[100] Zero Project, "Executive summary: the most important findings of the Zero Project Report 2014", https://share.google/o2FAUE5WssElwgHPj.
[101] Zero Project, "Cross-sectoral effort to build accessible homes for people with disabilities in poverty", 16 January 2022, https://zeroproject.org/view/project/266c36c8-ad4a-ec11-8c62-000d3ab5a6d0.

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 28.18, 28.19, 28.27, 28.31

Data Sources Guidance: Article 28 of the Convention

4. Indicator 1.2.2: Inclusive Early Childhood Care and Development (ECCD)

In the *Scorecard*, this indicator covers early childhood care and education (ECCE). ECCD is used in the present *Tool*, however, because it is a more comprehensive concept that more adequately addresses the programmes, services and interventions needed to provide care and support for children with disabilities.

Children with disabilities and their families need community support and early intervention systems to help them thrive. Care and support systems are key for children with disabilities to live in family settings. They help children to develop, especially as they go through early childhood, when there is significant development in their functioning and skills.[102] Early intervention systems provide stimulation and include family support services, which help prevent institutionalization. With adequate support and early intervention, children can progressively develop their autonomy and independence, which reduces the need for unpaid care and support giving.

Early childhood interventions are systems of services that provide support to children and their families.[103] They are essential for children from birth to the age of five years, as they help to identify and reduce the impact of developmental delays or diagnosed conditions. Such interventions can prevent further impairments, help children's functioning and facilitate their enrolment in education.[104] Families need support in understanding disability positively and in supporting their child to be independent.[105]

A twin-track approach to ECCD acknowledges that children with disabilities and their families require access to mainstream services such as healthcare, childcare and education, as well as targeted services such as early childhood interventions.[106] Targeted interventions can be included as part of developmental, health, education and social care services. Practical examples of targeted services include neonatal and immunization services, breastfeeding counselling, childcare visits, preschool programmes and school health services.[107]

Early identification can enable access to care for the development and well-being of children and young people with developmental conditions.[108] Investing in universal early identification systems such as eye-care and hearing screenings, as well as in the detection of congenital health conditions, can positively

[102] WHO and UNICEF, *Early Childhood Development and Disability: A Discussion Paper* (2012), p. 11.
[103] Emily Vargas-Baron and others, *Global Survey of Inclusive Early Childhood Development and Early Childhood Intervention Programs* (University of Birmingham, 2019), https://research.birmingham.ac.uk/en/publications/global-survey-of-inclusive-early-childhood-development-and-early-/.
[104] Alberto Vásquez Encalada and others, "The disability support gap: community support systems for persons with disabilities in low- and middle-income countries – discussion paper" (advance unedited version), Centre for Inclusive Policy for UNICEF and ILO, March 2023, p. 11. See also Committee on the Rights of Persons with Disabilities, general comment No. 4 (2016) on the right to inclusive education (CRPD/C/GC/4), para. 67, on the benefits of early childhood interventions.
[105] See, for example, Alberto Vásquez Encalada and others, "The disability support gap", p. 11, and the Tashkent Declaration and Commitments to Action for Transforming Early Childhood Care and Education.
[106] WHO and UNICEF, *Early Childhood Development and Disability*, p. 21.
[107] WHO and UNICEF, "Executive summary: Global report on children with developmental disabilities" (2023), p. 6.
[108] Ibid., p. 14.

affect children's growth and development.[109] This also supports a life-course approach in universal health coverage by providing quality healthcare across different ages and in the transitions between age groups.[110]

The Committee on the Rights of Persons with Disabilities has highlighted early identification in relation to education. It has issued recommendations indicating that early identification and support for young children with disabilities increase their chances of smoothly transitioning into inclusive pre-primary and primary education settings.[111] Pre-primary education, along with support and training for parents and caregivers, is essential for children with disabilities.[112] The Committee affirmed that primary education in the community must be compulsory, of high quality, free and accessible.[113] The Tashkent Declaration and Commitments to Action for Transforming Early Childhood Care and Education of 2022 noted that "ensuring at least one year of quality, free and compulsory ECCE can help disadvantaged and vulnerable children transition into primary education."[114]

Early identification can also contribute to closing the childcare-policy gap – that is, the period between the end of entitlements to paid childcare leave and the beginning of the right to free and universal early childhood care and education or primary education. When policies fail to deliver on sustainable and integrated care provision, inequalities at home, at work and in society are cemented. This has detrimental impacts on women, children and families across the life course.[115]

Preventing the placement of children with disabilities in institutions must be a priority, which should be enabled with financial and other forms of support, including peer support for children and adolescents. Early support for children with disabilities and families should be streamlined in support policies for children. Support and reasonable accommodations for parents with disabilities should also be included to prevent their children from being placed in institutions, separated from their parents, and to promote family life.[116]

Indicator 1.2.2 Assessment criteria	Score		
	Yes	Partial	No
There is a national policy for the provision of early childhood care and development services	1	0.5	0
There is a national policy that ensures inclusive education for all students, including students with disabilities, in public and private settings across all levels of education[117]	1	0.5	0
Programmes have been established for the early identification of impairments in children with disabilities and their support needs to facilitate their effective participation in mainstream schools[118]	1	0.5	0

[109] WHO, *Global Report on Health Equity for Persons with Disabilities* (2022), p. 42.
[110] Ibid.
[111] CRPD/C/GC/4, para. 67; see also European Association on Early Childhood Intervention, *Recommended Practices in Early Childhood Intervention: A guidebook for professionals* (2019).
[112] CRPD/C/GC/4, para. 67.
[113] Ibid., para. 24.
[114] Preamble, para. 11 (VII).
[115] ILO, "The benefits of investing in transformative childcare policy packages towards gender equality and social justice", p. 4.
[116] CRPD/C/5, section IV C, "Children and adolescents with disabilities".
[117] OHCHR, human rights indicators on article 24: right to education (advance version) (2021), p. 1.
[118] Ibid.

Indicator 1.2.2 Assessment criteria	Score		
	Yes	Partial	No
Accessibility and reach			
The policy is targeted towards underserved and marginalized populations, including informally employed workers	1	0.5	0
The policy is aimed at ensuring that ECCD services are affordable	1	0.5	0
Pre-primary education has accessible infrastructure and materials for children with disabilities.	1	0.5	0
Primary education is compulsory, of high quality, free, available in the community and accessible	1	0.5	0
The policy ensures ECCD services are universally available and accessible to everyone	1	0.5	0
The policy provides for ECCD services to be made available for children between birth and 5 years of age	1	0.5	0
The policy recognizes the importance of ECCD services having hours of operation that are practical in relation to the paid working hours of parents and/or operating for at least 8 hours a day	1	0.5	0
ECCD services under this policy are reaching the most underserved areas and populations, including persons who are likely to be marginalized	1	0.5	0
ECCD is integrated in primary healthcare policy and service delivery platforms	1	0.5	0
ECCD includes early identification and early interventions for children with developmental delays and disabilities	1	0.5	0
Budgeting and administration			
The budget allocation for the policy has risen (in real terms) since the previous budget cycle	1	0.5	0
The budget allocation is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect personnel and administrative costs)	1	0.5	0
The budget allocation for ECCD services is being sufficiently (≥ 80%) spent on both personnel costs and actual delivery/ implementation	1	0.5	0
There is adequate government human resource and technical capacity for implementation of the policy, including qualification and training for teachers	1	0.5	0
ECCD services are primarily (≥ 80%) government administered	1	0.5	0

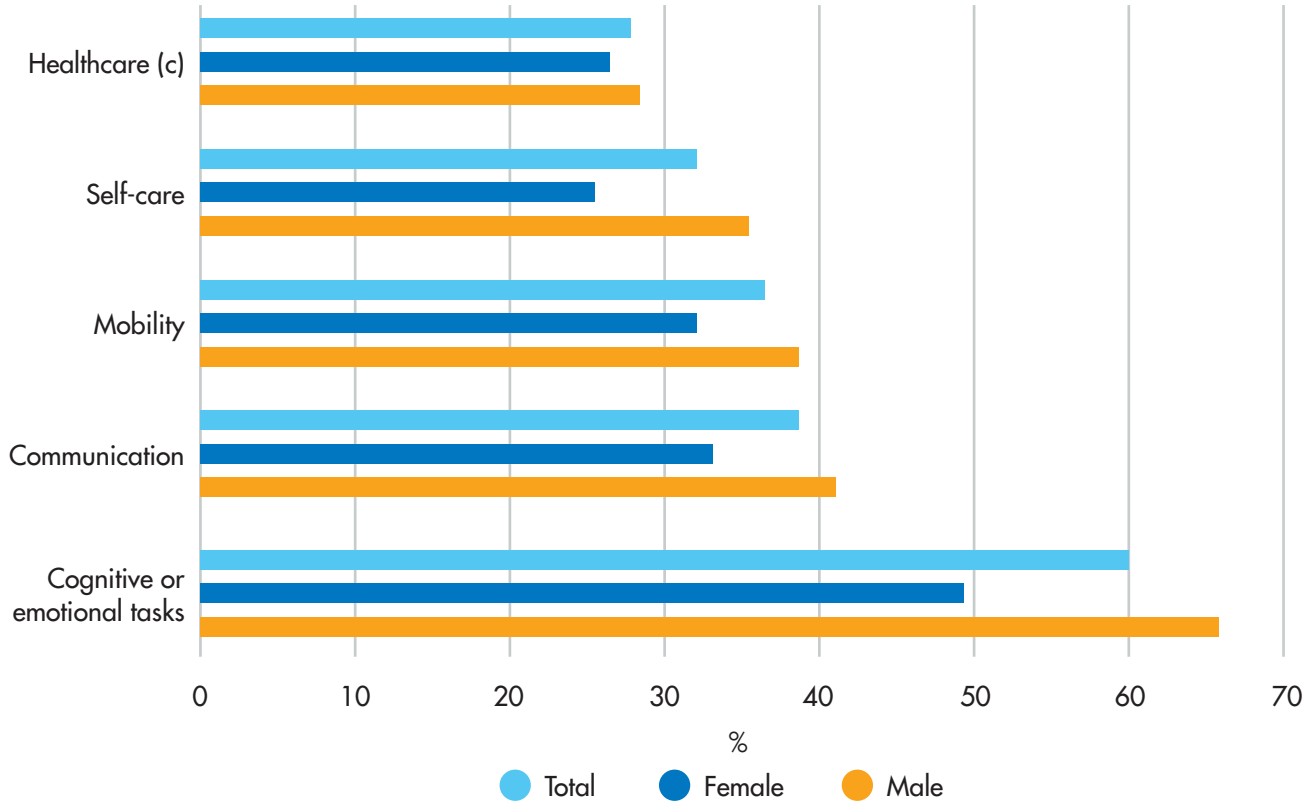
Indicator 1.2.2 Assessment criteria	Score		
	Yes	Partial	No
Regulation and monitoring			
There is a government department/unit/agency responsible for implementing the policy	1	0.5	0
The policy includes provisions for the oversight and regulation of the quality, accessibility, reliability and affordability of ECCD services	1	0.5	0
The Government collects and publishes disaggregated data on implementation of the policy, with indicators and targets	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on unpaid care and support giving	1	0.5	0
Design and impact			
The policy was developed through consultation with women and persons with disabilities from diverse backgrounds and their organizations	1	0.5	0
There is an explicit intention to address issues around unpaid care and support giving in the policy objectives or purpose (to reduce time, costs and labour for caregivers and/or to improve the quality of care received)	1	0.5	0
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0
There is evidence of a positive impact through the reduction or redistribution of unpaid care and support giving as a result of the policy	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for inclusive ECCD services	1	0.5	0
Persons with disabilities are equally (≥ 50%) represented in management and governance structures for inclusive ECCD services	1	0.5	0
Information is available on the rates of children with disabilities out of school and on their enrolment, attendance, promotion by grade, school completion and dropout in mainstream primary education compared with other children, disaggregated by location, sex, age, disability, minority or indigenous background, household wealth and grade.	1	0.5	0
The number and proportion of children with disabilities in alternative care compared with all children in alternative care (in a family setting or in small group homes, or in other residential care facilities), disaggregated by age, sex, disability and type of setting, is in line with demographic composition	1	0.5	0
The proportion of children aged 3–5 years who are attending an early childhood education programme (in accordance with the UNICEF Multiple Indicator Cluster Survey (MICS) indicator), disaggregated by sex, age and disability, is in line with demographic composition or projections.	1	0.5	0
Score for indicator 1.2.2: (out of 31)	**Y%**		
Degree to which policy is transformative (0–5)	**Z**		

Sources of verification:

A few specialized surveys and studies collect information on the support needs of children with disabilities and on the supports provided to their parents. Individual disability assessments usually have a strong medical bias in most countries, they are not flexible enough to consider the evolving capacities of children with disabilities, and they do not systematically collect this information.[119]

In Australia, data is collected on both parents with disabilities and parents of children with disabilities. The survey on disability, ageing and carers by the Australian Bureau of Statistics has relatively recent data on how many children with disabilities needed assistance for certain activities and how many actually received assistance.

Figure iv
Proportion of children aged 0–14 years with disability (a), activities for which assistance needed (b), by sex, 2018[120]



a. Living in households
b. Proportions may sum to more than 100% as respondents could report needing assistance with more than one activity
c. Children aged 5 years and over

Source: Australian Bureau of Statistics, "Disability, ageing and carers, Australia: summary of findings" (2018).

UNICEF has published Multiple Indicator Cluster Surveys (MICS) and *The Early Childhood Development Index 2030*. The Surveys and the Index both gather data that can be used to track this indicator. MICS is on its seventh round, while *The Early Childhood Development Index 2030* was published in 2023. Although MICS standard reporting tables do not disaggregate by functional difficulty, this can still be done with data from the survey. The ECE Accelerator toolkit is a resource designed to support the integration and strengthening of early childhood education within national education sector planning processes. Its website contains articles covering its use in several countries.

[119] Alberto Vásquez Encalada and others, "The disability support gap", p. 19.
[120] Australian Bureau of Statistics, "Disability, ageing and carers, Australia: summary of findings" (2018).

Policy examples in action || Practical policy implementation

Australia: The early childhood intervention programme provides support to children under the age of 7 with impairments or disabilities and to their families in the home, in the community and in early childhood education settings. To improve access to these programmes, the National Disability Insurance Agency funds "early childhood partners" to assist families with young children with disabilities. These partners offer guidance on understanding the child's needs, provide practical information on child development and early intervention, and connect families to mainstream services and community resources. They also support parents with the agency's application process when needed.[121]

Nicaragua: A project by the Astrid Delleman Association of Integrated Community Education Programmes (ASOPIECAD), a local NGO, involves detecting developmental disabilities in young children. This initiative trains community workers and local organizations to identify disabilities and make early interventions, ensuring that children receive the necessary care. It also provides parents with training in basic techniques to support their children's development.[122]

The United Nations Educational, Scientific and Cultural Organization (UNESCO) collects data on the rate of children who are out of school, and UNESCO and UNICEF published a report on the issue that highlights the situation of children with disabilities.[123]

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 7.21, 7.22, 7.23, 7.24, 7.25

Data Sources Guidance: Article 7 of the Convention

5. Indicator 1.2.3: Human support – paid support work [new indicator]

The *Scorecard* contains two indicators that refer to human support: indicator 1.2.3 on care services for older persons and 1.2.4 on care services for people with additional care needs. In the *Scorecard*, "people with additional care needs" refers to "persons living with a disability or a mental health condition".[124]

Persons with disabilities are a diverse group with different support needs. Support needs can be determined using tools such as scales of functioning for daily living activities, and they can be applied regardless of disability. To ensure alignment with the care and support paradigm, it is suggested that indicators 1.2.3 and 1.2.4 on the *Scorecard* and their language be replaced with an indicator on human support, the service targeted by the original indicators.

[121] Government of Australia, submission for report on A/HRC/55/34, p. 14.
[122] Zero Project, "Creating communities for early childhood interventions", 2016.
[123] Ibid. See also UNESCO and UNICEF, *Fixing the Broken Promise of Education for All* (UNESCO, Montréal, Canada, 2015); UNICEF, Education Commission and LEGO Foundation, "Add today multiply tomorrow: building an investment case for early childhood education", 2022.
[124] Butt and others, *Care Policy Scorecard*, p. 46.

Persons with disabilities might need personal assistance and individualized support to perform activities of daily living. A generalized lack of support services leads to support being provided by families without compensation. Personal assistance is central to independent living for those requiring human support. According to the Committee on the Rights of Persons with Disabilities, personal assistance must be:

- Funded through personalized criteria, with funding being allocated directly to and controlled by the person with disability, based on a needs-based individual assessment
- Controlled and self-managed directly by the person with disability, with adequate support if needed
- Based on an individual relationship between the person with disability and the personal assistant.

Human support can also come in the form of communication support, which is particularly important for deaf and deafblind persons. Accessibility in information and communication will create a higher baseline of access, but communication support will still be necessary.

Legal frameworks and budgets should ensure the provision of personal assistance and individualized support to persons with disabilities.[125] Support services must align with the will and preferences of the person with disability. Persons with disabilities must have genuine options and not be forced to choose between services that do not comply with the Convention.[126] According to the Committee on the Rights of Persons with Disabilities, the absence of support services in the community can constitute discrimination against persons with disabilities and can drive them into institutions.[127]

Costa Rica provides a recent example of progress in policymaking: the Law for the Promotion of the Personal Autonomy of Persons with Disabilities, which grants financial support for personal assistance. This law established a programme for individuals who require personal assistance but lack the means to pay for such support. The programme operates nationwide and provides a monthly cash transfer.[128]

Domain of support	Description	Examples
Communication	Support to overcome barriers that limit the ability to communicate and be understood.	Sign language interpretation
Decision-making	Support to make decisions and exercise legal capacity.	Support persons, peer support, self-advocacy support
Assistance with daily living activities	Support to assist persons with disabilities in a one-to-one relationship to perform activities of daily living and instrumental activities of daily living.	Full-time or part-time professional personal assistance, third-person support allowance

Table adapted from Xanthe Hunt and others, "Community support for persons with disabilities in low- and middle-income countries: a scoping review", *International Journal of Environmental Research and Public Health*, vol. 19, No. 14 (July 2022), pp. 1–17.

[125] Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017) on living independently and being included in the community (CRPD/C/GC/5), para. 15.
[126] CRPD/C/5, para. 65.
[127] Ibid., para. 40.
[128] Alberto Vásquez Encalada and others, "The disability support gap", p. 19.

Indicator 1.2.3 Assessment criteria	Score		
	Yes	Partial	No
There is a national policy for the provision of human support, or this is included in the national care and support system	1	0.5	0
Accessibility and reach			
The policy is targeted towards persons with disabilities, including underserved and marginalized populations	1	0.5	0
The policy ensures human support services are available and accessible to all persons with support needs	1	0.5	0
The policy ensures human support services are free/affordable for low-income groups	1	0.5	0
Human support services under this policy are reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0
Human support services are not conditional on having employment or education	1	0.5	0
Services and programmes covering all domains of support are available in the community	1	0.5	0
Centres for independent living and personal assistants' cooperatives are integrated in the network for the provision of human support	1	0.5	0
Training is available for providers of human support that includes instruction on sexual and reproductive rights and gender-based violence	1	0.5	0
Budgeting and administration			
The budget allocation for this policy has risen (in real terms) since the previous budget cycle	1	0.5	0
The budget allocation is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect personnel and administrative costs)	1	0.5	0
The budget allocation is being sufficiently (≥ 80%) spent on both personnel costs and actual delivery/implementation	1	0.5	0
There is adequate government human resource and technical capacity for implementation of the policy	1	0.5	0
Human support services are primarily (≥ 80%) government administered	1	0.5	0

Indicator 1.2.3 Assessment criteria	Score		
	Yes	Partial	No
Regulation and monitoring			
There is a government department/unit/agency responsible for implementing the policy	1	0.5	0
The policy includes provisions for the oversight and regulation of the quality, accessibility, reliability and affordability of human support	1	0.5	0
The policy includes complaints and grievance redressal mechanisms in case of non-compliance or a lack of quality provision	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on the well-being of care and support workers (especially women) and support recipients	1	0.5	0
Safeguards are in place to ensure that all services and programmes are person-centred and respect the will and preferences of the person receiving support	1	0.5	0
The Government collects and publishes disaggregated data on implementation of the policy, with indicators and targets	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on unpaid support work	1	0.5	0
Design and impact			
The policy was developed through consultation with women and persons with disabilities from diverse backgrounds and their organizations	1	0.5	0
Data is available on the number of persons with disabilities accessing community-based support services, including personal assistance, out of the total number of requests made, disaggregated by sex, age, disability and support service provided	1	0.5	0
There is an explicit intention to address issues around unpaid support work in the policy objectives or purpose (to reduce time, costs and labour for caregivers and/or to improve the quality of support received)	1	0.5	0
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0
There is evidence of a positive impact through the reduction or redistribution of unpaid support work as a result of the policy	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for human support services	1	0.5	0
Persons with disabilities are equitably (≥ 20%) represented in management and governance structures for human support services	1	0.5	0
Score for indicator 1.2.3: (out of 28)	**___%**		
Degree to which policy is transformative (0–5)	**___**		

Sources of verification:

In countries where there are plans for personal assistance and independent living programmes, or where such programmes have started to be implemented, a baseline for unmet support needs is usually produced. This includes budget estimations and, further ahead, reports on budget implementation, as is the case in Costa Rica. The disability and ageing survey that was carried out in Australia contains detailed data on support that has been requested and received, disaggregated by age, sex and disability.[129]

In cases where there is no information from existing programmes, disability surveys or studies sometimes capture the level of satisfaction of persons with disabilities with their level of independence – which can be indicative of unmet support needs. The model disability survey, developed by WHO, includes similar questions. Reports using combined information from disability assessments can provide insights into types of support needs when assessments use tools compatible with daily living activities classifications.

Policy examples in action || Practical policy implementation

Cambodia: The personal assistant service system addresses the limited availability of personal assistance, healthcare and rehabilitation services for persons with disabilities. The system provides awareness training for local decision-makers and develops accessibility guidelines. It includes training for personal assistants, accessibility improvements in community offices and homes, and lobbying for expanded services. The programme has been introduced in 15 communes, with the aim of scaling it up to a national level.[130]

Sweden: A personal assistance budget covers 100 per cent of service costs and allows individuals to choose their providers or to employ assistants directly. This policy has enabled approximately 90 per cent of recipients to live in ordinary homes and has created a competitive market for personal assistance services, contributing an estimated €3 billion in savings since 1994. The Swedish model has influenced similar legislation in other countries and continues to be a benchmark for disability policy reform.[131]

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 19.29, 19.30, 19.35, 19.36

Data Sources Guidance: Article 19 of the Convention

6. Indicator 1.3.2: Cash transfer policies related to care and support

The *Disability and Development Report 2024* by the United Nations Department of Economic and Social Affairs includes data indicating that the employment rate of persons with disabilities is 27 per cent, while persons without disabilities have an employment rate of 56 per cent.[132] Persons with

[129] Government of Costa Rica, Ministerio de Planificación Nacional y Política Económica, *Evaluación de Diseño y Proceso: Programa para la Promoción de la Autonomía Personal de las Personas con Discapacidad* (San José, 2021), https://repositorio-snp.mideplan.go.cr/bitstream/handle/123456789/279/EE.36-IF.pdf?sequence=1&isAllowed=y.

[130] Zero Project, "Introduction of the personal assistance model", 31 January 2019, https://zeroproject.org/view/project/05108b9f-9817-eb11-a813-000d3ab9b226.

[131] Zero Project, "The right to a personal assistance budget".

[132] Department of Economic and Social Affairs, *Disability and Development Report 2024*, "Promoting full and productive employment and decent work (Goal 8)", p. 43.

disabilities also face high inactivity rates. In addition, the majority of persons with disabilities who work do so in the informal sector, particularly in low- and middle-income countries.[133] In such cases, persons with disabilities are excluded from pensions or other contributory schemes.[134] To address the coverage gap, non-contributory schemes, such as disability allowances, have been set up in several countries.

Persons with disabilities and households that include them often face higher expenses compared with the general population. This is due to the need for disability-related goods and services such as mobility aids. Additionally, they may have to pay more to access general goods and services, such as health insurance. Failure to consider these costs in poverty measurement may perpetuate a cycle of poverty, potentially leading to institutionalization and violence. Covering disability-related extra costs contributes to reducing the level of unpaid care and support giving, it enhances autonomy and it contributes to the policy objective of cash for care for children with disabilities.

To effectively reduce poverty, social protection schemes (including both universal income support and disability-specific allowances) should account for disability-related extra costs. These need to be paid directly to persons with disabilities themselves. In some countries, including Georgia, Namibia and Thailand, disability allowances have been adopted that are compatible with work or other income support schemes, such as pensions.[135] Ensuring compatibility between different programmes allows people to cover their extra costs associated with disabilities.

Indicator 1.3.2 Assessment criteria	Score		
	Yes	Partial	No
There is a national policy for the provision of cash transfer policies related to care and support	1	0.5	0
There is a targeted cash transfer programme for persons with disabilities (disability allowance)	1	0.5	0
Cash transfers for persons with disabilities are paid directly to them	1	0.5	0
Accessibility and reach			
The policy prioritizes underserved and marginalized populations, including informally employed women	1	0.5	0
The policy ensures that cash transfers are available and accessible to all those within the selected recipient categories of the policy (e.g. childcare-related cash transfers are available to all who have children)	1	0.5	0
The policy stipulates that cash and in-kind transfers related to care and support are not subject to conditions	1	0.5	0
The policy ensures that cash transfers meet the real level of costs of care and support and account for disability-related extra costs	1	0.5	0
Cash transfers for care and support responsibilities under this policy are reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0

[133] ILO, "People with disabilities still face obstacles entering formal labour market", 15 February 2022, www.ilo.org/resource/news/people-disabilities-still-face-obstacles-entering-formal-labour-market.
[134] A/HRC/52/52, para. 18.
[135] Alexandre Côte, "Disability inclusion and social protection", in *Handbook on Social Protection Systems*, Markus Loewe and Esther Schüromg, eds. (2021), p. 360.

Indicator 1.3.2 Assessment criteria	Score		
	Yes	Partial	No
Budgeting and administration			
The budget allocation for this policy has risen (in real terms) since the previous budget cycle	1	0.5	0
The budget allocation is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect personnel and administrative costs)	1	0.5	0
The budget allocation for cash transfers is being sufficiently (≥ 80%) spent on both personnel costs and actual delivery/implementation	1	0.5	0
There is adequate government human resource and technical capacity for implementation of the policy	1	0.5	0
Cash transfer programmes are primarily (≥ 80%) government funded or administered	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for implementing the policy	1	0.5	0
The policy includes provisions for the oversight and regulation of cash transfer schemes	1	0.5	0
The policy includes complaints and grievance redressal mechanisms in case of a lack of provision	1	0.5	0
The Government collects and publishes disaggregated data on implementation of the policy, with indicators and targets for women and informally employed workers	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on the social and economic well-being of care and support givers (especially women) and care and support recipients	1	0.5	0
Design and impact			
The policy was developed through consultation with women from diverse backgrounds and/or women's rights organizations, and with persons with disabilities	1	0.5	0
There is an explicit intention to address unpaid care and support giving in the policy objectives or purpose (to recognize its social and economic value, to redistribute the responsibility between households and the state, and/or to improve the social and economic well-being of care and support givers (especially women))	1	0.5	0
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0

Indicator 1.3.2 Assessment criteria	Score		
	Yes	Partial	No
There is evidence of a positive impact on the social and economic well-being of care and support givers (especially women) and/or a transformation of gender norms as a result of the policy	1	0.5	0
There is evidence of a positive impact on the social and economic well-being and autonomy of persons with disabilities.	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for cash transfer programmes	1	0.5	0
Persons with disabilities are equitably (≥ 20%) represented in management and governance structures for cash transfer programmes	1	0.5	0
Score for indicator 1.3.2 (out of 25)	**___%**		

Sources of verification:

Data reported for indicator 1.3.1 of the Sustainable Development Goals ("Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable") can be used to assess the present indicator. ILO has a world social protection database that includes information on 214 countries and territories, which can be used as an initial tool, and ILO constantly requests States to update their information.[136]

The World Bank's Atlas of Social Protection Indicators of Resilience and Equity can be used as an alternative source. The Atlas has information from 139 countries on social assistance and social insurance based on administrative data and national household survey data.[137]

Policy examples in action || Practical policy implementation

Fiji: The Fiji Disabled Peoples Federation played a key role in designing a disability allowance and an accessible disability assessment mechanism at the community level. The federation's involvement has fostered strong ownership and enabled the successful and swift implementation of the programme.[138]

Panama: The Guardian Angel Programme, managed by the Ministry of Social Development, provides economic assistance to persons with disabilities who are in a state of dependency and extreme poverty. The programme offers a monthly stipend of 80 balboas to help cover basic health services, education and rehabilitation centre costs.[139]

[136] United Nations Statistics Division, "SDG indicator metadata", "Indicator 1.3.1", https://unstats.un.org/sdgs/metadata/files/Metadata-01-03-01a.pdf.
[137] World Bank, "ASPIRE: the Atlas of Social Protection Indicators of Resilience and Equity", www.worldbank.org/en/data/datatopics/aspire.
[138] ILO, *World Social Protection Report 2020–2022* (Geneva, 2021), p.145.
[139] Social Protection, "Programa Ángel Guardian (Guardian Angel Programme)", https://socialprotection.org/discover/programmes/programa-ángel-guardian-guardian-angel-programme.

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 28.16, 28.17, 28.18, 28.22, 28.23, 28.24, 28.25, 28.26

Data Sources Guidance: Article 28 of the Convention

7. Indicator 1.3.5: Concessions and discounts

Concessions are an important tool to increase support for persons with disabilities by enhancing their access to essential resources and services. Tax benefits, exemptions, discounts and subsidies have been implemented in many countries to facilitate the acquisition of support technologies and adapted vehicles, making them more affordable and accessible.[140] Additionally, subsidies are provided in various countries to alleviate disability-related expenses and extra costs. These cover a wide range of essential services and goods, including medical care, therapies, transportation, utilities and recreational activities. Concessions contribute to improving the quality of life for persons with disabilities and covering their disability-related extra costs by complementing cash transfers when they do not adequately address these costs.[141] When applied to households or unpaid care and support givers, they also reduce income inequalities, including gender inequalities. Concessions should be directed to persons with disabilities in adulthood.

Indicator 1.3.5 Assessment criteria	Score		
	Yes	Partial	No
There is a national policy for concessions and discounts for persons with disabilities	1	0.5	0
Accessibility and reach			
The policy covers underserved areas and populations, including those likely to be marginalized	1	0.5	0
Programmes under this policy are reaching the most underserved areas and populations, especially those likely to be marginalized	1	0.5	0
Budgeting and administration			
The budget allocated is sufficient to implement the policy (consider both direct costs implementation and maintenance costs, and indirect costs such as personnel and administrative costs)	1	0.5	0
The budget allocation for the programmes is being sufficiently spent (> 80%) on actual delivery/implementation	1	0.5	0
There is adequate government human resource and technical capacity for the implementation of the policy	1	0.5	0

[140] Vásquez and Pereira, *Autonomía: Un Desafío Regional*, p. 26.
[141] A/HRC/55/34, para. 23.

Indicator 1.3.5 Assessment criteria	Score		
	Yes	Partial	No
Regulation and monitoring			
There is a government department/unit/agency responsible for implementing the policy	1	0.5	0
The policy includes provisions for the oversight and regulation of the programmes/services	1	0.5	0
The Government collects and publishes disaggregated data on how many persons with disabilities have been reached by the programmes, with indicators and targets	1	0.5	0
Design and impact			
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the policy objectives or purpose	1	0.5	0
Concessions are designed to complement, not replace, cash transfers	1	0.5	0
Concessions are designed in consideration of disability-related extra costs	1	0.5	0
The policy was developed through consultation with persons with disabilities from diverse backgrounds and their organizations	1	0.5	0
There is evidence of a positive impact on care and support, including through the reduction of unpaid care and support giving as a result of the policy	1	0.5	0
There is evidence of a positive impact on the social and economic well-being and autonomy of persons with disabilities.	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for monitoring concession policies	1	0.5	0
Persons with disabilities are equitably (≥ 20%) represented in management and governance structures for monitoring concession policies	1	0.5	0
SCORE FOR INDICATOR 1.3.5 (out of 17)	**___%**		
Degree to which policy is transformative (0–5)	**___**		

Sources of verification:

At the national level, tax agency portals usually have information on available tax exemptions, subsidies and other benefits for individuals. Further research is needed to measure the full economic and social impact of concessions and discounts, but their significance in promoting accessibility and equality for persons with disabilities is evident.[142]

Some databases and resources systematize data on tax exemptions, subsidies and other financial incentives for individuals, including those for persons with disabilities. For example, the Organisation for Economic Co-operation and Development (OECD) created a database on tax benefits and welfare

[142] Vásquez and Pereira, *Autonomía: Un Desafío Regional*, p. 26.

entitlements, which provides detailed data on tax benefits and social welfare entitlements across member countries. This includes information on tax credits, deductions and exemptions for individuals. OECD also devised tax-benefit indicators for claimants of disability benefits. Some studies from other regional institutions have also briefly reviewed disability-related concessions.[143]

Policy examples in action || Practical policy implementation

Panama: Act No. 134 of 2013 provides a range of discounts for persons with disabilities, covering essential services and items including medical care, therapies, assistive devices, transportation and public utilities. This law is aimed at reducing the financial burden on persons with disabilities by offering discounts on medical services, technologies, recreational activities and everyday expenses such as utilities and the internet. This comprehensive support helps to improve the quality of life for persons with disabilities by making critical services and goods more accessible and affordable.[144]

Ecuador: The 2012 Organic Law on Disabilities provides financial relief to individuals with disabilities through various measures, including exemptions and reductions in income and property taxes, as well as in fees for notaries, consular services and registries. The law also provides for the reimbursement of value added tax (VAT) on personal goods and services and discounts on utilities and public entertainment.[145]

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 20.20

Data Sources Guidance: Article 20 of the Convention

8. Indicator 3.1.2: Government awareness-raising campaigns

Relevance:

Campaigns that focus on care and support work, its value and its connection to rigid gender roles should adopt an intersectional approach that highlights the autonomy of persons with disabilities. This includes respecting their right to receive care and support on their own terms and ensuring their active participation in all aspects of care and support systems. Campaigns should provide information about the rights of persons with disabilities in an accessible way and should debunk stereotypes leading to attitudinal barriers that hinder their inclusion. Any awareness-raising efforts should recognize the diversity of actors in care and support systems. The involvement of persons with disabilities in designing and implementing awareness-raising programmes and media-related legislation ensures the relevance and effectiveness of such initiatives and helps prevent the perpetuation of negative stereotypes.[146]

[143] Ibid.
[144] Ibid.
[145] Ibid.
[146] A/HRC/43/27, para. 76.

Indicator 3.1.2 Assessment criteria	Score		
	Yes	Partial	No
There is a national policy on government awareness-raising campaigns that aims to value and recognize care and support work, to shift gender norms around care and to recognize the autonomy of those receiving care and support.	1	0.5	0
Accessibility and inclusivity			
The campaigns are carried out regularly and at scale (at a national level)	1	0.5	0
Campaign messaging regarding care and support work is inclusive of all population groups	1	0.5	0
Campaigns include messaging on the rights of persons with disabilities in care and support systems	1	0.5	0
Campaigns are designed to meet accessibility standards	1	0.5	0
Budgeting and administration			
The budget allocated is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect costs such as personnel and administrative costs)	1	0.5	0
The policy has adequate human resource and technical capacity for monitoring implementation of the policy	1	0.5	0
Campaigns are primarily (≥ 80%) government funded or administered	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for the policy	1	0.5	0
The Government collects and publishes disaggregated data on how many people have been reached by the campaigns, with indicators and targets	1	0.5	0
The Government's monitoring and evaluation system includes the impact of the policy on norms and on unpaid care and support giving	1	0.5	0
Design and impact			
The policy was developed through consultation with women, including women with disabilities, from diverse backgrounds, and/or with women's rights organizations and workers associations	1	0.5	0
The policy was developed through consultation with persons with disabilities from diverse backgrounds and their organizations.	1	0.5	0
There is an explicit intention in the policy objectives or purpose to address attitudes related to care and support (e.g. that care and support work is not regarded as skilled or valuable, that it is regarded as a woman's responsibility, or that persons with disabilities are passive recipients of care)	1	0.5	0

Indicator 3.1.2 Assessment criteria	Score		
	Yes	Partial	No
There is evidence of a positive impact through transforming gender norms and disability stereotypes related to care and support as a result of the policy	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for government awareness-raising campaigns	1	0.5	0
Persons with disabilities are equally (> 50%) represented in management and governance structures for government awareness-raising campaigns	1	0.5	0
SCORE FOR INDICATOR 3.1.2. (out of 17)	**___%**		
Degree of transformation (0–5)	**___**		

Sources of verification:

Information on policies related to awareness-raising campaigns is commonly provided by specific ministries and agencies, such as the ministry of communication.

Policy examples in action || Practical policy implementation

Argentina: The *Cuidar en Igualdad* (Caring with Equality) campaign was designed to advance gender equality by promoting the shared responsibility of care work between men and women. As well as highlighting the economic and social value of unpaid care and support giving, the initiative has supported caregivers, with the aim of transforming societal norms regarding gender roles. The campaign advocated for autonomy and for ensuring high-quality care services for recipients, including older persons and persons with disabilities, through public messaging, training programmes and policy support.[147]

Australia: The Government's A Life Changing Life campaign, launched in 2023, promotes careers in the care and support sector, including in services for older people, persons with disabilities and veterans. Showcasing real workers and their clients, the campaign highlights the sector's professional and personal rewards, as well as its rapid growth, with hundreds of thousands of job posts expected in the next decade. The campaign underlines the Government's commitment to building a skilled, sustainable and compassionate workforce.[148]

[147] Government of Argentina, "Campaña Nacional 'Cuidar en Igualdad'", www.argentina.gob.ar/generos/cuidados/camp-nac-cuidar-en-igualdad.

[148] Government of Australia, Ministers for the Department of Social Services, "A Life Changing Life in the Care and Support Sector", 23 March 2023, https://ministers.dss.gov.au/media-releases/10646.

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 8.18, 8.19, 8.20, 8.21.

Data Sources Guidance: Article 8 of the Convention

9. Indicator 3.2.1: Measurement frameworks

Relevance:

Measurement frameworks for care and support systems enable adequate policy planning. Mainstream data collection frameworks have significant gaps when including disability, as recognized by the Committee on the Rights of Persons with Disabilities.[149] To improve these frameworks, the international consensus on disability data collection indicates the use of a functional approach to identifying persons with disabilities. It avoids listing medical conditions and impairments and reduces the number of questions for disaggregation purposes.[150]

To improve the availability of disability-related data, a twin-track approach is required. Standard censuses and surveys must collect data that can be disaggregated. In addition, disability-specific data must be collected through disability-specific surveys.[151] Examples of disability-specific surveys have been referenced in previous indicators for the collection of information on the need for and provision of support services. Administrative data can complement data from censuses and surveys.

The right to privacy of persons with disabilities requires States to adopt data protection laws that ensure statistical confidentiality in data collection and data management for statistical purposes.[152]

Indicator 3.2.1 Assessment criteria	Score		
	Yes	Partial	No
There is a national measurement framework that captures and monitors progress against well-being	1	0.5	0
Accessibility and reach			
The framework captures unpaid and paid care and support, including indicators on people's ability to receive and provide care, and on time use	1	0.5	0
The framework ensures that intersectional demographics are analysed as part of tracking progress	1	0.5	0
A functional approach to identifying persons with disabilities is used in all standard censuses and surveys, and all individual and household-level indicators already being reported are disaggregated by disability	1	0.5	0

[149] A/HRC/49/60, para. 6.
[150] Ibid., para. 12.
[151] Ibid., para. 18.
[152] Ibid., para. 62.

Indicator 3.2.1 Assessment criteria	Score		
	Yes	Partial	No
Budgeting and administration			
The budget allocated is sufficient for developing, updating and using the framework (consider both direct costs implementation and maintenance costs, and indirect costs such as personnel and administrative costs)	1	0.5	0
The policy has adequate human resource and technical capacity for the development, updating and use of the framework	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for overseeing the development and use of the framework to track progress on well-being indicators	1	0.5	0
There is publicly available data from national labour force statistics on key indicators on people's ability to receive and provide care and support, and on time use, disaggregated by population groups	1	0.5	0
A policy is in place to ensure that statistical confidentiality is enforced in data collection and data management for statistical purposes	1	0.5	0
Design and impact			
The framework has led to time use surveys being conducted regularly	1	0.5	0
Disability-specific surveys are conducted regularly to collect more detailed information on persons with disabilities and their environment	1	0.5	0
The framework is being used to analyse inequalities and changes in unpaid care and the effects of macroeconomic policies on unpaid care and support giving, poverty and gender inequality	1	0.5	0
Evidence generated on unpaid care and domestic work is being used by key ministries and departments to inform policy decisions and budget allocations.	1	0.5	0
Persons with disabilities, feminist economists and carers were/are involved in the development of the framework	1	0.5	0
Women are equally (≥ 50%) represented in management and governance structures for developing, updating and using national measurement frameworks	1	0.5	0
Persons with disabilities are equitably (≥ 20%) represented in management and governance structures for developing, updating and using national measurement frameworks	1	0.5	0
Score for indicator 3.2.1 (out of 16)	___%		
Degree of transformation (0–5)	___		

Sources of verification:

National measurement frameworks are published by bureaux and statistical agencies.

Policy examples in action || Practical policy implementation

Zimbabwe: The National Disability Survey is a comprehensive tool used to capture data on barriers faced by persons with disabilities. This survey collects information on barriers to transportation, accessibility, information, healthcare, home support and education. The data helps identify gaps and challenges, which can guide policy development and interventions aimed at improving overall accessibility and support systems for persons with disabilities.[153]

Colombia: The National Administrative Department of Statistics analysed the differential requirements of persons with disabilities and their care and support givers. Using 2021 data, it examined demographics, living conditions and the impact of demographic transition on care capacity. Central to the department's approach was the "care diamond", highlighting the roles of families, the State, the market and communities in providing support. The report that was produced characterizes caregivers' socioeconomic conditions and identifies challenges for public policy aimed at reducing care work while ensuring the enjoyment of rights, inclusion and an improved quality of life for persons with disabilities and their households.[154]

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 31.20, 31.21.

Data Sources Guidance: Article 31 of the Convention

10. Indicator 3.2.3: Disability assessment and certification

Relevance:

Some elements of care and support systems, such as childcare, accessible public transport and housing, ought to be universal or to use non-disability-related eligibility criteria. For others, Governments may need to identify children and adults with disabilities, as well as their family members, who may require disability care and support schemes. Similarly, Governments may need such identification to grant people concessions or priority in accessing services. This may cover fees or waiting lists for the general population or for those who are otherwise eligible.[155]

To identify persons with disabilities and provide adequate care and support, Governments have developed disability assessment and certification mechanisms:

[153] Ibid., para. 7.
[154] Government of Colombia, Departamento Administrativo Nacional de Estadística (National Administrative Department of Statistics), *El diamante del cuidado frente a la experiencia de la discapacidad en Colombia: Una aproximación a los requerimientos diferenciales de las personas con discapacidad y de sus propios cuidadores en 2021 – Nota Estadística No. 1 de 2023* (Bogotá, 2023).
[155] Alexandre Côte, Charles Knox-Vydmanov and Louisa Lippi, *Guidance document V1.0: Towards Inclusive Social Protection Systems: Enabling Participation and Inclusion of Persons with Disabilities* (UNICEF and ILO, New York and Geneva, 2024), pp. 65–69.

- **Disability assessment** is the process of collecting information about an individual's situation to determine their eligibility for disability-related care and support.[156] The process may include gathering data on medical conditions, impairments, functional difficulties, support needs, barriers, participation in the community and family context.[157] The information obtained is valuable for disability determination, referral, case management and policy planning, and additional assessments may be needed for those requiring assistive devices, home adaptations or rehabilitation services.[158]
- **Disability certification** (or determination) is the official decision regarding whether an individual is granted a disability status. This decision is based on the information collected during the assessment, following officially defined criteria and thresholds established by specific programmes or legislation.[159]

As they progressively develop their social protection and care and support systems, more and more countries are developing or reforming such mechanisms. Such mechanisms have different components:

- Pre-identification of people likely to benefit from obtaining disability certification, which may include awareness and information campaigns, outreach in communities, and screening and referral in health, education or social protection
- Disability and needs assessment, which involves the collection of information about the individual applying for disability certification and their situation, usually through a standard process and forms, which may include one or more stages
- Disability determination or certification, which is an official decision based on criteria set by laws or regulations and on the information collected during the assessment.

Children and adults with disabilities often do not access existing disability certification mechanisms. Among the common reasons for this are that they or their family do not have access to information about such mechanisms, they do not have the means to meet the administrative requirements (e.g. providing official documents or medical certificates that require fees or travel to cities), or they do not meet disability determination criteria that may exclude certain groups. Delays in disability assessment, due to insufficient budget allocation or other administrative barriers, result in exclusion. Some systems require unnecessary certification reviews, sometimes yearly, which can lead to redundancies, delays and burdens for both people and administrative systems.

The Committee on the Rights of Persons with Disabilities has made recurrent recommendations to States parties on how they should undertake disability assessment and certification mechanisms. These include:

- Ensuring that the disability certification procedure they implement is easily accessible and affordable for the diversity or persons with disabilities all over the country, regardless of type of functional limitation, income or location, and including for those living in rural and remote areas
- Adopting a human rights-based model of disability assessment that has a person-centred approach, that respects privacy and dignity and that does not solely assess impairment but considers the personal circumstances of the individual, the support they require and the barriers they face to achieve equal participation
- Avoiding multiple assessment and certification mechanisms to access different disability-targeted schemes

[156] OHCHR, *SDG-CRPD Resource Package*, 2024.
[157] Côte, Knox-Vydmanov and Lippi, Towards Inclusive Social Protection Systems, p. 65.
[158] Ibid.
[159] Ibid.

- Actively involving persons with disabilities in their assessment and involving their representative organizations in the design, implementation and monitoring of the mechanism(s)
- Ensuring that protection against disability-based discrimination does not require the person with disabilities to have an official disability-related certificate or card.

Over the past decade, important lessons have emerged from reform processes. Disability certification mechanisms must be reliable, ensuring consistency and preventing fraud. They must also be accountable, which requires transparency and effective grievance mechanisms for central and local government entities, organizations of persons with disabilities, individuals with disabilities and their families, and service providers. Additionally, digitization and management information systems should facilitate proper assessments by non-specialized personnel at the local level, even in lower-income contexts, and they should reduce the time required to process applications. Electronic certificates should be issued, the reliability of the mechanisms should be increased, and the use of collected data should be enhanced.

Accessible, comprehensive and reliable disability assessment and certification are essential to avoid the exclusion of many persons with disabilities from essential support mechanisms, which could push them into further marginalization and poverty. They are also essential for local and central governments for the purposes of case management, policy planning and resourcing, as they can provide granular information about support needs and barriers that no other data instruments provide in most countries.

Indicator 3.2.3: Disability assessment and certification

Assessment criteria	Score		
	Yes	Partial	No
There is a disability assessment and certification mechanism (or mechanisms) that follow a human rights-based approach	1	0.5	0
Accessibility and inclusivity			
Disability and needs assessment procedures under this policy are reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0
Information about the mechanism, the requirements and the related benefits are accessible for the diversity of persons with disabilities	1	0.5	0
The mechanism ensures that assessments and certification are free of cost	1	0.5	0
The mechanism, its assessment and its certification criteria consider the diversity of children and adults with disabilities	1	0.5	0
The mechanism is focused on assessing support requirements and the social and environmental factors that affect a person's ability to perform daily living activities and to participate in the community	1	0.5	0
The assessment collects information about the level, type(s) and provider(s) of the unpaid and paid care and support that the person assessed is currently receiving	1	0.5	0

Indicator 3.2.3 Assessment criteria	Score		
	Yes	Partial	No
Budgeting and administration			
The budget allocated is sufficient for developing and updating the mechanisms(s) (consider both direct costs implementation and maintenance costs, and indirect costs such as personnel and administrative costs)	1	0.5	0
The mechanism(s) are supported by a disability management information system that is interoperable with other relevant management information systems (such as civil registration and vital statistics, social protection, health and education)	1	0.5	0
The mechanism(s) have adequate human resource and technical capacity to undertake assessments without significant delays	1	0.5	0
The budget allocation for assessment services is being sufficiently (≥ 80%) spent on personnel costs and actual delivery/implementation	1	0.5	0
Assessment services are primarily (≥ 80%) government funded or administered	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for overseeing the development and use of the mechanism(s)	1	0.5	0
Safeguards are in place to ensure that information confidentiality is enforced in data collection and management, including for exchanging information with other management information systems	1	0.5	0
The Government collects and publishes disaggregated data on the progress and coverage of assessments, including data on the number of persons with disabilities who have been assessed and who require different types and levels of care and support, with indicators and targets	1	0.5	0
Design and impact			
There is an explicit intention to promote the autonomy and well-being of persons with disabilities in the framework objectives or purpose	1	0.5	0
There is evidence of a positive impact through the reduction or redistribution of unpaid care and support giving as a result of the policy	1	0.5	0
Persons with disabilities were/are consulted in the development and review of the mechanism(s)	1	0.5	0
Persons with disabilities are significantly (≥ 50%) represented in management and governance structures for developing, updating and using assessment and determination mechanism(s)	1	0.5	0
Score for indicator (out of 19)	___%		
Degree of transformation (0–5)	___		

Sources of verification:

Agencies responsible for overseeing disability policy publish information on disability assessment and determination.

Policy examples in action || Practical policy implementation

Argentina: The Ministry of Science, Technology and Innovation, along with the National Disability Agency (ANDIS), launched the digital version of the Single Disability Certificate (CUD). The digital CUD, accessible through a mobile phone application, has the same validity as the physical version and can be used for all necessary administrative processes. The certificate includes a scannable QR code for verification and can be downloaded in portable document format (as a PDF), allowing persons with disabilities to access their rights and services easily using their mobile phones without needing a printed version. Users can also access the mobile app to apply for a CUD. (See Government of Argentina, "La versión digital del Certificado Único de Discapacidad ya está disponible en Mi Argentina" (The digital version of the Single Disability Certificate is now available on Mi Argentina), www.argentina.gob.ar/noticias/la-version-digital-del-certificado-unico-de-discapacidad-ya-esta-disponible-en-mi-argentina).

Cambodia: The Government of Cambodia, with support from UNICEF and the European Union, implemented the Social and Rights-based Disability Identification Mechanism (SRDIM) to assess persons with disabilities and provide them with identification cards for accessing public services. The project trains local, non-specialist focal points to conduct disability assessments in communities and links the disability database with the IDPoor social assistance system. By June 2022, 234,094 persons with disabilities had been assessed, with 200,000 set to receive disability cards, which grant access to social protection schemes, vocational training and health services, improving overall access to support systems. See Asian Development Bank, "Asia-Pacific Social Protection Week 2023: social protection in a changing world", https://socialprotection.org/sites/default/files/multimedia_files/4B.pdf, slides 42–52.

Spain: The System for Autonomy and Care for Dependency provides a comprehensive framework for assessing disabilities, focusing on support needs to determine eligibility for care and support services. The system integrates a robust disability assessment process, which was updated in 2022 with the participation of organizations of persons with disabilities, that allows persons with disabilities to access a wide range of social services, including home-based care and support and financial assistance.

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 1/4.24.

Data Sources Guidance: Article 1-4 of the Convention

11. Policy area 3.3: Legal capacity and deinstitutionalization [new policy area]

What does it involve, and how does it address inequalities in care and support?
Denial of the legal capacity of persons with disabilities and placing them in institutions are human rights violations that negate their ability to receive care and support, in general, and on their own terms, in particular.

Legal capacity is both an enabler for support (as a precondition for the exercise of rights) and a domain of support (an area where support might be needed). Without recognition of their legal capacity, persons with disabilities cannot make decisions that are legally binding for activities that are essential, as has been referenced in previous indicators. In particular, they cannot:

- Define their support arrangements
- Decide where to live
- Open a bank account to have access to cash transfers and benefits
- Independently manage their money according to their own will and preferences
- Buy products, including assistive technology.

As addressed under indicator 1.2.3 on human support services, decision-making is a domain of support for persons with disabilities where support must be available when requested. Due to its all-encompassing nature, legal capacity requires its own indicator.

Institutionalization is disability-based discrimination and implies the denial of legal capacity. It exposes persons with disabilities to a range of additional human rights violations such as involuntary medical interventions.[160] Institutionalization can never be considered a form of protection, support or choice for persons with disabilities.[161]

12. Indicator 3.3.1: Legal capacity [new indicator]

Relevance:

Under article 12 of the Convention, persons with disabilities have the right to exercise their legal capacity. Recognition of legal capacity is core to the autonomy and agency of persons with disabilities by centring their will and preferences.[162] According to the Committee on the Rights of Persons with Disabilities, article 12 rights are subject to immediate realization. Therefore, expeditious actions for implementation are required.[163]

Implementation of legal capacity under article 12 of the Convention requires the provision or recognition of support for decision-making and the establishment of safeguards. Supports in this context allow persons with disabilities to "(a) obtain and understand information, (b) evaluate the possible alternatives and consequences of a decision, (c) express and communicate a decision, and/or (d) implement a decision."[164] Safeguards are measures to ensure that no abuses in the provision of support can overcome the will and preferences of the person with disabilities.

If legal capacity reform has not taken place yet, those involved in advocacy and care and support systems should consult directly with persons with disabilities and their organizations to back up their initiatives.

[160] CRPD/C/5, para. 6.
[161] Ibid., para. 8.
[162] Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law (CRPD/C/GC/1), para. 29.
[163] Ibid., para. 30.
[164] A/HRC/37/56, para. 41.

Indicator 3.3.1 Assessment criteria	Score		
	Yes	Partial	No
Legislation is in place recognizing the legal capacity of persons with disabilities on an equal basis with others. It abolishes all forms of substitute decision-making (including through concepts of "best interests"), and it provides safeguards and prompt, effective remedies in case of any restriction of legal capacity	1	0.5	0
Legislation is in place for the provision or recognition of supported decision-making arrangements	1	0.5	0
Accessibility and inclusivity			
Informal and formal support arrangements are available, accessible and adequate, and they allow for the creation and implementation of diverse supported decision-making schemes	1	0.5	0
Accommodations are available in all contexts for the exercise of legal capacity	1	0.5	0
Budgeting and administration			
The budget allocated is sufficient for providing supported decision-making for persons with disabilities to exercise their legal capacity	1	0.5	0
The policy has adequate human resource and technical capacity for its development and implementation	1	0.5	0
Regulation and monitoring			
There is a government department/unit/agency responsible for overseeing the development and use of the framework to track progress on well-being indicators	1	0.5	0
Quality standards are in place covering formal and informal support arrangements and the modification or termination of support in accordance with the individual's will and preferences, as well as covering the right to refuse support	1	0.5	0
Mechanisms and procedures are in place for the monitoring of formal or informal support arrangements that ensure the participation of persons with disabilities, including through their representative organizations, in the monitoring process	1	0.5	0
Design and impact			
Persons with disabilities were consulted and were actively involved, including through their representative organizations, in the design, implementation and monitoring of laws, regulations, policies and programmes related to equal recognition before the law and supported decision-making and safeguards for the exercise of legal capacity	1	0.5	0
The policy was developed through consultation with women, including women with disabilities, from diverse backgrounds, and/or with women's rights organizations	1	0.5	0

Indicator 3.3.1 Assessment criteria	Score		
	Yes	Partial	No
Persons with disabilities are significantly (> 50%) represented in management and governance structures for developing, updating and implementing supported decision-making frameworks	1	0.5	0
There is a decreasing number of persons with disabilities who are formally deprived of their legal capacity (either fully or partially), disaggregated by sex, age, and disability	1	0.5	0
There is an increasing number of persons with disabilities who have had their full legal capacity restored, disaggregated by sex, age and disability	1	0.5	0
Persons are receiving formally requested support for decision-making, and the proportion who received such support is disaggregated by sex, age and disability and by the type or duration of support received	1	0.5	0
There is an increasing number and proportion of persons with disabilities who report that their requirements for supported decision-making have been met, disaggregated by sex, age and disability.	1	0.5	0
Score for indicator 3.3.1 (out of 16)	**___%**		

Sources of verification:

In countries where legal capacity reforms have not been passed, data on the restriction and restoration of legal capacity is usually found in the judiciary or in civil registration instruments. The extent to which this data is collected varies. For example, before the legal capacity reform of 2019 in Colombia, information on how many persons were under guardianship was not comprehensively collected by the judiciary or by the National Registry of Civil Status. Legal capacity reforms must establish centralized mechanisms that allow for the oversight of supported decision-making arrangements. The administrative data of agencies requiring representatives for the collection of disability benefits can be used as a proxy.

Policy examples in action || Practical policy implementation

Colombia: Law 1996 of 2019 marked a significant advancement in civil and human rights for persons with disabilities. The law recognizes the legal capacity of persons with disabilities and promotes supported decision-making mechanisms in line with the Convention, including through advanced directives and support arrangements. This reform positions Colombia alongside Peru as a leader in legal reforms in Latin America.[165]

In 2021, similar legislation was approved in Spain.

[165] The website of the Ministry of Justice of Colombia has several resources (in Spanish) explaining the law and its implementation. See www.minjusticia.gov.co/programas-co/tejiendo-justicia/Paginas/Discapacidad.aspx. For recent analysis on implementation, see also Juan Daniel Franco, *La implementación de los procesos judiciales de la Ley 1996 de 2019 ¿En qué vamos?* (Programa de Acción por la Igualdad y la Inclusión Social, 2024), https://drive.google.com/file/d/1i6QlaztCfVkJVeL6pNJQbXMIn_8EbmR8/view.

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 12.19, 12.20, 12.21, 12.22.

Data Sources Guidance: Article 12 of the Convention

13. Indicator 3.3.2: Deinstitutionalization [new indicator]

Relevance:

Institutions have long formed part of the response of non-rights-based care systems for persons with disabilities, and they have been said to provide the mental health "solution" for persons with psychosocial disabilities or persons with mental health conditions.[166] However, institutionalization is incompatible with the care and support paradigm. In fact, it is the complete opposite. Deinstitutionalization requires the closure of all institutions and the creation of inclusive community-based support systems.[167]

States should adopt a person-centred approach, ensuring that community services such as income support, housing assistance, peer support and other networks are available for persons transitioning out of institutions.[168] Norway and Sweden are moving away from institutional care by closing large social care residences and long-stay psychiatric hospitals. Recently, the Republic of Moldova has taken steps towards deinstitutionalization.[169]

Care and support services and programmes that should be in place instead of institutions are mentioned throughout the *Care Policy Scorecard* and this *Country Assessment Tool*. As a result, these services are not included again in this indicator.

Indicator 3.3.1 Assessment criteria	Score		
	Yes	Partial	No
A national policy framework is in place to guide deinstitutionalization processes towards the closure of institutions, abolishing all forms of institutionalization, and prohibiting investment in institutions	1	0.5	0
A national policy is in place to ensure support to families of children with disabilities to prevent family separation, including through the provision of appropriate and adequate social services for high-quality, family-based alternative care options, to ensure the right of children with disabilities to a family life and inclusion in the community	1	0.5	0
A moratorium is adopted on new admissions of persons with disabilities to institutions	1	0.5	0

[166] Institutions, as defined in the Guidelines on deinstitutionalization, including in emergencies, have some defining characteristics "such as obligatory sharing of assistants with others and no or limited influence as to who provides the assistance; isolation and segregation from independent life in the community; lack of control over day-to-day decisions; lack of choice for the individuals concerned over with whom they live; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of individuals under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; and a disproportionate number of persons with disabilities in the same environment" (CRPD/C/5, para. 14).
[167] WHO and OHCHR, *Mental Health, Human Rights and Legislation: Guidance and Practice* (Geneva, 2023), p. 93.
[168] Ibid.
[169] A/HRC/55/34, para. 46.

Indicator 3.3.1 Assessment criteria	Score		
	Yes	Partial	No
A moratorium is adopted on new admissions of children with disabilities to institutions	1	0.5	0
No legal provision directly or indirectly restricts the right of persons with disabilities to choose where and with whom to live on an equal basis with others.	1	0.5	0
Accessibility and reach			
Support and programmes, including economic assistance, are available, accessible and adequate for persons with disabilities transitioning out of institutions	1	0.5	0
Services under this policy are reaching the most underserved areas and populations, including those likely to be marginalized	1	0.5	0
Budgeting and administration			
The budget allocated is sufficient to implement a deinstitutionalization strategy	1	0.5	0
The policy has adequate human resource and technical capacity for its development and implementation	1	0.5	0
Regulation and monitoring			
There is a legal requirement to collect data on the number and proportion of persons with disabilities exercising the right to choose their living arrangements, including those leaving institutions for community living, and those accessing support services for living independently	1	0.5	0
Complaints on the right of persons with disabilities to live independently and be included in the community are investigated and adjudicated; and decisions are complied with by the Government and/or duty bearer.	1	0.5	0
NGOs and national human rights institutions have access to institutions to monitor them	1	0.5	0
Design and impact			
Persons with disabilities were consulted and take the lead, including through their representative organizations, in the design, implementation and monitoring of laws, regulations, policies and programmes on deinstitutionalization	1	0.5	0
The policy was developed through consultation with women, including women with disabilities, from diverse backgrounds, and/or with women's rights organizations	1	0.5	0
Persons with disabilities are significantly (≥ 50%) represented in management and governance structures for developing, updating and implementing a deinstitutionalization strategy	1	0.5	0

Indicator 3.3.1 Assessment criteria	Score		
	Yes	Partial	No
Persons with disabilities are no longer residing in institutions such as psychiatric inpatient settings or residences for persons with intellectual disabilities (which can range from large-scale facilities to group homes)	1	0.5	0
Persons with disabilities are transitioning out of institutions (e.g. psychiatric inpatient settings or residences for persons with intellectual disabilities) and entering into independent living arrangements, with data disaggregated by sex, age and disability.	1	0.5	0
Persons with disabilities who have been released from institutions are being provided with community-based support services, including personal assistance, to the extent requested by the person, with data disaggregated by sex, age, disability and support service provided.	1	0.5	0
Score for indicator 3.3.2 (out of 18)	**0**		
Degree of transformation (0–5)	**___**		

Sources of verification:

Data related to persons in institutions and those transitioning out of institutions is often not being collected systematically at the national level. As a result, data would need to be gathered from different sources, in particular from authorities with oversight on "social care" institutions and institutions for older persons, as well as from health systems that collect data from "patients" in psychiatric institutions.

When programmes are created for persons transitioning out of institutions, administrative data should be available on the beneficiaries of services and programmes. For example, the Centers for Medicare and Medicaid Services in the United States implemented a "money follows the person" initiative.[170] The aim of this initiative was to transition persons into the community through appropriate support services. The federal Government provided funding to states, which were then obligated to submit detailed annual reports.

Policy examples in action || Practical policy implementation

Georgia: The Government adopted a deinstitutionalization strategy in 2023, aimed at closing large-scale institutions for children and adult persons with disabilities. Since 2005, over 80 institutions have been shut down, with all children's institutions closed and replaced by alternative services such as foster care. This strategy supports transitioning from institutional care to community-based alternatives.[171]

[170] OHCHR, "Data sources for outcome indicators on Article 19: Living independently and being included in the community" (advance version), 2021, p. 12.

[171] OHCHR, "Experts of the Committee on the Rights of Persons with Disabilities commend Georgia on anti-discrimination legislation, ask questions on legal capacity reform and access to healthcare for vulnerable persons in occupied regions", 10 March 2023, www.ohchr.org/en/news/2023/03/experts-committee-rights-persons-disabilities-commend-georgia-anti-discrimination.

Norway and Sweden: These two countries took similar paths to deinstitutionalization, albeit with a few differences. Sweden implemented a gradual transition through legislative amendments, while Norway, after initial delays, rapidly closed all its institutions between 1991 and 1995. Both countries focused on developing services and programmes and transferred full responsibility for services to local authorities by the mid-1990s.[172]

SDG-CRPD Resource Package:

Outcome indicators to measure impact on people: 19.32, 19.33, 19.34.

Data Sources Guidance: Article 19 of the Convention

[172] Jan Tøssebro, "Scandinavian disability policy: from deinstitutionalisation to non-discrimination and beyond", *Alter*, vol. 10, No. 2 (April-June 2016), pp. 111–123.

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