



SOCIAL PROTECTION RESPONSES TO THE COVID-19 CRISIS FOR PERSONS WITH DISABILITIES

SYNTHESIS PAPER

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EXECUTIVE SUMMARY

Social protection for persons with disabilities before COVID-19

In conjunction with a broader inclusive policy framework, social protection has a critical role to play in support of inclusion of children, working age adults and older persons with disabilities. To do so, effective social protection systems for persons with disabilities require a multi-layered set of interventions. In addition to general social protection needs, persons with disabilities commonly faced two key interlinked issues which must be addressed by social protection systems: disability-related extra costs that undermine socio-economic participation at all ages and increased challenges to earning an income. Without adequate social protection responses, these issues constitute major drivers of poverty and social exclusion of persons with disabilities across the life cycle and increase vulnerability to shocks such as that created by COVID-19. An effective multi-layered social protection system for persons with disabilities requires:

- Cash benefits that ensure a minimum level of **income security** in the context of barriers to paid work, provided by a mix of disability-specific and mainstream schemes.
- A blend of cash benefits as well as care and support services addressing and compensating for **disability-related extra costs across the life cycle**, such as assistive products, transport, personal assistance, and other care and support services.
- **Universal health care coverage** which also addresses specific health needs of persons with disabilities, including early intervention, rehabilitation, and assistive technology.
- **Interlinkages** between social protection schemes and the provision of other relevant services.

Depending on the country context, this set of support will be provided through different combinations of inclusive mainstream schemes and disability-specific schemes as well as contributory and non-contributory schemes.

Before the onset of COVID-19, social protection systems in low- and middle-income countries had low coverage of persons with disabilities. Globally, estimates suggest that only one third of persons with severe disabilities (34 per cent) received a disability cash benefit, with significantly lower coverage in lower-middle-income countries (11 per cent) and low-income countries (9 per cent). The landscape of regular disability-specific cash benefits that were in place before the crisis can be characterised as follows:

SCOPE: While most countries across the globe have some form of disability-specific cash benefit in place, only 36 per cent have a non-contributory scheme in place (ILO, 2021), which are particularly relevant given the barriers that persons with disabilities face to accessing the labour market. Cash benefit schemes are usually oriented towards providing a minimum level of income security, while those seeking to address disability-related extra costs are relatively rare. Mainstream social assistance schemes targeted at poor households may provide some additional support but are rarely designed with persons with disabilities specifically in mind.

ELIGIBILITY: The nature of eligibility criteria for cash benefits can significantly limit coverage and inclusivity:

- Non-contributory schemes are commonly **means tested**, adding complexity to eligibility assessment, and often excluding some of the poorest people with disabilities (given the exclusion errors to which means-tested schemes are prone). This is exacerbated by the fact that poverty measurement and means-testing techniques rarely take account of disability-related extra costs.
- Eligibility is often limited to those **deemed unable to work**, ignoring the disability-related extra costs of persons with disabilities with capacity to work, and that addressing these costs can facilitate access to the labour market.

- Disability assessment commonly uses a **medical model** which can add complexity and inaccessibility to assessment processes and usually does not incorporate an assessment of how social and environmental factors affect an individual's ability to carry out their daily lives.

ADEQUACY: Some countries such as Brazil, Georgia, Mauritius and South Africa have benefit levels for disability benefits which can be considered to provide a minimum level of income security, but many others fall far short of this benchmark. Meanwhile, even in countries with comparatively high benefit levels (and supplementary schemes) these are unlikely to adequately address disability-related extra costs.

ACCESSIBILITY: Issues relating to accessibility further limit the inclusiveness of social protection. Disability assessment and determination processes are commonly complex and time consuming, requiring extensive travel. Meanwhile, significant accessibility barriers exist across the delivery chain, including physical barriers, information and communication barriers, and attitudinal barriers.

Prior to COVID-19, health systems in low- and middle-income countries commonly fell far short of providing universal health coverage. Persons with disabilities are significantly affected by the limited financial protection of health systems in general, although many have benefitted from efforts to improve financial protection, in some cases having been prioritised in efforts to extend coverage of financial protection. Another major issue is service coverage, which may not address the needs of persons with disabilities such as provision of assistive devices and appropriate paediatric expertise. Health services can also suffer from issues of poor service quality and inaccessibility. It is common for staff to lack the necessary training to address discriminatory attitudes, medical practices, and stigma. All those issues can ultimately limit the use by persons with disabilities of health services and increase their costs of doing so.

Social protection responses to COVID-19 for persons with disabilities

People with disabilities have been particularly vulnerable to the impacts of the COVID-19 pandemic. Households with children and adults with disabilities had higher poverty rates before the crisis, fewer working members, and less savings, and those in employment were more likely to be found in the informal economy. As a result, they have been more exposed to the impact of COVID-19 on the labour market. Persons with disabilities have also been exposed to increases in the cost of goods and services, such as the need to use specialised – rather than public – transport. A growing body of research on the impacts of the crisis shows a disproportionate impact on children and adults with disabilities.

The social protection response to COVID-19 has considered persons with disability to a certain extent, but the lack of inclusiveness of social protection systems prevented adequate support. Overall, the social protection response to COVID-19 witnessed across the globe has been unprecedented, even if the scale of this response has been uneven between countries. Within this broader picture, just under half of countries that announced social protection measures (44 per cent) specifically referred to persons with disabilities. These measures primarily consisted of cash and in-kind benefits. Of 36 in-kind measures identified, most of these related to food or provision of hygiene packages, although some countries also provided medical items.

While effective support would require a combination of cash and services, in those countries where announced measures specifically referred to persons with disabilities, cash benefits constituted the main kind of scheme being adapted or introduced. Measures involving cash benefits have related to a diverse range of programmes including disability benefits paid to adults and/or children, adjustment to household-targeted social assistance schemes which include specific eligibility criteria for persons with disabilities or the initiation of ad hoc schemes making specific provision for persons with disabilities.

Disability benefits were adjusted in one of three main ways:

- **VERTICAL EXPANSION** of schemes – entailing a temporary increase in benefit levels – was the most common type of adjustment to disability benefits. In many cases this involved meaningful increases in benefit levels for a substantial duration of time (6 months or more). However, vertical expansion needs to be understood in relation to the adequacy of regular benefits. For example, topped-up disability benefits in Thailand remained below those provided in normal times in countries such as Brazil, Georgia, Mauritius and South Africa.
- **HORIZONTAL EXPANSION** of schemes – where coverage was temporarily increased – was less common than vertical expansion in part because countries struggled to identify persons with disabilities during the crisis. Meanwhile, in countries that sought to expand coverage horizontally, this does not appear to have addressed the very low coverage of schemes before the crisis. This experience highlights the significant challenge of expanding coverage of disability benefits in times of crisis and the importance of nationwide disability management information systems and registries.
- **ADMINISTRATIVE ADJUSTMENTS** related to three main areas: first, adjusting eligibility assessment by extending the validity of ID cards/delaying assessment processes; second, adapting payment delivery, such as using digital transfers or home deliveries; and third, advancing payments.

Given the limited role of disability benefits in responding to the COVID-19 crisis in many countries, mainstream schemes provided a potential route to address these gaps. Many persons with disabilities may have fallen into the population groups that governments sought to protect with these measures, such as informal sector workers and/or low-income households. Few countries extended social insurance sick leave for parents taking care of children with disabilities. However, the experience of these schemes has been mixed:

- **LIFE CYCLE CASH BENEFIT SCHEMES** (including child benefits, disability grants and old age pensions) provided an important channel to support persons with disabilities in many countries. For example, in South Africa, 80 per cent of persons with disabilities live in a household receiving one of the social grants which were vertically expanded in 2020.
- **SCHEMES SUPPORTING INFORMAL WORKERS** may have reached some persons with disabilities, but few appear to have been specifically adapted to their needs. In Thailand, while some persons with disabilities were reached by the schemes for informal workers and farmers, around 60 per cent of those who applied were not successfully enrolled.
- **EXPANSION OF SOCIAL ASSISTANCE:** In various countries, social registries were used to horizontally expand coverage of social protection benefits during the crisis. However, there are significant questions regarding the extent to which they have been effective in reaching persons with disabilities. Generally, these registries do not take adequate account of the specific circumstances of people with disabilities, which may have limited their effectiveness in response to COVID-19.
- **AD HOC PROGRAMMES** that included persons with disabilities also appear to have mixed levels of success. The Philippines provides an example of a country that sought to provide benefits to most of the population – with specific consideration of persons with disabilities – however, the process of registering persons with disabilities varied by locality, and often resulted in exclusion.

For many mainstream measures, benefits were provided at a household level which raises important questions about the level of control persons with disabilities had over decision-making. This was illustrated in the case of Timor-Leste where persons with disabilities noted a significant difference between the country's regular disability benefits – where they had control over the use of the benefit – and short-term benefits targeted at households – where funds were pooled at a household level.

Conclusions and recommendations

The overarching conclusion of this synthesis is that countries with existing benefits and administrative systems in place have been better able to support persons with disabilities during the crisis, even if significant gaps remain. On this basis, the synthesis makes the following recommendations.

- **Expand coverage of disability benefits towards universal coverage.** This can be achieved through a mix of non-contributory and contributory schemes. Extending coverage should involve a progressive move away from narrow means-testing and a focus on persons with disability deemed unable to work.
- **Take better account of disability extra costs in normal times, and in times of crisis.** This can take many forms, but a starting point would be the implementation of disability benefits that would be compatible with work, greater coverage of health care costs and community care and support services for children and adults with disabilities. Over time, countries can gradually build up multi-tiered systems of disability benefits addressing a more complex range of extra costs.
- **Build disability registries and information systems as a key pillar of inclusive and shock-responsive social protection.** These can provide a gateway to a range of benefits and services including disability-specific benefits, mainstream social protection schemes, concessions, support services and health care. They can facilitate case management and policy planning. In connection with social protection related registries and MIS, they can also provide a foundation for horizontal expansion of cash benefits in response to covariate shocks.
- **Improve the disability inclusion of mainstream social protection schemes.** This would include taking account of disability related costs in poverty assessment and eligibility criteria, as well as improving disability related data in social protection related registries and MIS.
- **Increase the accessibility of both disability and mainstream social protection schemes.** This involves adequate training, accessible information and communication channels, data disaggregation, development of minimum standards, implementation of disability-inclusive administrative processes and appropriate management and organisational processes.
- **Persons with disabilities should be actively involved in the policy formulation, design, and implementation of social protection systems, including during times of crisis.** Not only is their participation key to ensure that social protection schemes are designed to respond to the circumstances faced by persons with disabilities, but they can be partners in the implementation.

1. INTRODUCTION

As part of a broader inclusive policy framework, social protection has a critical role to play in supporting inclusion of children, working age adults and older persons with disabilities. Social protection systems also have significant potential to support persons with disabilities and their families to manage shocks such as those created by COVID-19. Effective social protection systems, including floors, should ensure income security and coverage of health care and disability related costs for persons with disabilities and their families in normal times. This will increase their resilience to covariate shocks. When a crisis hits, social protection systems can also be an important channel to provide support to persons with disabilities and their families. Despite this potential, its fulfilment depends significantly on the nature of a social protection system and how it is mobilised in times of crisis.

This paper provides a synthesis of research exploring the extent to which social protection systems in low- and middle-income countries have been able to respond to the needs of persons with disabilities during the COVID-19 crisis thus far. It draws on a set of country case studies (Box 1) analysing the pre-existing support provided by social protection systems and how they have responded during the crisis. It is also supplemented by findings of other research undertaken on social protection and disability in the context of COVID-19. The case studies were selected based on a range of criteria including diversity in terms of geography, level of economic development and the extent of pre-existing social protection provision for persons with disabilities. Many countries were included due to notable features of their social protections systems, meaning that they are not representative of low- and middle-income countries as a whole. This paper seeks to identify key trends in the case studies and other countries, and lessons which can feed into future response measures and the long-term development of social protection systems. An important caveat is that the synthesis comes part of the way through an ongoing crisis, where measures are continuing to evolve. Evidence on the specific nature of responses, and particularly on their effectiveness, is also still only emerging at the time of writing. Unless otherwise stated, discussion of case study countries is based on the case study reports, which are forthcoming.

Box 1: Case study countries

Brazil	Mauritius	Thailand
Ethiopia	Peru	Timor-Leste
Georgia	Philippines	Uganda
Kenya	South Africa	Uzbekistan
Indonesia	Sri Lanka	Vanuatu

The first part of the paper describes the landscape of social protection in relation to persons with disabilities before COVID-19, both in terms of the potential role of social protection, and the nature of schemes actually in place. The second part of the paper describes social protection measures announced and put in place in response to COVID-19. After a brief summary of the impacts of COVID-19 on persons with disabilities, the paper discusses disability-specific social protection responses, and then mainstream responses that had the potential to support persons with disabilities. The primary focus of the paper is on low- and middle-income countries, although some reference is made to relevant experiences in high-income countries. With regards to the scope of social protection, the paper primarily focuses on cash benefits, although it also includes some discussion of in-kind benefits (including health services) and concessions.

2. SOCIAL PROTECTION FOR PERSONS WITH DISABILITIES BEFORE COVID-19

Effective social protection systems play a critical role for persons with disabilities and their families. In addition to addressing social protection needs of the general population, social protection systems respond to two key interlinked issues commonly faced by persons with disabilities: additional disability-related costs faced at all ages undermining socioeconomic participation, and increased challenges to earning an income. First, disability is commonly associated with additional costs such as for assistive devices, medical care, personal care and support, and specific means of transportation. These additional disability related costs create barriers to socioeconomic participation. Second, an interaction of a person's functional difficulties with the wider environment means it can be more challenging for persons with disabilities to access decent work. Across the globe, levels of employment are consistently lower for persons with disabilities than average, and they are more likely to be working in the informal economy where earnings tend to be lower (ILO, 2020). Disability may also create barriers to work for other family members where they take on responsibilities for providing care and support for children and adults with disabilities. These issues have an important gender dimension; levels of disability at a global level are higher for women than men, but women with disabilities tend to have lower levels of employment. Women and girls also shoulder the majority of care responsibilities for persons with disabilities with significant impact on their education and employment opportunities (ILO, 2020; UNDESA, 2020; WHO, 2011; UNICEF, 2021)

Lower incomes and additional costs contribute to higher levels of poverty and vulnerability to shocks for persons with disabilities and their families. Across the globe, households which include persons with disabilities are consistently found to face higher levels of poverty and vulnerability than those without (Mitra and Yap, 2021; Pinilla-Roncancio, 2018; UNICEF, 2021). Existing poverty measures also likely underestimate levels of poverty as they rarely take account of the specific additional disability-related costs described above. Insecure income means persons with disabilities face greater vulnerability to covariate shocks, such as that created by COVID-19. These factors also create further barriers to education, employment, and wider participation in society, thus perpetuating a vicious cycle of poverty and exclusion. This not only constitutes a significant human rights issue but is also a lost opportunity for persons with disability to contribute to economic and social development.

To be effective for persons with disabilities and their families, social protection systems need to encompass a multi-layered set of interventions. This is due to the significant diversity in the experience of persons with disabilities, both in terms of functional limitations and how these interact with the wider environment. This diversity includes the extent of the barriers that persons with disability face to paid work, and the nature of additional costs. The layers of support provided by social protection systems can be divided into four main categories, illustrated by some examples of relevant schemes in Table 1.

- **INCOME SECURITY:** These schemes seek to support people who have reduced access to paid work due to the interaction between their functional difficulties and barriers in the wider environment. This is achieved by providing cash benefits which allow them to access common necessary goods and services (not specifically related to disability). **Disability benefits** (often called “allowances” or “pensions”) is the most common scheme providing such support, usually focused on working age adults. Meanwhile, “**mainstream**” schemes – not specifically or only partially targeting persons with disabilities – may also provide some support throughout the life cycle. These include life cycle schemes (such as child, unemployment and maternity benefits and old age pensions) as well as general social assistance targeted at poor households and individuals. Income security schemes can be either contributory or non-contributory.
- **COVERAGE OF DISABILITY RELATED COSTS:** Such schemes seek to cover the additional costs for persons with disabilities over and above the common necessary goods and services. This can be achieved in a mix of different approaches including:

- **Cash benefits** covering additional disability-related costs, which could include child disability benefits and disability support/inclusion allowances or personal independence payments for adults.
- **Third person support benefits**, (often called Caregiver benefits) to cover/remunerate the costs of individual care and support provided by a third person. This might be provided directly to carers, or to persons with disabilities for them to purchase care/support services.
- **Concessions** such as discounts for utilities and transportation, and tax credits and exemptions which can contribute to offset disability-related costs.
- **Support services** including provision of community support services, childcare, long-term care, personal assistance, counselling and respite care.
- **HEALTH CARE COSTS** are of critical importance given the additional health care needs of many persons with disabilities and the higher barriers in access that they face. This should be achieved through universal health care coverage, including disability-related medical care, rehabilitation, and provision of assistive devices.
- **INTERLINKAGE** relates to making linkages to services which support access to wider range of services and programmes including education, early childhood development, vocational training, support to employment and livelihood generation.

Table 1: Types of social protection schemes for persons with disabilities

	CHILDHOOD	WORKING AGE	OLD AGE
INCOME SECURITY	General social assistance	Disability benefit/allowance, poverty alleviation programs, general social assistance, Sickness, maternity, unemployment benefit etc.	Old age pension
COVERAGE OF DISABILITY RELATED COSTS,	Child with disability benefit Concessions Caregiver benefit	Disability/inclusion support allowance covering disability related costs and compatible with paid work and other benefits Concessions	
INCLUDING SUPPORT SERVICES	Early identification and intervention, counselling, respite care	Personal assistance schemes, third person support benefit, caregiver benefit, interpreters...	
HEALTH CARE	Universal health care coverage, including rehabilitation and assistive technology, health insurance subsidies		
INTERLINKAGE	Connection with Early childhood development programmes, education	Economic empowerment programmes, return to work programmes, public works, women's empowerment...	

Source: Adapted from UNPRPD (2021a)

Before the onset of COVID-19, social protection systems in low- and middle-income countries had low coverage of persons with disabilities. ILO (2021a) data suggests that at a global level 34 per cent of persons with severe disabilities received a disability benefit. However, this average is strongly influenced by more elevated levels of coverage in high-income countries. In lower-middle-income countries, 11 per cent of persons with disabilities receive a benefit, and in low-income countries the figure is just 9 per cent. It is also worth highlighting the focus of this measure on *severe* disability, and it is likely that coverage of those with moderate disabilities was even lower.

SCOPE, DESIGN AND ACCESSIBILITY OF CASH BENEFITS

A major driver of this low coverage is the limited extent to which countries have social protection schemes in place for persons with disabilities. Various issues emerge, which can be illustrated with reference to the case study countries in Table 2. A significant issue is that many countries rely exclusively on contributory disability benefits. As of 2017, nearly half of countries across the globe (44 per cent) only had social insurance schemes in place for persons with disabilities, which tend to cover a minority of the labour force in most low- and middle-income countries (ILO, 2017). Among the case study countries, five have only contributory schemes in place (Ethiopia, Indonesia, the Philippines, Uganda and Vanuatu).

Where non-contributory disability benefits are in place, their reach is often limited by the way in which eligibility is defined. Globally, just over a third of countries (36 per cent) have such a benefit in place. Non-contributory benefits are more common in case study countries (partly due to the country selection process), however, three important design features limit their coverage in many cases:

- **Eligibility is usually limited to those deemed unable to work.** This stems from a long-standing rationale for disability-related social protection as providing compensation for lack of income-earning capacity. However, the simplistic and binary categorisation of persons with disabilities according to ability to work ignores the fact that with effective social protection many persons with disabilities would be able to access paid employment. It also fails to take account of the additional disability-related costs encountered by persons with disabilities who are able to access the labour market. Among case study countries, Georgia and Thailand do not explicitly exclude recipients of disability benefits from paid work, nevertheless, there remains a focus on severe disability. In Georgia, persons with less severe disability – who are more able to access work – face higher levels of poverty than those with more severe disabilities. One contributing factor is that those with less severe disabilities receive lower benefits.
- **Means testing creates additional barriers.** Means testing adds another level of complexity to eligibility assessment processes, and persons with disabilities may be affected by the significant exclusion errors inherent in all forms of poverty targeting. Means testing also further reinforces the dichotomy between support for those able to work and those unable to work and may contribute to perverse incentives to disengage from the labour force. Additionally, means-testing methodologies – including proxy means testing which has become the primary targeting methodology in low- and middle-income countries – rarely take adequate account of additional disability-related costs (Banks et al., 2021; Kidd et al., 2019). Among the 11 case study countries with non-contributory disability benefits in place, six are means-tested, and four are universal. South Africa has a means test which only excludes individuals with relatively higher incomes (often called “affluence testing”), while Uzbekistan only excludes those receiving other benefits (a form of insurance-testing).
- **Disability assessment commonly uses a medical model.** This is a major factor in the complexity and inaccessibility of assessment processes as it usually requires visits to medical facilities situated in urban areas. A medical model also does not usually incorporate an assessment of how social and environmental factors affect an individual’s ability to carry out their daily lives nor does it provide enough information on the specific kinds of support required, and instead is solely focused on a persons’ impairments (Kidd et al., 2019). Some countries, including Fiji and Vietnam, have

adopted mechanisms which combine a basic assessment of functional limitations with assessment of needs of assistance carried out by community-level workers (Cote, 2021). Brazil and Georgia have also been seeking to move disability assessment toward a social model.

The scope of mainstream benefits is also mixed. Old age pensions display a similar global distribution of contributory and non-contributory schemes as disability-specific benefits, although the scope of schemes in place is slightly more extensive in the case study countries. For example, Uganda and the Philippines have non-contributory old age pensions, but no non-contributory scheme specifically for persons with disabilities. Globally, old age pension coverage is higher than that of disability benefits, covering 68 per cent of the population over statutory retirement age (ILO, 2017). Most countries also have some form of **general social assistance** targeted at poor households, but these schemes vary in terms of the proportion of the population they seek to cover and the extent to which they explicitly address disability. For example, the social assistance schemes in Indonesia and Mauritius both provide increased benefits linked to disability status.

Box 2: Mauritius: a system of multi-tiered social protection benefits for persons with disabilities

Mauritius stands out as a country which – when compared with most low- and middle-income countries¹ – has put in place a relatively comprehensive and multi-tiered set of social protection interventions. These tiers include:

INCOME SECURITY

A non-contributory hybrid universal **Basic Invalidation Pension** (BIP) is available for all persons with a disability under 60 years old, if the individual is assessed to have an assessed disability of at least 60 per cent. The benefit is compatible with work. As discussed later in this paper, the adequacy of this benefit is high by international standards. All persons aged 60 and over are eligible for the country's universal non-contributory **Basic Retirement Pension** (BRP), which has the same benefit level as the BIP for most recipients.²

Contributory invalidity and retirement pensions also exist through the country's social insurance scheme, with benefits paid in addition to the universal BIP and BRP.

Mauritius also has a **Social Aid** poverty-targeted social assistance programme. This includes a number of eligibility criteria relating to disability.

DISABILITY EXTRA COSTS

A **Carer's Allowance** exists for recipients of both the BIP and BRP who are deemed to require "constant care and attention of another person."

The **BIP can be considered a "hybrid" scheme** as it is not conditional on recipients being unable to work. For recipients in employment, it has the potential to cover disability-related extra costs.

Within the contributory system there also exists a **Constant Attendant Allowance** for an employee who has developed a disability and who requires constant attendance of another person.

A **child allowance** is also available for carers who are recipients of the Basic Invalid's Pension. The child should be under the age of 15 (or 20 if in full-time education).

Source: Mauritius case study developed under the project ILO-UNPRPD COVID-19 response

¹ While Mauritius recently graduated to high income country status, it provides a relevant reference point for low- and middle- income countries.

² Recipients of both schemes receive MUR9,000 per month, apart from BRP recipients aged 90 and over that receive higher monthly benefits.

Table 2: Scope of disability-relevant cash benefit schemes in case study countries

COUNTRY	INCOME SECURITY					DISABILITY EXTRA COSTS		
	Household social assistance	Disability related benefit		Old age pension		Child disability benefit	Disability support benefit (covering additional costs for adults)	Caregiver benefit
	Non-contributory	Non-contributory	Contributory	Non-contributory	Contributory			
Brazil	✓	MT	SI	MT	SI	✓	X	✓ (SI)
Ethiopia	✓	X	PF	X	PF	X	X	X
Georgia	✓	U	X	U	IA	✓	✓ (H)	✓
Kenya	X	MT	PF	U	PF	X	X	X
Indonesia	✓+	MT*	SI + PF	MT*	SI + PF	X	X	X
Mauritius	✓+	U	SI	U	SI	✓	✓ (H)	✓
Peru	✓	MT	SI + IA	MT	SI + IA	✓	X	X
The Philippines	✓	X	SI	MT	SI	X	X	X
South Africa	X	MT**	X	MT**	X	✓	X	✓
Sri Lanka	✓	MT	PF	MT	PF + SI	X	X	X
Thailand	✓	U	SI	U	SI	✓	✓ (H)	X
Timor-Leste	✓	U	SI	U	SI	X	X	X
Uganda	X	X	PF	U	PF	X	X	X
Uzbekistan	✓	IT	SI	IT	SI + IA	✓	X	X
Vanuatu	X	X	PF	X	PF	X	X	X

Key: U = Universal, MT = Means tested, SI = Social insurance, PF = Provident fund, IA = Individual account, IT = Insurance tested, H = Hybrid scheme. Hybrid disability benefits are often primarily income security benefits but are compatible with work which means that for people with disabilities earning income they can play a function of coverage of some disability costs. They also can be compatible with other schemes such as old age pension as in Thailand. For social assistance schemes “+” indicates that specific account is taken of persons with disabilities, for example, in topped up benefits.

Note: *Small non-contributory schemes exist for older persons and persons with disabilities in Indonesia, but have very low coverage, and are household targeted.

**While South Africa’s disability and old age grants are means-tested, they are primarily focused on excluding relatively better off individuals, rather than narrowly targeting poor individuals.

The table only includes public social protection schemes (not voluntary private/occupational schemes). It also excludes reference to schemes specifically for public servants.

Cash benefits compensating for disability-related costs are generally rare in low- and middle-income countries. As illustrated in Table 2 for the case study countries, schemes addressing disability-related extra costs are far less common than other schemes. **Child disability benefits** are the most common and, in most cases, provide the same benefit paid for adults (or with minor adjustments). Even though the benefits provided are often the same, the function can be considered as distinct, as child disability benefits are not designed to compensate for lost income from paid work by children. Just three countries have some form of **caregiver benefit**, and no countries have a disability support cash transfer specifically aimed at covering **disability-related extra costs for adults**. Three countries (Mauritius, Thailand and Georgia) have universal disability benefits that are compatible with work (which can be considered “**hybrid**” as their function varies depending on individual’s circumstances) (Cote, 2021). This means that, for people with disabilities earning an income, those benefits may perform the function of covering disability-related extra costs. Mauritius (Box 2) provides a particularly notable example of a multi-tiered system of disability benefits. The 2015 Brazilian Law of Inclusion made provision for an Inclusion Benefit (*Auxílio-Inclusão*) that sought to address the exclusion of those deemed unable to work by the BPC, by providing a benefit to BPC beneficiaries who obtained employment in the formal sector. The scheme has, however, not been implemented.

Further to the limitations in the scope and design of existing social protection schemes, low coverage is also the result of issues of accessibility in implementation. Two key issues are:

- **Disability assessment and determination processes are commonly complex and time consuming.** Disability assessments are carried out to determine eligibility for individual disability-related support. This commonly requires visits to multiple service locations (including government offices and hospitals) which tend to be located in urban areas. These visits often require extensive travel which is challenging for persons with significant functional impairments. They often constitute a significant time commitment from applicants as well as family and friends who may support the process. For this reason, even disability benefits that are technically universal can suffer from low coverage, such as in Timor-Leste where just 20 per cent of people with severe disabilities aged 18-59 are covered by the scheme. Similar issues have been found in universal schemes in the Maldives and Nepal (Banks et al., 2018; Banks and Kuper, 2021).
- **Significant accessibility barriers exist across the delivery chain.** These can include physical barriers (e.g., long distances to government offices and difficulty entering/navigating buildings), information and communication barriers (e.g., informational materials not being in accessible formats) and attitudinal barriers (e.g., discriminatory attitudes from administrative staff).

Another issue which has consequences for both design and implementation is a lack of adequate disability-disaggregated data.

ADEQUACY OF CASH BENEFITS

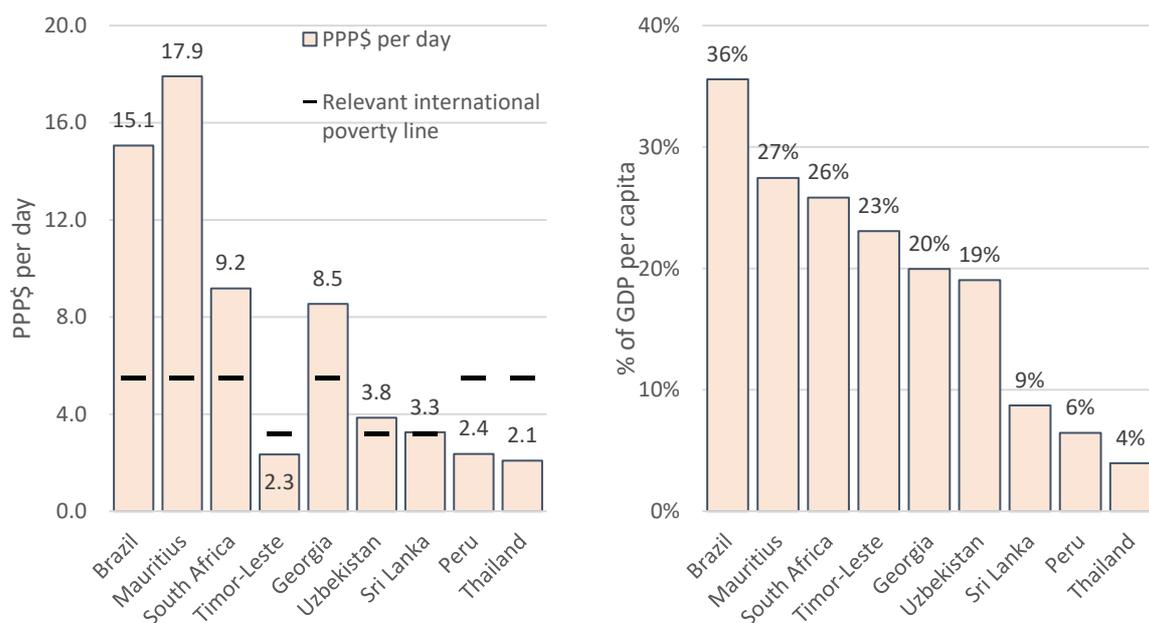
The adequacy of disability benefits is often limited in terms of the basic level of income security provided.

Disability benefits, which tend to have the function of providing income security for those unable to work, vary significantly in terms of adequacy. Figure 1 presents the benefit levels for non-contributory disability benefits in the case study countries. When shown in international dollars (PPP\$), benefits in Peru, Thailand and Timor-Leste can be seen to fall below the relevant international poverty lines for their country income groups. Despite being an upper-middle income country, the benefit in Thailand is only slightly above the PPP\$ 1.90 per day poverty line (usually applied to low-income countries). Benefit levels also vary significantly relative to GDP per capita, which provides an indication of their adequacy relative to the level of economic development of the country. The benefit in Thailand is just 4 per cent of GDP per capita, compared to 36 per cent in Brazil.

Even in countries with comparatively higher benefits, these may not meet important benchmarks of adequacy of social protection. For example, the highest disability benefit in Georgia – for severe disabilities

(Group 1) – is only between 75 and 84 per cent of values that would be considered minimally acceptable as income replacement by the relevant ILO Conventions (Nos. 102 and 128, respectively).³ It should also not be assumed that adequacy of benefits from contributory schemes is sufficient. In four case study countries (Ethiopia, Kenya, Sri Lanka, Uganda and Vanuatu), contributory schemes are in the form of provident funds which pay lump sum benefits providing very limited income security – especially in the case of disability.

Figure 1: Benefit levels of non-contributory disability benefits (PPP\$ per day and as a % of GDP per capita)



Notes: GDP per capita and PPP\$ conversion rates are for 2019. Economic data from IMF (2021). The poverty lines included are PPP\$ 3.20 per day (for lower-middle income countries) and PPP\$ 5.50 per day (for upper-middle income countries).

Disability benefits focused on income security are unlikely to address disability-related extra costs. Disability related extra costs can relate to a wide range of goods and services, including transportation, health care, assistive devices, rehabilitation services, and human assistance (such as interpreters, personal assistants and caregivers). In terms of care and support, a lack of adequate social protection can also result in family caregivers having to forego paid work, thus reducing household income. The type and extent of disability related costs vary significantly depending on an individual’s functional difficulties, the inclusivity of the environment and their level of participation (UNPRPD, 2020). Nevertheless, there is growing evidence that disability-related costs are often substantial. For example, research in South Africa found, on average, that a household with at least one member with a severe disability faces an additional cost of approximately 40 per cent in order to reach the same standard of living as households without any members with a disability (Kidd et al., 2019). Given that the benefit levels of disability benefits discussed

³ ILO Conventions 102 and 128 establish a minimum standard replacement rate of 45 per cent or 50 per cent per month, respectively, of the prevailing wage for an unskilled manual worker, for schemes that provide tax-financed benefits for persons with permanent disabilities who have no capacity for gainful employment. Using the average monthly nominal wage of elementary occupations in Georgia of 581.20 GEL in 2017, McClanahan et al. (2021) suggested that the benefit would need to be 262 GEL and 291 GEL per month, respectively, to meet the standard.

above commonly fail to achieve a minimum level of income security, they will not address these additional costs.

The role of schemes specifically addressing disability-related costs is mixed. Two key trends emerge which can be illustrated with reference to case study countries summarised in Table 2 above:

- **Schemes taking specific account of disability-related costs are rare, with low coverage and adequacy.** Just four case study countries have schemes in place to cover additional disability-related costs (Brazil, Georgia, Mauritius and South Africa) and these all relate to the provision of care and support. Coverage of these schemes is also often low. For example, South Africa's Grant-in-Aid scheme provides an additional benefit to recipients of the country's old age and disability grants with the stated aim to pay for the cost of someone who provides full-time care (South African Government, 2021). However, the scheme only covers 263,701 recipients, just 6 per cent of the 4.7 million recipients of the old age and disability grants combined.⁴ The benefit level is also extremely low, at just 6 per cent of GDP per capita (or 25% of the value of the old age and disability grants) which is far short of the stated aim to cover the cost of full-time care.
- **Child disability benefits and "hybrid" schemes can implicitly take account of disability-related costs.** The fact that they are provided to children means child disability benefits are not designed to replace income from work, and the same applies to "hybrid" schemes where they are provided to adults in employment. This means that – whether or not an explicit objective – these schemes primarily address disability-related costs. In cases where child disability benefits and hybrid benefits have more adequate benefit levels by international standards (for example, in Georgia and Mauritius), it is likely that they make an important contribution to covering disability-related costs. An obvious shortcoming is that this function does not apply to adults who are not in employment.

HEALTH CARE

Prior to COVID-19, health systems in low- and middle-income countries commonly fell far short of providing universal health coverage. Three key factors contributing to these gaps were:

- **Limited financial protection:** Health care financing arrangements for persons with disabilities vary significantly, including across case study countries. Brazil, Georgia, Mauritius, Sri Lanka and Thailand all have tax-financed universal health care systems which include persons with disabilities at low or no cost. Other countries, such as Indonesia and the Philippines have health insurance-based models. In Indonesia, people with disabilities from the poorest 40 per cent of the population have access to fully subsidized health insurance (around 1.2 million people) (Larasati et al., 2019). In the Philippines, people with disabilities became eligible for free membership of the PhilHealth scheme in 2019, but the provision has still not been fully implemented.
- **Service coverage:** Even in countries where financial protection is relatively high, service coverage can be low. It is common for health care systems and schemes to provide additional services for people with disabilities. For example, Thailand's Universal Coverage Scheme includes provision for 9 rehabilitation services and 76 assistive devices for persons with disabilities. However, even where such provision is legally in place, these services may not be readily available, as in Brazil where waiting lists for rehabilitation services are long. In Mauritius, research has found that a lack of paediatric expertise means that early screening and identification of impairments is not adequately undertaken. Where necessary services are not readily available, persons with disabilities may be forced to purchase them through private channels.

⁴ The Disability Grant has 1,062,456 recipients, and the Old Age Grant 3,638,233 recipients

- **Accessibility and quality** also provide a major barrier to accessing services and result in increased costs. In South Africa, studies have shown that persons with disabilities living in rural areas were less likely to use health services when they needed to, compared to persons without disabilities, primarily due to poor accessibility of transport and rural infrastructure. Issues of accessibility also relate to health infrastructure, as in Brazil, where research has found that around 60 per cent of Basic Health Units have not made any reasonable accommodation for persons with disabilities in terms of ensuring that the centres were physically accessible. Inaccessibility increases the indirect cost of health care, for example, due to increased cost of transportation and the need for personal assistance. It can also increase the opportunity cost of accessing health care, as in Kenya, where research has found women with disabilities often forgo seeking healthcare services, due to their responsibilities of caregiving in the home, even when health services are subsidised. A common issue identified across case study countries was the skills and attitude of staff, often lacking understanding of the needs of persons with disabilities or harbouring discriminatory attitudes.

3. SOCIAL PROTECTION RESPONSES TO COVID-19 FOR PERSONS WITH DISABILITIES

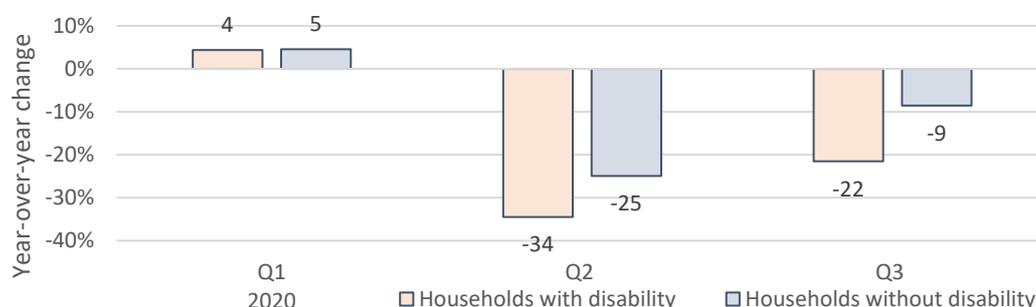
People with disabilities have been particularly vulnerable to the impacts of the COVID-19 pandemic. While detailed analysis on the impact of the crisis is still emerging, there is growing evidence of the disproportionate effects on persons with disabilities and their families. These impacts strongly relate to barriers to earning an income and additional disability-related costs that were an issue before the crisis.

The impact of the crisis on employment and earnings has particularly affected persons with disabilities. Households with persons with disabilities had higher poverty rates and lower savings before the crisis, which made them more vulnerable to the economic shock. Persons with disabilities in employment were more likely to be found in the informal economy, which means that they will have been more exposed to the impact of COVID-19 on the labour market (ILO, 2020). Meanwhile, households with persons with disabilities on average have fewer members in employment, and higher dependency ratios, which makes them very sensitive to employment impacts on those members in paid work before the crisis (Banks et al., 2021). The closure of services providing care and support means other family members will have taken on more unpaid care responsibilities, therefore foregoing income-earning opportunities. This burden will have primarily fallen on women (ILO, 2020). Various surveys conducted throughout the crisis point to the disproportionate impact of the crisis on the livelihoods of persons with disabilities and their families (Meaney-Davis, 2020; Satriana, 2020). Children with disabilities have faced greater difficulties in access to health care, education, and were more likely to be separated from their parents/caregivers and to report violence at home and distress than those without disabilities (Orsander, 2020).

Box 3: Uzbekistan: Employment and poverty impacts of COVID-19 on persons with disabilities

Analysis of the household-level impact of COVID-19 in Uzbekistan shows a disproportionate impact on households including persons with disabilities. Figure 2, based on analysis of the L2CU⁵ baseline and panel survey, shows that there was a 34 per cent decrease in the number of households with a member with a disability receiving an income in the second quarter of 2020 compared to the previous year (from 68 per cent to 44 per cent). In contrast, there was only a 25 per cent decrease for households without a member with a disability (from 79 per cent to 59 per cent).

Figure 2: Percentage change on the same quarter in previous year (total labour) for households that receive income from wages and self-employment



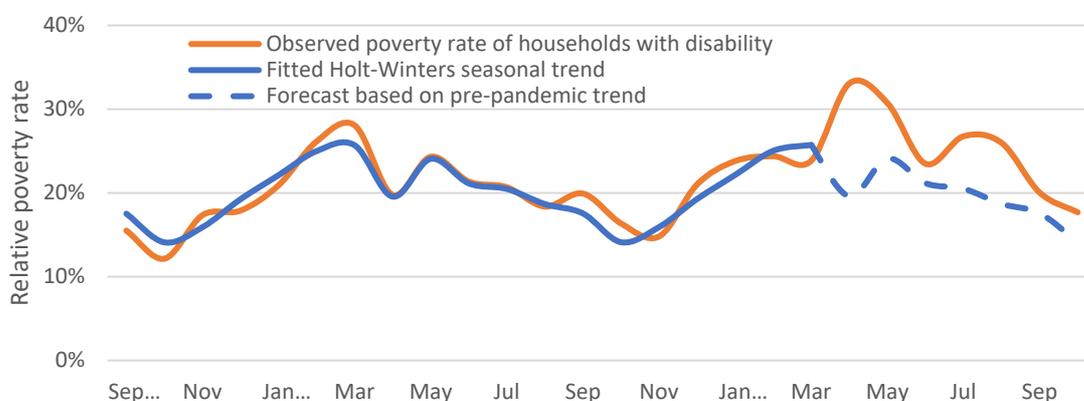
Source: Development Pathways' analysis of L2CU baseline and panel surveys

⁵ Listening to the Citizens of Uzbekistan survey, <https://www.worldbank.org/en/country/uzbekistan/brief/l2cu>

This reduction in earnings resulted in a fall in income of households with disabilities, and a dramatic increase in poverty in 2020. As

Figure 3 demonstrates, from April to October 2020, the average poverty rate for households with a disability was 31 per cent greater than it would have been had the pandemic not happened.⁶ This impacted households' capacity to purchase essential items. For example, when comparing the answers given in the third quarter of 2019 and 2020, 72 per cent more households with a member with a disability reported, in 2020, not being able to buy enough food for all members (from 11 per cent to 19 per cent). In comparison, 57 per cent more households without a member with a disability gave the same answer (from 7 per cent to 11 per cent). Given that households were struggling to purchase essential items, it is likely that they have been unable to cover the additional items that persons with disabilities require. It could, therefore, be concluded that, even within the household, persons with disabilities have been disproportionately impacted by the pandemic.

Figure 3: Monthly poverty headcount for households with a member with a disability⁷



Source: Development Pathways' analysis of L2CU baseline and panel surveys

Box source: Uzbekistan case study developed under the project ILO-UNPRPD COVID-19 response

The COVID-19 crisis has also contributed to rising costs for persons with disabilities. Surveys conducted with persons with disabilities throughout the crisis highlight that many experienced rising costs of food, medical items and other goods and services (COVID-19 Disability Rights Monitor, 2020). Rising food prices may affect the population as a whole, but persons with disabilities and their families are more vulnerable to such rises given their higher levels of poverty before the pandemic and greater barriers to accessing markets. Disruption to transport networks will have forced many persons with disabilities to use more expensive taxis to access medical and other essential services, including those that previously would have been provided at home.

A notable feature of the COVID-19 crisis has been the unprecedented social protection responses launched by many countries, but the scale of this response has been uneven. Many low- and middle-income countries responded to the first wave of the crisis with significant social protection measures including different forms of cash and in-kind transfers. Databases monitoring policy responses to COVID-

⁶ The poverty line is anchored to 50% of the average real median monthly household incomes in 2019

⁷ The poverty line is anchored to 50% of the average real median monthly household incomes in 2019

19 indicate that almost all countries (93 per cent according to the ILO) have put in place some form of social protection response to the crisis, consisting of between 1,698 and 3,333 measures across the globe as of May 2021 (Gentilini et al., 2021; ILO, 2021b).⁸ The majority of these measures were announced between March and May 2020, but countries have continued to introduce and adapt measures in the meantime (ILO, 2021b). Nevertheless, the scale of the response has varied significantly, and in many countries has been very limited in terms of coverage, duration, and adequacy. This is illustrated by the comparison of two African case study countries – South Africa and Uganda. While South Africa’s response included top-ups to child, disability, and old age grants and two new cash benefits to protect those that lost – or were at risk of losing – their jobs, Uganda’s only social protection response involved a proposed urban cash-for-work programme which had still not been implemented by late 2020.⁹

Persons with disabilities may have received support from both disability-specific and mainstream social protection schemes. First and foremost, adjustments to disability cash benefits had the potential to provide a channel for supporting persons with disabilities during the crisis. Persons with disabilities may also have benefitted from disability-specific in-kind benefits. Second, it is possible that persons with disabilities benefitted from mainstream schemes that were not directly targeted at issues of disability, such as other life cycle benefits (including old age pensions, child grants, sickness, and unemployment benefits) and social assistance schemes targeted at poor households or in-kind benefits such as food distribution or waivers on utilities and other expenses. The following sub-sections discuss the evidence on the extent to which these two kinds of approaches supported persons with disabilities, beginning with disability-specific responses, and then considering adjustment to or introduction of mainstream schemes. The discussion also reflects on the relationship between measures announced and put in place, and systems in place before the crisis.

DISABILITY-SPECIFIC SOCIAL PROTECTION RESPONSES TO COVID-19

Of those countries that announced some form of social protection measure, less than half included measures that specifically referred to persons with disabilities. As of May 2021, of the 215 countries and territories that had adopted social protection measures, 98 countries (44 per cent) had specifically referred to persons with disabilities (UNPRPD, 2021b). This consisted of 153 relief measures, which is equal to 5 per cent of the total 3,333 measures surveyed by Gentilini et al (2021) as of May 2021, and 9 per cent of the 1698 measures surveyed by the ILO (2021b) as of May 2021. The measures counted here include disability-specific schemes (such as disability cash benefits) or other measures where disability was specifically mentioned. Old age pensions and mainstream schemes not specifically targeting or mentioning persons with disabilities are not included in this figure but are discussed in the next section.

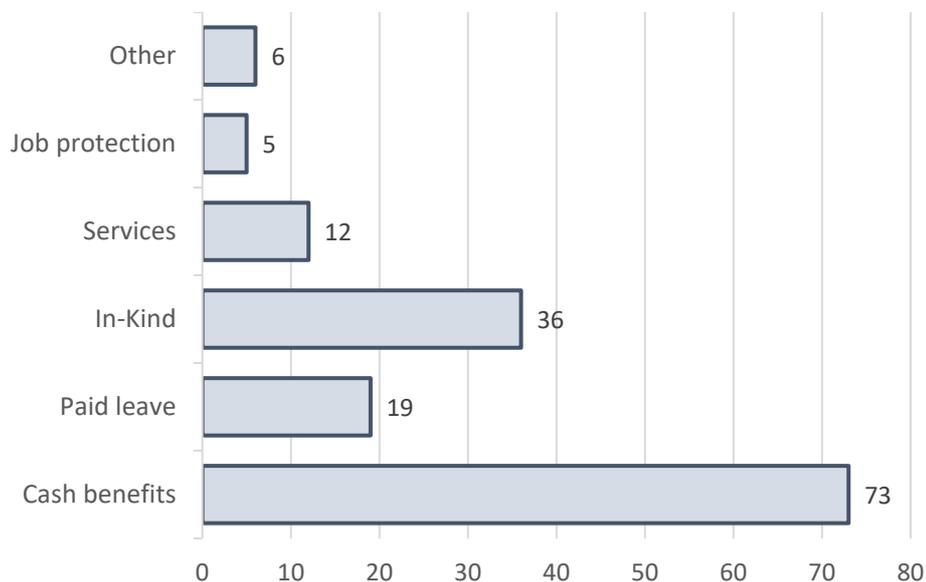
In those countries where announced measures specifically referred to persons with disabilities, cash benefits constituted the main type of scheme being adapted or introduced (Figure 4). Cash benefits were provided through both contributory and non-contributory schemes, although the latter were more common. In-kind benefits specifically targeting persons with disabilities were also relatively widespread (see Box 4), and included the distribution of food, hygiene items, medicine and other basic items, and provision of services (a separate category in Figure 4) such as helplines and care and support services. Another notable measure has been paid leave provided for parents and carers of persons with disabilities

⁸ Gentilini et al (2020) counted 215 countries with 1414 measures by December 2020, and the ILO (2021b) counted 2019 countries with 1662 measures by January 2021.

⁹ <https://www.calpnetwork.org/wp-content/uploads/ninja-forms/2/Maintains-SRSP-responses-to-COVID-19-Uganda-case-study-final.pdf>

unable to access school or other care and support services. However, this approach was primarily implemented in high-income countries.

Figure 4: Social protection measures to COVID-19 supporting persons with disabilities, by type



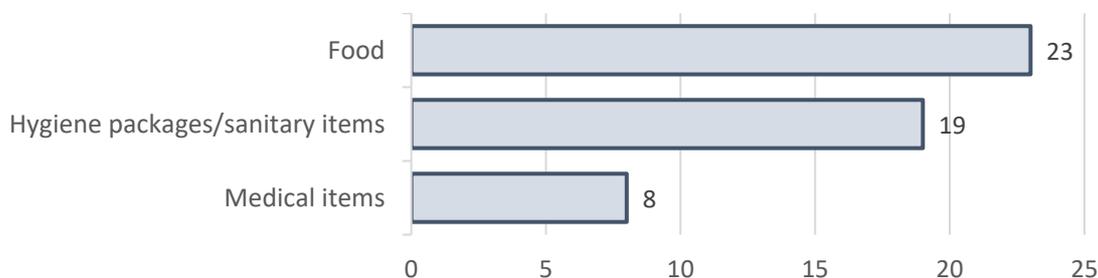
Source: UNPRPD (2021b)

Notes: "Other" includes waivers (e.g., for social security, tuition fees), adjustment to sick leave, and measures that were not possible to classify.

Box 4: Features of in-kind benefits for persons with disabilities in response to COVID-19

Of the 36 measures announced to provide in-kind support, the majority (23) related to the provision of food items (Figure 5). Hygiene packs were also a common form of in-kind support, followed by medical items in a small number of cases. Some countries distributed packages containing multiple forms of support, such as Antigua and Barbuda which provided both food and medical items. Commonly, countries that provided in-kind support to persons with disabilities often did so alongside other groups such as older persons and poor households.

Figure 5: Nature of in-kind support provided



Source: UNPRPD (2021b)

Measures involving cash benefit have related to a diverse range of programmes. The most common has been the adjustment of existing disability benefits paid to adults and/or children. In a smaller number of cases, measures have involved adjustments to social assistance schemes targeted to households which

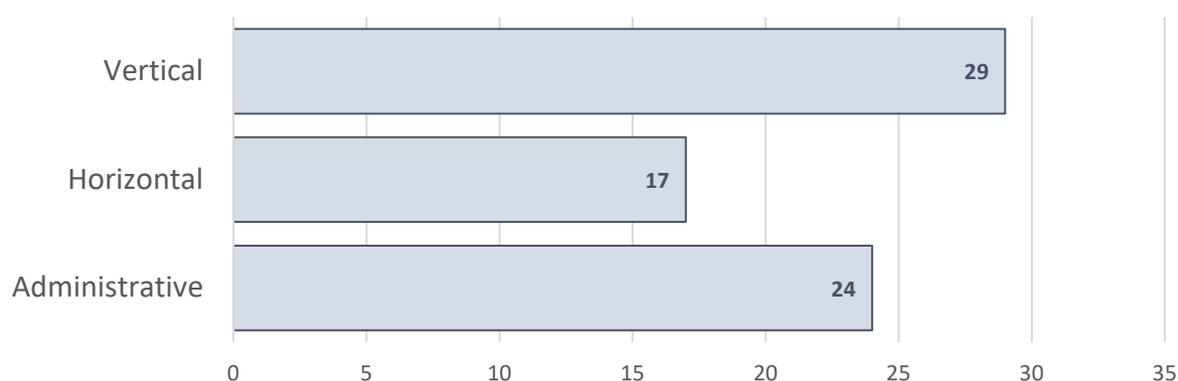
include specific eligibility criteria for persons with disabilities, or the initiation of ad hoc schemes making specific provision for persons with disabilities.

These cash transfer measures have involved one of three forms of adjustment:

- *Vertical expansion* involving a top-up of existing benefits for a defined period of time.
- *Horizontal expansion* involving paying benefits to new beneficiaries, either by expanding coverage of existing programmes, or putting in place new, short-term programmes.
- *Administrative measures* including advancing the payment of existing benefits, adapting payment delivery, and relaxing administrative procedures, such as renewal of disability ID cards or certificates.

The most common measure related to cash benefits was their vertical expansion through temporary increases in benefit levels. As illustrated in Figure 6, 29 cash benefit measures involved an increase to benefits. The frequency of such transfers has varied across countries but mostly they were paid for a limited period during the initial phase of the pandemic in 2020. Of the 29 countries from the global database that vertically expanded cash transfers, in around half of countries (14) the response was only for a month or as a one-off payment during the initial phases of the crisis.¹⁰ In seven countries top-up benefits were paid for three months, and four countries announced cash transfer measures for a period of six months or more. A smaller number of countries have horizontally expanded the coverage of cash transfers during the crisis.

Figure 6: Cash transfer measures by type of adjustment



Source: UNPRPD (2021b)

The experience of the case study countries included in this research demonstrates the diversity of approaches. Table 3 outlines the nature of adjustments to pre-existing non-contributory disability cash benefits in the countries covered by the case studies.¹¹ In these countries, vertical expansion (Georgia, Kenya, South Africa, and Thailand) was as common as horizontal expansion (Brazil, Kenya, Peru, and Sri Lanka). Two countries with existing cash benefits made no adjustment (Mauritius and Timor-Leste) while three countries had no pre-existing scheme (the Philippines, Vanuatu, and Ethiopia). In the case study countries there were no adjustments made to the schemes specifically designed to cover disability-related extra costs, including caregiver allowances. As noted above, the nature of the country selection means that these trends are not necessarily representative of low- and middle-income countries as a whole.

¹⁰ In some countries the duration of the benefit could not be identified.

¹¹ There were no examples within the case studies of adjustments being made to contributory disability benefits.

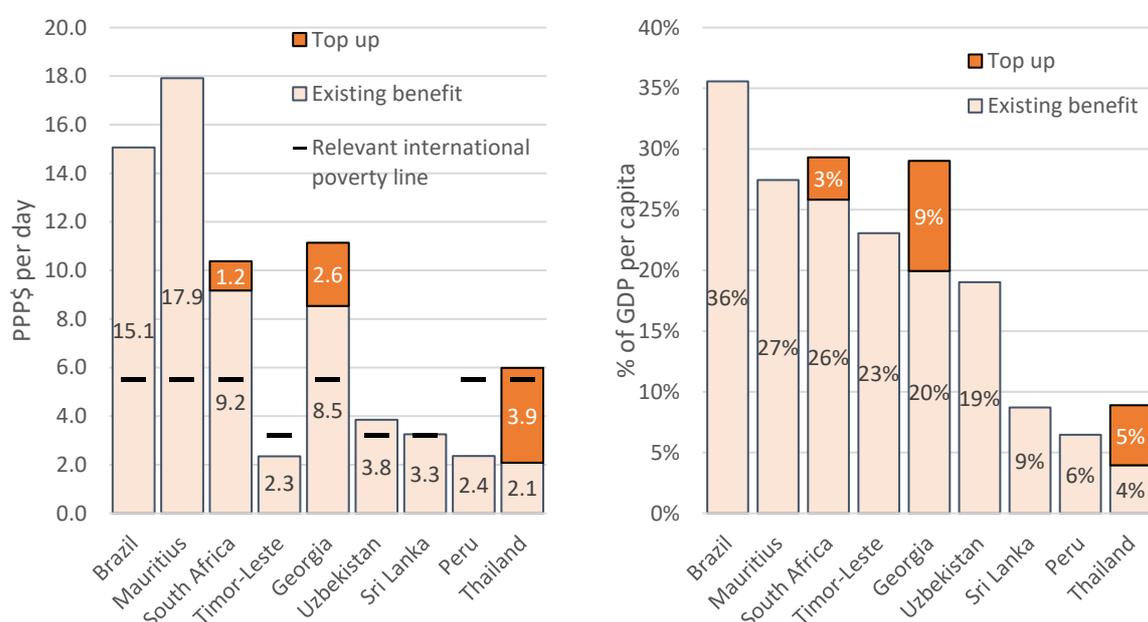
Table 3: Key features of adjustments to non-contributory disability cash benefits in case study countries

Country	Scheme	Vertical	Horizontal	Description
Brazil	Benefício de Prestação Continuada (BPC) disability benefit		Y	Horizontal: Advance payments of BRL 600 for applicants of the BPC who had not yet been accepted onto the programme. As of July 2020, 178,000 persons with disabilities had applied for the BPC.
Georgia	Disability benefit	Y		Vertical: An additional direct transfer (on top of Social Package disability benefit) of 100 GEL per month for up to 6 months for persons with assessed Group I disabilities and children with disabilities (excluded those with assessed Group II and III disabilities).
Kenya	Cash Transfer for Persons with Severe Disabilities (PwSD-CT)	Y	Y	Vertical: One-off payment of KES 8,000 to existing recipients from April 2020. Horizontal: 33,333 poor and vulnerable persons with disabilities received an ad hoc monthly transfer of KES 2,000 for a duration of three months between June to August 2020.
Mauritius	Basic Invalid's Pension			No adjustment
Peru	Contigo (disability allowance)		Y	Horizontal: Increase from 40,075 to 74,000 users.
South Africa	Disability grant	Y		Vertical: A top-up of ZAR 250 (US\$ 17) per month per recipient was provided for a period of six months (May to October 2020).
Sri Lanka	Disability allowance		Y	Horizontal: 38,791 households with a member with a disability on the waiting list received a transfer.
Thailand	Disability allowance	Y		Vertical: Two top-ups were provided to recipients: 1,000 baht in May 2020 (to cover one month) and 3,000 baht to up in July 2020 (intended to provide 1,000 baht per month from May to July).
Timor-Leste	Support of the Elderly and Invalid (SAII) Program			No adjustment
Uzbekistan	Allowance for disabled from childhood			From 1st September 2020, transfer value increased by 10% to UZS513,350 (US\$50.00).
Uzbekistan	Disability Social Pension			From 1st September 2020, transfer value increased by 10% to UZS315,030 (US\$31.00)
The Philippines	No disability specific scheme			
Vanuatu	No disability specific scheme			
Ethiopia	No disability specific scheme			

Vertical extension appears to have involved meaningful increases to benefit levels, but these need to be considered in the context of pre-existing benefit levels as even with the top-ups the benefits still fell short of what would be required. Figure 7 (which builds on Figure 1 above) shows how the top-ups provided in

Georgia, South Africa and Thailand compared to the benefits that were previously in place. Notably, while top-ups in Georgia and South Africa resulted in important increases in benefit levels, these augmented benefits remained below or similar to regular benefits in place in other countries. For example, the regular benefit in Brazil was higher than the topped-up benefits in Georgia and South Africa, both as a share of GDP per capita, and in international dollars (PPP\$). Even with the top-up in Thailand, the total benefit remained low by international standards, and only just reached above the relevant international poverty line for upper-middle income countries (PPP\$ 5.50 per day). In Georgia and South Africa, the top-ups also had a longer duration (six months) compared to four months in Thailand. In this respect, it is likely that the regular benefits in place in some countries (e.g., Brazil and Mauritius) may have played a more significant role in protecting persons with disabilities and their families than topped up benefits in other countries (e.g. Thailand).

Figure 7: Benefit levels of pre-existing disability benefits and top-ups (PPP\$ and % of GDP per capita)



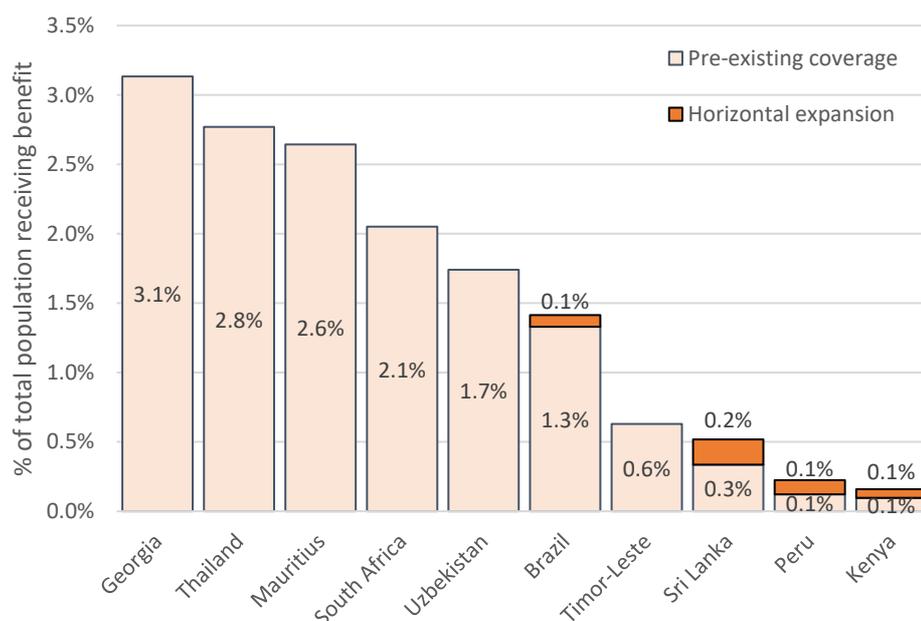
In the few cases where benefits were horizontally expanded, this does not appear to have fundamentally addressed pre-existing issues of low coverage. Horizontal expansion in Kenya, Peru and Sri Lanka entailed increases of between 54 and 85 per cent in the number of beneficiaries receiving the programme benefits.¹² However, the baseline number of beneficiaries in all cases was low, primarily due to the use of means testing to target only the very poorest persons with disabilities. Figure 8 shows the number of recipients of disability benefits as a share of the total population, and the size of increases from horizontal expansion. Even with this horizontal expansion, the total coverage of these schemes remained lower than all the other case study countries with non-contributory disability benefits, and significantly below those such as Georgia, Mauritius, South Africa and Thailand¹³. In the case of Sri Lanka and Brazil, the horizontal

¹² Sri Lanka had 72,000 beneficiaries before the crisis and added 38,791 (54 per cent), the PwSD-CT in Kenya had 41,374 beneficiaries before the crisis and 33,333 were added (81 per cent), and Peru had 40,075 beneficiaries before the crisis and 33,925 were added (85 per cent).

¹³ It is worth noting that older persons are eligible for the disability allowance in Thailand, which is not the case in other countries listed (although Mauritius and South Africa have supplementary forms of support for older persons with disabilities, which are not included in Figure 8). This means that the figures for Thailand are not directly comparable.

expansion involved making payments to those who had applied to the scheme but had not yet been enrolled. However, in Kenya this involved the registration of new beneficiaries (see Box 5). In many cases, it is not clear whether new recipients were temporarily or permanently enrolled into existing schemes. Early in the crisis, Brazil announced the intention to increase the income threshold used for the means-test of the BPC disability benefit from a quarter of the minimum wage to half the minimum wage. However, it appears that this was never implemented due to high-level political resistance.

Figure 8: Proportion of total population receiving disability benefits with and without horizontal expansion



Source: Case studies produced under UNPRPD project, UN et al. (2018) and NESDC (2021). Denominator for total population is for 2020 from UN Population Division (2019).

Notes: For benefits provided at a household level (Kenya and Sri Lanka) the number of recipients is divided by the total population, thus assuming one person with disability per household.

Box 5: Kenya: Ad hoc horizontal expansion of disability benefits during the crisis

Before the COVID-19 crisis, Kenya already had a small means-tested disability allowance in the form of the Cash Transfer for Persons with Severe Disabilities (PwSD-CT). The scheme targeted households living in poverty with a member with a severe disability, selected through a combination of community-based selection and a form of proxy means test. By 2020, 51,890 households were receiving the cash transfer of Ksh 2,000 per month (US\$ 18).

In addition to vertical expansion of the PwSD-CT scheme (with a top-up of Ksh 8,000 to existing recipients), an ad hoc temporary scheme providing 2000/month was granted to 33,000 persons with disabilities for a period of 3 months from June to August 2020. This was based on the national listing exercise by National Council for Persons with Disabilities during June 2020. Through this measure poor and vulnerable persons with disabilities not receiving any other benefit were targeted, prioritizing families with multiple persons with disabilities and chronic illnesses. The disbursement of cash was conducted via mobile transfers.

Source: Kenya case study developed under the project ILO-UNPRPD COVID-19 response

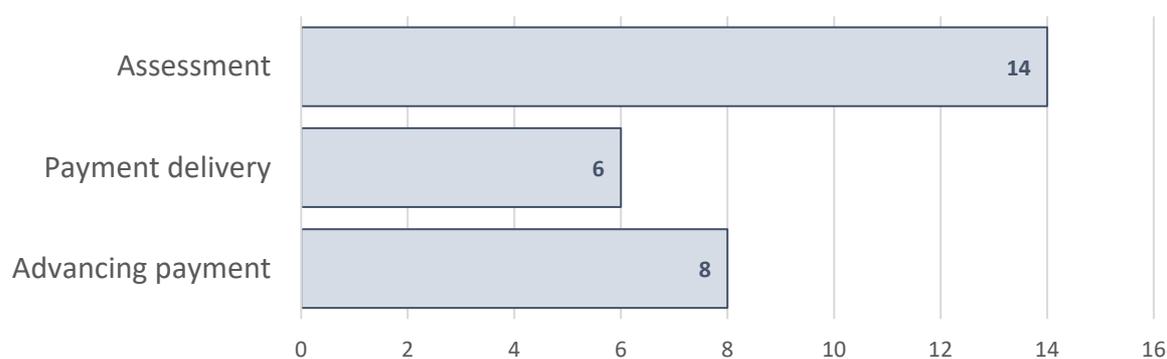
In sum, most disability-specific schemes were fundamentally constrained by their limited scope and coverage before the crisis. Overall, horizontal expansion of disability benefits was relatively rare across countries and, where it did take place, constituted a relatively small increase in coverage (often starting from a low base). This reflects the fundamental challenges of undertaking disability assessment in normal times, let alone in the context of the COVID-19 crisis.

An important consequence was that adjustments to existing disability benefits primarily related to persons with disabilities deemed unable to work. This is the result of the nature of existing eligibility criteria discussed above. Even in Georgia, which has a less restrictive definition of disability, a decision was taken to only provide topped-up benefits to those assessed with the most severe disabilities (Group I), which left out many of those with less significant disabilities who had faced elevated levels of poverty before the crisis. This is notable given that households with a person with disability in Group II and III (less severe) had higher levels of poverty than those in Group I before the crisis, largely due to the more limited social protection provision in place. In Thailand, where there are not explicitly different levels of disability benefits, the scope of the response may have been broader. However, in this case the low value of pre-existing and topped-up benefits likely limited the impact of the response.

Beyond horizontal and vertical expansion, many countries have made administrative adjustments to existing schemes. These adjustments have predominantly related to flexibility around assessment processes and advancing payments. An important rationale for these adjustments has been to protect recipients of social protection benefits from infection. Such measures are particularly relevant for persons with disabilities given their greater risk of serious disease resulting from the virus. A total of 24 measures making administrative adjustment to cash transfers were identified in the global database (Figure 9), including:

- **ELIGIBILITY ASSESSMENT**, including extending the validity of disability ID cards or delaying assessment processes. This is particularly relevant for persons with disabilities who may have been scheduled to undergo a review of their disability status during the crisis.
- **PAYMENT DELIVERY**, including online transfer or home delivery. As well as extending entitlements due to expire, Armenia adopted both delivery of benefit at the homes of persons with disabilities as well as an extension of entitlements that were soon to expire. Mauritius, Sri Lanka and Timor-Leste put in place mechanisms to deliver support to the homes of persons with disabilities. In Brazil, an adjustment was made to the payment modality to allow beneficiaries to receive their benefits in a current account instead of the limited simplified INSS bank account (with magnetic card). This means that beneficiaries would no longer need to withdraw all their benefit from a physical channel and are able to transact digitally.
- **ADVANCING PAYMENTS:** Some countries advanced the payment of their existing cash transfer programmes during the initial phase of the pandemic. For example, Peru advanced its usual bi-monthly payment of pension to persons with severe disabilities.

Figure 9: Administrative adjustments to cash transfers



Source: UNPRPD (2021b)

There are indications that the experience of the crisis is catalysing the improvement of disability benefits.

Various examples exist in case study and other countries:

- In **Thailand**, the disability allowance was increased from 800 baht to 1,000 baht in October 2020 for persons with disabilities under 18 or with a government welfare card. This change affected around 1.2 million of the nearly 2 million persons with disabilities receiving the allowance.
- In **Uzbekistan**, the benefit levels of the allowance for persons with disabilities from childhood and the disability social pension were increased by 10 per cent as of September 2020.
- In **Tamil Nadu** state in India, a 2018 reform of the state disability pension – which had not been implemented – was operationalised. This involved removing the criteria to target only those assessed above 60 per cent impairments, and moved from a poverty-targeted to affluence-tested approach (UNPRPD, 2021b).

THE ROLE OF MAINSTREAM SOCIAL PROTECTION SCHEMES

Given the limited contribution of disability-specific benefits in responding to the COVID-19 crisis in many countries, an important question is the extent to which mainstream schemes provide effective support to persons with disabilities. In many countries, these mainstream schemes formed the core of the social protection response to COVID-19, and, in theory, such schemes could have played an important role for persons with disabilities. Many persons with disabilities will have fallen into the population groups that governments sought to protect with these measures, such as informal sector workers and/or low-income households. The nature of responses via mainstream schemes has varied significantly, and included (with reference to case study countries):

- Adjustments to other **life cycle cash benefits**, such as old age pensions and/or child benefits (Kenya, South Africa, Sri Lanka, and Thailand).
- Adjustments to **social assistance schemes** targeting low-income households (Brazil, Georgia, Indonesia, Mauritius, Sri Lanka, the Philippines, and Uzbekistan).
- Ad hoc measures to provide **support to informal economy workers** (Brazil, Mauritius, Peru, Thailand, South Africa, Sri Lanka).
- **Measures for formal workers** covered by contributory social security schemes, including wage subsidies (Mauritius, South Africa, Thailand, and Vanuatu).

In many cases multiple complementary measures were put in place in one country. Some countries (such as Brazil, the Philippines, and Timor-Leste) introduced new schemes, although these were sometimes channelled in part through existing schemes (such as the conditional cash transfers in place in Brazil and the Philippines).

Life cycle cash benefits (beyond those specific to disability) provided an important channel to support persons with disabilities in many countries. Many persons with disabilities will have been reached via old age pension and child benefit programmes, which were often adjusted in a similar fashion to disability benefits. Old age pension benefits are likely to have been particularly relevant, given that levels of disability increase with age. Of the four case study countries that topped up disability benefits, three also topped up non-contributory old age pension benefits (Kenya, South Africa, and Thailand). Meanwhile, Georgia and Peru introduced new one-off benefits for children and families. South Africa provides an example of how vertical expansion of a range of pre-existing life cycle cash benefits means that the majority of persons with disabilities were reached. An important caveat is that the support provided was not tailored to the specific needs of persons with disabilities. In some cases, while persons with disabilities would have been in households receiving support, they would not have been direct recipients.

Box 6: South Africa: The role of life cycle social protection schemes in responding to COVID-19

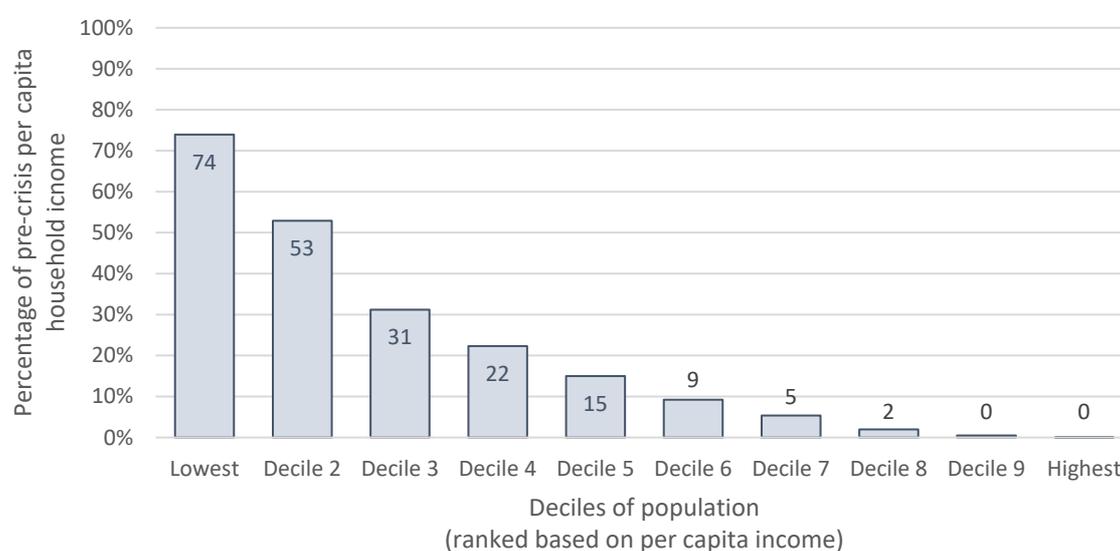
South Africa has a relatively comprehensive package of non-contributory cash benefits (social grants), with the most significant (in terms of coverage) being the child support grant, disability grant, and old age grant. While all these schemes are means-tested, they use an “affluence test” which seeks to exclude relatively well-off individuals, rather than narrowly target benefits at the very poorest.

Under this system, approximately two thirds (65 per cent) of persons with severe disabilities were directly receiving at least one social grant before the crisis, a much higher proportion than the 24 per cent of persons without a disability directly receiving a benefit. An even larger proportion of persons with severe disabilities (80 per cent) lived in a household where at least one member received a benefit.

During the crisis, the benefits of the child support grant, disability grant and old age grant were all topped up, and the figures below suggest most persons with severe disabilities would have lived in households benefitting from this support, mostly as direct beneficiaries. This, nevertheless, leaves approximately 20 per cent of persons with disabilities not receiving this support.

Analysis of household survey data also suggests that these top-ups would have been meaningful, particularly for low-income households. For those in the poorest 10 per cent of the population, the top-ups would have constituted 74 per cent of pre-crisis per capita income. Evidently, this does not shed light on the adequacy of benefits in relation to specific disability-related costs during the crisis.

Figure 10: Average monthly value of COVID-19 top-ups over a 6-month crisis period as a percentage of pre-crisis per capita household income in South Africa¹⁴



Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2017 by Development Pathways

Box source: South Africa case study developed under the project ILO-UNPRPD COVID-19 response

¹⁴ Since there is no information on exactly which individuals, or how many individuals in each household, received a top-up, it has been estimated based on personal characteristics. For example, it is assumed that each person with a disability in a household receiving the Disability Grant received the top-up.

While schemes supporting informal workers may have reached some persons with disabilities, few appear to have been specifically adapted to their needs. Given that persons with disabilities who are in employment are more likely to work in the informal economy, cash benefits for informal workers have had the potential to provide an important form of support. This is particularly relevant given that persons with disabilities deemed able to work are usually excluded from disability benefit schemes. Nevertheless, data remains limited on the extent to which persons with disabilities were reached by such schemes, and few appear to have been specifically designed with persons with disabilities in mind. The case of Thailand (Box 7) points to the inclusion of persons with disabilities in such support, but also raises important questions.

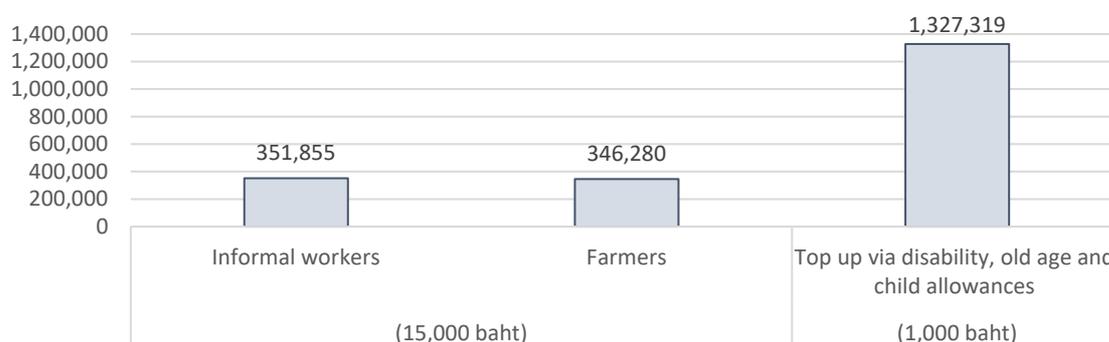
Box 7: Support to informal workers with disabilities in Thailand

One of the main social protection measures introduced in response to COVID-19 in Thailand in 2020 was short-term cash benefits provided to informal workers and farmers. This consisted of payments of 5,000 baht per month for 3 months¹⁵ to 15 million informal off-farm workers and 7.5 million farmers (World Bank, 2021). Eligibility was determined via an online application process. This was in addition to a range of other measures including top-ups provided to disability benefits described in Table 3 above.

As shown in Figure 11, a not insignificant number of persons with disabilities received benefits from the schemes for non-formal workers and farmers: 698,135 by 30 June 2020, divided roughly equally between the two groups of workers. Nevertheless, the majority of persons with disabilities receiving support benefitted from the 1,000 baht per month top-up, which was significantly lower than the 15,000 (5,000 per month) for informal workers and farmers.

It also appears that a significant portion of persons with disabilities who applied for the scheme for informal workers and farmers missed out, although evidence on the reasons is not clear. Only 41 per cent of 849,110 persons with disabilities who had registered for the scheme for informal workers were successfully enrolled. It is also notable that the number of persons with disabilities receiving support under the informal workers and farmers' schemes were a small minority of the total number of people who benefitted from the scheme. Persons with disabilities represented 2.3 per cent of informal workers and 4.6 per cent of farmers receiving the benefits, although data is not available on the prevalence of disability within these populations as a whole. Finally, no information is available about the extent to which social protection responses covered persons with disabilities who do not have a disability card (estimated to be more than half of persons with disabilities).

Figure 11: Persons with a disability card receiving cash benefits, by scheme, 30 June 2020



Note: In addition, 1,964 persons with disabilities received support via social insurance schemes, 3,210 in institutions, and 172 government officers.

Source: Thailand case study developed under the project ILO-UNPRPD COVID-19 response

¹⁵ The payment for informal workers was from April to June, and for farmers was from May to July.

In various countries, social registries were used to horizontally expand coverage of social protection benefits during the crisis. Social registries are databases including poor- and low-income households that had been established before the crisis in order to target social assistance and other poverty-targeted social protection schemes. Various countries used such social registries to horizontally expand cash benefits during the crisis. For example, Indonesia expanded its Family Hope Program (PKH) – from 9.2 to 10 million households – and launched an ad hoc programme to an additional 9 million households using the scheme’s social registry (Box 8 provides more detail on the case of Indonesia). Brazil also used its Cadastro Unico social registry to reach 10 million households over and above the 19 million previously reached by the Bolsa Familia conditional cash transfer. It also registered 37 million new applicants beyond the social registry.

However, there are significant questions regarding the extent to which use of such registries has been effective in reaching persons with disabilities. As discussed above, means-testing methodologies rarely take adequate account of the specific additional costs associated with disability, and inherently suffer from high exclusion errors. This applies to proxy means testing, which is a common methodology used for determining targeting thresholds within social registries. For example, analysis in Indonesia before the crisis found that households with a person aged above 15 with a severe functional limitation were less likely to be included in the PKH than households without a person with a disability (Kidd et al., 2019). Evidence on the extent to which these mechanisms reached persons with disabilities during the crisis remains limited.

The role of ad hoc programmes that included persons with disabilities also appears to have been mixed. Recognising the limits of existing social registries and other benefits in place, some countries put in place more general cash transfers targeting low-income families. For example, in the Philippines, an Emergency Subsidy Program was introduced as a part of a broader package of measures launched in March 2020. The scheme sought to provide cash or in-kind benefits to 18 million households (around three quarters of the 24 million households in the country). In addition to the 4.4 million households receiving the country’s conditional cash transfer programme, it also extended to other groups including informal economy workers and vulnerable groups including persons with disabilities (Cho et al., 2021). However, there were significant challenges in reaching persons with disabilities. While existing beneficiaries of the conditional cash transfer received the additional support relatively rapidly, there were significant delays in registering and paying new groups of beneficiaries (Cho et al., 2021). Eligibility determination was primarily left to the discretion of local governments and the approach used varied from locality to locality. Only limited use was made of the country’s Registry of Persons with Disabilities (under the Department of Health) primarily because the coverage of the registry is extremely low.¹⁶ There was evidence of individuals being unfairly excluded. A community-based peer monitoring survey conducted between March and June 2020 found that most women with disabilities surveyed reported not benefitting from the cash transfer. The reasons for disqualification included being single, and not being registered to vote in their place of residence during lock down (Commission on Human Rights, 2020). Significant issues were also reported with the accessibility of benefit delivery, including crowded payment points which resulted in some persons with disabilities having to wait for many hours in pain (Lapuz, 2020).

¹⁶ The Registry of Persons with Disabilities includes around 230,000 individuals, equivalent to approximately 0.2 per cent of the total population of the Philippines.

Box 8: COVID-19 Impacts on People with Disabilities in Indonesia: an in-depth look

The COVID-19 pandemic has had severe and lasting impacts on the Indonesian economy. The country's economy contracted by 5.3 per cent in the second quarter of 2020 while, in the third quarter of 2020, over 5 million people lost their jobs, and 24 million individuals were working reduced hours.

While these economic impacts brought hardships across the population, they were even more profound for the lives of people with disabilities in Indonesia. In a survey taken since the outbreak of COVID-19, 31 per cent of children with disability between the ages of 13 to 15 had dropped out of school – compared to only 7 per cent of children without a disability in the same age group.

Low education attainment poses significant barriers to the labour market and consequently a low rate of labour force participation. By April 2020, 81 per cent of workers with disability had experienced reduced income due to the COVID-19 crisis; 68 per cent claimed to have stopped working all together; and up to 69 per cent of people with disabilities had become poor or fallen deeper into poverty after the COVID-19 pandemic.

Women in households with members with disability experienced more significant barriers to employment and were more likely to take on the role of caregiving for people with disabilities – with fewer in paid work as a result – leading to higher physical and mental strain and lower economic opportunity.

Like many countries, Indonesia experienced health service disruptions due to the COVID-19 pandemic. Hospitals and clinics had seen a drop in non-COVID patient numbers – both for inpatient and outpatient visits. People with disabilities who regularly need medical attention had reduced their visits to clinics due to fear of exposure to COVID-19, as well as difficulties reaching health facilities due to movement restrictions.

Despite their high vulnerability, only five per cent of the people with disabilities benefited from Indonesia's social protection programs prior to the pandemic. The national social protection schemes for people with disabilities are also inadequate. In 2020, the national disability benefit (Asistensi Social Penyandang Disabilitas) reduced its benefit amount from Rp 3,600,000 (US\$ 254) per person per year to Rp 2,000,000 (US\$ 141) per person per year, and the conditional cash transfer (Program Keluarga Harapan) applied a cap of one person with disabilities able to benefit per household.

In the face of the pandemic, however, the Government of Indonesia responded decisively by expanding existing schemes and rolling out new programs at an unprecedented scale. This resulted in a significant increase in social protection coverage among people with disabilities. By July 2020, most people with disabilities received some form of social assistance including temporary subsidies on utilities and the new COVID-19 cash transfers. The COVID-19 Village Unconditional Cash Transfer (BLT Dana Desa), which provided Rp. 600,000 (US\$ 42) per month to individuals significantly affected by the crisis, was particularly impactful. Recognising that the Indonesia's social registry was inadequate in identifying these people, beneficiaries were identified through village administrations, who often prioritised people with disabilities.

Given that the most people with disabilities earn less than Rp. 1 million (US\$ 70) per month and have experienced an economic decline of over 50% during the pandemic, BLT Dana Desa provided a significant income boost to those who would otherwise go hungry or become indebted to crisis-cope. Furthermore, BLT Dana Desa was distributed safely through bank accounts and post offices, illustrating the government's ability to shift from providing in-kind support to cash, quickly and efficiently.

Source: Satriana et al (2021)

The provision of benefits at a household level raises important questions about the level of control persons with disabilities had over decision-making. Whether via the extension of existing general social assistance programmes, or the provision of new ad hoc benefits, it has been common for COVID-19 mainstream schemes to be provided at the household level. While such schemes may reach households that include persons with disabilities, there are questions surrounding the extent to which they result in the specific needs of persons with disabilities being met, and the extent of control that persons with disabilities have over the transfer. Research from The Asia Foundation in Timor-Leste sheds some light on this issue. In March 2020 the country announced a household cash transfer that paid a one-off sum of US\$200 (intended to last two months) targeted at households earning below \$500 per month. Targeting was based on a system of household registration (Ficha de Familia) and payments were made to household heads (more likely to be males than females). Overall, the benefit reached three quarters of households in the country, with payments being made from June 2020 (ORIMA Research, 2020; World Bank, 2020). Qualitative research by The Asia Foundation suggests that persons with disabilities did not benefit specifically more or less from the benefit than other household members. The degree of control that persons with disabilities had in the household decision-making processes around the payment was seen to be linked to several intersecting factors such as their position in the household, gender, and type of disability. However, a distinction was noted between this household transfer and the disability and old age pensions in place in the country which were seen as individual payments and usually controlled by the recipients themselves (The Asia Foundation, 2020).

4. CONCLUSIONS

The analysis in this paper points to a set of conclusions which are relevant to making social protection systems more inclusive and shock-responsive for children and adults with disabilities.

- **Countries with existing disability benefits in place have been better positioned to provide support for persons with disabilities.** This greater responsiveness was related to three main factors. First, persons with disabilities receiving such benefits will have been more resilient to the crisis – with comparatively lower poverty – than had they not been receiving such support. Second, even without any modification, existing disability benefits will have provided a cushion for those receiving such benefits, ensuring a continued flow of income within households. Third, it has been relatively simple to vertically expand these benefits through top-ups provided to persons with disabilities and their families.
- **Adequacy of disability benefits was a major issue before and during the crisis.** Many disability benefits in place before the crisis had benefits far below what can be considered a minimum level of income security, and even fewer adequately addressed disability-related extra costs. Vertical top-ups went some way to address extra costs during the crisis in some cases, but small top-ups to inadequate benefits will have provided limited protection. Higher pre-existing benefits that were not adjusted in countries such as Brazil and Mauritius will have likely provided more protection than topped up benefits in countries such as Thailand.
- **The generally low coverage of pre-existing disability benefits limited the reach of the social protection response.** Drivers of this low coverage include the nature of disability assessment often focused on a medical model, restricting programmes to those deemed unable to work, the use of means testing and associated targeting errors, and issues of accessibility across the delivery chain. The restriction of pre-existing benefits to persons with disabilities deemed unable to work was particularly problematic in this crisis given the acute vulnerability faced by persons with disabilities who were in employment.
- **Few countries were able to significantly expand the coverage of disability benefits (horizontal expansion).** This was a challenging process for social protection systems in general, but is particularly acute in relation to disability, given the inherent complexity in disability assessment. The support to persons with disabilities appears to have been most significant in countries with high coverage life cycle schemes including disability benefits, but also child benefits and old age pensions.
- **The lack of care and support services for children and adults with disabilities in many countries pre-crisis severely limited capacity of social protection system to tackle issues of disruption of family and community support informal systems due to COVID-/19.** Over reliance on residential care in some higher income countries, also contributed to a disproportionate death toll among persons with disabilities living in such segregated and congregated settings.
- **Disability registries represent an untapped resource for shock-responsive social protection.** Even where disability benefits are low in coverage or absent, a strong disability registry system can provide a framework for initiating ad hoc schemes or expanding existing schemes to a broader population during a crisis. Had such registries been in place before the crisis, countries would have been in a far better position to deliver social protection to a broader population of persons with disabilities. In connection with more accessible and comprehensive disability assessment, they can become critical tool for case management and policy planning.
- **Mainstream programmes supporting poor households and workers appear to have played a limited role in providing appropriate support during the crisis.** While evidence is scarce on their performance, many of these schemes were limited by design. Social registries, which form the backbone of poverty targeting for social assistance schemes, rarely take specific account of barriers to employment and disability related extra costs. While schemes targeted at informal workers had important potential to support persons with disabilities during the crisis, few appear to have been designed with their needs in mind.

5. RECOMMENDATIONS

- **Expand coverage of disability benefits towards universal coverage.** This can be achieved through a mix of contributory and non-contributory schemes. This should involve a progressive move away from narrow means-testing and a focus on persons with disability deemed unable to work.
- **Take better account of disability extra costs in normal times, and in times of crisis.** This can take many forms, but a starting point would be the implementation of disability benefits compatible with work and other benefits, in addition to better coverage of health care costs and greater access to community care and support services for children and adults with disabilities. Over time, countries can gradually build up multi-tiered systems of disability benefits addressing a more complex range of extra costs.
- **Build disability registries as a key pillar of inclusive and shock-responsive social protection.** These can provide a gateway to a range of benefits and services including disability benefits, mainstream social protection schemes, concessions, support services and health care. They can also provide a foundation for horizontal expansion of cash benefits in response to covariate shocks.
- **Improve the disability inclusion of mainstream social protection schemes.** This may involve taking account of disability related costs in poverty assessment and eligibility criteria.
- **Increase the accessibility of both disability and mainstream social protection schemes.** This involves adequate training and data disaggregation, the development of minimum standards, implementation of disability-inclusive administrative processes, and appropriate management and organisational processes.
- **Persons with disabilities and organizations representing them should be actively involved in the policy formulation, design, and implementation of social protection systems, including during times of crisis.** Not only is their participation key to ensure that social protection schemes are designed to respond to the circumstances faced by persons with disabilities, but they can be partners for more effective implementation.

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