



## Social Protection Discussion Paper Series

### **Disability and Social Safety Nets in Developing Countries**

**Sophie Mitra**

**May 2005**

Social Protection Unit  
Human Development Network  
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**Social Safety Nets Primer Series**

# **Disability and Social Safety Nets in Developing Countries**

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May 2005

**WORLD BANK INSTITUTE**  
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# Social Safety Net Primer Series

The World Bank Social Safety Nets Primer is intended to provide a practical resource for those engaged in the design and implementation of safety net programs around the world. Readers will find information on good practices for a variety of types of interventions, country contexts, themes and target groups, as well as current thinking of specialists and practitioners on the role of social safety nets in the broader development agenda. Primer papers are designed to reflect a high standard of quality as well as a degree of consensus among the World Bank safety nets team and general practitioners on good practice and policy. Primer topics are initially reviewed by a steering committee composed of both World Bank and outside specialists, and draft papers are subject to peer review for quality control. Yet the format of the series is flexible enough to reflect important developments in the field in a timely fashion.

The primer series contributes to the teaching materials covered in the annual Social Safety Nets course offered in Washington DC as well as various other Bank-sponsored courses. The Social Safety Nets Primer and the annual course are jointly supported by the Social Protection unit of the Human Development Network and by the World Bank Institute. The World Bank Institute also offers customized regional courses through Distance Learning on a regular basis.

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## Papers in the Safety Nets Primer as of April 2005<sup>1</sup>

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Cash Transfers Benefits	Lafaurie and Valasquez
Community-based Health Insurance	Tabor, Steve
Conditional Cash Transfers	Rawlings, Laura
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Fee Waivers in Housing	Katsura and Romanik
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Very Low Income Countries	Smith and Subbarao
<b><i>Special Vulnerable Group</i></b>	
Disability	Mitra, Sophie

1. Papers may be added or deleted from the series from time to time.

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# Abstract

This paper deals with how social safety nets may reach the poor with disabilities in developing countries. It presents a framework for analyzing the inclusion of disability in social safety nets. The paper first reviews evidence on the relation between disability and poverty, and discusses the roles that safety nets may play with regard to disability. Safety nets can reach persons with disabilities through inclusive mainstream programs as well as disability targeted programs. The advantages and challenges of disability targeting are then discussed. The paper proceeds to analyze different ways that can be used to include disability considerations in the implementation of mainstream safety nets through the reduction of physical, communication and social barriers surrounding such programs and through the careful design and evaluation of safety nets. The use of disability targeting versus or in combination with disability mainstreaming is then discussed.

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# Disability and Social Safety Nets in Developing Countries

## 1. Introduction

Safety net programs protect persons or households against two adverse outcomes: “chronic incapacity to work and earn (*chronic poverty*) and a decline in this situation that provides minimal means for survival with few reserves (*transient poverty*)” (Subbarao *et al* (1997; p. 2)). There is a broad range of social safety nets. In some countries, private safety nets in the form of informal or community based arrangements help mitigate the above adverse outcomes. In addition, there are publicly supported social safety nets including government funded transfers such as family assistance and in-kind transfers, income generation programs such as micro-credit or public works programs, and social insurance programs such as pensions. The scope of programs that come under the term ‘social safety net’ varies within the literature. In this paper, ‘social safety net’ refers to government funded safety nets, whether they are transfers, income generation programs, or social insurance programs.

In all the different types of social safety nets that have been adopted, program implementation, design and evaluation have given little attention to persons with disabilities<sup>2</sup>. In mainstream development policy, the conventional wisdom is that persons with disabilities are incapable of earning an independent living and thus are economically dependent. An illustration of this conventional wisdom is found in Devereux (2002a): persons with disabilities “survive by being cared for within their families or communities, by institutional redistribution from the state (funded by taxes bid by the economically active), or by charity and begging (which is a form of work)”. A simplistic view thus prevails whereby persons with disabilities are not expected to participate in livelihood programs, but may be eligible for cash transfers if available.

Reality is far more complex for persons with disabilities. In developing countries that have cash transfer programs funded by the government, such programs are often not accessible to persons with disabilities because of the physical or social barriers that surround them. Persons with disabilities may, depending on various factors, be able to work and thus contribute to development promoting livelihood programs. This paper does not attempt to demonstrate that persons with disabilities are not adequately reached by social safety nets. While this is an important issue, the focus is instead on how social safety nets can be designed, implemented and evaluated in ways that allow them to reach the poor with disabilities. There is very little guidance on how to include persons with disabilities in the program design and delivery of social safety nets, and this study attempts to fill that gap. In this paper, inclusion refers to how persons with disabilities are taken into account in the design, implementation and evaluation of social safety nets.

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<sup>2</sup> In this paper, we use the term ‘persons with disabilities’. However, we realize that academic and political discourse in some countries favors the term ‘disabled people’.

The paper is organized as follows: the next section provides a background on disability, poverty and social safety nets; the third section discusses whether social safety nets should be targeted by disability; the fourth section provides an analysis of how to reduce or remove the physical and social barriers that prevent persons with disabilities from accessing social safety nets; the fifth section deals with how to include disability in the design and evaluation of social safety nets, and how to assess whether a social safety net is disability inclusive. The sixth section analyzes the advantages and disadvantages of disability targeting versus disability inclusion, and the last section gives a summary of the paper and recommendations.

## **2. Disability, Poverty and Social Safety Nets**

This section sets the background for this paper by reviewing definitions of disability, by analyzing the relation between disability and poverty and by examining the role of safety nets in the context of disability.

### ***Defining and Measuring Disability***

Disability has proved to be a very controversial and complex concept to define and measure, and analyzing its definitional problems is beyond the scope of this paper. In brief, different conceptual models have been developed to define disability<sup>3</sup>. In the charity model, persons with disabilities are to be pitied and helped by welfare approaches (Coleridge (1993)). In the medical model, disability is considered to be a problem of the individual that is directly caused by a disease, an injury or other health conditions, and that requires medical care in the form of treatment and rehabilitation. An individual with an impairment is considered disabled, where impairment is the term used for an individuals' condition, irrespective of whether the person experiences limitations in his or her life activities.

The medical model is usually opposed to the social model, which considers disability purely as a social construct. Disability is not the attribute of the individual, rather it is created by the social environment and requires social change. For instance, a person with an impairment may not be able to find work not because of an inability to work per se, but as a result of being discriminated against or because of the inaccessibility of work places. In the social model, disability becomes a human rights issue at the political level. A fourth model of interest is the International Classification of Functioning, Disability and Health (ICF) developed by the World Health Organization. Conceptually, ICF is presented as an integration of the medical and the social models (WHO (2001, p. 20)). This model starts with a health condition that gives rise to impairments, and then activity limitations and participation restrictions. Relevant domains where restrictions can be experienced include among others: learning and applying knowledge, mobility, self-care, education, remunerative employment, and economic self-sufficiency. Disability is an umbrella term, which includes impairments, activity limitations and participation restrictions.

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<sup>3</sup> A detailed coverage of these models is available in Altman (2001), Pfeiffer (2000) and Campbell Brown (2001).



Finally, of particular interest in the context of poverty and development, A.K. Sen's capability approach<sup>4</sup> was used to define disability (Mitra (Forthcoming)). The capability approach was developed to analyze concepts of the standard of living, poverty and development. Here, disability is understood as a deprivation of capabilities where capabilities refer to practical opportunities. Disability occurs when an individual with an impairment is deprived of practical opportunities and results from the interaction between the resources available to the person, personal characteristics (e.g., type of impairment, age, gender) and the environment (physical, social, cultural, political, economic). In the remainder of this paper, the complexities of the definition of disability are left aside and the term "disability" is used in the context of the capability approach. The term impairment is also used to refer specifically to an individual's condition, which can be physical, sensory or mental (intellectual or behavioral).

The complexity of defining disability has implications for the measurement of disability prevalence. Disability prevalence estimates are derived from national censuses or national population surveys. Prevalence estimates are not comparable across countries for numerous reasons, which are briefly reviewed below and are explained in more detail in Mitra (2005). First of all, there are factors related to the way impairments and disabilities are perceived and reported across countries. These include differences in knowledge and awareness of impairments, diagnosis and screening, medicalization of problems, perceived standards of good health, and eligibility to public benefits based on disability. All these factors lead to differences in perceived disability and would explain in part why there is a higher reported disability prevalence in developed countries compared to developing countries. In addition, fundamental differences in disability definitions also impact on prevalence estimates across countries. Developed countries typically use disability screens that assess activity limitations (e.g., limited ability to work), whereas developing countries tend to use impairment screens (e.g., inability to hear, see). Activity limitation screens generally lead to higher rates of reported disability than impairment screens. Indeed, individuals are more likely to identify activity restrictions because they immediately connect with daily experience; whereas an impairment may only be vaguely familiar, and its nomenclature may be unknown. Finally, the wording and sequence of questions also compromise the comparability of prevalence estimates across countries.

Despite these limitations in the comparability of prevalence estimates, Table 1 gives some prevalence estimates for different countries and notes whether an impairment or an activity limitation type of question was used to define disability in each case. When estimates are available for both activity limitation and impairment definitions (Brazil, Chile), impairment prevalence rates are substantially lower than activity limitation rates. Based on impairment definitions, prevalence estimates range from 1.41% in Brazil to 5% in Costa Rica. The case of Turkey is interesting: one estimate is based on an impairment-based definition (2.6%), and another one includes both an impairment and a chronic illness definition of disability (12.3%). The country estimates based on impairment definitions are significantly lower than the global prevalence estimate of 10% that is used by the United Nations (United Nations (1990)), while those based on activity limitations

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<sup>4</sup> e.g., Sen (1985, 1999).

**Table 1: International Disability Prevalence Estimates**

Country	Year	Disability prevalence (%)	Disability definition	Source	Reference
Brazil	1991	1.41	Impairment-based	Census	IDRM (2004)
	2000	14.5	Activity limitations	Census	IDRM (2004)
Costa Rica	2000	5	Impairment-based	Census	IDRM (2004)
	1998	8	Impairment-based	Multipurpose household survey	IDRM (2004)
Chile	2002	2.2	Impairment-based	Census	IDRM (2004)
	2000	21.7	Activity limitations	Quality of life and health survey	IDRM (2004)
India	2001	2.1	Impairment-based	Census	Census (2001)
	2002	1.8	Impairment-based	National Sample Survey National Survey of Disabled People	GOI (2003)
Korea	2000	3	Activity limitations	People	OECD (2003)
Pakistan	1998	2.54	Impairment-based	Census	Arjumand & Associates (2003)
South Africa	1999	4.5	Impairment-based	October Household Survey	Statistics South Africa (2001)
Turkey	2002	2.58	Impairment-based	Disability Survey	The State Institute of Statistics
	2002	12.29	Impairment-based and Chronic Illnesses	Disability Survey	The State Institute of Statistics

and a combination of impairments and chronic illnesses are higher than the global estimate.

### ***Disability and Poverty***

Defining disability is a complicated and controversial exercise. In contrast, the relation between poverty and disability is commonly accepted as a ‘vicious circle’<sup>5</sup>. “It is a two-way relationship – disability adds to the risk of poverty and conditions of poverty increase the risk of disability” (Elwan (1999; p. i)). “The result of the cycle of poverty and disability is that people with disabilities are usually amongst the poorest of the poor” (DFID (2000; p.2)). Of course, not all persons with disabilities are poor, but this vicious circle points out that a person with a disability is more likely to be poor than a non-disabled counterpart.

The fact that disability may lead to poverty is common sense. First, disability places constraints on an individual’s earning capacity through sometimes a reduced ability to work, a lack of accessibility in work environments and discrimination. This link from disability to poverty is considered to be particularly acute for women who may suffer a double discrimination on the grounds of gender and impairment. Secondly, disability adds direct costs related to the disability, such as medical expenses, equipment, adaptations to housing and means of transportation and personal care. Personal care may not come with direct costs in developing countries since relatives are more likely to care for persons with disabilities. However, this translates into a third source of disability related costs for the household, the foregone earnings of the caretakers.

There is a large literature on the labor force participation of persons with disabilities, in high income countries in particular, but there is a need to assess the costs of a disability in terms of both foregone earnings and direct costs at the individual and household levels in order to gain a better insight into the poverty status or risk of such individuals and households. Regarding the direct costs of disability, Zaidi *et al* (2003) found that in the UK, extra costs of disability are substantial; especially for individuals with disabilities living alone and that these costs rise with the severity of disability. In Jones *et al* (1995), costs were assessed for individuals in the U.K. in different categories (gas, transport, food, alcohol, clothes and other). They find that disability has a positive impact on consumption costs associated with gas and transportation. Jones *et al* (1995) do not cover the health care needs of persons with disabilities, although these may be significant for persons with disabilities. Klavus (1999) demonstrates that health care expenditures have a considerable effect on the welfare of households in Finland. He finds that a household with a chronically ill individual needs 40% more income to reach the income level of a healthy reference household. One study by Erb *et al* (2001) found, based on a village-level survey in South India, that the direct cost of a chronic illness or an impairment in terms of equipment and treatment averaged three months of a person’s income. This does not include foregone earnings due to an inability to work, nor the opportunity costs borne by other members of the household. Elwan (1999; p. 26) notes that the costs to caregivers, particularly in terms of foregone work earnings, are increasingly recognized

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<sup>5</sup> This vicious circle has been described in several sources, for instance, DFID (2000), Elwan (1999), Mitra (Forthcoming a), Shirley (1983) and Yeo and Moore (2003).

and have been evaluated in the United Kingdom. The cost of personal care on the household<sup>6</sup> may be more important in developing countries than in high income countries, since the former generally do not offer income maintenance programs and other funded entitlements as the latter do. In developing countries, “disabled people are usually considered to be the responsibility of their families” (Elwan (1999; p. 26)). The direct costs of disabilities and the foregone earnings they entail warrant more research in both developed and developing countries.

While disability can lead to poverty, poverty itself can be the cause of a disability. This is particularly the case in developing countries where preventable impairments associated with communicable, maternal and perinatal diseases and injuries are common. Poor individuals and families do not have enough resources to satisfy their basic needs, and their sanitation and shelter are inadequate. They may contract some diseases, which, with a lack of access to health care, make them become disabled. It is well established that malnutrition, in particular vitamin A and iodine deficiencies, is a cause of disability for adults and children (Harris-White (2003; p. 48)). As reported in Elwan (1999), UNICEF notes that the incidence and severity of disability are the greatest in countries at earlier stages of development as a consequence of factors that are mainly related to poverty. Another link between poverty and disability is via the incidence of crime. Higher poverty can lead to more crime in developing countries (Bourguignon (2001)), which is likely to lead to more injuries and higher disability but is yet to be investigated.

Finally, it should be noted that this part of the vicious circle from poverty to disability may be more complicated than it seems as poverty leads to high impairment incidence rates, but does not necessarily lead to higher impairment prevalence rates given that a lot of poor die from their impairments in developing countries.

Box 1 presents some information on disability prevalence in India and a patchy sketch of the socio-economic profile of persons with disabilities in India. Is there any evidence on the vicious circle of disability and poverty? Disentangling both sides of the causation is a complex exercise that requires reliable detailed data and is yet to be undertaken. Aside from this disentangling challenge, very little research has been done on the association of poverty and disability in both developed and developing countries. As noted by Elwan (1999), the literature on disability and poverty is general in nature and is based on anecdotal evidence and case studies. The lack of quantitative research is in part due to limited data available and to concerns about existing data, including comparability issues between countries in the way disability is defined and measured. Table 2 gives the results of some recent research on the association of poverty and disability. In the three studies reported on India, Uganda and the United States, the percentage of households living below the poverty line is significantly higher when the household has a person with a disability.

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<sup>6</sup> In many countries, women in the family play an important role in caring for persons with disabilities. Gender differences in foregone earnings due to the care for persons with disabilities are also an important issue related to the impact of disability on household welfare.

### Box 1: A Profile of Persons with Disabilities in India

Disability prevalence estimates in India are provided in the table below. The share of the population with a disability was estimated at slightly below 2% in 1991 and 2002 as part of the national sample survey (NSS).

	1991	2002
<b>Share of persons with disabilities</b>	1.9%	1.8%
- rural	2.0%	1.9%
- urban	1.6%	1.5%
- male	2.3%	2.1%
- female	1.7%	1.7%
<b>Share of households with person with disability</b>		
- rural	9.1%	8.4%
- urban	6.8%	6.1%

Sources: NSS 47<sup>th</sup> and 58<sup>th</sup> rounds

There are several reasons to believe that these estimates should be considered as lower bound estimates. Some types of disability have not been included in the survey, although they are important ones such as autism and hemophilia (World Bank (2004)). In addition, for some of the disabilities that are reported, other surveys find higher prevalence rates. For instance, in a national survey of the Rehabilitation council of India, it was found that 2.9% of rural children had delayed mental development, which could be a proxy for mental retardation (World Bank (2004)). Even under the conservative estimates of the NSS, the incidence of disability at the household level is significant, with over 8% of rural and 6% of urban households having a person with a severe disability in 2002.

There has not been any comprehensive socio-economic profile of persons with disabilities in India, and in particular of the relationship between poverty and disability. The table below shows some indicators from different sources for persons with disabilities, and if available for the overall population, which can be a starting point to understand the socio-economic position of persons with disabilities in India. The literacy rate is slightly lower for persons with disabilities (55%) compared to the overall population (56.5%). What is striking is that the employment rate for persons with disabilities is less than half of that of the overall population (26% versus 55%). Another important statistic is that 47% of persons with disabilities have never been married, which in the context of India may signal the lack of social integration of this group.

	Persons with disabilities	Overall population
Employment rate	26%	55%
Adult literacy rate	55%	56.50%
Secondary school and above	9%	N/A
Never married	47%	N/A

Sources: NSSO (2003a, b), World Bank (2004), UNDP (2001)

**Table 2: Evidence on Disability and Poverty**

Country	Households without disabilities below the poverty line	Households with disabilities below the poverty line	Source
India (3 villages in Tamil Nadu)	36-51%	54-62%	Harris-White (1999)
Uganda (urban areas)	26%	42%	Hoogeveen (Forthcoming)
United States	8.30%	28%	Fujiura <i>et al</i> (1998)

Whether disability is associated with chronic and/or transient poverty is an unanswered question. Qualitative research and analysis such as Lwang-Ntale (2003) and Yeo (2001) point toward the permanent barriers persons with disabilities face in their physical and social environment and to their resulting state of chronic poverty. Theoretically, the onset of an illness or injury can be considered as an idiosyncratic shock that may lead to disability in terms of a capability deprivation. Whether or not it leads to chronic poverty is likely to vary depending on the type duration of the impairment, households' coping strategies and resources (medical, care, economic) and the environment. Not all impairments are permanent; some are temporary, others are episodic (e.g., some mental illnesses). Based on data for the United Kingdom, Burchardt (2000) shows that over half of persons who become limited in activities of daily living as adults have spells lasting less than two years. However, such temporary disability may well be able to pull a person into chronic poverty. To my knowledge, no research has been done based on longitudinal data on both disability and poverty to investigate the chronic or transient nature of poverty for persons with disabilities.

### ***Disability and Social Safety Nets***

If, as evidence suggests, higher disability is associated with higher poverty, poverty-reducing social safety nets clearly have a role to play with regard to disability. This role is three-fold. First of all, it is obvious that social safety nets may play a poverty alleviation role (relief) by providing resources to the poor with disabilities. If the poverty alleviation target of social safety nets is to be met, it is essential that persons with disabilities are included in such programs, since they are more likely to be poor compared to persons without disabilities.

Secondly, beyond poverty alleviation, social safety nets have a long-term poverty reduction and development role. This may take place in different ways; including by

providing insurance that may allow for risky behaviors, which lead to productivity and growth; and by reducing inequities that lead to long term asset depletion, and thus compromise economic growth. If social safety nets do not reach persons with disabilities, they can disadvantage persons with disabilities and contribute to increased inequality between those with and without disabilities. This in turn can compromise long term poverty reduction and development.

Finally, given that poverty can lead to disability, social safety nets can play a prevention role with regard to disability. This prevention role has two dimensions: impairment prevention and disability prevention, where disability is understood in terms of a deprivation of capabilities. Cash and food transfer programs can help prevent impairments that arise because of malnutrition. Cash transfers conditional on the use of health care services or health fee waivers and subsidies may prevent impairments by encouraging vaccinations or improvements in birth practices. In addition, livelihood programs and cash and in-kind transfers that assist persons in obtaining assistive devices or personal care may expand the capability set of persons with impairments, and thus prevent their impairment from depriving them of capabilities. In this respect, safety nets can prevent an impairment from being disabling. While it is important to recognize the impairment prevention role of social safety nets, impairment prevention is not within the scope of this paper. This paper deals with the inclusion of a disability dimension in social safety nets in order to reach persons who are poor and have impairments.

Although social safety nets play important and varied roles with respect to disability, it is important to note that social safety nets are not expected to entirely solve the poverty problem for persons with disabilities. The welfare of persons with disabilities is affected by disability related policies and legislations. In particular, inclusive employment, education and health policies need to be designed and implemented, which is beyond the scope of this paper. This paper focuses on a narrow question: how social safety nets can be designed, implemented and evaluated in ways that do not exclude persons with disabilities? Answers to this question need to be fully integrated within a country's broader disability policy. Until effective education, employment and health policies are in place, income support will be needed for the poor with disabilities and may be delivered through disability targeted transfers or disability inclusive safety net programs.

### **3. Disability Targeting of Transfers**

Given that the premise of disability-caused poverty seems to be supported by empirical evidence, one may wonder whether social safety nets should differentiate by disability. In other words, should the programs vary depending on whether the person has a disability? Although there is some evidence that persons with disabilities are at a disadvantage economically, it does not necessarily follow that there should be some form of disability targeting as part of social safety nets. This section presents the different types of disability targeted social safety nets found in different countries and provides an analysis of issues related to targeting, whether they arise across most types of programs or only in specific ones.

### *Cross-Country Patterns*

Persons with disabilities may receive targeted social safety net benefits through social insurance programs, publicly funded transfers and income generation programs. Social insurance programs provide workers with protection against future contingencies, including unemployment, maternity, sickness, old age and disability. Public funded transfers include social assistance programs, family allowances and in-kind transfers such as subsidies. Income generation programs include public works and micro finance programs.

Most developing countries provide disability protection through social insurance schemes but these earnings related contributory programs generally cover a small portion of the population as only persons employed in the formal sector are eligible. This is particularly the case in Africa and Asia but less so in countries in Latin America<sup>7</sup> and in Eastern Europe.

As for public transfer programs, in developing countries, there was a shift in the 1990s from universal benefits to highly targeted transfers. Publicly funded transfers that are specifically focused at the poor with disabilities and their households (i. e., with a means-test and a disability test) are scarce. Such transfers are more common in high and middle income countries, especially in countries where persons with disabilities are organized as a political force. These countries tend to have a dual disability benefit system with disability targeted social insurance and public transfer programs.

Disability targeted public transfer programs are usually in the form of social assistance transfers but may also be provided as part of family allowances (e.g., Costa Rica). Table 3 gives a list of selected developing countries that have publicly funded transfers for persons with disabilities. Most of these transfers are means tested, except for Namibia and Kyrgyzstan. For instance, South Africa has a non-contributory and means-tested disability grant for working age persons who are unable to work due to physical or mental disabilities. The grant is provided on a permanent or temporary basis. Disability grant recipients may receive an additional grant if they require personal assistance or personal care. South Africa also has a means-tested program that provides support to families who have a child under the age of 18 with a disability, called the care dependency grant. Four percent of the working age population receive disability grants in South Africa (Honeycutt *et al* (2004)).

In addition, some developing countries have disability targeted in-kind transfers or subsidies. In-kind transfers for food, energy or housing have generally not been disability targeted, although persons with disabilities have some times been considered as part of a broader eligible vulnerable group, for example in Jamaica for a food stamp scheme (Cornia *et al* (1995)). More importantly, there have been targeted transfers for the supply of assistive devices. Assistive devices are mainly used for mobility, information, communication and personal care. For example, in India, persons with disabilities receive assistive devices free of charge or at a 50% discount if their monthly income is below specified limits; and in Vietnam, the poor with disabilities and persons who became

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<sup>7</sup> For a review of disability social insurance schemes in Latin America, see Grushka and Demarco (2003).



**Table 3: Selected Countries with Social or Family Assistance Programs for Persons with Disabilities**

Country	Type of Program Disability test	Means test	Coverage		Benefits
			Adults	Children	
<b>Africa</b>					
Liberia	Social Assistance Inability to work	Yes	*		N/A
Mauritius	Social Assistance	Yes	N/A	N/A	N/A
Namibia	Social Assistance N/A	No	N/A	N/A	N/A
South Africa	Social Assistance Inability to work	Yes	*	*	flat rate
<b>Asia</b>					
Azerbaijan	Social Assistance N/A	Yes	*	*	three flat rates
Georgia	Social Assistance N/A	Yes	*		flat rate
Hong Kong	Social Assistance 100% loss of earning capacity or profoundly deaf	Yes	*		two flat rates
Kyrgyzstan	Social Assistance ability to work, attendance needed and mobility	No	*	*	flat rate (% of minimum wage)
Turkmenistan	Social Assistance ability to work and attendance needed	Yes	*	*	flat rates (full and partial disability)
<b>Latin America</b>					
Argentina	Social Assistance N/A	Yes	*		flat rate
Bahamas	Social Assistance N/A	Yes	*		flat rate
Barbados	Social Assistance Incapable of work due to defective eyesight or serious hearing and speech problems	Yes	*		flat rate
Bermuda	Social Assistance Incapable of employment	Yes	*		flat rate
Brazil	Social Assistance Unable to work or unable to live independently	Yes	*	*	flat rate (Minimum wage)
Costa Rica	Family allowance N/A	Yes	*		flat rate
Dominican Republic	Social Assistance N/A	Yes	*		flat rate (% of minimum wage)
Saint Kitts and Nevis	Social Assistance N/A	Yes	*		flat rate
Trinidad and Tobago	Social Assistance Age 40 or older if certified as blind and needy	Yes	*		flat rate

Sources: SSA (2002, 2003a, 2003b), Subbarao (1996) for Namibia.

disabled in war receive orthopedic devices for free (ESCAP (1997)). Such programs are generally funded by governments and administered by government agencies and/or NGOs.

Finally, with regard to livelihood programs, programs that are disability targeted are rare. To my knowledge, there have not been any public works programs that are disability targeted, and there have been a few isolated experiences of micro-finance programs for persons with disabilities set up by disability NGOs. For instance, in 1997, Leonard Cheshire set up its own credit facilities for small business entrepreneurs with disabilities in different countries (Dyer (2004)). In Ethiopia, disability NGOs with the support of the International Labor Organization, started a micro-finance program for women with disabilities and women with disabled dependents (ILO (2003)).

### ***Disability Targeting Issues***

Disability targeting has advantages and disadvantages across most of the different types of social safety nets described above. First, an argument in favor of providing disability targeted transfers is that they would increase the welfare of persons with disabilities as well as that of their care-takers who are predominantly women. Such transfers may have efficiency benefits, as it has been shown that transfers received by women have positive externalities on children's health and human capital<sup>8</sup>.

However, much depends on how the household's resources are distributed among different individuals in the family, particularly among persons with and without disabilities, and among men and women. The distributional arrangements within the family are influenced by factors such as the value systems of the society and by the economic empowerment of persons with disabilities. In societies where there is stigma associated with disability, persons with disabilities can be hidden in a back room, subject to violence or persistently under- or malnourished. It is hard to imagine in such contexts, where persons with disabilities are likely to be more disadvantaged, how transfers directed to them could improve their welfare. At the same time, as noted by Sen (1983), an individual's own source of income increases the perceived contribution to the household and the individual's sense of autonomy and thus provides them with a greater bargaining power.

Evidence on intra-household income distribution and disability transfers is very limited. Results would be expected to vary greatly across countries. In South Africa, Schneider *et al* (1999) find that a large proportion of old age and disability pensions are controlled by relatives but does not provide data that is restricted to disability pensioners, nor that is broken down by gender. Of course, the issue of intra-household distribution of resources and disability targeting is not expected to arise in the case of in-kind transfers of assistive devices that would be of little use to relatives without disabilities.

In addition, one could argue that persons with disabilities should receive social safety net transfers on equity grounds given their economic disadvantage. Since disability appears

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<sup>8</sup> For instance, Duflo (2000) shows that old age pensions have a positive impact on children's health when they are received by women in South Africa.

to be a covariate of poverty, given the challenges of observing incomes in means-tested programs, transfers could be made according to the disability status of the person and in combination with other covariates of poverty such as age. This view is often found in the safety net literature (e.g., Devereux (2002b)): like age or gender, disability is considered as a group characteristic that is easier to observe than a person's assets and income in a means test. This assumes that disability is an observable and homogenous phenomenon, while in fact disability is sometimes invisible (e.g., some mental illnesses, pain) and always heterogeneous. It is heterogeneous in so far as there are many types of disabilities and in that a similar health condition or impairment can affect people's lives in very different ways.

A major challenge that arises with targeting programs at persons with disabilities is that the art of disability targeting is a very complicated one. It is extremely difficult to identify the target disability group and developing countries generally lack the administrative capacity that is required to run such targeted programs. Box 2 gives information on the disability test in the social security disability benefit programs in the United States. Indeed, it is, in practice, very difficult to determine whether or not a person is able to work, which is the typical test of eligibility for disability targeted cash transfers. Persons with disabilities form a very heterogeneous group and the challenge of disability targeting is particularly acute in the case of invisible impairments such as lower back pain, or episodic ones such as certain mental illnesses. Therefore, the disability determination process is usually a lengthy and complex individual assessment that requires the provision of detailed medical information and sometimes a visit to a health clinic.

As a consequence, the individual disability assessment is inherently prone to classification errors with some persons who are on the disability rolls not being disabled (inclusion error), while others who are rejected have disabilities (exclusion error). In the United States, some studies have found that a significant portion of Social Security Disability Insurance applicants are not disabled at the time they join the disability rolls, while others are disabled and yet are rejected. These studies are based on disability self-reports (Benitez-Silva *et al* (2004)) and on audit examinations (Nagi (1969)). For instance, preliminary results reported in Benitez-Silva *et al* (2004) are as follows: 58% of those who are denied Disability Insurance benefits are truly disabled, while 22% of those who are awarded benefits are not truly disabled. While the use of disability self-reports may not perfectly measure benefit eligibility (OECD (2003; p. 43), such a study indicates that errors in disability targeting seem to be frequent.

In addition, there is widespread concern that disability benefit programs are subject to fraudulent claims and that fraud plays a role in driving up program costs. For instance, in workers compensation in the United States, Leigh *et al* (2000) analyzed workers' compensation fraud cases in 1999 and estimated that claimant fraud accounts for USD1.2 billion and 2% of the total costs of the program. Such estimates of the extent of fraud in disability targeted programs are scarce. According to a recent survey of disability program administrators in 17 OECD and developing countries (Zeitler (2003)), only five countries (Australia, Brazil, Canada, Netherlands, Philippines) reported fraud on disability

### **Box 2: The Disability Test in the United States**

The two largest disability programs in the United States are the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. SSDI is an insured program that requires past work to qualify while SSI is a means tested program that requires that participants fall below income and asset thresholds. SSDI and SSI both use the same basic disability test to determine who is eligible for program benefits. Social Security employees conduct a *five step disability test*. The first step in the protocol is an *initial work test*. The current work status of applicants is determined. In order to qualify for SSI or SSDI, an applicant must not be currently working at or above an earnings limit of \$810 per month. If current earnings average more than the earnings limit, a person is denied entry into the program. If a person is not earning at or above the earnings limit, their case moves to the second step in the process, a test of the *severity of the disabling condition*. In order to qualify for SSI or SSDI, an applicant must have a condition severe enough to interfere with the basic activities needed for work. If an applicant's condition is judged to be severe enough to interfere with basic work activities, that applicant's case is moved to the third step in the process. The third step is a *medical listings test*. The Social Security Administration maintains a listing of disabling conditions deemed so severe that if an applicant is facing one of these he or she is automatically placed into the SSI or SSDI program. If an applicant is facing a condition not on this list, the disability examiner will attempt to determine if the condition is as severe as a listed condition. If such a match can be made, the applicant is placed into the SSI or SSDI program, if not, they are moved on to the fourth step. The fourth step is the *previous work test*. During this step the applicant is evaluated to determine if they could perform the type of work they did before they became disabled. If an applicant can perform such work, that applicant's claim is denied. If it is determined that the applicant cannot do the work they did prior to becoming disabled, their case is moved on to the final step. The fifth and final step in the process is a more *comprehensive work test*. During this step the applicant is evaluated to determine if they could do any work that exists in the national economy. An applicant's skills, education, age, and experience all factored into this decision. If it is determined that an applicant cannot perform any other work that exists in the national economy, that applicant is placed in the SSDI program. If it determined that there exists some job that the applicant could work at, their claim is denied. This process, from the time of initial contact by an applicant with the Social Security Administration and a final decision takes over 106 days according to data from SSAB (2001). An applicant that is denied entry into the SSI or SSDI program is entitled to appeal this decision.

Source: Szymendera (2004)

benefits as a problem. In general, this concern for fraud in disability benefit programs would be particularly widespread in high-corruption country settings.

Fraud is certainly not restricted to disability targeted transfers, social safety nets of all kinds can be subject to fraud, for instance in the form of so-called "ghost-beneficiaries".

With disability targeted transfers, fraud may take the form of false medical documents and some types of impairments, in particular invisible ones such as back pain or certain mental illnesses, may be more conducive to fraudulent claims. It may also take the form of beneficiaries failing to inform program administrators regarding changes in the severity of their disability and in the level of work earnings. In Zeitzer (2003), disability administrators reported using a multi-prong approach to curb fraud through “greater investigatory and enforcement efforts, enhanced technology and public awareness campaigns.” Poland’s efforts at curbing fraud are briefly described in Box 3.

It is important to note that while it is well known that disability determination processes are replete with errors, not all inclusion errors are the result of fraudulent claims, some may be, but others may result from the large element of subjectivity in the disability determination process. Impairments can be objectively measured, for instance hearing loss, intellectual impairment or vision loss. However, disability is a concept that can be defined in various ways as explained above. If for the administration of a benefit program, disability means an inability to work above an earnings limit, then labor market conditions, prevailing norms and expectations, available technology and the environment will influence the outcome of the determination process.. Some of the personal characteristics of the applicant such as motivation may also tremendously affect the ability to work. Inclusion errors may arise as a result of the subjective nature of the disability assessment as well as fraudulent claims.

Given the difficulty of the disability assessment, disability targeting requires an administrative infrastructure for successful program implementation for the collection of adequate information on beneficiaries and for monitoring disability determination decisions. Such disability targeting infrastructure carries high costs. In the United States, while disability benefits account for only 15% of Social Security’s total benefit payments for its Old-Age, Survivors and Disability Insurance programs, administering the disability benefits accounted for 45% of the agency’s annual administrative expenses (OASDI Trustees (2004)). These administrative costs include the initial screening costs, the costs of delivering benefits and the costs of undertaking periodic assessments to determine if beneficiaries still have disabilities, since some disabilities may be temporary.

Whether or not to provide disability targeted transfers is an empirical issue that can be solved by analyzing a given country’s distributional incidence of disability, administrative capacity and expected administrative costs of disability targeting. If, for instance, persons with disabilities are over represented among the poor, a means test should be able to allow persons with disabilities to capture the benefits.

Given the high cost of disability targeting and the complexity of a disability eligibility test, community-based targeting may come to mind as a simpler way to implement disability targeting: the community may be in a better position than program administrators to determine an inability to work due to an impairment. However, community-based targeting with respect to disability is unlikely to work in communities where persons with disabilities are socially excluded. If persons with disabilities are not part of well identified communities, it is hard to imagine the role that community-based

targeting could play in disability targeting. While it is well known that overall community-based targeting has had mixed results (Devereux (2002b)), it is uncertain whether any community has used disability as part of a poverty targeting mechanism.

We turn below to some targeting issues that arise for different types of social safety nets.

### ***Disability Targeting of Cash and In-kind Transfers***

In principle, transfers targeted at persons with disabilities recognize that some persons have disabilities that are so severe that they will not be able to earn a living even if they have the opportunity to participate in livelihood programs and even if education and employment policies are inclusive. Disability targeted transfers thus provide economic security to this vulnerable group. Nevertheless, it can be argued that transfer programs targeted at persons with disabilities seem to follow a charity view of disability rather than a development perspective to empower and involve persons with disabilities. One way to overcome this problem is to have a highly stringent program that provides support to persons with severe disabilities, but this in turn entails the administrative challenges discussed above.

In addition, a specific disadvantage of disability targeted transfers is that they provide a disincentive to work. This is the case for cash transfers in general but is particularly the case when the test to qualify for transfers is an inability to work as it usually is for disability cash transfers. There is a large body of evidence on the labor disincentive effect of disability cash transfers in high income countries.<sup>9</sup> In the 1990s, interest was in part generated by the steady rise of the disability rolls in countries such as the Netherlands and the United States. Much of this research is focused on benefit levels, screening stringency and exits from the labor force. While little is known about the labor market impact of disability targeted transfers in developing countries, it is important to recognize that the prospect of losing a disability transfer if one were to earn beyond a limit can deter persons with disabilities from working.

Besides work disincentives, a second major concern about providing public cash transfers to persons with disabilities is that they may displace private transfers. The empirical evidence on the impact of public transfers on private transfers is mixed (Ezemenari (1997)). To my knowledge, no evidence is available regarding the crowd out effect of disability transfers specifically. This may be an important issue as private transfers to persons with disabilities may be large in countries where a charity view of disability prevails.

Overall, the consequences of disability cash transfers are poorly understood, given the lack of evaluation effort and data in relation to these programs. One exception is Namibia's disability cash transfer, which was thoroughly evaluated and was found to achieve very little coverage (Subbarao (1996)). More research is needed to understand the consequences of disability cash transfers in terms of their disability targeting and poverty reduction effectiveness.

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<sup>9</sup> A review of this literature can be found in Bound and Burkhauser (1999).

### ***Disability Self-Targeting for In-Kind Transfers***

An alternative to an individual assessment of disability is to design a program where persons with disabilities self-select into programs that provide goods and services that are of no value to persons without disabilities. This would be the case of programs that supply assistive devices or personal assistance for free, or at subsidized prices. Self-targeting to the poor with disabilities can further take place through a selection of goods and services that are unattractive to the non-poor. Assistive device programs are found in a lot of countries and can be administered through self-targeting in combination with a means test (e.g., India) or a disability assessment (e.g., Thailand) (ESCAP (1997)).

An obvious justification for subsidy programs on assistive devices is that they may remove barriers to the participation of persons with disabilities in society and improve employment prospects, which may lead to an increase in earnings and thus provide a rope out of poverty. The use of subsidies on assistive devices has several advantages compared to cash transfers. Received income transfers may be dedicated to purchase food or other basic commodities and may be biased in favor of persons without disabilities in the household. Also, it may well be politically easier to use funds on disability related goods than it is to persuade taxpayers to support income transfers.

In-kind transfers for assistive devices are not a panacea though. While they seem to be appropriate when markets for such commodities are imperfect, one has to make sure that the program does not crowd out private trade and result in an inefficient distribution system. The costs of such distortions need to be kept in mind when designing such programs. In addition, in-kind transfers of assistive devices suffer from high exclusion errors by catering exclusively to persons with mobility, hearing, and seeing impairments; they do not reach out to persons with mental impairments. In addition, in-kind transfers of assistive devices are often not nearly sufficient. This is because they cover a fraction of the need for such devices (and sometimes with poor quality and long delays); for instance, in India (NSSO (2003a; p. A436), only 9% of persons with mobility impairments had acquired assistive devices (e.g., wheelchair, artificial limbs, crutch). In addition, assistive devices are not sufficient because even after getting the most adequate set of assistive devices the livelihood problem will not be solved, especially if overall transportation, education, employment practices are not inclusive.

### ***Disability Targeting of Livelihood Programs***

While there does not seem to have been disability targeted public works programs, there is some experience for targeted micro-finance programs. In developing countries, the ownership of land and capital has tended to be concentrated among the males without disabilities of the household. It is harder for a person with a disability, let alone a woman with a disability, to start an enterprise given the lack of collateral resources. An advantage then of disability targeting for livelihood programs is that it contributes to long-term efficiency by addressing credit market failures that prevent persons with disabilities from accessing growth promoting economic opportunities for investment.

The evidence on the impact of targeted micro-finance programs is limited and mixed so far. Case studies from the targeted micro-finance program in Ethiopia (TDVA *et al*

(2003)) show that the program had a positive impact on the lives of participating women that became disabled during war. In Kenya, the Disabled People Loan Scheme reached 240 persons with disabilities who received loans and business training (Harris (2003)). Such micro-finance or enterprise schemes are not without problems though. Dyer (2004) reports that the impact of targeting micro-finance programs set up by a disability organization, Leonard Cheshire, is bound to be low in terms of the number reached. In addition, as a disability organization, Leonard Cheshire faced challenges in developing and administering micro-finance programs. The administrative costs were very high and loan repayment rates were as low as 65%, while the rate expected for a sustainable micro-finance program is 90%. These disappointing results were attributed to resource constraints, conflicting interests and priorities, and limited technical knowledge for the disability NGOs who developed these targeted micro-finance programs.

All in all, disability targeting represents fundamental challenges for developing countries. Beyond the obvious question of its financial affordability, disability targeting is likely to be infeasible in countries that do not have the administrative capacity to run a disability test of eligibility. Disability targeted micro-finance programs have the disadvantages of reaching a small portion of the population with disabilities and of being administered by disability NGOs that do not have the necessary expertise. The programs where disability targeting seems to be the most feasible are in-kind transfers of assistive devices, although their design excludes persons with mental impairments, and needs to be carefully crafted so as to minimize market distortions.

Disability targeting is not the only way to ensure that persons with disabilities participate in social safety nets. An alternative to disability targeting is to mainstream existing social safety nets so as to include persons with disabilities in these programs.

The rest of this paper is dedicated to identifying ways to mainstream disability in social safety nets in their implementation through the reduction or removal of physical and social barriers and in their design and evaluation. Mainstream safety nets include cash, in-kind transfers and livelihood programs and can be universal or targeted at specific groups, such as poor adults or the elderly.

#### **4. Disability Inclusion by Removing Physical and Social Barriers**

This section deals with the physical and social barriers that prevent persons with disabilities from accessing mainstream social safety nets. The focus is on the implementation of mainstream safety nets, whether they are cash or in-kind transfers or livelihood programs, but some of the issues discussed below may also arise in the context of disability targeted programs.

Access can be defined as a means of approaching or entering a place and as an opportunity or a right to use something or approach somebody. Accessibility is the time, effort and cost, in brief the ease, with which a good, a service or a facility can be reached or used. Accessibility is closely linked to both poverty and disability. It is commonly



acknowledged that a lack of access is an important contributing factor to poverty given that it limits the opportunities that people have to improve their economic well-being. Having a disability creates accessibility challenges, therefore accessibility is one of the mechanisms whereby disability can lead to poverty. The nature of these challenges varies depending on the severity and the type of disability (physical, sensory or mental). As tools to reduce poverty, safety nets need to be accessible to persons with disabilities. If they are inaccessible, social safety nets contribute to exacerbating inequities between persons with and without disabilities.

Accessibility has been a key issue in the debate on mainstreaming disability in development (e.g., Heinicke-Motsch *et al* (2004)), but little consideration has been given to the accessibility of social safety nets. There are a variety of ways in which safety nets may not be accessible to persons with disabilities. There may be physical and social barriers in the implementation of safety nets as well as obstacles that result from the very design of the social safety net. This section deals with accessibility in the implementation of social safety nets and more specifically in their physical and social environments and through communication. Design issues will be addressed in the next section.

### ***Physical Accessibility and Transport***

Some persons with physical, sensory or mental impairments may not have access to programs because they cannot physically get to the centers that provide information on eligibility, application and receipt procedures for benefits and services. They cannot physically access those centers.

Physical accessibility is determined by the location of the households, the location of the good, service or facility they need to reach and the transport system that allows travel from the former to the latter. In developing countries, various local conditions may make the regional distribution of a safety net's benefits or services more challenging for persons with disabilities. Some of the transport takes place on foot, and in rural and remote areas, much of it takes place away from the main road network. Short distances but mountainous terrains in countries like Nepal and Bhutan make the time required to travel to a safety net delivery center very long. In large countries, the distance a person must travel to reach the nearest center may be prohibitive for persons with disabilities. This is because of the cost involved in travel as well as the loss of income from work for those who accompany them. The lack of physical access and means of transportation to local program facilities delivering transfers or services may result in an inability to participate in existing social safety net programs.

How can physical accessibility be improved? Ideally, for a country's system of delivery to be inclusive, it has to be decentralized with a good infrastructure and transportation system. Of course, with the limited resources available in developing countries, it is not feasible to try to achieve a decentralized and accessible infrastructure and transport network. There is a need to find innovative solutions in program delivery that are easier and cheaper to implement. Countries that have public works programs need to ensure that, if appropriate, the infrastructure that is built is accessible by persons with disabilities.

More importantly, governments can adopt a policy and legislative framework of making new structures and public transportation facilities accessible to persons with disabilities, which will avoid the cost of retrofitting buildings and facilities in the future.

In the case of cash transfers, as long as benefits cannot be paid into bank accounts, the receipt of benefits poses challenges for persons with disabilities. In the case of in-kind transfers of goods (e.g., food), collecting benefits may be difficult or impossible for persons with physical disabilities. Accessibility may be achieved indirectly by allowing persons with disabilities to freely choose representatives to receive benefits. Of course, given that benefits are fungible, the cash transfers may never reach the actual beneficiaries. An effective system of registration and identity check for proxies needs to be in place to minimize fraud. Alternatives to the use of proxies for the delivery of cash or food transfers include the use of mobile teams or a less frequent system of delivery to cut the transportation costs of persons with disabilities and their caretakers, as well as the risk of being robbed on the way to the delivery center or vehicle. For example, some provinces in South Africa made the delivery of social pensions and grants on a bimonthly rather than on a monthly basis (Lund (1993)).

How does one assess if a particular safety net is physically accessible to persons with disabilities? An analysis of a country's infrastructure and transport system is a starting point. It is also important to analyze the regional distribution of program eligibles and recipients with disabilities. Such data is often not available, in particular for program eligibles. A largely skewed distribution of recipients with disabilities across regions may provide enough information to diagnose the lack of physical accessibility of a program<sup>10</sup>. Finally, it would be important to conduct an analysis of the deficiencies of the regulatory framework for accessibility and the built environment. SAHRC (2002) provides an example of such an analysis for the case of South Africa.

### ***Communication and Social Barriers***

Having access physically to the advice and delivery centers is not sufficient to get access to the programs. There may be communication and social barriers between persons with disabilities and program staff. For persons with sensory impairments, information about the program procedures for application, registration and payment need to be available in alternative formats (e.g., non-print and large print versions of print materials on the programs). Besides the need for information in alternative formats, illiteracy constitutes another barrier to program access for persons with disabilities. Disability is indeed associated with illiteracy in developing countries for different reasons, including exclusive educational systems. Therefore, program staff may need to use person centered methods to communicate with poor communities. Some countries are currently testing methods such as drawings.

In addition, there may be a lack of sensitivity among program personnel about disability matters, including confused perceptions on persons with disabilities as medical cases rather than as persons with entitlements. An information campaign and training on

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<sup>10</sup> See Subbarao (1996) in the case of Namibia.

disability, as well as the employment of persons with disabilities among the staff of the advice and delivery centers, would serve a useful purpose. It would raise awareness and foster an attitude of respect for the rights of persons with disabilities and promote an image of persons with disabilities as capable and contributing members of society. The expertise of disability organizations may be useful in developing public information campaigns and staff training programs. Suggested topics that would need to be covered include basic disability awareness and etiquette and delivering accessible services. Similarly, disability organizations should be trained on the benefits and services provided through safety nets.

Program delivery centers are also a logical place to have information on disability targeted programs such as those providing subsidized assistive devices and personal assistance, or links with community-based rehabilitation organizations. However, it is important that staff do not present these services or benefits as the only options available for persons with disabilities. People with disabilities are entitled to the same full range of mainstream core services as persons without disabilities.

However, program delivery centers may be inaccessible to persons with disabilities, may be difficult to locate and contact, and may have limited ability to find information to apply for benefits. Outreach programs may be needed to better spread information regarding social safety nets among the eligible with disabilities. Among those who may benefit the most from such outreach programs are homeless persons with disabilities who do not have family members to assist them in applying for benefits. In the United States, the Social Security Administration ran an outreach program in the 1990s to attempt to better meet the needs of the homeless with mental illnesses who may be eligible for the Supplemental Security Income. Various outreach activities were undertaken (Committee on Ways and Means (2000)): for instance, local service agencies, soup kitchens, shelters and churches screened homeless persons for potential eligibility, referred them to the Social Security Administration and helped them through the application process.

Overall, there is no one solution to enhance the accessibility of safety net delivery and advice centers. Every country needs to devise a set of solutions that is tailored to local conditions, in particular with due consideration of the existing infrastructure and transport network and delivery system for safety nets, available resources, the geographic distribution of program eligibles and recipients with disabilities, and existing awareness with respect to disability. One cannot over-emphasize the importance of understanding the socio-cultural context of each country, and in particular attitudes toward persons with disabilities that may act as barriers to their participation in safety nets.

## **5. Disability Inclusion in the Design and Evaluation of Mainstream Social Safety Nets**

This section deals with how mainstream social safety nets need to be carefully designed so as to be inclusive. Of particular importance is assessing whether the cost to apply for benefits is high for persons with disabilities (e.g. in terms of documentation

requirements). The cost to apply and collect benefits is tied in with physical and social accessibility issues, which were discussed earlier. Eligibility requirements

### ***Extra costs of disability and their implications***

While explaining the relation between disability and poverty, the extra costs of disability were described earlier as contributing to the poverty of persons with disabilities. Additional costs associated with disability can consist of two types of costs: (i) additional expenditures on items that persons without disabilities also purchase (such as transportation, food, and health care), and (ii) expenditures on items specifically related to disability (e.g., communication aids, modification of a home or vehicle). In practice, there is no clear distinction between these two types of costs. Large scale household expenditure surveys capture costs under (i) but also have a portion of those under (ii). Studies using household and individual expenditure data sets may assess the level of additional costs associated with disability.

An evaluation of the extra costs of disability is important to policy makers. Providing estimates of disability-related expenditures allows policy makers to assess the adequacy of the levels of means tests, and whether a different means test needs to be applied to persons with disabilities. If costs associated with a disability are significant, then applying the same means test at program entry to persons with disabilities would imply that persons with disabilities would need to be more deprived than persons without disabilities in order to access a benefit program.

Providing estimates of disability-related expenditures also allows the policy makers to assess the extent of poverty for persons with disabilities and the adequacy of benefit levels. The US Social Security Administration (SSA) (2000; p. 119) reports annually on the poverty status of disabled beneficiaries by applying the standard poverty threshold to SSDI and SSI beneficiaries. SSA's assessment assumes that the minimum standard of resources encapsulated in the poverty threshold is sufficient to meet the needs of persons with disabilities.

Applying a different means test or providing a higher or separate benefit to account for the extra costs associate with a disability requires establishing a disability determination process. This process may take the form of an individualized assessment of the needs of the person given that the additional costs of living with a disability vary with the severity and the type of disability.

It may be that benefit amounts should be higher for persons with disabilities to reach the same standard of living as persons without disabilities. A possibility to address the extra costs of disability is to provide allowances as part of stand alone programs that compensate for disability related expenditures. In Sweden, special allowances are provided for a wide range of disability related costs, including durable medical equipment, attendant care and a modified automobile (Zeitser 2002; p. 256)). In Great Britain, the so-called "disability living allowance" compensates for the extra costs incurred due to the effects of a disability (Mitra *et al.*, 2004). The allowance has two components, a care component and a mobility component and is provided on a temporary

or a permanent basis, irrespective of the work status of the person. The amount of the allowance is determined on the basis of an individual assessment of the needs of the person.

A necessity before such programs can be established is to measure the extra costs of disability and the major sources of these extra costs, which is likely to vary from country to country and may be constrained by the absence of disability flags in household consumption surveys.

### ***Eligibility Requirements***

In addition, the program needs to be designed in such a way that eligibility requirements do not indirectly exclude persons with disabilities. This challenge is likely to vary across different types of safety nets. Whether we are dealing with programs with work requirements (income generation programs), programs with behavioral conditions (conditional cash transfers) or standard cash transfers will make the challenge of designing an inclusive program quite different. Two examples are discussed in detail below: income generation programs and conditional cash transfers.

#### *- Income generation programs*

For livelihood programs, as noted earlier, making the registration and service delivery centers accessible is an important component of an inclusive social safety net. However, this may be a necessary but not a sufficient condition to make the programs accessible.

In public works programs, the very nature of the work, often heavy manual labor, is likely to exclude a large portion of persons with physical disabilities. Disability quotas can be introduced in an attempt to ensure that persons with disabilities can benefit directly from employment creation but could backfire in different ways. Experiences from several high income countries show that quotas are difficult to enforce and are administratively burdensome (OECD (2003)). In order to increase the participation of persons with physical disabilities, it may be possible (depending on the nature of the program) to expand the scope of public works to include tasks that are less physically demanding, and to give priority to persons with physical disabilities for the realization of these tasks. This expansion of tasks in public works program has also been recommended as a way to increase the participation of women in such projects (ESCAP (2003, p. 28)).

More generally, the place where persons are going to work, whether it is a large construction site or a market place also needs to be accessible. Such accessibility comes at a cost for persons with disabilities. Persons with disabilities in Kampala noted: “The physical facilities in markets are not conducive to disabled people’s work. In order, for example, to be able to make bulk purchases from the market a disabled person needs to take along with him/her an assistant, which increases the operating costs for disabled persons” (Lwanga-Ntale (2003; p. 10). Making such places accessible is beyond of the scope of designing an inclusive social safety net.

There are other areas where innovations in the design of the safety nets may provide some solutions at promoting disability inclusion. One way is to establish linkages

between livelihood programs and disability targeted programs such as assistive devices, personal assistance and vocational rehabilitation programs. Conditional in-kind transfers for assistive devices or personal assistance can provide an incentive to persons with disabilities to participate in livelihood programs. The person is given a free or subsidized assistive device or personal assistance if she agrees to participate in livelihood programs. For instance, in the United States, some states have programs whereby persons with physical disabilities receive personal assistance services if such services are going to make it possible for the person to work, attend school or vocational training or participate in volunteer activities.

Such conditional in-kind transfers would require that livelihood programs are designed in such a way that persons with disabilities qualify for the programs. This is particularly relevant for micro-finance programs that sometimes require applicants to demonstrate business management skills or work experience. For persons with disabilities who may have not been able to access employment or schools in the past, the participation in a vocational rehabilitation program could be used as a substitute for work experience or education required.

#### *- Conditional Cash Transfers*

For cash and in-kind transfers, making delivery and advice centers physically and socially accessible seems to be the essential requirement for making such programs inclusive. For some of these transfer programs though, disability needs to be incorporated into the very design of the programs so that persons with disabilities are not excluded. This is the case for conditional cash transfers. Conditional cash transfers (CCTs) are a new type of social safety net that provides cash to poor families conditional on certain behaviors. CCTs are certainly not the mainstay of social safety nets. However, because they are currently the subject of much discussion in development, and because they raise interesting design challenges in disability inclusion, the example of CCTs is detailed below.

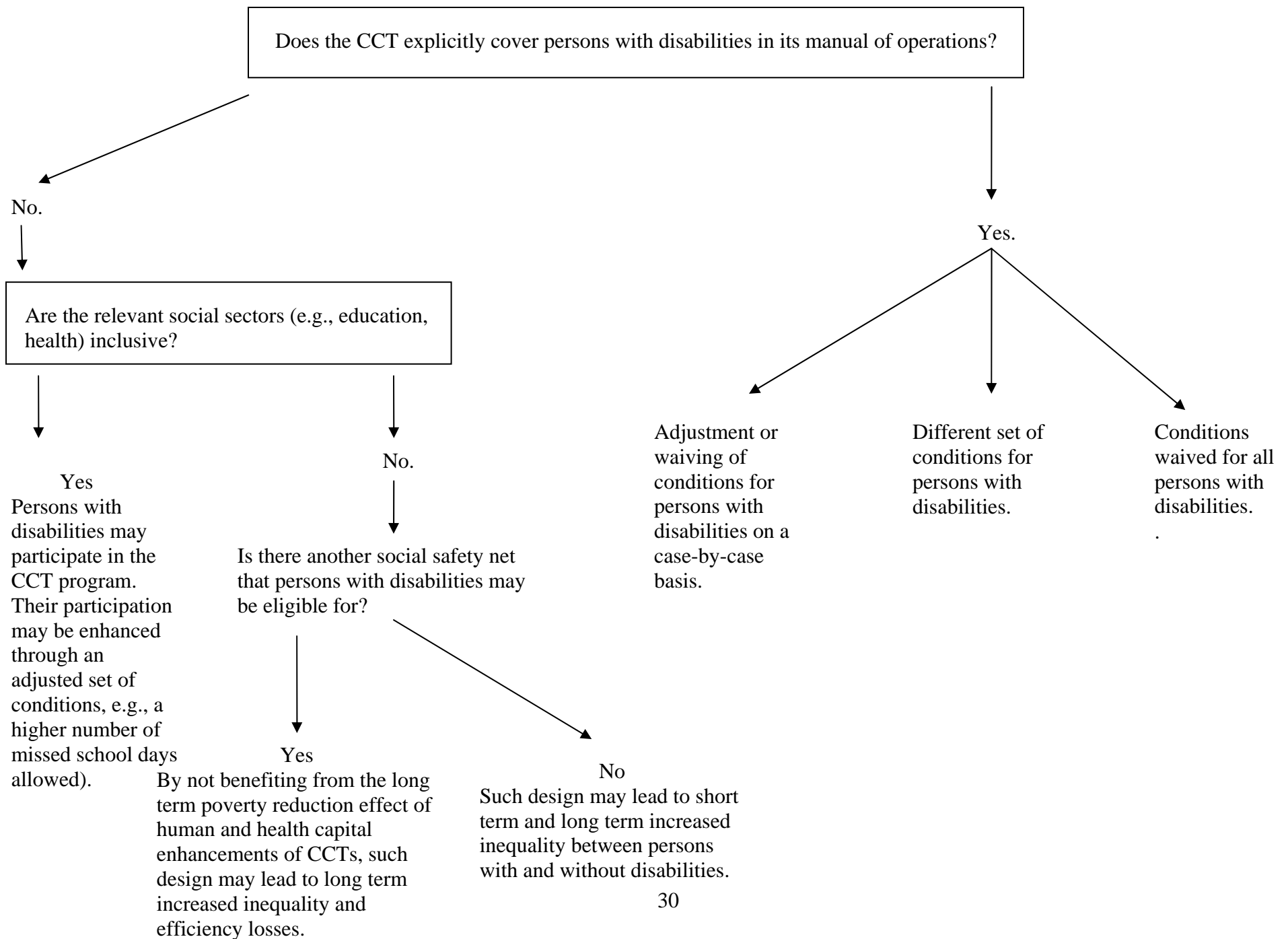
The cash transfer aims at alleviating poverty in the short term, while the conditions enhance human or health capital, especially for children, and are thus expected to have a long-term poverty reduction impact. Several countries have adopted conditional cash transfer programs in recent years and have had positive results (e.g., Gertler (2004)<sup>11</sup>). They include Bolsa Escola in Brazil, SUF in Chile, PRAF in Honduras, Progresá (now Oportunidades) in Mexico, PATH in Jamaica, food for education in Bangladesh, and the conditional cash transfer program in Turkey.

Whether such programs are disability inclusive remains an unanswered question, and what follows is a first attempt to bring an answer. Figure 1 presents a framework for assessing the disability inclusiveness of CCT programs. It starts with the assessment of whether the program explicitly refers to persons with disabilities in its manual of

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<sup>11</sup> Rawlings (2004) provides a review of conditional cash transfer programs in Latin America.

**Figure 1: A Framework for the Assessment of Disability Inclusion in Conditional Cash Transfers**



operation. In a lot of CCTs (e.g., Colombia, Brazil, Turkey), persons with disabilities have not been explicitly considered as potential participants. Like persons without disabilities, persons with disabilities may participate if they meet the eligibility criteria and fulfill the conditions of the transfer. If the social sector (e.g., education, health) in which the CCT conditions take place is not inclusive, then the CCT program will not reach persons with disabilities. Often though, in developing countries, sectors such as health and education are not inclusive. Schools are often inaccessible for persons with physical or sensory disabilities and students with mental disabilities who go to school may be ignored (Lwanga-Ntale (2003)). The access to health clinics is problematic for persons with physical disabilities, and health staff are not trained to communicate with persons with sensory disabilities. For persons with mental disabilities, psychiatric drugs are often not available in hospitals, and workers in local health units are not trained to respond to cases of depression or early signs of mental illness.

If persons with disabilities cannot participate in CCTs due to exclusive education and health sectors, and if they can access another cash transfer program, they will not be induced to participate in the CCT program and will lose the impact of the human and health capital enhancements that are expected from the conditions. For instance, in Brazil, persons with disabilities are not explicitly recognized in Bolsa Escola, but they may access the means-tested cash transfer program targeted at persons with disabilities (BPC-LOAS). If persons with disabilities cannot access another cash transfer program, the lack of disability inclusiveness of the CCT would have no poverty alleviation impact among persons with disabilities and may well exacerbate inequality between persons with and without disabilities.

It first appears that a prerequisite for CCTs to reach the poor with disabilities is that the facilities that deliver the services that are part of the conditions, typically schools and clinics, are inclusive. Making mainstream cash transfers conditional on investments in education and health inclusive appears to require making the education and health sectors inclusive, which is beyond the scope of this paper. There may be other ways to adjust conditional cash transfer programs to make them disability inclusive, which is what is explored below.

One way to ensure that persons with disabilities are not excluded from CCT programs is to explicitly recognize them as possible beneficiaries. One challenge this presents is the design and implementation of a disability test, as discussed earlier in section 3. In a way, this implies disability targeting, not in one specialist program, but in a mainstream program so that the program is applied to persons with disabilities in an adjusted manner. The disability test would not need to be as elaborate as in a disability specialist program, say a disability targeted cash transfer program where disability is part of key eligibility criteria. However, it would need to be sophisticated enough to determine if the program needs to apply to a person differently due to a disability.

Another challenge deals with how to apply conditions to persons with disabilities. Once they are explicitly recognized, conditions can be waived, as in Palestine and in pilot programs in Mozambique and Swaziland. This approach of waiving conditions has the



advantage of having persons with disabilities receive cash benefits, which would be particularly important in countries where the CCT is established as a substitute for a previous unconditional social assistance program, or where there is no other social assistance program that may reach persons with disabilities. However, this approach does not allow persons with disabilities to develop their health and human capital as a result of the conditions, which may in turn exacerbate inequalities between persons with and without disabilities in the long run. The health grant of Jamaica's PATH program follows an approach that appears to limit such negative consequences. In this program, conditions are waived for persons with disabilities on a case by case basis by the social worker depending on the type of disability of the individual and on the accessibility of his or her local clinic. More information on the Jamaica program is available in Box 3.

**Box 3: Improving Accountability in Disability Determination in Poland**

The disability determination decision is made by medical experts of the social insurance institution (ZUS). In 1997, as part of efforts to reform the disability pension program, the authority and accountability of medical experts was increased. The disability determination decision stopped being the responsibility of a medical board consisting of several members, but instead became the responsibility of one person: a medical expert from ZUS. The medical expert is under the supervision of a Chief Physician, who ensures compliance with medical determination rules.

Sources: Woycicka, Ruzik and Zalewska (2002) and Hoopengardner (2001)

When persons with disabilities are explicitly recognized in a CCT, conditions do not necessarily need to be waived. They may also be adjusted to reflect the different constraints a person with a disability faces in order to go to school or to a clinic. For instance, a higher number of missed school days could be allowed for children with disabilities. To our knowledge, there have not been any CCTs with adjusted conditions for children and persons with disabilities.

If CCT programs are designed in such a way that more persons with disabilities are induced to participate in education and health services (for instance through adjusted conditions), there is a need to provide some support on the supply side to schools and health centers to ensure an adequate supply of education and health services for persons with disabilities. The design of inclusive CCT programs needs to be coordinated with the overall disability inclusion policies in health and education.

It could also be that the conditions that apply to persons with disabilities are entirely different from the ones that apply to persons without disabilities, although this is yet to take place. One way is to link conditional cash transfer programs with in-kind transfers of assistive devices and personal assistance for children with disabilities. This would allow not all but certainly a portion of children with disabilities to participate in such programs. Another possibility is to provide parents of children with disabilities who need personal assistance while at school to be entitled to a disability bonus in the transfer that compensates parents for the time spent with their children at school. There may also be

**Box 4: Jamaica's CCT program and Persons with Disabilities**

Jamaica's Program of Advancement through Health and Education (PATH) is a means-tested conditional cash transfer (CCT) program that was established in 2001 as a consolidation of three safety nets (food stamps, public assistance and out-door relief). It has two components: an education grant for parents of children aged 6 to 17 years in school and a health grant for children up to the age of 59 months, pregnant and lactating women and adults (poor adults, elderly, and disabled). The education grant does not explicitly consider children with disabilities, whereas in the health grant, adults and children with disabilities are part of a separate category: 'the disabled'. In order to be considered disabled, a person needs to be certified by the National Council for Persons with Disabilities as being permanently disabled. Children with disabilities are children that have disabilities that are so severe that they cannot attend school, and thus fall under the disabled category in the health grant. The person with disability does not have to apply, enroll or receive benefits in person. A family representative, typically the adult female in charge of the family, will submit all the required documentation for application, will attend enrollment and collect benefits on behalf of the family. The conditions to receive the health grant are to attend a public health clinic twice a year, six months apart.

The Jamaica CCT program is designed in such a way that it does not exclude children and persons with disabilities. Children with disabilities who attend school can be covered by the education grant, and like other children, if they miss school due to illness, they are not deemed non-compliant. Children with disabilities who do not attend school and adults with disabilities may receive a health grant. The decision to waive conditionalities for the health grant is made by the social worker on a case-by-case basis depending on the type of disability of the person and the accessibility of the nearest clinic.

One could argue though that a limitation of the program is that it does not attempt to induce parents to send children with disabilities to school. As a result it appears that the PATH program may not have an impact in terms of human capital enhancement on households with disabilities as it may have for households without disabilities.

scope for developing conditional cash transfers in other fields that may enhance the human capital of persons with disabilities, such as vocational rehabilitation and training. In some high-income countries, the receipt of cash transfers by persons with disabilities is conditional on the beneficiary's participation in vocational rehabilitation services (e.g., Spain (OECD (2003))). Of course, a precondition for developing such programs is to have local vocational rehabilitation resources, as part of institutional or community based rehabilitation programs. In the past two decades, community-based rehabilitation (CBR) schemes have increasingly been adopted in developing countries and have been implemented by government, communities, and development or disability focused NGOs. The primary objective of CBR is to improve the lives of persons with disabilities who live in poverty. One major unknown quantity in considering conditional cash transfer programs with a vocational rehabilitation conditionality is that, as opposed to education and health, evidence on the effectiveness of vocational rehabilitation programs in labor

market integration and poverty reduction is scarce and inconclusive<sup>12</sup>. For CBR programs, their ability to empower persons with disabilities is a controversial matter (Lang (1999)) and is likely to be heterogeneous across communities. While a few studies have shown the positive impact of CBR programs on the lives of participants (Hellander (1993)), there has not been any systematic quantitative evaluation of the impact of CBR programs on poverty.

There is no easy way to make persons with disabilities participate in CCTs. In testimony of this challenge, a lot of governments have changed or are in the process of changing the way they deal with persons with disabilities in their CCT programs. For example, in the original program in Colombia, persons with disabilities were not explicitly mentioned. The Government of Colombia is now in the process of revising its program to include persons with disabilities by waiving conditions for them.

Waiving conditions seems to be the preferred strategy adopted by governments so far. It seems to be a reasonable short term solution since it has the advantage of enabling the poor with disabilities to access cash transfers, especially when there is no other social assistance program in place. However, waiving conditions is not a panacea and comes with notable equity and efficiency problems. If persons with disabilities are not induced to invest in human and health capital, the long term poverty reduction effect that is expected from this investment is not achievable for this group. Inequality between persons with and without disabilities is thus likely to be enhanced, and participation in society by persons with disabilities would not be encouraged. In addition, to maximize the efficiency of CCT programs, transfers need to be made to children who are unlikely to go to school without the transfer (Sadoulet and de Janvry (2004)) and to children and adults who are least likely to go to health clinics. In most developing countries, children with disabilities are unlikely to go to school, and children and adults with disabilities have limited access to health care services. Therefore, the efficiency of CCT programs could be enhanced by covering children with disabilities in education grants and both children and adults with disabilities in health grants. All in all, there are efficiency costs associated with not covering children and adults with disabilities in CCTs, either by not explicitly recognizing persons with disabilities in CCT programs or by systematically waiving conditions. Providing adjusted or new sets of conditions for persons with disabilities appears to be a way to design more equitable and efficient programs.

### ***Inclusion in Program Evaluation***

As part of a social safety net evaluation, persons with disabilities need to be included in qualitative studies, in all of their analytical components including focus groups and semi-structured interviews.

In addition, it is impossible to over-emphasize the importance of collecting adequate statistics on disability. Different disability definitions (e.g., impairment, activity limitations, work limitation) need to be used in surveys so as to assess the sensitivity of the results to the selection of a disability definition. If adequate statistics are collected

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<sup>12</sup> OECD (2003; p. 112) explains the challenges of conducting such evaluations.

regarding disability status, then it will be possible to conduct a coverage analysis and an impact evaluation for persons with and without disabilities.

The program impact evaluation will evaluate a program's impact on persons with disabilities in terms of poverty reduction. In this assessment, specific attention needs to be paid to women and girls with disabilities and to inequality between persons with and without disabilities. As noted earlier, if a social safety net is not inclusive, by reaching persons without disabilities and not persons with disabilities, it may well strengthen inequality between the two groups.

### ***Assessing Disability Inclusion***

If a government aims at making social safety nets more disability inclusive, a starting point is to make a baseline evaluation of how inclusive its safety nets are. Below are some guidelines on how to conduct such an assessment. It is intended for mainstream social safety nets and evaluating how they reach persons with disabilities, but it could also be useful in assessing programs that are targeted at persons with disabilities and how they may be improved to increase their coverage.

Table 4 presents the different dimensions of a disability inclusion assessment. It recapitulates the main issues covered in sections four and five above and gives the analytical tools that can be used to assess the different aspects of disability inclusion. At the implementation level, inclusion takes place by making a program physically and socially accessible for persons with disabilities, and by ensuring that appropriate communication tools are in place. Whether this is the case can be assessed through the direct observation of the built environment and a review of a program's manual of operation, information materials and administrative data, if available. Administrative data can be useful to measure the distribution of beneficiaries by area and type of impairment, and identify any particular barriers to inclusion in certain regions or for some types of impairments. Semi-structured interviews and focus groups with beneficiaries, eligible individuals and program staff can also facilitate the identification of social barriers to program participation.

**Table 4: A framework for the Assessment of Disability Inclusion in Social Safety Nets (SSN)**

<b>Several Dimensions:</b>	<b>Relevant Analytical Tools:</b>
<p><b>1. Program Implementation</b></p> <p><b>1.a Physical Accessibility</b></p> <ul style="list-style-type: none"> <li>• accessibility of built environment, including SSN facilities and transport system.</li> <li>• can social workers go and visit persons with disabilities?</li> <li>• can a family representative apply, enroll and receive benefits on behalf of a person with disability?</li> <li>• are there any geographical asymmetries in program coverage (by region, urban vs. rural)?</li> </ul> <p><b>1.b Communication and Social Accessibility</b></p> <ul style="list-style-type: none"> <li>• is program information available in different formats (e.g., Braille)?</li> <li>• how does the program deal with illiteracy among potential and actual beneficiaries?</li> <li>• is program information delivered through different channels besides the government (media, community)?</li> <li>• do the attitudes of SSN staff prevent or discourage access to benefits for persons with disabilities?</li> <li>• do some of the SSN staff have disabilities?</li> </ul>	<p>Direct observation and review of program’s manual of operation. Administrative data on beneficiaries, if available. Analysis of legislative framework.</p> <p>Review of existing information materials; semi-structured interviews and focus group discussion with current and potential beneficiaries with disabilities and with program staff.</p>
<p><b>2. Program Design</b></p> <ul style="list-style-type: none"> <li>• is the cost to apply or collect benefits high for persons with disabilities?</li> <li>• are some of the eligibility conditions difficult to meet for persons with disabilities?</li> </ul>	<p>Semi-structured interviews and focus group discussion with current and potential beneficiaries with disabilities. Desk review and analysis.</p>
<p><b>3. Program Evaluation</b></p> <p><b>3.a Program Coverage</b></p> <ul style="list-style-type: none"> <li>• what is the proportion of eligibles with disabilities that participate in the program?</li> <li>• what are the profiles of participants with disabilities compared to non-participant eligibles with disabilities (e.g., demographic characteristics, type of impairment)?</li> </ul> <p><b>3.b Program’s Impact on Poverty</b></p> <ul style="list-style-type: none"> <li>• what poverty alleviation and reduction impact does the program have on persons with disabilities?</li> </ul> <p><b>3.c Program’s Impact on Inequality</b></p> <ul style="list-style-type: none"> <li>• how does this poverty alleviation and reduction impact compare to the one that is found for persons without disabilities?</li> </ul>	<p>Household data collection and analysis.</p> <p>Household data collection and analysis.</p> <p>Household data collection and analysis.</p>

At the design level, an analysis of the cost to apply for benefits for persons with disabilities and of the eligibility conditions that may be difficult to meet for persons with disabilities. This can be done through desk review and analysis and can be enhanced through semi-structured interviews and focus groups of current and potential beneficiaries.

The program's coverage of persons with disabilities is an important part of the inclusion assessment. If for instance a country has a disability prevalence rate of 10% and if among its cash transfer recipients, only 2% report having disabilities, it may indicate that the coverage of persons with disabilities is inadequate. In order to study coverage more closely, household survey data is necessary regarding benefit receipt, benefit eligibility (e.g., income) and disability status.

Finally, at the outcome evaluation stage it is essential that household data include information on disability prevalence, so as to enable a comparison of the program poverty reduction impact on persons with and without disabilities and to derive implications regarding inequality between the two groups.

Following this baseline evaluation, each government may then develop a disability inclusion strategy, which needs to be consistent with the country's overall disability policy. This strategy needs to be put in place in such a way that the rigorous evaluation of the disability inclusion measures that are implemented is made possible.

## **6. Disability Targeting versus/and Mainstreaming**

### ***Targeting versus Mainstreaming***

The advantages and disadvantages of disability targeting versus disability mainstreaming are presented in Table 5. The advantages and disadvantages of targeting were discussed earlier in section three. As opposed to disability targeting, disability mainstreaming has the advantage of low levels of added administrative capacity and costs, as well as the potential to reach a large portion of the poor with disabilities. Moreover, disability mainstreaming may help promote an overall culture of inclusiveness with respect to disability, which leads to better social integration and participation. However, one disadvantage of disability mainstreaming in social safety nets is that progress may be slow, especially in countries with no overall disability policy or legislative framework and when barriers to inclusiveness are social ones. In such a context, years could indeed be required before attitudes toward disability change so that a person with a disability is considered as an individual with entitlements.

**Table 5: Disability Targeting versus Disability Mainstreaming in Social Safety Nets**

<b>Disability Targeting</b>	<b>Disability Mainstreaming</b>
<p><b>Advantages</b></p> <ul style="list-style-type: none"> <li>• Improves the bargaining position of the person with disability within the household.</li> </ul>	<p><b>Disadvantages</b></p> <ul style="list-style-type: none"> <li>• May be effective only in the long run, especially when it comes to bringing down some of the social barriers of the program.</li> </ul>
<p><b>Disadvantages</b></p> <ul style="list-style-type: none"> <li>• High level of additional administrative capacity required.</li> <li>• High level of additional administrative costs, which reduces funds available for transfers.</li> <li>• May promote segregation versus inclusiveness by providing persons with disability with a separate special program</li> <li>• May affect only a portion of the poor with disabilities, those that meet the disability test in place.</li> </ul>	<p><b>Advantages</b></p> <ul style="list-style-type: none"> <li>• Low level of additional administrative capacity required.</li> <li>• Low level of additional administrative costs.</li> <li>• Promotes inclusiveness versus segregation for persons with disabilities.</li> <li>• Has the potential to affect a large portion of the poor with disabilities.</li> </ul>

From a political economy standpoint, support for disability targeted safety nets may come about as persons with disabilities may be considered as particularly deserving, especially in societies whether the charity model of disability prevails. At the same time, the very forces that lead to the exclusion of persons with disabilities could contribute to having disability targeted programs compete strongly for resources and end up under-funded.

Overall, it seems reasonable to say that disability targeting cannot be considered as the main instrument for poverty reduction for persons with disabilities in developing countries. Disability mainstreaming is more likely to be a suitable approach to follow, given the administrative and financial resources needed for disability targeting. Of course, in practice, the assessment of disability targeting versus disability mainstreaming needs to be made on a country by country basis, and the political and socio-economic background of a country will loom large in this assessment.

***Mainstreaming with a pinch of Targeting***

It is also important to realize that disability targeting and mainstreaming are not necessarily exclusive strategies. This seems contradictory following the discussion above of the advantages and disadvantages of each strategy. For example, a public works program can be mainstreamed in such a way that some of the facilities of the program (e.g., the place where individuals apply to participate) are made physically accessible. In addition, the conditions to participate in the program, such as the type of work to be done, could be altered for persons with physical disabilities. In this case, a targeting system

needs to be established within a mainstream program to identify persons with physical disabilities.

In a mainstream safety net, some amount of disability targeting may apply to conditions of eligibility, so that the safety net reaches persons with disabilities. Whether or not persons with disabilities may participate in the program will largely depend on how the disability test is implemented as part of the program where persons with disabilities are unlikely to meet standard eligibility requirements as described in section five above for livelihood programs.

Some amount of disability targeting may also apply to the types of services received or the benefit levels to account for the extra costs of disability. Here, disability targeting as part of the safety net will help improve the welfare of persons with disabilities by better serving their service and financial needs.

The disability test in a mainstream program is likely not to be as elaborate as in a disability targeted program as it will be part of a broader benefit eligibility system. The administration that runs the safety net program may be able to delegate the disability test to another institution with disability determination expertise. This is the case in Jamaica's CCT program where the National Council for Persons with Disabilities certifies whether a person has a disability.

## **7. Conclusions**

This paper attempted to provide principles for guiding the implementation, design and evaluation of social safety nets so that persons with disabilities are not excluded from such programs. There is very little empirical knowledge on the relation between poverty and disability and the impact of social safety nets on the welfare of persons with disabilities. There is also very little evidence on what works and what does not in terms of disability inclusive policies for social safety nets, and therefore a lot of the guidelines in this paper are based more on reason than on evidence. This paper covered both disability targeted programs and disability inclusion in mainstream safety nets, and the main conclusions are listed below.

- One way to reach persons with disabilities is to target the safety nets based on disability. However, a major challenge that arises with targeting programs at persons with disabilities is that the art of disability targeting is a very complicated one. It is, in practice, very difficult and costly to determine whether or not a person is able to work, which is the typical test of eligibility for disability targeted cash transfers. Developing countries generally lack the administrative capacity that is required to run such targeted programs.
- Of course disability inclusion does not require developing or improving disability targeted safety nets. Making mainstream programs disability inclusive is likely to be the most feasible way for social safety nets in most developing countries to reach persons with disabilities.



- Making mainstream safety nets inclusive can start with an assessment of disability inclusion of the safety nets in their implementation, design and evaluation. It is key to identify the physical, social and communication barriers that prevent the inclusion of persons with disabilities in safety nets in each country. In addition, it is necessary to identify the program's eligibility requirements that may indirectly contribute to exclude persons with disabilities.
- In section five above, we focused on an example of safety nets, conditional cash transfers (CCT) and whether their design is disability inclusive. We found that CCTs have so far failed to adequately include persons with disabilities. Even when persons with disabilities are explicitly recognized in CCT operational manuals, most governments in fact systematically waive health and human capital conditions, which is likely to have negative long term implications in terms of both equity and efficiency.
- At the design level, mainstream safety nets may become more accessible to persons with disabilities through linkages with disability targeted programs for the provision of assistive devices, personal assistance and vocational rehabilitation services.
- At the program evaluation stage, it is impossible to over-emphasize the importance of collecting adequate statistics on disability in order to evaluate a program's processes and impact on persons with and without disabilities. Such statistics would also enable monitoring of the effectiveness of new disability inclusion measures.
- Disability targeting and mainstreaming are not necessarily to be considered as alternative strategies. Mainstream safety nets may need to be designed with some element of disability targeting in their conditions of eligibility, benefit levels or services provided to better reach and serve persons with disabilities.

Finally, there is a need for more research in the area of disability and social safety nets to inform policy development and further explore some of the preliminary guidelines given in this paper.

- With regard to disability targeted transfers, it is important to refine our understanding of the poverty reduction impact of such programs, as well as their indirect impact on labor force participation for persons with disabilities. For instance, a cross-country evaluation of the coverage and adequacy of the benefits of disability social insurance and social assistance programs would be useful in refining our understanding of the welfare impact of such programs on persons with disabilities.
- As for mainstream social safety nets, it is important to assess the baseline disability inclusiveness of social safety nets in specific countries and the effectiveness of new inclusion measures. New inclusion measures needs to be implemented in a framework that allows the conduct of rigorous evaluations.

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