

Seeds to Inclusion

What We Know and Don't Know about Disability Policy

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**Cataloging-in-Publication data provided by the
Inter-American Development Bank
Felipe Herrera Library**

Duryea, Suzanne.

Seeds to inclusion: what we know and don't know about disability policy / Suzanne Duryea, Claudia Martínez A., María Antonella Pereira

p. cm.

Includes bibliographic references.

"Latin American and Caribbean Microeconomic Report".

1. People with disabilities-Government policy-Latin America. 2. People with disabilities-Government policy-Caribbean Area. 3. People with disabilities-Social aspects-Latin America. 4. People with disabilities-Social aspects-Caribbean Area. I. Martinez, Claudia. II. Pereira, Maria Antonella. III. Inter-American Development Bank. Department of Research and Chief Economist. IV. Inter-American Development Bank. Gender and Diversity Division. V. Title. VI. Series.

IDB-AN-384

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Cover design: Paula Saenz Umaña
Layout: The Word Express, Inc.

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Preface

In Latin America and the Caribbean, a region long recognized for high levels of inequality, a growing literature is addressing how to reduce gaps across income and demographic groups. Rigorous evidence on topics related to inequity and inequality is rapidly expanding. This includes evaluations of interventions aimed at promoting the social and economic participation of people with disabilities.

Inclusion is an economic imperative. People with disabilities represent approximately 15 percent of the population in Latin America and the Caribbean. There is immense promise in facilitating the socioeconomic participation of such a significant share of the population. Reducing barriers to inclusion can boost education levels, facilitate employment, and improve the health, overall well-being, and quality of life of people with disabilities. At the same time, inclusion presents opportunities for spillovers at the societal level with simulations suggesting notable contributions to gross domestic product. Not including people with disabilities is a missed opportunity.

Despite these important arguments, disability inclusion is often deemed a question solely of human rights and not of economic development. The amount and quality of causal research focused on disability have grown significantly in the last decade. Yet, disability policy still lacks a rigorous research base, especially in low- and middle-income countries.

Driven by important moral imperatives, legal commitments, and the evident needs of their populations, governments in the region have implemented a vast array of public policies on disability. However, good intentions do not always translate into good outcomes, as such policies are often adopted with little knowledge of their true effects.

This year's Latin American and Caribbean Microeconomic Report synthesizes the causal evidence on the effectiveness of disability inclusion policies in education, health, labor markets, and social protection. The report further contextualizes this synthesis by providing up-to-date analysis on the socioeconomic status of people with disabilities. The result is a snapshot of policies already implemented in the region that are backed by positive evidence, and others that are being implemented despite neutral, mixed, negative, or limited evidence. The report also identifies opportunities to pilot and evaluate programs based on successful, evidence-based interventions from outside the region.

Finally, the report identifies interventions, both from within and outside Latin America and the Caribbean, that lack rigorous evaluation but have promising theories of change.

Further, in the true spirit of “nothing about us without us,” this report seeks to directly involve people with disabilities in the research agenda. Given resource constraints, both of time and funding, it is important to understand which research gaps the community views as most critical. The opinions of the people most impacted by relevant policies should inform this assessment. The Inter-American Development Bank is therefore conducting an accessible online survey to establish the priorities of people in the region, especially people with disabilities and their families, regarding which disability policies and interventions should be studied first.¹ Our hope is that this report will thereby contribute to future research and evidence-based policymaking that better responds to the concerns of civil society.

Eric Parrado
Chief Economist

¹ The survey remains open until June 2025. To participate, please access: <https://accessiblesurveys.com/survey/-NoXa0IVithWvED1daoy/intro>.

Acknowledgments

The Latin American and Caribbean Microeconomic Report is an annual publication of the Inter-American Development Bank (IDB). This edition was coordinated by a team of researchers from the Research Department and the Gender and Diversity Division of the Inter-American Development Bank (IDB). The report was authored by Suzanne Duryea, Claudia Martínez A., and María Antonella Pereira. Chapter 3 on health was also coauthored by Edmundo Beteta, with contributions from Andrea Olivares.

Invaluable research assistance and data analysis was provided by Juan Ramón Larraín, Cindy Rojas Alvarado, and Rocío Senra.

The survey on research priorities in disability policy was developed by María Antonella Pereira with support from Suzanne Duryea and Claudia Martínez A. The authors are grateful to the various civil society organizations and government bodies that helped distribute the survey throughout Latin America and the Caribbean.

Several colleagues from other IDB departments provided feedback at various stages in the production of the report, including Pedro Gerardo Bernal Lara, Emma Ingrid Naslund-Hadley, Matilde Neret, and Manuel Enrique Urquidi.

Tom Sarrazin oversaw the production process of the report. Fayre Makeig edited the English manuscript. Alberto Magnet translated the report into Spanish, and Patricia Ardila edited the Spanish manuscript.

Paula Saenz Umaña created the cover design under the creative direction of Lina María Botero Estrada. The Word Express Inc. typeset the publication.

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Executive Summary

Robust and contemporaneous disability data and causal evidence on policy effectiveness are key inputs emerging to strengthen disability inclusion in Latin America and the Caribbean. While a grim picture has often been presented of the situation of people with disabilities in education, health, labor markets, and social protection, the reality is much more nuanced. This report looks at inclusion gaps in the above four sectors, as well as the landscape of inclusion policies being implemented in the region. A review of rigorous evidence on the effectiveness of policies and programs in the region and around the world provides an evidence base for deciding which programs to scale up or pilot in the region, and highlights knowledge gaps where causal studies are needed.

People with Disabilities in Numbers



Approximately 1 in 7 people in Latin America and the Caribbean has a disability.



Disability prevalence increases with age. Given the aging of the Latin American and Caribbean population, the prevalence rate of disability is predicted to be 5.5 percentage points higher in 2050 than in 2020, representing a population size of approximately 150 million. Women constitute a larger share of the overall population with disabilities, in part because they live longer. However, up to 17 years of age, boys are more likely to have a disability than girls, and prevalence is higher among women in most countries after age 25 or 30.



Most children with disabilities attend and complete primary school, although gaps persist, particularly at higher schooling levels, and inclusive education remains elusive in most countries. A large share of children attends special schools, with some important exceptions.



Access to health coverage does not differ much between people with and without disabilities, although people with disabilities allocate more of their budget to health expenses, and they face accessibility and attitudinal barriers that can limit their access to specific health care services.



Most working-age adults with disabilities in the region are employed (56.4-68.0%). However, they are less likely to be formally employed and more likely to be self-employed than people without disabilities. People with disabilities earn 88 cents for every dollar earned by their equally experienced and educated counterparts without disabilities.



Households with members with disabilities are 5.7 percentage points more likely to be in the lowest two income quintiles relative to households without members with disabilities. These households are also more likely to experience food insecurity and to be deprived of key conditions of adequate housing.



An ongoing accessible online survey asks respondents which inclusion-related policies they consider the most important to study. So far, most respondents are people with disabilities (69%), and education is the top research priority, ranking higher than employment, social protection, and health policy.¹

The Evidence

Figures E1 to E4 summarize the key findings about which interventions are most commonly used in the region and which have the most causal evidence to support their use.

Interventions on the right side of the graphs (in the green columns) are commonly deployed, while those on the left side (in the blue columns) are not typically used in the region. Interventions supported by rigorous evaluations are listed above the horizontal line, while those lacking evidence but with a promising theory of change are listed below the line.

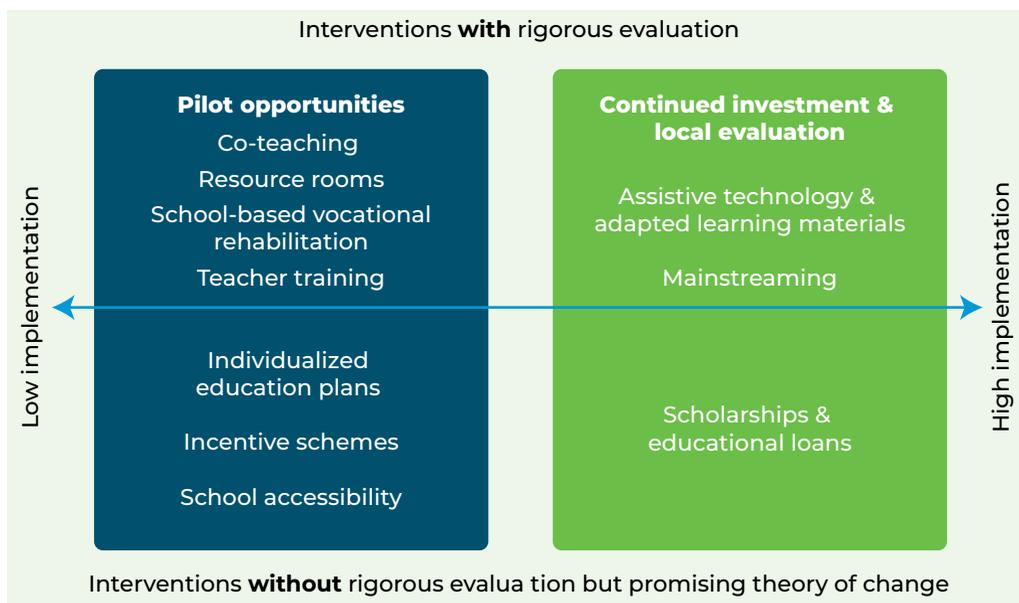
Thus, the upper left quadrant of each figure shows interventions with a large body of causal literature that are currently not being implemented in Latin America and the Caribbean. The lower left quadrant of each figure includes interventions that are uncommon in the region and for which there is little to no causal evidence; however, these interventions have promising theories of change. As a result, the interventions in the left column can be considered good candidates for pilot programs in the region.

The upper right quadrant of each figure lists programs and policies that are common in the region and have causal evidence supporting their effectiveness, although in many cases this evidence comes from outside the region. The lower right quadrant shows programs that are widely implemented in the region but for which there is little to no causal evidence of effectiveness, although these interventions have promising theories of change. Programs in the upper and lower right quadrants therefore represent opportunities for continued investment and local evaluations to add to the existing literature.

¹ The survey remains open until June 2025. To participate, please access: <https://accessiblesurveys.com/survey/-NoXaOIVthWvED1daoy/intro>.

Education

FIGURE E.1 | Education Interventions



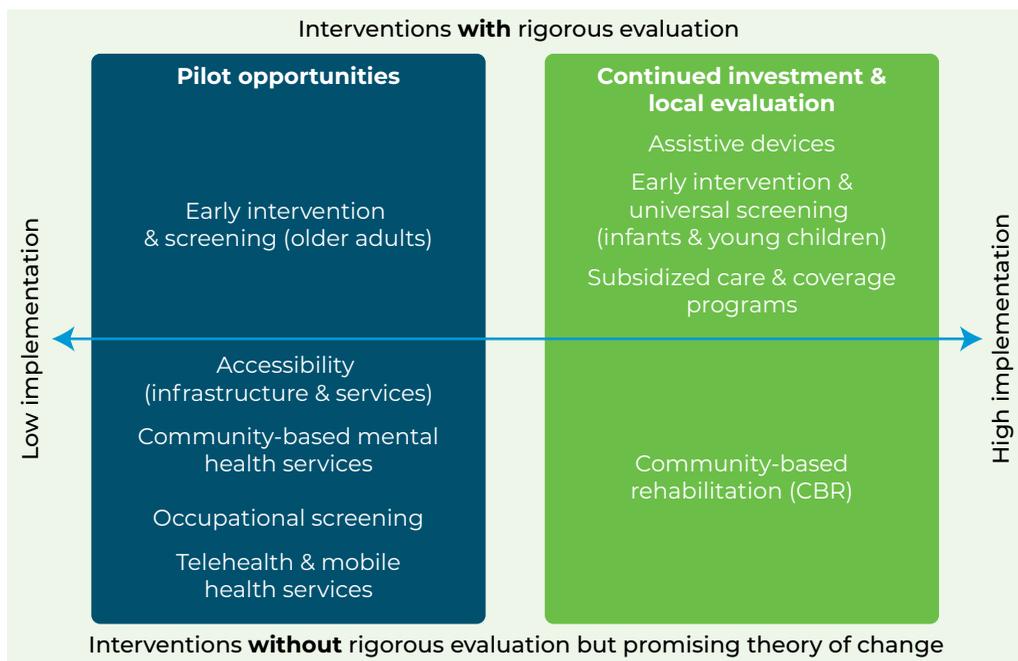
Source: IDB staff elaboration.

Preliminary evidence suggests that including children with disabilities in mainstream schools improves their learning without adversely affecting their peers' learning when additional classroom support is provided. Co-teaching and the provision of assistive technology have shown positive impacts, albeit in a few studies from high-income countries, while in Latin America and the Caribbean, the provision of alternate teachers (co-teaching) is less common than the provision of assistive technologies. Evidence on resource rooms (designated spaces equipped with materials and technology within mainstream schools) in Brazil suggests that these rooms improve enrollment and grade promotion. However, the implementation of resource rooms varies regionally, presenting an opportunity to evaluate pilots. Evidence on teacher training is limited, although existing evidence suggests a need for teachers' curricula to include training on special education and to evaluate the corresponding effects, since in-service training appears to have no effects on learning. Although evidence from the United States and other high-income countries suggests that school-based vocational rehabilitation helps students with disabilities transition out of secondary school, few Latin American and Caribbean countries have such programs. On the other hand, initial evaluations of incentive schemes like Chile's Education Integration Program (Programa de Integración Escolar, PIE) are positive.

Individualized education plans, school accessibility programs, scholarships, and education loan programs have not been rigorously evaluated, yet they have positive theories of change. While rigorous evaluations of segregated special schooling are lacking, special schooling should be gradually phased out, with some exceptions, given the ethical arguments against segregation.

Health

FIGURE E.2 | Health Interventions



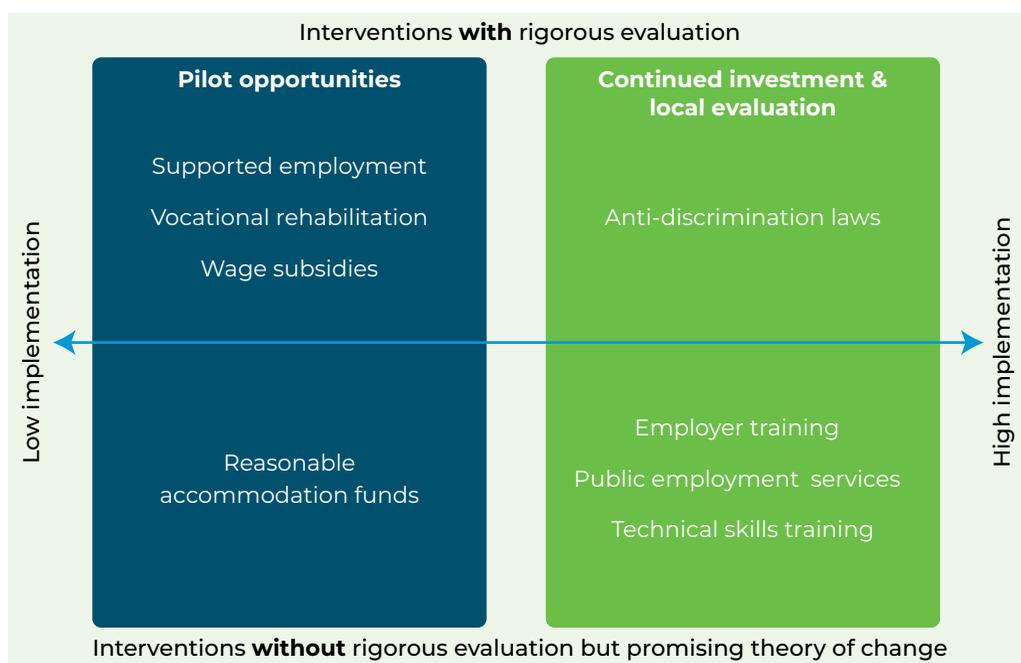
Source: IDB staff elaboration.

Universal screening programs improve learning, social, and developmental outcomes for infants and children, while early intervention and screening for older adults can slow functional decline and improve quality of life. However, many countries lack screening programs for older adults. Occupational screening for working-age adults shows potential health benefits but lacks rigorous evaluation and widespread implementation. Community-based rehabilitation can improve clinical outcomes and quality of life, although study quality is generally low, and the design of community-based rehabilitation varies by country. Studies suggest that traditional health coverage programs and subsidizing health care for people with disabilities may be sufficient to address higher health care costs, although this requires local-level evaluation.

There are little to no studies on the impacts of accessibility in health care, mobile health, telehealth services, and community-based mental health services on people with disabilities. Yet, these interventions have promising theories of change and should be evaluated. Finally, a knowledge gap was identified regarding rigorous studies on community-based health care programs for people with disabilities as an alternative to long-term institutionalization, against which there are strong ethical arguments.

Labor Markets

FIGURE E.3 | Labor Markets Interventions



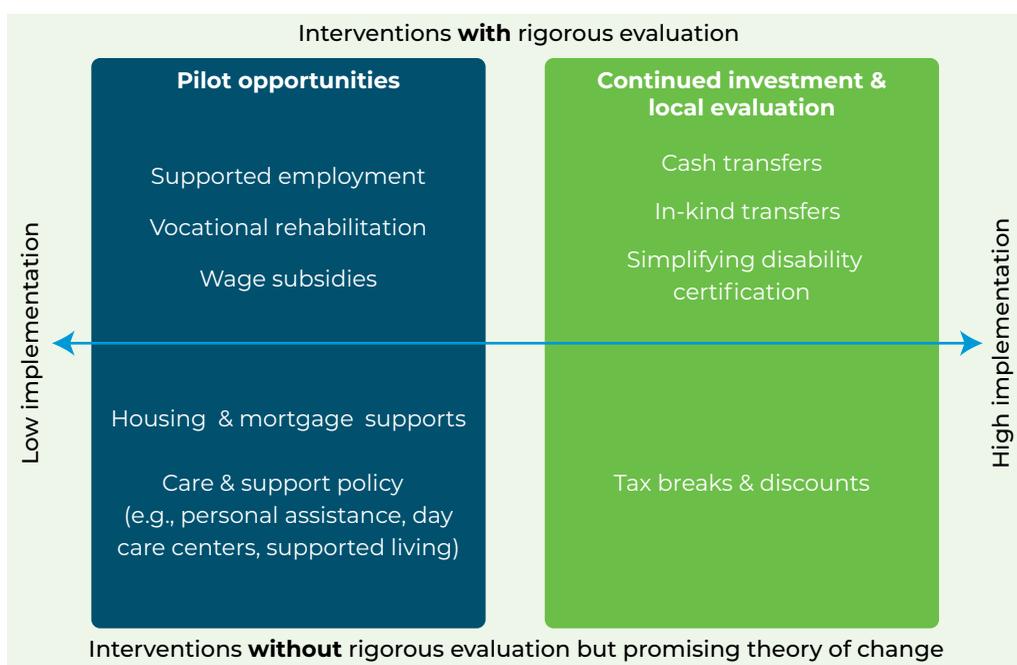
Source: IDB staff elaboration.

Research indicates antidiscrimination legislation positively impacts employment for persons with mild to moderate disabilities, despite its potential short-term adverse effects for those with more severe disabilities, due to the cost to employers of providing more substantial accommodations. Funding for reasonable accommodations could mitigate these adverse effects, although these interventions have not been evaluated. Quotas, evaluated in Latin American and Caribbean as well as high-income countries, show mixed results, often indicating that employment increases may be due to reclassification rather than hiring. However, interventions to improve compliance with quotas can be beneficial. Wage subsidies show mixed or inconclusive results, whereas vocational rehabilitation and supported employment are supported by positive evidence.

Promising but unevaluated policies include employer training programs, technical skills training, and disability-targeted public employment services. Further, rigorous evidence on sheltered workshops is lacking. Nonetheless, qualitative research has found sheltered employment to be associated with abusive labor practices and earning a sub-minimum wage. Sheltered work is not common in most Latin American and Caribbean countries and should thus not be promoted as an inclusion strategy.

Social Protection

FIGURE E.4 | Social Protection Interventions



Source: IDB staff elaboration.

Evidence on inclusive social protection policies is not comprehensive; most studies focus on a few themes in high-income countries. Positive results on take-up are found where application for disability certification is simplified, although this has not been evaluated in Latin America and the Caribbean, even though many certification systems have been updated. Extensive research on disability cash transfers reveals that they have small to moderate effects on reducing work; however, these studies have mostly been conducted in developed countries, where informal work is scarce. More recent studies have found disability cash subsidies to significantly improve household consumption, financial stability, and quality of life, and reduce mortality and incarceration. They also positively

impact the well-being of beneficiaries' children. Causal studies for in-kind transfers of assistive devices are limited; one small study in Ethiopia shows that wheelchairs increase work hours and income and reduce mendicity. Similar evaluations are lacking in Latin America and the Caribbean.

Housing support and care policies (e.g., personal assistance, day care, and assisted living) for people with disabilities are provided in several countries but lack rigorous evaluation. These programs are becoming more common in Latin America and the Caribbean and should be evaluated. Further, several countries provide people with disabilities with tax breaks and discounts, although it is unclear how these benefits impact their well-being and government costs.

Sowing the Seeds of Inclusion



Persons with disabilities constitute an increasing share of the Latin American and Caribbean population: approximately one out of every seven persons in the region has a disability, and the prevalence is expected to increase by 60 million people over 2020–50 (Berlinski, Duryea, and Perez-Vincent 2021). However, the needs of people with disabilities and the policies designed to promote inclusion are often underdocumented and understudied.

This report has a multifold purpose. First, it aims to describe the status of people with disabilities, primarily through analysis of recent household surveys in the region. Second, it describes the Latin American and Caribbean policy landscape specifically with respect to people with disabilities in the four main policy areas of education, health, labor markets, and social protection (including housing). Finally, the report reviews the rigorous causal evidence, especially from impact evaluations, on policies and interventions focused on promoting disability inclusion.

Focusing on these three objectives makes it possible to identify which policies are backed by positive evidence and which are being implemented despite neutral, mixed, or negative evidence. This review also identifies opportunities for evaluating policies and programs that have had little to no evaluation, as well as considering interventions that are not currently widely adopted in the region but for which evidence from other regions suggests positive impacts. In other words, the overall objective of this report is to synthesize available research to promote evidence-based policy on disability inclusion in Latin America and the Caribbean. The report thus focuses on reviewing the effectiveness of policies and programs on people with disabilities; effects on other persons, for example, family members, caregivers, or peers, may be discussed but are not the focus.

Disability arises from the interaction of individual impairments with environmental and social barriers. The United Nations Convention on the Rights of Persons with Disabilities (CRPD), which has been ratified by all countries in Latin America and the

Caribbean, defines that persons with disabilities “include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1, UN 2007). This definition of disability moves away from a strictly medical model and emphasizes the environmental or attitudinal barriers that limit social and economic participation. Inclusive public policy subscribes to this understanding of disability, and focuses on reducing barriers and promoting participation rather than “curing” disability.

Box 1.1 Key Concepts in Disability Research

Research design and implementation should begin with ensuring that conceptual and ethical frameworks are in place. The following concepts and principles embedded in the 2008 UN Convention on the Rights of Persons with Disabilities (CRPD) are critical for research pertaining to persons with disabilities.

The concept of disability has evolved in recent decades from a strictly medical model to a social model. The social model defines disability as the interaction of a long-term impairment with external barriers that limits effective participation in society. In other words, disability is not defined solely as a health condition, but a result of limitations imposed by external barriers. This interactive concept is inscribed in Article 1 of the CRPD, which builds on the 2001 International Classification of Functioning, Disability and Health of the World Health Organization. In contrast, the medical model views disability as an issue originating within the individual, resulting from physical, sensory, or cognitive impairments or medical conditions.

Research agendas focusing on people with disabilities or disability inclusion should have a primary focus on people with disabilities. The effects of programs on family members or peers can be considered secondary effects. The concept of inclusion rather than segregation is another critical concept. Under the CRPD, sheltered work, special schools, and most institutionalized care facilities are considered to enable segregation, and as such, these policies are not considered in the review of interventions in this report. The concept of self-determination is also highlighted in the CRPD. Autonomy and improved decision-making capacity of people with disabilities are themselves outcomes of interest.

The motto “nothing about us without us” applies to the participation of people with disabilities in research as well as in setting priorities within research agendas. Toward this end, a survey on the prioritization of knowledge gaps was sent to organizations of people with disabilities, government agencies focused on disability (e.g., the national disability councils (CONADIS) and national disability departments (SENADIS) of each country), and other groups focusing on disability inclusion. Box 1.2 presents the results of this survey to date.

Arguments for disability inclusion are of two types. The first is the ethical argument. Disability, like race, ethnicity, gender, or sexuality, is another facet of human diversity. People with and without disabilities have the same rights to full social and economic participation. The CRPD recognizes the right to “the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (Article 1, UN 2007). Since all countries in the region have ratified the CRPD, it is unsurprising that 21 countries have a specific national law on disability

inclusion. The content of these laws is unique to individual countries, ranging from rights and inclusive education to rights to participate in cultural life.¹ Further, the constitutions of ten countries in the region include safeguards against discrimination on the basis of disability (Bregaglio Lazarte 2021). Additionally, countries have established legal frameworks on disability in various areas of public policy, including education, health, labor markets, and social protection, as discussed in the other chapters of this report. Countries have thus made important legal commitments to disability inclusion. However, this does not guarantee that they are complying with such commitments, and in many cases, the reality is far from the legal standard.

There is also an important economic argument backing inclusion. Including individuals with disabilities in society can improve their education levels, enable employment, improve health, increase tax contributions, and reduce reliance on social protection. This has important implications for the quality of life and well-being of people with disabilities, but also has important implications for society at large. For instance, estimations in the region show that including people with disabilities in the labor market could increase the gross domestic product (GDP) by 2–3 percent (Contreras, Riveros, and Vargas 2019). These two arguments are transversal to all dimensions of inclusion.

Disability in Latin America and the Caribbean

Designing effective disability-inclusive public policy requires an accurate understanding of what it means to have a disability in the region. Therefore, this report leverages analysis of recent household surveys from eight countries to describe the situation of people with disabilities along several comparable socioeconomic characteristics across countries (see Box 1.2).

A large share of the population has a disability. Analysis of household surveys in Latin America and the Caribbean suggests that, overall, 15.1 percent of the population in the region has a disability (Table 1.1). Yet, there is an important heterogeneity in the prevalence rate across countries: it ranges from 4.8 percent in Peru to 28.7 percent in Chile. This suggests that despite efforts to use comparable survey questions across countries to identify persons with disabilities (Box 1.2), there are likely important differences in how data are collected, thus affecting estimates. For instance, the quality of enumerator training in implementing the Washington Group Questions is critical, yet there is little information on how this training was conducted across countries. However, the regional average of 15.1 percent is consistent with other estimates of disability prevalence. For instance, an analysis using predictive modeling based on 2010 census data for eight countries in

¹ A comprehensive legal framework for the rights of people with disabilities in Latin America and the Caribbean across education, employment, health, culture and sports, and personal and financial autonomy is presented in Bregaglio Lazarte (2021).

the region estimated that the disability prevalence rate would be 14.8 percent in 2020 (Berlinski, Duryea, and Perez-Vincent 2021).

TABLE 1.1 | Disability Prevalence Rates (%)

Country	Overall	Urban	Rural
<i>Average</i>	15.1	14.7	16.7
Bolivia	5.6	5.0	7.2
Brazil	27.3	26.7	31.3
Chile	28.7	28.3	32.4
Colombia	15.6	15.3	16.7
Costa Rica	10.2	9.9	11.1
Mexico	16.4	16.0	17.7
Panama	11.9	12.0	11.8
Peru	4.8	4.5	5.7

Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

When examining urban-rural differences, we find that people with disabilities are slightly more likely to live in rural areas (Table 1.1). This is particularly true in Brazil and Chile, where rural and urban prevalence rates differ by 4.7 and 4.2 percentage points, respectively (Table 1.1).

It is also worth highlighting that people with disabilities are more likely to be older. Analysis of the age profile shows that the proportion of people with disabilities increases as the population ages—consistent with patterns from other regions (Table 1.2). On average, 5.5 percent of children under 6 years have a disability, compared with 6.3 percent of children ages 6–17, 10.4 percent of adults ages 18–54, and 37.1 percent of adults 55 years or older. This illustrates the sharp increase of disability in older age groups. The differences in urban-rural prevalence are directly tied to age differences. On average, people with disabilities below 55 years of age are only 0.7 percentage points more likely to live in rural areas; in other words, there appears to be no systematic difference. However, people with disabilities ages 55 years or above are 5.6 percentage points more likely to live in rural than urban areas; percentage point differences range from 2.3 in Panama to 9.7 in Chile.

This can also be illustrated by considering the share of people of a certain age among all people with disabilities (Figure 1.1). In seven of the eight countries analyzed, over half of all people with disabilities are ages 55 years or above. Individuals 18–54 years old represent 26.5–45.7 percent of all people with disabilities, whereas individuals under 18 years of age represent a 7.5–12.6 percent share. These figures demonstrate the strong correlation

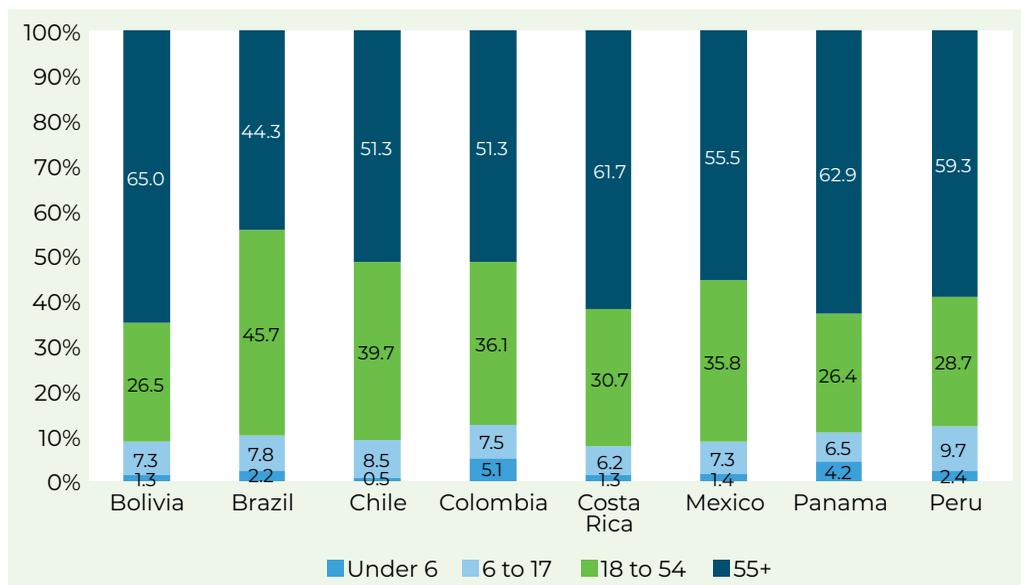
between disability and age. Additionally, the average age of people with disabilities across countries is 54, compared with 32 for people without disabilities. Given the evident relationship between age and disability, age must be factored in when analyzing socioeconomic data on disability and designing policies.

TABLE 1.2 | Disability Prevalence Rates by Age and Gender (%)

Country	0–6			6–17			18–54			55+		
	All	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female
Average	5.5	6.2	4.8	6.3	6.6	5.9	10.4	9.8	11.0	37.1	34.9	39.0
Bolivia	0.7	0.9	0.5	1.7	1.7	1.7	3.0	3.1	2.9	23.9	22.4	25.2
Brazil	10.3	11.4	9.3	12.5	12.9	12.1	22.3	19.6	24.8	57.1	53.1	60.4
Chile	11.5	13.4	9.5	15.0	15.1	14.9	20.2	17.7	22.7	56.9	52.3	60.8
Colombia	9.9	10.3	9.5	5.9	6.4	5.4	10.8	10.6	11.0	40.5	39.1	41.7
Costa Rica	2.3	2.6	2.0	3.8	4.5	2.9	6.1	6.3	5.9	24.4	24.1	24.6
Mexico	3.0	3.1	2.8	5.7	6.3	5.1	11.3	11.6	11.1	47.4	45.3	49.0
Panama	5.3	6.6	4.0	3.5	3.6	3.5	6.8	6.2	7.4	33.3	29.5	36.7
Peru	1.4	1.8	0.9	2.1	2.5	1.7	2.8	3.2	2.4	13.4	13.2	13.6

Source: IDB staff calculations based on data from household surveys in Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

FIGURE 1.1 | Age Distribution among People with Disabilities



For instance, a comparison of the education level of people with and without disabilities without disaggregating by age group might suggest that persons with disabilities are less educated. However, this observation could also reflect the lower education levels of older generations. Most children with disabilities in the region attend school, and most complete primary education (see Chapter 2).

Given that, on average, women live longer, and that disability is strongly associated with older age, it is unsurprising that disability prevalence is higher among women on average. In all countries, except Peru, there are more persons with disabilities among women than men, and gender differences are larger in Brazil and Chile, where the prevalence of disability is the highest. However, disability prevalence is higher among male than female children up to age 17. More females than males have disabilities starting at age 18, and the share increases with age. Therefore, while on average, disability is more prevalent among women than men, it must be acknowledged that this varies by age. Policy analysis must include these gender and age considerations.

More information is needed on the demographic characteristics and living conditions of people with disabilities in large-scale residential institutions in the region, including psychiatric hospitals, orphanages, and prisons, whether publicly or privately operated. In most countries, these institutions are excluded from censuses and surveys, and the conditions within them are not monitored systematically—partly because many are run by nongovernmental organizations. While some countries have established standards and quality indicators, such as limiting the number of residents per facility, it remains unclear whether these standards are actively monitored or enforced. Reports on specific institutions in the region have found abusive conditions and a lack of specific mechanisms to challenge involuntary commitments (Ríos-Espinosa 2018; Rodríguez 2015). Moreover, among nonresidential government programs aimed at people with disabilities, very few monitor for conditions of abuse and neglect.

Box 1.2 A Note on the Data Sources

Analysis of the status of people with disabilities in Latin America and the Caribbean is made possible using multiple data sources from the region. The following criteria were established when deciding which data sources to utilize for this report:

- **Includes the Washington Group short set of questions:** Survey instruments include various methods to identify people with disabilities. However, the Washington Group short set of questions subscribes to the social model of disability (see Box 1.1), is concise, and has been validated in multiple contexts (Groce and Mont 2017).
- **Makes comparisons between people with and without disabilities possible:** It is not possible to estimate gaps based on disability without data on people with disabilities and their counterparts without disabilities.

(continued on next page)

Box 1.2 A Note on the Data Sources *(continued)*

- **Contemporaneousness:** To ensure statistics are contemporaneous and avoid cross-temporal comparisons, we exclusively use surveys from 2021 and later.
- **Large sample sizes:** Representative estimates cannot be made using small sample sizes. This is especially relevant when considering indicators associated with education, where indicators often have to be disaggregated by age and gender, yet the prevalence of disability among children is smaller.
- **Comprehensiveness of indicators:** Considering this report spans multiple policy areas, it was imperative that data sources cover a wide range of socioeconomic indicators.

This report primarily relies on analysis of the following household surveys from the region, for which all the criteria are met.

Other data sources were considered for this report although they were excluded because they did not meet all the criteria. For instance, the Multiple Indicator Cluster Surveys or Demographic and Health Surveys in the region have smaller sample sizes and do not capture the same wide range of demographic and socioeconomic data. For most countries in the region, the 2010 round is the most recent available census, and at the time, the census of only some countries included the Washington Group Questions. These data are from over 14 years ago, and hence no longer provide up-to-date representations of the state of disability inclusion. Finally, some Latin American and Caribbean countries have conducted disability surveys, many of which, however, have been conducted exclusively among people with disabilities, limiting the ability to make comparisons with people without disabilities; besides, smaller sample sizes result from the extensive length of disability surveys, limiting the ability to perform representative disaggregated analysis. Censuses, Multiple Indicator Cluster Surveys, Demographic and Health Surveys, and disability surveys are hence not the primary data sources for this report, which, nevertheless, cites results from previous analysis of these sources, where relevant.

TABLE B1.1 | Data Sources

Country	Survey Name	Year
Brazil	Pesquisa Nacional por Amostra de Domicílios Contínua (PNADC)	2022
Bolivia	Encuesta Continua de Hogares (ECH)	2021
Chile	Encuesta de Caracterización Económica Nacional (CASEN)	2022
Colombia	Gran Encuesta Integrada de Hogares (GEIH)	2022
Costa Rica	Encuesta Nacional de Hogares (ENAHO)	2022
Mexico	Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH)	2022
Panama	Encuesta de Hogares de Propósitos Múltiples (EHPM)	2022
Peru	Encuesta Nacional de Hogares (ENAHO)	2022

Note: Although the great majority of countries using these questions follow the Washington Group guidelines (the Washington Group Short Set on Functioning [WG-SS]), there are two exceptions: Costa Rica (ENAHO 2022) and Peru (ENAHO 2022). While the WG-SS questions are used in both cases, the response options offered are binary (Yes/No), instead of a scale of difficulty (No difficulty / Some difficulty / A lot of difficulty / Cannot do it at all).

Principles of Disability-Inclusive Policy

People with disabilities and their families should be able to apply for and benefit from all public policy, programs, and services on an equal basis as others. To ensure equitable access to mainstream programs, service providers must consider the needs of people with disabilities. With this objective, governments may benefit from implementing four main principles across all their policy and programmatic offerings: universal design and accessibility, reasonable accommodations, destigmatization and efforts to raise awareness, and autonomy and legal capacity. Since these principles apply to all areas of public policy, we discuss them in this introduction, rather than in the individual chapters on education, health, labor markets, and social protection. There is little to no evidence of interventions focused on these principles, which is why we do not dedicate a separate chapter to their discussion.

Universal Design and Accessibility

The concept of universal design was initially developed in the context of architecture to express that buildings and infrastructure should be designed from the get-go with accessibility in mind, that is, in a way that allows all persons to use them. By doing so, expensive future retrofitting is avoided. For instance, by building an entrance with a ramp, planners ensure that people who have difficulty using stairs can enter. This not only includes wheelchair users, but also pregnant women, older persons, or persons carrying or pushing wheeled objects. Modifying an existing entrance after it has already been built to include a ramp is much more complex and expensive.

At present, the concepts of universal design and accessibility are not only used to guide construction, but also to guide user experience design. This is particularly relevant for public service provision. For example, a public office that offers printed information in various formats such as large print or in various languages may avoid having to pay for translations or interpreters that would otherwise be needed, for instance, if the text were too small to read for a person with low vision or if a beneficiary spoke only an indigenous language. This would also increase the efficiency of service provision. As a result, when infrastructure and services are designed from the beginning to consider universal design and accessibility, this reduces future costs of adaptations while ensuring equitable access and efficiency. Most countries in the region have legal frameworks that govern universal accessibility in public infrastructure, particularly in new construction, including for buildings in the health and education sectors (Bregalio Lazarte 2021). Although most countries in Latin America and the Caribbean count on these provisions in national legislation, the accessibility of public facilities continues to be low for people with disabilities, because legal requirements are not described in coherent and consistent regulations and enforcement is low (World Bank 2021).

In general, scarce information is available about the accessibility of services; nonetheless, it is likely that many services and public infrastructure are inaccessible, impeding the use of public programs. However, many countries are making important efforts to promote accessibility. For instance, several countries, such as the Dominican Republic and Chile, are assessing and upgrading the digital accessibility of government websites and platforms to meet international standards. In Colombia, the Ministry for Information Technology and Communications (Ministerio de Tecnologías de la Información y las Comunicaciones, MINTIC) with the National Digital Agency has developed guides and content to support government entities in implementing digital accessibility (Correa-Barros et al. 2024). Similarly, the government of Brazil has developed a *Digital Accessibility Best Practices Guide* with support from the UK government. Brazil stands out from other countries in that it has leveraged artificial intelligence to create an animated avatar available on government websites to provide real-time interpretation from Portuguese to Brazilian Sign Language (Libras), which is particularly useful when videos are not closed-captioned and human sign language interpreters are not available (SGD/MGI et al. 2023). The avatar is presently used on 120,000 websites and provides 3 million translations per month. Despite these innovative efforts, there is still a long way to go. For example, an analysis of the main government platforms of Latin American and Caribbean countries finds that 4 countries have platforms that are completely illegible for users of screen readers, while those of 19 other countries are somewhat accessible but need improvements; only Ecuador's platform is fully accessible for screen reader users (Pallero and Marquez 2023).

Reasonable Accommodations

While universal design and accessibility guarantee that most people can access infrastructure and services, some people may need additional accommodations. Accommodations refer to adaptations to the environment or services to support access and participation (Duryea, Salazar Salamanca, and Pinzón Caicedo 2019). They are considered reasonable when they do not pose undue hardship, monetary or otherwise, to the institution providing the service. While the concept of reasonable accommodation is most well known in the context of employment and education (see Chapters 2 and 4), it is applicable to all areas of public service provision. For instance, even if a public health clinic is fully accessible, some blind persons will still need the assistance of a guide dog to navigate the facilities. It would be unreasonable and unsafe to let all animals enter the clinic, yet an exception should be provided for guide dogs and service animals. This would constitute a reasonable accommodation, as it does not impose undue hardship on the clinic. In fact, most reasonable accommodations are low cost and imply easy adaptations.

Nonetheless, systems to finance and coordinate reasonable accommodations are imperative, especially for higher-cost, more complex accommodations such as sign

language interpretation. While most countries in Latin America and the Caribbean (at least 19 countries) have provisions in their legislation regarding the right to reasonable accommodations (Bregaglio Lazarte 2021), few large-scale initiatives fund and provide reasonable accommodations in public services.

An important exception is regarding sign language interpretation. For instance, in Colombia, the Ministry for Information Technology and Communications along with the National Federation of the Deaf (Federación Nacional de Sordos de Colombia, FENASCOL) funds and manages the Center for Relay Interpretation (Centro de Relevó). The Center employs sign language interpreters who provide interpretation services through video call to deaf people and government workers. This process decreases the costs and barriers associated with having interpreters on call in person at every public agency while providing reasonable accommodation to people who need them. Up to March 2024, the Center for Relay Interpretation reports having benefited close to 60,000 people through interpretation of close to 6 million calls (Gobierno de Colombia n.d.). Other countries are implementing similar services to provide real-time virtual sign language interpretation, such as within the police force “Carabineros” of Chile or within municipal services in Guadalajara.

Destigmatization and Awareness Raising

There are many misconceptions about disability. Erroneously, many people still believe that people with disabilities are incapable of studying, working, making their own decisions, having a family, and generally, having a “normal” life. This stems from incorrect assumptions that people with disabilities are sick or lack the intellectual or physical capacity to be independent. In some contexts, some communities may even consider disability to be a form of punishment. Coupled with a long history of excluding people with disabilities from social and economic participation, even by placing them in segregated institutions away from society, such beliefs have led disability to be highly stigmatized, even today (Duryea, Salazar Salamanca, and Pinzón Caicedo 2019). This in turn may lead to outright discrimination in the provision of public services and can also disincentivize people with disabilities from trying to participate in public programs. Latin America and the Caribbean is no exception, which is why, as previously noted, several countries actively recognize the right to nondiscrimination on the basis of disability in their legislation (Bregaglio Lazarte 2021).

Public policy must be accompanied by awareness-raising initiatives to reduce stigma and discrimination. These initiatives should target public sector workers, people with disabilities themselves, and society at large. Public communication campaigns, targeted training for public sector employees, and complaint systems for harassment and discrimination are examples of such initiatives. Overall disability representation in popular media

is also imperative, and initiatives such as the paralympic games can change perspectives (Heumann, Salas, and Hess 2019). Furthermore, public programs must avoid segregated provision of mainstream services to avoid perpetuating the sense of “us” versus “them.” This does not mean, however, that governments should not create targeted programs to address the specific needs of people with disabilities.

Autonomy

Historically, the approach to disability policy has been highly paternalistic due to the misconception that people with disabilities are incapable of making their own decisions and living independently (Duryea, Salazar Salamanca, and Pinzón Caicedo 2019). It is imperative that public policies and programs themselves do not perpetuate paternalistic attitudes toward disability and that they advance the self-determination of people with disabilities. By doing so, people without disabilities can support people with disabilities in living independently and being active contributors to society.

The process begins with important legislative reform concerning legal capacity. Legal capacity refers to people’s ability to make their own decisions and exercise their rights on their own. Article 12 of the CRPD compels countries to provide people with disabilities access to the support they may need to exercise their legal capacity. This includes people with intellectual or psychosocial disabilities, who have historically been placed under guardianship or interdiction simply because they have a disability, without undergoing a comprehensive and thorough assessment of their ability to make their own decisions.

Costa Rica, Peru, Colombia, and Mexico are at the global forefront of legislation on legal capability since they have adopted reforms that eliminate interdiction based on disability and have replaced it with various forms of support. There is still a long way to go in implementing and monitoring these legislative changes. Moreover, legislative changes need to translate into concrete changes in public policies and programs. For instance, some countries are changing their disability cash transfer programs such that the transfer is received and managed directly by the beneficiary with a disability rather than another family member (see Chapter 5).

So, What Else Needs to Be Done?

All policies and programs must consider universal design, accessibility, reasonable accommodations, destigmatization, awareness raising, and autonomy. Ensuring that public service provision is guided by these principles is a first step in ensuring that mainstream programs are inclusive of people with disabilities. However, people with disabilities also face additional barriers and gaps not addressed by mainstream public

programs. These barriers are specific to different areas of public policy, mainly education, health, employment, and social protection policy. Many countries have implemented disability-specific policies and programs to address these barriers and gaps, at various levels of investment.

A recent study examining fiscal expenditure on disability policies and programs in eight countries in the region (Argentina, Brazil, Chile, Guatemala, Mexico, Paraguay, Peru, and Uruguay) suggests that spending on disability inclusion varies widely between countries (Astudillo and Pessino, forthcoming). The fiscal analysis considered initiatives that assigned resources to programs with the specific objective of addressing disability topics; indirect expenditures were not included such as the receipt of subsidies by people with disabilities in general cash transfer programs. Expenditures on disability programs were between 0.04 percent and 6 percent of a given country's total budget, or between 0.01 and 1.5 percent of GDP. In most countries, the shares were considerably below the average found for European countries of 2.6 percent of GDP (Portillo Navarro, Lagos Rodríguez, and Meseguer Santamaría 2021). Nonetheless, countries are making important fiscal commitments to disability inclusion. It is imperative to ensure that spending on disability is directed toward evidence-based, highly effective policies and programs. Below, we summarize the main conclusions from the data analysis, policy mapping, and evidence review provided in each chapter.

Chapter 2 focuses on reviewing the evidence concerning education policy. Many countries have successfully closed the primary school enrollment gap for students with disabilities, with some, notably Brazil and Chile, nearly closing the gap at the secondary level as well. However, countries like Bolivia and Peru still face substantial gaps at all levels, and many countries have a substantial share of students with disabilities in special schools. Notably, Brazil and Chile, which have been most successful in closing the gap, also have a lower proportion of students with disabilities in special schools. These countries have adopted different models to achieve inclusion in regular schools. In Chile, schools receive a special voucher for each student with disabilities enrolled, whereas Brazil has expanded the availability of resource rooms. There is positive evidence regarding the effect of vocational interventions in developed countries, particularly when implemented in high school. This promising strategy could be implemented and carefully evaluated in the region.

Chapter 3 reviews the evidence on health policy. Available data do not indicate significant disparities by disability status in access to health insurance. However, they suggest that people with disabilities allocate a larger portion of their budget to health expenses, which might signal an unmet need for additional services. Further, while there are no differences in coverage levels, it is likely that people with disabilities experience gaps in seeking and receiving medical assistance when needed, based on data from disability surveys. Since household surveys do not include questions on specific medical services,

it is not possible to estimate the true unmet health care needs of people with disabilities, highlighting an area for which surveys across the region could be improved. Most countries offer neonatal screening, and the evidence strongly supports this intervention. However, the conditions being screened for differ across countries.

Chapter 4 focuses on reviewing the evidence on labor market policy. People with disabilities have less access to jobs, especially formal employment, and often receive lower wages, even after considering their education and experience levels. Many countries in the region have adopted employment quotas for persons with disabilities, though the evidence regarding their effectiveness is mixed. Other labor market policies, such as case management and supported employment, have demonstrated positive impacts in developed countries. However, these strategies have neither been studied nor widely implemented in the region.

Chapter 5 focuses on reviewing the evidence on social protection. Although poverty rates tend to be higher in households with a member with disabilities, this is not observed in all countries. However, we do observe that households with members with disabilities are more likely to be in the lower household income quintiles: 22.6 percent of households with a member with a disability are in the fifth income quintile, compared with 16.8 percent of households without members with disabilities. At the same time, households with members with a disability tend to have higher health expenditures and higher food insecurity. Regular cash transfers and noncontributory pensions in the region include individuals with disabilities, and they should be considered as a mechanism to reach them. However, subsidy levels should consider the greater expenditures needed in households with disabilities. Specific budget efforts targeted to persons with disabilities vary widely across countries, with Argentina, Brazil, and Uruguay approaching the fiscal commitments of European countries, whereas other countries spend approximately 0.01 percent of their budget (see Chapter 5). Regarding care for people with disabilities, the region has implemented several policies of limited scope, but systematic evidence of effects and costs is needed. However, across the seven countries, expenditures on social protection, particularly noncontributory disability transfers, accounted for the largest shares of spending on disability. The region has implemented several disability cash transfers, which account for the largest share of the disability budget in Argentina, Chile, Brazil, Mexico, Paraguay, and Uruguay (Astudillo and Pessino, forthcoming).

This report is an invitation to reexamine what we know about disability policy and identify key knowledge gaps. Reviewing the evidence regarding the effectiveness of different policies provides many insights into opportunities to improve inclusion in the region and documents numerous areas where stronger evidence is needed. Setting priorities for a research agenda, as well as the research itself, must be an inclusive process. Box 1.3 describes one part of this longer-term process.

Box 1.3 Setting Research Priorities

This report documents the considerable knowledge gaps regarding what works to promote disability inclusion. Given resource limitations, both of time and funding, it is important to understand which research gaps are viewed as most critical—by the people most impacted.

The Inter-American Development Bank conducted an online survey in three languages (English, Portuguese, and Spanish) to gauge the perspectives of people in the region, especially people with disabilities and their families, regarding which policies and interventions should be studied first. The survey is digitally accessible, allowing people to adjust text, contrast, and color, and is fully compatible with accessible devices such as screen readers. Additionally, respondents can answer the survey in easy-read, read-aloud, and voiced formats (where they give their answers using their voice). Up to May 2024, 17 respondents (11 percent) used these alternative formats to answer the survey. This box presents the results from the survey from March to May 2024. However, the survey is still accepting responses until June 2025.^a

While the response rate to the survey so far has been low (150 responses from 20 countries in the region), there has been a high proportion of respondents with disabilities or who live with family members with disabilities (69 and 15 percent, respectively). As a result, although the results of this survey are far from being representative, given the challenges in surveying people with disabilities, the results provide insights that can be further analyzed in future initiatives. Respondents were predominantly female (68 percent) and lived in urban areas (81 percent). On average, respondents were 46 years old.

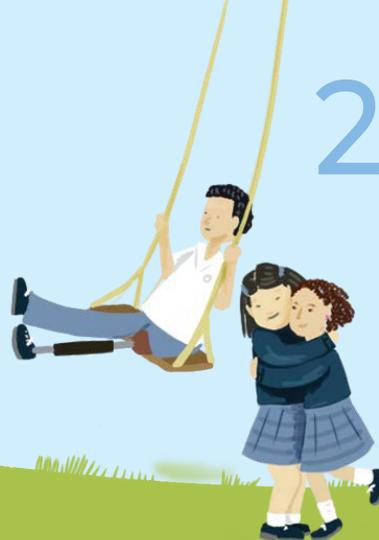
Respondents were asked which policy areas they considered most important to study. Respondents' perspectives can be summarized as follows:

- The number-one sectoral priority is education policy; 50 percent of respondents considered this to be the most important research topic, relative to employment, social protection, and health policy (19, 18, and 13 percent, respectively). Education policy is the number-one priority regardless of whether the respondent has experience with special education (either their own or a family member's).
- Seventy-five percent of respondents considered it absolutely important to study the synergies and interactions of disability policies (on a five-point scale from not important at all to absolutely important).
- Seventy-eight percent of respondents considered it absolutely important to study the effects of awareness-raising campaigns focused on disability (on a five-point scale from not important at all to absolutely important).

Respondents were also asked which specific policies within education, employment, social protection, and health policy they considered most important to study. We summarize the survey results up to May 2024 for each area in the boxes at the end of the respective chapters of this report.

^a If you would like to offer your opinion on research priorities for the inclusion of people with disabilities, please fill out the survey at the following link through June 2025: <https://accessiblesurveys.com/s2/-NoXaOIVthWvVED1daoy>.

Education



Ensuring an Equitable Education for Children with Disabilities

Children with disabilities and learning difficulties compose an estimated 10–15 percent of all school-age children (i.e., ages 6–17) in Latin America and the Caribbean. This amounts to 12.5–18.9 million children who have some combination of (1) seeing, hearing, physical, and psychosocial disabilities; (2) learning difficulties, that is, challenges in the way the brain receives and processes information; or (3) learning disabilities, that is, specific impairments that affect their ability to learn (see Box 2.1). Children with disabilities, just like any other children, have a right to go to school and receive quality education. Inclusive education, whereby children with and without disabilities learn side by side in the same classrooms, benefiting from a common if differentiated curriculum, is regarded as both a right and a means to ensure access to equal opportunities. Moreover, there is an economic argument for investing in the education of children with disabilities. In addition to being an environment where students learn self-determination and interpersonal skills, school fosters skills that increase labor productivity later in life. Thus, schooling boosts future earning potential and decreases the probability of being in poverty or relying on social protection schemes in adulthood.

Inclusive education is endorsed by various international and national legal frameworks. The right of persons with disabilities to access education on an equal basis is embedded in Article 24 of the United Nations Convention on the Rights of Persons with Disabilities (CPRD) (UN 2007), which has been ratified by every country in Latin America and the Caribbean. Target 4.5 of the UN Sustainable Development Goals specifically highlights the need to ensure equal access for persons with disabilities in the creation and delivery of high-quality learning environments (UN n.d.). The framework for inclusive education was shaped by the 1994 World Conference on Special Needs Education (Ainscow and César 2006). The Salamanca Statement from this conference is regarded as the first

international instrument to endorse inclusive education for children with diverse needs (UNESCO 1994). At the national level, many countries in Latin America and the Caribbean have demonstrated a legal commitment to the inclusive schooling of children with disabilities. As of 2021, sixteen countries in the region had recognized the right to reasonable accommodations in education at the primary and secondary school levels, and eleven countries had recognized the right at the tertiary level.¹

Box 2.1 Target Population: Children and Youth with Disabilities and Learning Difficulties

Of the well-known challenges to the measurement and identification of children's disabilities, some are particularly relevant to the education sector. First is the well-known pattern of underreporting disability among children in household surveys and censuses, even when using the highest standards of measurement—the Washington Group (WG) questions. Parents and teachers may be wary of stigmatizing or labeling children or may not be able to interpret questions about child functioning. Children are also less likely to go through national certification processes of disability than older individuals, once again because parents may want to avoid labeling their children and also, because the social programs available to children with disability certification typically do not convey income subsidies or provide subsidies, but at lower levels than for adults. To improve the identification of disabilities among children, specific instruments have been developed, such as the WG/UNICEF Child Functioning Module (CFM), which has 24 questions for children ages 5 to 17, as reported by a parent, primary caregiver, or teacher. The estimate that 10–15 percent of regional children ages 6–17 have a disability is based on a global estimate for 44 countries using questions from the CFM (Emerson and Llewellyn 2023) as well as estimates for Chile, where household surveys, census data, and administrative data all provide estimates within this range. The CFM is a longer instrument than the WG short set of questions and tends to be included in surveys of specific populations about child well-being rather than broader survey instruments such as censuses, household surveys, and labor market surveys. The household surveys used in this report use the traditional WG questions, although some countries (such as Chile) are beginning to implement the CFM in their household surveys and censuses.

A related challenge pertains to measuring learning difficulties among children and youth. Many educational settings use the term *special needs* to include students with disabilities and learning difficulties. A learning difficulty fulfills the definition of a disability if the barrier to participation is met. Children with learning difficulties are a population at risk of developing learning disabilities, if they do not already have disabilities. The chapter considers a variety of instruments that may be used to better screen and assess students with disabilities and learning difficulties. In line with the literature, references to children with disabilities include children with learning difficulties.

¹ Only two countries do not legally recognize this right at the primary schooling level (Barbados and Suriname), and seven countries do not legally recognize it at the tertiary level (Barbados, Bahamas, Belize, Guyana, Haiti, Jamaica, and Suriname). Further, thirteen countries have laws establishing the obligation for educational infrastructure at all levels to be physically accessible (Argentina, Bolivia, Brazil, Chile, the Dominican Republic, Ecuador, Haiti, Honduras, Mexico, Panama, Paraguay, Peru, and Uruguay) and six countries establish the obligation for the government to provide accessible learning materials (Brazil, Costa Rica, Honduras, Mexico, Paraguay, and Peru).

While there is a strong commitment to promoting inclusive education, the region has not parted fully with segregated modalities (Bregaglio Lazarte 2021). Yet, in some circumstances children with disabilities may benefit from attending special schools or having separate instruction within mainstream schools. For instance, deaf children may benefit from the language and cultural exposure gained from studying in deaf schools. Article 24 of the CRPD supports environments that maximize the academic and social development of deaf and blind children.

Given the interest in promoting the schooling of children with disabilities, it is an imperative to support countries in the region in understanding what works for inclusive education and how to improve the learning outcomes of students. This chapter considers (1) the regional status of education for people with disabilities, and (2) outcomes of past interventions focused on students with disabilities.

Students with Disabilities in the Region: Statistics and Trends

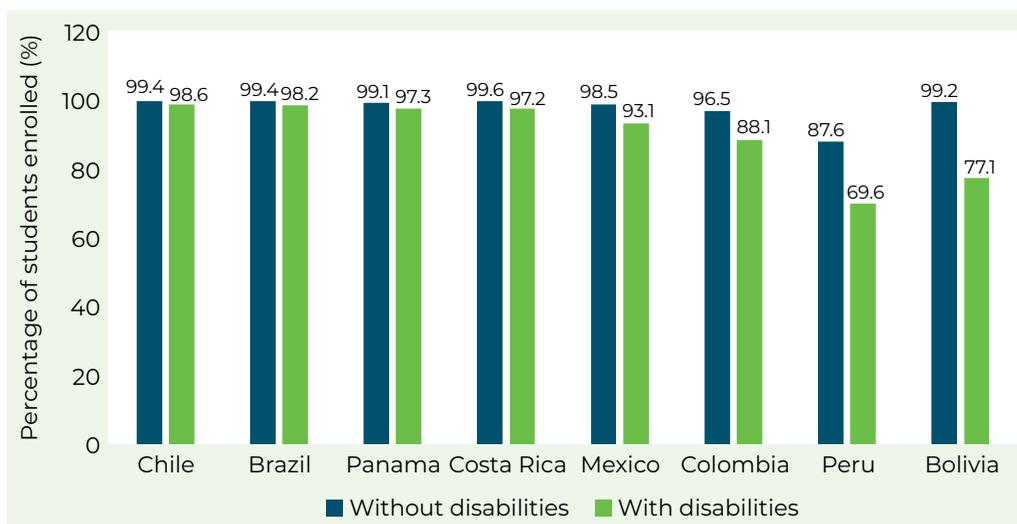
Most children with disabilities in the region are successfully enrolled in school and may expect to complete at least six years of education. However, comparing these outcomes with those of all adults, both with and without disabilities, reveals significant discrepancies. This broad comparison often shows a large gap, but is complicated by factors such as age differences. The experiences of many adults with the education system occurred decades ago; this is especially so among people with disabilities, who generally have an older age profile. For a more accurate assessment of the performance of education systems, the following analysis compares outcomes across disability statuses, for recent cohorts using recent household surveys and administrative data.²

As shown in Figure 2.1, enrollment rates among children with disabilities of primary school age (that is, 6–11 years) are at 70 percent or higher in all eight countries for which recent household survey data are available.³ In five of the eight countries, children with disabilities are enrolled at similar rates as their peers without disabilities, with enrollment gaps ranging from 1.0 to 5.4 percentage points. However, substantial enrollment gaps for primary-age children are estimated in Peru, Bolivia, and Colombia.⁴

2 One downside of the household survey data is that they do not cover children living in institutions. This is an area where improved measurement is needed.

3 The rates of enrollment follow the United Nations Educational, Scientific and Cultural Organization (UNESCO 2024a) methodology with primary ages corresponding to ages 6–11 and secondary to ages 12–17, which is also followed by the United Nations Children’s Fund (UNICEF 2022). Disability is assessed using Washington Group questions.

4 The larger gaps in Peru and Bolivia may reflect the lower prevalence rates recorded in the household surveys, as lower prevalence rates tend to record higher levels of disability.

FIGURE 2.1 | Enrollment Rates for Children of Primary School Age (6–11 years) (%)

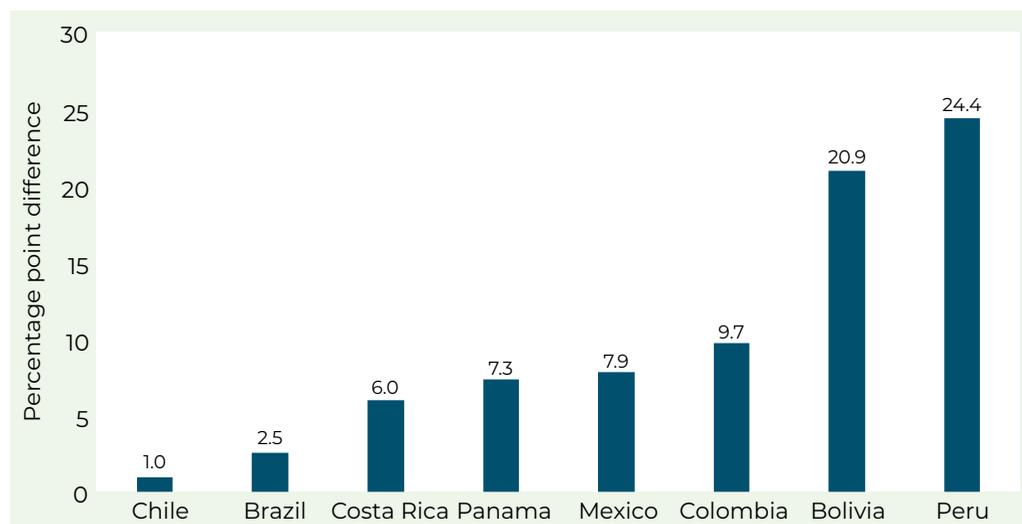
Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: The estimates utilize the Washington Group (WG) questions to identify children with disabilities. Learning difficulties would be captured under the WG questions related to communication and cognition.

In some countries (notably Brazil and Chile), more than two-thirds of children complete secondary school, and the gap between those who enroll in primary and secondary school is small. However, generally, the gaps in enrollment are higher at secondary-school ages. The average gap increases from 7.5 percentage points in primary years to 10 percentage points in secondary. This suggests that efforts to narrow these gaps should focus on secondary education. Bolivia and Peru have especially large gaps in secondary school enrollment, at more than 20 percentage points (Figure 2.2) following a large observed gap at the primary level. This implies a widespread challenge in achieving inclusion in enrollment, regardless of educational level.

Despite a strong legal framework, education systems, policies, and practices have not been traditionally designed to include children with disabilities. In Argentina and Bolivia, 49–61 percent of students with disabilities attend special schools. Even in countries where differences in enrollment are small, such as Costa Rica, a significant share of children with disabilities still attend special, separate schools (see Table 2.1). Specifically, in Costa Rica, the Dominican Republic, Ecuador, and Peru, 20 to 25 percent of students with disabilities are in separate educational settings. In contrast, Chile and Brazil have a significantly smaller share of students with disabilities and learning difficulties studying in separate settings (see Table 2.1).

The limited number of students with disabilities in mainstream schools in some countries may suggest that the transition to inclusive education is incipient and that there are political-economy challenges to implementing inclusion.

FIGURE 2.2 | Gaps in Enrollment Rates for Secondary School Ages (12–17 years)

Source: IDB staff calculations based on data from household surveys. Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: See note in Figure 2.1.

TABLE 2.1 | Administrative Data on Enrollment of Students with Disabilities and Learning Difficulties (SDL D) in Primary and Secondary Education

Country	Year	Total Registered SDL D		
		Regular schools with inclusion programs	Special schools	% of SDL D in special schools
Argentina	2018	91,244	40,857	44.8
Brazil*	2022	1,373,486	154,307	10.1
Chile	2020	342,900	41,141	10.7
Costa Rica	2023	9,769	2,919	23.0
Dominican Republic	2013	24,959	6,239	20.0
Ecuador	2023	32,356	9,705	23.1
Peru	2015	39,636	12,831	24.5
Uruguay	2022	NA	9175	NA

Source: IDB staff calculations using data from administrative reports from the ministries of education of Argentina (2019), Chile (2021), Costa Rica (2023), the Dominican Republic (2014), Ecuador (2023), Peru (2016), and Uruguay (2022). All sources are in the references section.

Note: The estimated number of students includes students with disabilities and with learning difficulties in primary and secondary schools as reported by the ministry of education of each country. The estimates do not include students in preschool or tertiary programs.

*In Brazil, the estimated percentage of students with disabilities in special schools also includes children in mainstream schools that are taught in separate classrooms and do not have any learning time alongside students without disabilities.

Since the years of schooling completed as reported in the household surveys do not account for the quality of the institution, strict comparisons are difficult, particularly when comparing years completed in mainstream and special schools. Our analysis indicates that two-thirds or more of children with disabilities ages 14–18 have completed six

or more years of schooling.⁵ The analysis also suggests that lower enrollment rates lead to lower completion rates, particularly at the secondary and tertiary levels; this supports earlier findings (Hincapié, Duryea, and Hincapié 2019).

For example, in Costa Rica, Mexico, and Panama, small gaps in primary school enrollment rates (2.35, 5.41, and 1.79 percentage points, respectively) do not translate into closed gaps at the secondary level (6, 7.85, and 7.32, respectively). This trend, in turn, translates into even larger gaps in completion rates at higher education levels (Table 2.2). In contrast, Brazil and Chile show a more positive trend, where gaps in enrollment at the primary and secondary levels are under 3 percentage points, and more than 68 percent of people with disabilities are likely to complete these levels of education. Their completion rates are within 10 percentage points of their peers without disabilities.

TABLE 2.2 | Gaps in Completion Rates between Persons with and without Disabilities

Country	Primary (6 years) (ages 14 to 18)	Secondary (ages 20 to 24)	Any Tertiary (ages 20 to 24)
Bolivia	21.6	30.0	19.9
Brazil	5.8	7.6	5.2
Chile	0.3	3.2	2.4
Colombia	14.1	8.8	4.1
Costa Rica	7.9	6.0	15.5
Mexico	5.9	13.2	7.7
Panama	4.7	10.5	9.6
Peru	33.5	48.4	38.0

Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: The gaps within each age group are defined as the average completion rate of people without disabilities minus the average completion rate of people with disabilities. Primary completion is defined as finishing at least 6 years of education. Secondary completion is defined as finishing the terminal year of schooling (equivalent to completing 11 or 12 years depending on the country). Completion of any tertiary education is defined as finishing at least one year of post-secondary education.

In Bolivia and Peru, the gaps in both enrollment and completion are large at all education levels. Specifically, the gaps in completion are 21.6 and 33.5 percentage points at the primary level, 30.0 and 48.4 at the secondary level, and 19.9 and 38.0 at the tertiary level for Bolivia and Peru, respectively (Table 2.2). These results may be related to the lower disability prevalence rates in these countries, which may be primarily capturing people with higher levels of functional difficulty (see Table 1.1). There is often an inverse relationship between prevalence rates and gaps in various indicators of well-being, including in education outcomes. Further research is needed on this issue. Nonetheless, these findings suggest that

5 This analysis follows UNESCO's methodology (UNESCO 2024b).

while children and youth with disabilities are not excluded from attending school, particularly at the primary level, significant disparities in both enrollment and completion persist into higher levels of education. Also, the integration of students with disabilities into mainstream schools and classes remains a significant challenge, with few exceptions.

Overall, children and youth with disabilities are attending school in the region, particularly at primary levels.⁶ Small gaps at primary levels, however, become larger at higher levels of education.

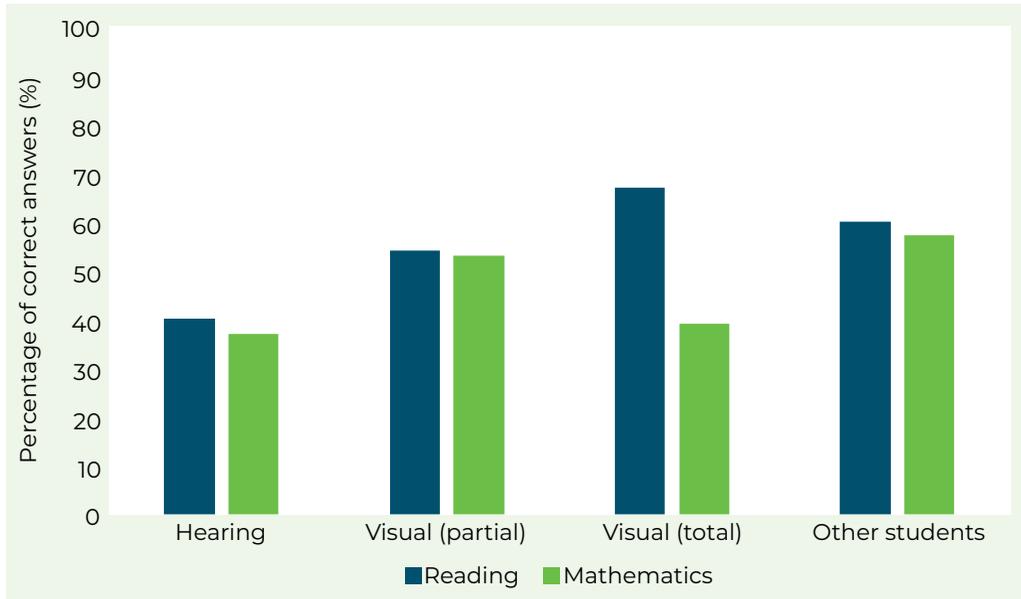
The differences in attendance, completion, and access to inclusive schooling likely have important implications for differences in learning outcomes between children with and without disabilities. Only a few countries in Latin America and the Caribbean collect data on how students with disabilities are doing in school. For instance, in 2019, the Ministry of Education in Peru reported that 3,230 students from a randomized sample of schools took part in the National Evaluation of Learning Outcomes (*Evaluación Nacional de Logros de Aprendizaje*, ENLA), which assesses students in the second, fourth, and tenth grades. Most students with disabilities scored below satisfactory, regardless of education level (Ministerio de Educación del Perú 2020). However, there are no publicly available data from ENLA that allow a comparison of the test results of students with disabilities relative to those without.

In Chile, the National Evaluation of the Quality of Education (*Sistema de Medición de la Calidad de la Educación*, SIMCE) allows for a comparison of the test results of fourth and tenth graders with and without disabilities. However, the evaluation specifically identifies and makes accommodations only for students with sensory disabilities. This leaves some uncertainty about how students with other types of disabilities perform compared against students without disabilities. Despite this, results from 2022 suggest that students with sight and hearing disabilities generally score lower than their peers without. For instance, fourth graders without disabilities outperform those with hearing disabilities in both reading and mathematics (see Figure 2.3). They also score higher in math than students with total sight disabilities, but not in reading, where students with total sight disabilities actually score higher (see Figure 2.3). Students with partial sight disabilities score only slightly lower than their peers without sight and hearing disabilities (see Figure 2.3).

SIMCE results for the fourth grade reveal that students with visual and auditory disabilities in mainstream schools tend to have better learning outcomes than those in special schools (see Figure 2.4). This suggests that inclusion might be more effective than segregation. However, it is also possible that students who require greater educational support or have lower achievement levels may predominantly choose or be placed in special schools. Further research is needed to clearly understand the differences in learning achievement between students with and without disabilities, and the effects of inclusive versus separate schooling.

6 The analysis finds no systematic differences by gender.

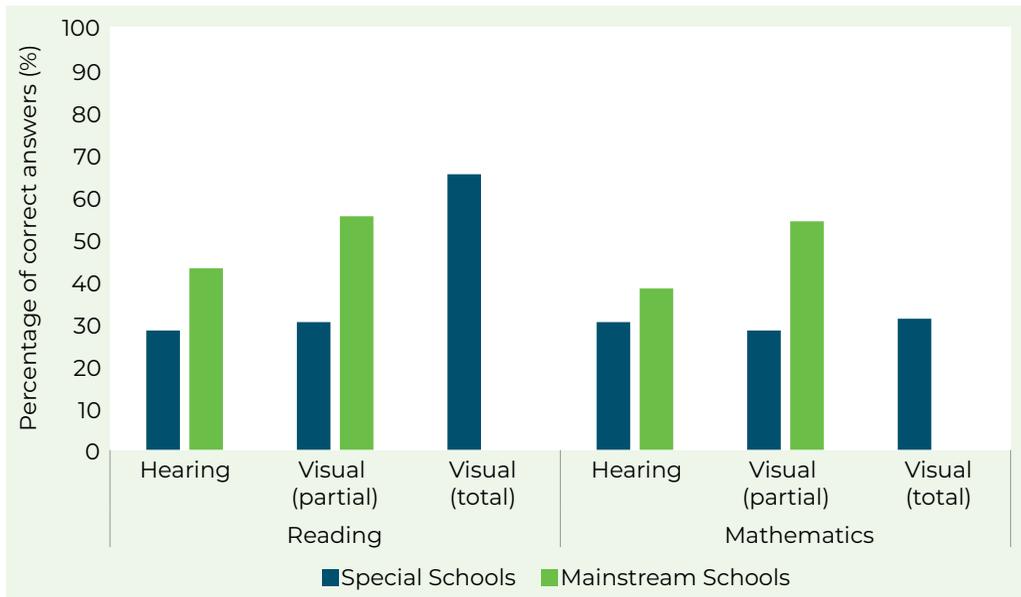
FIGURE 2.3 | Average Percentage of Correct Answers from Fourth Graders in SIMCE 2022, by Disability Status and Subject



Source: IDB staff calculations based on the 2022 SIMCE data.

Note: The report does not provide information on sample sizes yet guarantees that the results are representative. SIMCE = National Evaluation of the Quality of Education.

FIGURE 2.4 | Average Percentage of Correct Answers in SIMCE 2022 among Fourth Graders with Auditory and Sight Disabilities, by School Type



Source: IDB staff calculations based on 2022 SIMCE data.

Note: The report does not provide information on sample sizes yet guarantees that the results are representative. Results for students with total visual disabilities in mainstream schools are omitted since they are not representative. SIMCE = National Evaluation of the Quality of Education.

Policy Landscape

Primary and Secondary Education

Recognizing the large gaps in educational outcomes by disability, countries in Latin America and the Caribbean have responded by developing a wide variety of education policies and programs. Chile and Brazil stand out as having some of the most comprehensive measures. Furthermore, both countries have been successful in incentivizing the transition from segregation to inclusion.

In Chile, the Education Integration Program (*Programa de Integración Escolar*, PIE) offers vouchers to publicly funded schools that accept students with disabilities. For every student admitted under PIE, the educational institution receives a special education voucher that is three times the amount of the regular public education voucher. Each school can receive up to seven special education vouchers per classroom, two for children with longer-term support needs and five for children with learning difficulties.⁷ PIE requires schools to have specialized staff and differentiated teaching strategies to make them inclusive and accessible to all students.

Given the comprehensiveness of PIE, the program has been considered a best practice for inclusive education in the region. PIE and a centralized admission process are widely credited for the substantial decrease in the number of students enrolled in special schools in Chile. Presumably, children exiting special schools are being incorporated into PIE; at the same time, PIE is reaching children that were previously not receiving any support.

Chile's approach to inclusion stands out in the region by directly linking fiscal and educational resources with schools enrolling students with disabilities and learning difficulties. Also, by design, its centralized admission process does not discriminate against students with disabilities, allowing them access to any school receiving public funds. However, the voluntary nature of the PIE program is concentrating PIE students in vulnerable schools. Vulnerability is defined based on a school's score on the School Vulnerability Index (*Índice de Vulnerabilidad Escolar*), which is constructed using student poverty rates and indicators suggesting low academic achievement at the school level. The index considers whether the school has low average standardized test scores, low average grades, low attendance rates, a high probability of grade repetition, or a high probability of dropouts. In 2022, 58 percent of publicly funded schools had PIE, and of these close to 60 percent had more than 5 PIE students per classroom (Zúñiga, Carpentier, and Barilari 2023).

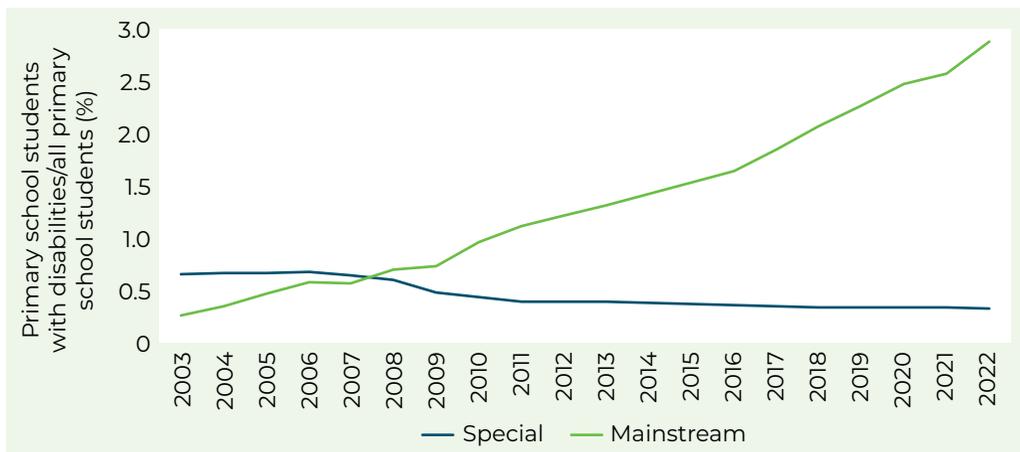
In Brazil, the national Specialized Educational Support Program (*Atendimento Educacional Especializado*, AEE) was launched in 2007 to provide learning support to students with disabilities in resource rooms within mainstream schools. These resource

⁷ Starting in 2023, the limit to students with permanent needs was eliminated.

rooms are support classrooms where students receive extra assistance, including tutoring and training. Baptista (2019) shows a steep decline in segregated education (learning exclusively in separate schools or exclusively in separate classrooms) after the policy was introduced. Resource rooms are intended to promote inclusion in mainstream classrooms and reinforce, not substitute for, learning that occurs there. Other countries in the region, including El Salvador and the Dominican Republic, use resource rooms to foster inclusion and learning.

Both Chile and Brazil have demonstrated that expanding inclusion is possible, albeit with different strategies. In both countries, most students with disabilities and learning difficulties are studying in mainstream settings. Presumably, children exiting special schools are being incorporated into PIE or AEE. Further, PIE and AEE are likely reaching children who were previously not receiving any support. The transition has been faster in Brazil than in Chile. In Brazil, from 2014 to 2021, the number of students in fully segregated settings decreased by 17.3 percent while the number of students with disabilities in mainstream schools increased by 69.5 percent (Figure 2.5). In Chile, during the same period, the number of students in separate schools decreased by 7.4 percent and the number of students with disabilities in mainstream schools increased by 36.5 percent (Figure 2.6). Yet, this is not an indication that the AEE program in Brazil outperforms PIE in Chile. If anything, the program in Chile covers a significantly larger share of children (15.8 percent of all primary school students) than the program in Brazil (3.2 percent of basic education students). Moreover, gaps in enrollment and completion rates are slightly wider in Brazil than in Chile (see Figure 2.2 and Table 2.2). Both systems require closer examination.

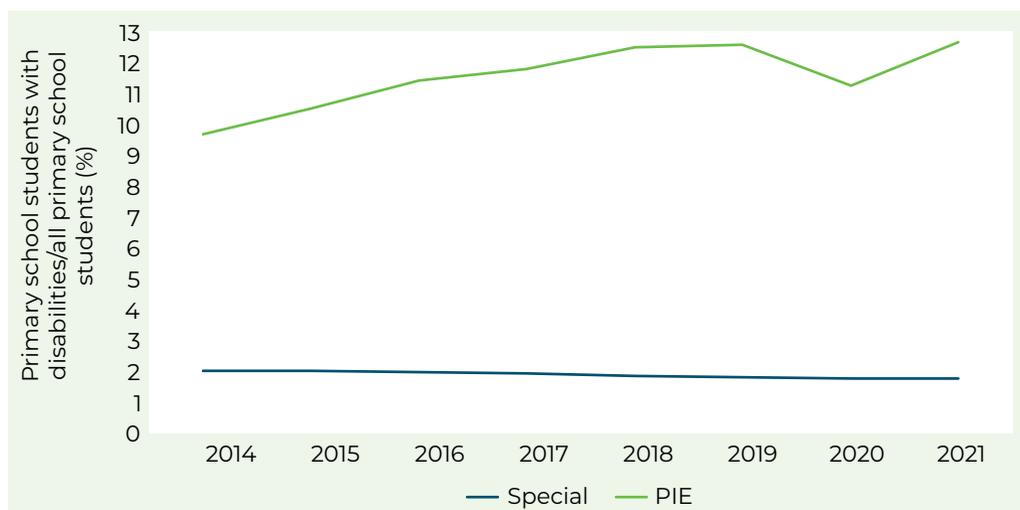
FIGURE 2.5 | Percentage of Children with Disabilities Enrolled in Special and AEE Primary and Lower Secondary Schools in Brazil, as Share of All Students, 2003–2022



Source: IDB staff calculations based on administrative data from Brazil's Ministry of Education and the Instituto Rodrigo Mendes (2024).

Note: AEE = Specialized Educational Support Program.

FIGURE 2.6 | Percentage of Children with Disabilities and Learning Difficulties Enrolled in Special and PIE Primary Schools in Chile, as a Share of All Students, 2014–2021



Source: IDB staff calculations based on administrative data from Chile's Ministry of Education.

Note: PIE = Education Integration Program.

Screening and Assessment

The screening and assessment of students with disabilities and learning difficulties is not approached in a uniform way across the region, in contrast to screenings for infants and children in the health sector (see Chapter 3). Countries use different instruments, without an age or grade standard. Students may then be assessed for specific difficulties. Many assessment instruments require training that is not widely available, for instruments that are not normed for populations in Latin America and the Caribbean. Assessments of learning disabilities often involve expensive licenses that are out of reach for many countries.

These screening and assessment processes seek to ensure that children with disabilities or learning difficulties can access the appropriate resources to ensure inclusion in academic and nonacademic activities. For instance, the Ministry of Education in the Bahamas implements the Bahamas National Screening Programme to locate, identify, and refer all first grade students who present learning difficulties and may have a disability (The Bahamas Ministry of Education & Technical & Vocational Training 2019). As in the Bahamas, many countries focus screening efforts on preschool and the early stages of primary school to prevent learning gaps from accumulating.

Several countries provide screening and assessment services throughout the basic education system. In some countries, such as El Salvador, teachers are using student information systems (EMIS) to screen for disabilities and learning difficulties. Other countries, such as Belize, are experimenting with teachers' reports on student functioning using a version of the Child Functioning Module for schools (CFM-TV). Chile and Brazil conduct

assessments throughout basic education for different types of disabilities and learning difficulties and require periodic updates to such assessments depending on the type of disability or learning difficulty. In contrast, smaller or resource-constrained countries may only provide services for specific types of disability. For example, Belize's Ministry of Education offers free hearing tests and hearing aids through its Special Education Unit (Ministry of Education, Culture, Science and Technology, Belize 2024). Similarly, the Dominican Republic provides testing for students with visual disabilities through the National Center for Educational Resources for Visual Disabilities Olga Estrella (Ortiz Bosch 2002).

Screening and assessment efforts are designed to be complemented by appropriate services. In Ecuador, for example, the Ministry of Education funds District Support Units (*Unidades Distritales de Apoyo a la Discapacidad*, UDAI), which provide free screening, referral, and psychoeducational supports to students with disabilities within each designated district. In 2022, there were 140 units, representing all districts in the country; in total, the UDAI served 56,370 students with disabilities, 82 percent of whom attended mainstream schools (Ministerio de Educación del Ecuador n.d.).

Learning support plans such as individualized education plans (IEPs) are increasingly common in the region. These plans are developed by a team of people that usually includes a child's parents, teacher, and other school personnel familiar with the assessment tools and the student's needs. The plan outlines educational goals, services, and reasonable accommodations the student will receive in school. However, the implementation of IEPs in the region is not without challenges. In Guyana and Chile, for example, researchers have noted mismatches between the needs identified in assessments and the support provided, and raised questions about whether IEPs are adequately monitored and adjusted (Spencer-Ernandez et al. 2023).

Assistive Devices and Adapted Materials

The provision of assistive devices (such as screen magnifiers and screen reader software) and adapted materials (such as Braille books) or even resources as low cost as easy-grip pencils is less common in Latin America and the Caribbean than in Europe or North America.⁸ Several national programs distribute accessible learning materials to students with disabilities in inclusive and special schools. Most commonly, programs focus on distributing learning materials in-person or online for students who are blind or have low vision, including Braille books, large print, audiobooks, and other didactic materials. In Brazil, schools can request adapted materials to be purchased and distributed through the Ministry of Education (Serviços e Informações do Brasil 2023). Similarly, Argentina has a program through which students, teachers, and schools can

8 While vision and hearing screening often occurs in schools, it is typically the health system, not education system, that provides assistive devices such as hearing aids or glasses.

request that printed materials be converted to Braille or audio versions (Gobierno de Argentina n.d.b). The program is run by the nonprofits National Braille Editorial and Libro Parlante with funding from the Ministry of Education and National Disability Service (*Servicio Nacional de la Discapacidad, SENADIS*). The approach exemplifies how countries in the region have used public-private partnerships to leverage the knowledge of specialized nonprofits and civil society organizations to enhance public service delivery.

During the COVID-19 pandemic, many countries developed online platforms, and television and radio learning materials to promote distance learning. Some countries took additional steps to ensure that materials and learning opportunities were accessible to students with disabilities. In a few cases, resources and materials targeting parents and teachers included training on various topics of inclusive education. While many of these initiatives are no longer being implemented, some have prevailed and continue to be used by students with disabilities, their families, and teachers. For example, during the COVID-19 pandemic, Peru's Ministry of Education adapted over 500 learning materials and resources for the online distance learning platform "*Aprendo en Casa*." These resources are now available under an updated platform "*PeruEduca*," and new, adapted materials are continuously being added. Similar initiatives to create and distribute accessible resources online were seen in Guatemala, El Salvador, Colombia, Chile, and Argentina (Kreussler et al. 2020). Their resources continue to be available through learning platforms of the ministries of education. Surprisingly, only Brazil has a large-scale program to improve the accessibility of schools for children with disabilities. Through the Accessible School Program (*Programa Escola Acessível*), schools can request grants to make architectural or structural adaptations. These include the construction and equipping of resource rooms.

Enhancing the accessibility of standardized tests is crucial for assessing the performance of students with disabilities and plays a significant role in their educational advancement. Ecuador, Colombia, Peru, and Chile, among others, have modified standardized test materials and procedures, ensuring that tests are available in high-contrast fonts, and made reasonable accommodations in test settings for students with disabilities, such as offering rooms with less stimuli and ensuring students have extra time so as to perform their best.

Educational Subsidies

Providing adapted learning materials and assistive technology is one way to diminish the learning gaps between children with and without disabilities. Another strategy focuses on giving students with disabilities and their families the necessary monetary resources so they can cover these needs themselves. In some cases, specialized resources are available only through private education. Few countries have publicly funded scholarship programs to increase access to primary and secondary education among students with

disabilities. In Ecuador, for example, students with disabilities in primary and secondary schooling can apply for a scholarship of US\$4,250, which can be renewed yearly. The scholarship funds can be used on education, transportation, and household expenses (Secretaría de Educación Superior, Ciencia, Tecnología e Innovación del Ecuador 2022).

Teachers

Although there has been a growing recognition of the importance of preparing all teachers to work effectively with diverse learners, including those with disabilities and learning difficulties, the extent and depth of pre-service training in inclusive education still varies widely. In some education systems, this training is offered only through dedicated courses or specializations in special education within teacher education programs. As a result, many new teachers may enter the workforce with little to no knowledge of how to implement inclusive practices.

While some teachers in Latin America and the Caribbean receive basic initial training on inclusive pedagogy, few systems in the region provide opportunities for in-service training or ongoing professional development (Payà 2020). More than half of teachers interviewed in three countries of the region reported a high level of unmet need for training on inclusive education (UNESCO 2020). Some supportive practices common elsewhere are missing in the region, including the provision of trained teacher aides who accompany students with disabilities in mainstream classrooms, as is common in the United States, Canada, and Europe. Also, human resource policies that support hiring teachers with disabilities are scarce in the region.

Tertiary Education and School-to-Work Transitions

Several countries in Latin America and the Caribbean have programs to support high school students with disabilities in the transition to life after graduation. Most focus on developing skills through technical and vocational education and training (TVET). A few countries have set up specific TVET programs for young persons with disabilities or have disability-specific components within larger programs.

In Peru, for instance, up to 100 students with disabilities receive a full scholarship through the Ministry of Education's National Scholarships and Educational Credit Program (*Programa Nacional de Becas y Crédito Educativo*, PRONABEC) to take on short technical-productive courses. In addition to funding tuition, the scholarship covers housing, food, transportation, and any educational materials needed during four months of study (PRONABEC 2023a). In Argentina, the Ministry of Labor, Employment and Social Security finances the cost of technical courses for people with disabilities (Gobierno de Argentina, n.d.a). In Costa Rica, the program *Empléate* provides free technical vocational courses for

young men and young women who are not working or studying. The program has a disability-specific modality, *Empléate Inclusivo*, which allows persons with disabilities between 17 and 35 years old to access free training (Ministerio de Trabajo y Seguridad Social de Costa Rica 2023; ILO 2017). Other countries in Latin America and the Caribbean have similar programs focused on encouraging youth with disabilities to access technical skills training. However, no countries have implemented comprehensive programs to support students in their school-to-work transitions in the manner of widespread school-based vocational rehabilitation programs, as is the norm in the United States and other high-income countries.

Looking at higher education, a few countries have programs to support students with disabilities through grants and loan programs. In addition to the grants for students accessing technical-productive training, PRONABEC in Peru also funds 10 full scholarships for students with disabilities accepted into university or technical institutes. In addition to covering tuition, housing, food, and transportation over the course of the entire degree program, the program also gives each beneficiary a laptop (PRONABEC 2023b). In Colombia, the National Institute for Educational Credit and Technical Studies Abroad (*Instituto Colombiano de Crédito Educativo y Estudios Técnicos en el Exterior*, ICETEX) has a loan program for vulnerable populations, including persons with disabilities; students start repaying their loans only after they have finished studying, at a subsidized interest rate of 1.03 percent per month (ICETEX n.d.). In 2021, ICETEX announced that low-income students with disabilities could apply for grants covering 100 percent of tuition and living expenses (ICETEX 2021). Chile offers support to students with disabilities in higher education, targeting around 1,000 students (*Programa de Apoyo a Estudiantes con Discapacidad en Educación Superior*). Grants range between US\$1,000 and US\$4,700 and cover expenses like personal assistance, transportation, care, and materials such as computers or software. These types of programs are especially vital in areas without other mechanisms supporting access to higher education for students with disabilities.

What Does the Evidence Say?

There is limited rigorous evidence from low- and middle-income countries on interventions focused on improving the educational outcomes of children with disabilities; instead, most data come from high-income countries. Yet, findings from studies of high-income countries can provide important guidance for Latin America and the Caribbean, both in terms of policy and research development. This section considers the evidence on school-, teacher-, and student-based interventions that have been rigorously evaluated and explores their policy and research implications for the region.

The debate on inclusion versus segregation in education is crucial and merits rigorous study. Advocates for inclusive education argue that allowing children with disabilities to study alongside their peers without disabilities is not only a right, but it may also

improve their educational outcomes. There may be important spillover effects through which students with disabilities benefit from studying alongside peers without disabilities. Moreover, by studying in inclusive schools, students with disabilities may be exposed to higher standards of learning than those typically applied to special schools. On the other hand, advocates for special, separate schools argue that mainstream schools may not be equipped, both in terms of resources and educational training, to meet the needs of students with disabilities. Building a solid evidence base is essential to determine if inclusive education truly enhances learning outcomes for all students.

Incipient research suggests neutral or positive effects from inclusion on the learning outcomes of children with disabilities. For instance, Hanushek, Kain, and Rivkin (2002) find that including children with disabilities in a mainstream classroom in Texas increased their educational performance by 3–4 percentage points. Similarly, Myklebust (2007), using data from upper secondary education in Norway, finds that students in inclusive education were over 75 percent more likely to obtain a vocational or academic credential than those receiving an adapted education in special classes. And several studies indicate that inclusion is a win-win solution for all concerned. Literature examining spillover effects suggests that inclusion with adequate supports and with a reasonable proportion of students with disabilities to students without disabilities does not have large negative effects on the learning of students without disabilities. Hanushek, Kain, and Rivkin (2002); Friesen, Hickey, and Krauth (2010); and Ruijs (2017) find that including students with disabilities in regular classrooms has no significant impact on the academic achievement of their peers in the United States, Canada, and the Netherlands, respectively. While inclusive education is generally seen as beneficial, a few studies find negative spillovers associated with inclusive education (Fletcher 2010; Kristoffersen et al. 2015). For example, Balestra, Eugster, and Liebert (2022) show a negative peer effect when the share of students with disabilities was larger than 15–20 percent. However, these adverse effects can likely be mitigated with appropriate support. For instance, Contreras et al. (2020) find that while mainstreaming children with disabilities in regular classrooms in Chile has small negative effects on the math and literacy test scores of students without disabilities, these negative effects vanished when additional resources and support protocols for inclusive education were introduced. This suggests that with proper support, the challenges of inclusive education can be effectively addressed.

In high-income countries such as Canada, Portugal, the United Kingdom, and the United States, a common approach is to provide classroom assistants for students with disabilities in mainstream classrooms. Co-teaching both reduces the student-teacher ratio and provides teachers with relevant expertise in the classroom to support differential learning.⁹ A recent study in the United States found that a co-taught classroom improves the test scores of students with and without disabilities, particularly in math

⁹ In Europe the terms *learning assistant* and *support assistant* are most common, whereas in the United States, *teacher's aide* or *assistant teacher* are commonly used.

(Jones and Winters 2022). The same study finds that the benefits of co-teaching are greater in middle than in primary school.

In summary, including children with disabilities in mainstream schools can improve their educational outcomes without sacrificing the learning of those without disabilities. However, given that these studies take place in high-income countries, it is unclear whether the effects of inclusion would be similar in low- and middle-income countries. In high-income contexts, many key preconditions are in place to ensure the success of inclusive education, such as accessible infrastructure, extensive teacher training, and student access to assistive technology. For example, in Chile, as discussed, the strategy supporting inclusive education is much more comprehensive than in other Latin American and Caribbean countries. It is unclear whether the same results would hold in more resource-constrained contexts where comprehensive measures may not be feasible. This uncertainty highlights the importance of ongoing research on how to effectively implement inclusive education across Latin America and the Caribbean, ensuring it does not compromise the learning outcomes of any students.

As described earlier, in many Latin American and Caribbean countries, inclusion strategies have largely centered on providing targeted support to students with disabilities rather than implementing large-scale, comprehensive programs like Chile's PIE. The targeted support provided to date includes access to assistive technology, adapted materials, and specialized teaching. While most of these interventions have not been formally evaluated, there is some evidence from outside the region that isolated interventions can significantly benefit students with disabilities, demonstrating the potential for positive outcomes even in the absence of broader inclusion programs.

For instance, providing glasses to children with vision impairments has benefits that include enhanced academic performance and psychological well-being. Glewwe, Park, and Zhao (2016) discovered that distributing eyeglasses to primary school students in China raised test scores, especially among those with lower levels of academic achievement. Similarly, Hannum and Zhang (2012) observed positive outcomes in math and literacy scores, as well as grade advancement. However, a study conducted in low-income schools in the United States by Glewwe, West, and Lee (2018) revealed that merely screening for vision impairments was insufficient to boost student achievement. Although providing free eyeglasses initially improved test scores, the effects diminished over time, indicating the necessity of ongoing support mechanisms to maintain academic progress. Guan et al. (2018) found that while glasses reduced general anxiety levels among students, they also exacerbated learning anxiety for some students. However, overall, the evidence on providing glasses to school children shows positive impacts on learning outcomes.

It is expected that providing other types of assistive technology, such as hearing aids or prostheses, may have similar impacts, as would adapted learning materials. Since most countries in the region have programs to distribute adapted learning materials and/or assistive

technology it is important to evaluate these programs. Also, it is important to evaluate relevant regional initiatives to date. Vidigal (2023) examines the effects of providing schools in Brazil with a range of resources, including text-to-audio screen readers and adapted furniture for resource rooms. Equipping resource rooms led to a significant increase in enrollment and the promotion of students with disabilities in grades 6–12. Research conducted by Contreras, Duryea, and Martínez (2023) underscores the disproportionate impact of COVID-19 on high school students with disabilities, suggesting the importance of in-school resources that were often limited during the pandemic due to widespread school closures.

There is limited evidence of the impact of teacher training on inclusion. Feng and Sass (2013) analyzed the effects of special education training in Florida, United States. Being taught by a teacher with special education certification significantly improved math and reading achievement among students with disabilities—by 0.01–0.02 standard deviations (SDs) and 0.02–0.03 SDs, respectively. However, students without disabilities saw a slight decrease in achievement when taught by these teachers—by 0.01 SDs in both subjects. Notably, the positive influence of teachers trained in special education increases alongside years of experience, highlighting the importance of early career retention. Surprisingly, the study also found that in-service professional development did not seem to affect the performance of students with disabilities. These findings underscore the importance of incorporating special education training into teachers' college curriculums, and the challenge of translating training into practice. Jones and Winters (2022) study the impact of co-teaching in Massachusetts, United States, finding it improved the math test scores of students both with and without disabilities. Students with disabilities who shifted from a single-teacher classroom to a co-taught setting saw their scores increase by 2.6 percent of a standard deviation, while the scores of students without disabilities increased by 1.2 percentage points.

School-to-work interventions for students with disabilities, mostly studied in the United States, show promising results. Yin, Siwach, and Lin (2023) consider the impact of vocational rehabilitation programs in Maine, United States. These programs are delivered by counselors who assist secondary school students with disabilities in developing personalized work plans that aim to meet their employment goals and connect them to relevant services. Such services include training (on the job or in higher education programs) and apprenticeships, job support, job placement, work tools or accommodations, and job skills coaching, among others. The study found significant benefits: students with an individualized employment plan saw a 15.4 percentage point increase in employment and an 84 percent increase in average quarterly earnings, amounting to US\$1,442 (2018 dollars). The effects were particularly pronounced among participants under 18 years. Similarly, Langi et al. (2017) find that school-based vocational rehabilitation programs that include targeted, contract-based employment matching are more effective than traditional vocational rehabilitation provided outside school. These findings underscore the potential of integrating vocational support in educational settings to improve the job prospects of youth with disabilities.

Key Takeaways

The analysis of data and programs finds that children and youth with disabilities in Latin America and the Caribbean are not excluded from attending school, particularly at primary levels. However, inclusion in accessible mainstream schools with differentiated curricula and assistive technology continues to be a challenge. Furthermore, there is a rapidly growing evidence base, both in the region and globally, on interventions to support the learning of children with disabilities. From this analysis, several conclusions and recommendations emerge.

It is important to build a knowledge base by evaluating promising practices. This would provide concrete data on what works and what doesn't. Perhaps the most important overall promising practice is inclusion itself, followed by the distribution of assistive technology and adapted materials. For instance, it may be relevant to explore questions regarding the optimal level of students with disabilities per classroom. Further, it is important to evaluate whether inclusion alone has positive effects or if accompanying interventions (such as the provision of school resources) are necessary to yield positive effects, as is the case in Contreras et al. (2020).

Evaluating high-cost and widely implemented programs is crucial to ensure the efficient use of resources in education. These include programs that distribute assistive technology and adapted materials, prevalent across countries in the region. While evidence on the provision of glasses suggests that these types of programs likely have positive impacts, it is important to gauge to what extent they are sufficient in enhancing learning outcomes.

On the other hand, the preliminary evidence supporting PIE in Chile and AEE in Brazil is positive. It is important to evaluate whether incentive-based policies outperform other approaches to inclusion in fostering mainstreaming and improving learning outcomes. Doing so can help establish the cost-effectiveness of different policy packages, a critical consideration in many countries. Exploring performance-based incentive schemes could also be beneficial. No country has yet evaluated such approaches to ensure that children with disabilities are not only admitted to mainstream schools but also receive the support necessary to improve their learning outcomes.

A lack of knowledge regarding effective strategies to help people with disabilities transition from school to work is concerning. Some countries in Latin America and the Caribbean have large scholarship and educational loan programs, but there is no solid evidence of their effectiveness. Reasonable accommodations and programs that facilitate the school-to-work transition have been studied to a small extent in the United States. It is imperative to expand the knowledge base on how to support students exiting secondary education. At the same time, it is remarkable that there is no systematic drop in enrollment from secondary to tertiary education.

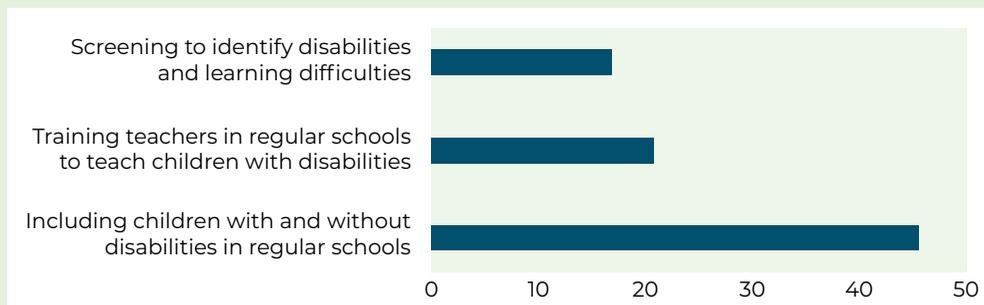
The review suggests that Latin American and Caribbean countries could gain from adopting co-teaching programs, evaluating teacher training, and monitoring IEPs. While evidence of their efficacy is still emerging, it is advisable to expand these practices more broadly across the region.

By continuing to collect evidence and conduct assessments, countries in the region can make more informed decisions about educational policies and practices that enhance the learning experiences and outcomes of students with disabilities, promoting a more inclusive and equitable educational environment.

Box 2.2 Priorities for Education Research

As mentioned in Box 1.3, the IDB is conducting an online survey to gauge existing views in the region, particularly those of people with disabilities and their families, on what disability inclusion policies and measures should be prioritized in research agendas. This box presents the results of the responses received as of May 2024.^a While these results are based on only 150 survey responses and are therefore not representative, they can provide insights for future initiatives, particularly given the challenges associated with surveying people with disabilities. As shown in Box 1.3, survey respondents identified a focus on education research as their top priority. Within this policy area, the top three research priorities are given in Figure B.2.2.

FIGURE B.2.2 | Top Priorities for Education Research



Source: IDB staff calculations based on results from the online survey.

Overall, the main priority is researching the effects of inclusion of children with and without disabilities on learning outcomes, training teachers on inclusive pedagogy, and screening to identify children with disabilities and learning difficulties. These are interesting results considering that most respondents had direct or indirect experience with special schooling: 17 percent of respondents had attended a special, separate school for an average of 7 years, and 60 percent of respondents had a child or dependent who had attended a special school for an average of 10 years. The research priorities do not vary depending on the age of respondents.

^a If you would like to offer your opinion on research priorities for the inclusion of people with disabilities, please fill out the survey at the following link through June 2025: <https://accessiblesurveys.com/s2/-NoXa0IViThWvED1daoy>.



Health



The Benefits of Inclusive Health Care

Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) recognizes the right of people with disabilities to discrimination-free access to the highest standard of health care (United Nations 2007). Having a disability is not equivalent to poor health. For instance, many hearing impaired individuals need only periodic appointments to calibrate their hearing devices, without requiring additional treatment associated with their disability. Yet, like everyone else, people with disabilities fall sick and need health services, including prevention, diagnosis, and treatment. Moreover, people with disabilities have higher health care needs on average. Some of these needs are directly related to specific impairments while others result from comorbidities (Kuper and Heydt 2019; Kuper et al. 2014). For instance, individuals with a spinal cord injury and resulting mobility disabilities often require periodic medical care to manage medications for pain, spasms, and bladder and bowel dysfunction associated with the injury (Schwartz and Unni 2021). Individuals with disability deserve equal access to quality treatment for their well-being and to prevent further functional decline, regardless of whether specific health care needs are associated with their disability.¹ Providing access to reliable, quality health care to persons with disabilities is an important obligation of the state.

Given that all countries in Latin America and the Caribbean—including all 26 member countries of the Inter-American Development Bank in the region—have ratified the CRPD, they inherently recognize such obligations. Of these, nineteen countries recognize both the right to comprehensive health care and the right to rehabilitation for

¹ A functional limitation is defined by the level of difficulty that a person has in key domains of bodily functioning, including seeing, hearing, mobility, communication, cognition, and self-care. Functional decline is the increase in functional limitation over time, that is, the ability to independently perform in these key domains (National Center for Health Statistics 2024).

people with disabilities in their local legislation, four recognize one or the other, and three (Suriname, Belize, and Barbados) are notable exceptions for recognizing neither. Rehabilitation services are medical interventions designed to help maintain or improve an individual's functioning. Such services may include physical therapy, speech and language therapy, psychosocial therapy, occupational therapy, and access to appropriate assistive devices, along with medication regimens. Most rehabilitation is temporary, related to the immediate needs of navigating a change in functionality or facilitating a life transition, such as returning to work or school. Nonetheless, some people with disabilities may require rehabilitation services for longer periods of time. Rehabilitation is considered a primary strategy for improving the health and functioning of people with disabilities. Also, seven countries in the region (Brazil, Peru, El Salvador, Honduras, Mexico, Nicaragua, and Panama) have laws recognizing the right to nondiscrimination based on disability in accessing private insurance (Bregaglio Lazarte 2021). However, some regulatory frameworks are yet to be aligned with the CRPD. Many of the problematic norms are centered on denial of legal capacity, with the absence of adequate procedures to determine decision-making capacity or mechanisms to facilitate supported decision-making.² For instance, 22 Latin American and Caribbean countries have regulations that allow medical professionals to reassign consent to another party for persons with intellectual or psychosocial disabilities, and 23 countries still allow the involuntary surgical sterilization of people with disabilities under certain conditions, especially women with intellectual disabilities (Bregaglio Lazarte 2021). Evidently, there is still a long way to go in improving the legislative framework for the health of people with disabilities.

In addition to legal and moral arguments, several economic arguments favor promoting disability inclusion in the health sector. Doing more to include persons with disabilities in health services can result in improved school attendance and learning outcomes for children, and can subsequently improve their productivity and long-term earning potential. This in turn can reduce reliance on social protection schemes in the long run, reducing government expenditure (see Chapter 5).

By contrast, delayed access to medical services can result in deteriorating levels of functioning in persons with disabilities, increasing personal medical expenditures in the long run. Persons with disabilities may face higher overall health care costs relative to their peers without disabilities due to underlying conditions requiring periodic care.

2 Article 12 of the CRPD recognizes the right of persons with disabilities to enjoy legal capacity on an equal basis as others. Legal capacity refers to a person's authority, under law, to make their own decisions. It is a legal status that cannot be arbitrarily determined by health professionals, although health professionals are often consulted when legally determining that a person has limited legal capacity and is placed under conservatorship or guardianship. Increasingly, the least restrictive alternative requirement for diminished legal capacity includes the consideration of technological assistance and supported decision-making. Supported decision-making is an alternative to having a legal guardian and allows people with disabilities to keep their rights and their decision-making capacity with the help of trusted advisors, such as friends, family, or professionals (Pope 2023).

Additionally, people with disabilities often face accessibility and attitudinal barriers to accessing health care services that may hinder them from receiving timely care, and subsequently can result in a worsening of illnesses or complications; this can imply higher costs relative to receiving care before an illness worsens (Banks, Kuper, and Polack 2017). Persons with disabilities are also more likely to experience catastrophic health expenditures (Azzani, Roslani, and Su 2019).³ Indeed, according to the *World Report on Disability*, people with disabilities were 50 percent more likely to report catastrophic health expenditures than people without disabilities (WHO and World Bank 2011). More recent analysis from Argentina also shows that persons with disabilities experience higher health costs (Puentes, forthcoming). These extra medical costs can perpetuate the poverty cycle among persons with disabilities and their families.

Exclusion from health care also imposes large societal costs. The productivity gains from improved health can aggregate at the macroeconomic level as improvements to the gross domestic product. Additionally, involving persons with disabilities in public health campaigns to reduce the prevalence of preventable diseases, may have important positive spillover effects for society at large (Banks and Polack 2014).

There is a fine line between general health interventions and interventions focused on disability health. General health interventions focus on preventing, treating, and potentially curing underlying medical conditions—and are not the focus of this chapter. Instead, this chapter focuses on disability health policy, which looks to sustain or improve the functioning of people with disabilities or those that could develop a disability. For example, preventing a congenital condition by offering prenatal vitamins is considered a health intervention that can reduce the health burden of certain diseases. By contrast, providing an early intervention for children with autism to maximize their developmental potential or providing glasses for a person with vision difficulties is considered a disability intervention. Given the important distinctions between these two frameworks, Box 3.1 presents an examination of the health and disability terminology used to calculate the Global Burden of Disease. In a nutshell, the interventions considered in this chapter are those that aim to improve the welfare of people with disabilities, including interventions to identify persons with disabilities and those at risk of developing a disability, interventions that aim to address their health needs, and interventions to reduce barriers to health care services.

It is essential to support countries in the region in promoting the health and well-being of persons with disabilities. Encouraging access to timely, quality, accessible health

3 Catastrophic health expenditures refer to medical costs that are so substantial relative to a person's income or financial resources that they pose a severe burden, often leading to significant financial hardship or impoverishment. These expenses typically arise from unexpected or serious medical events, for example, major surgeries, prolonged hospitalization, or chronic illnesses. In the literature, catastrophic health expenditures are usually considered to exceed 25 percent of the household income or the past year's expenditures (The Global Health Observatory n.d.).

care begins by evaluating what works for inclusive health care. This chapter considers (1) the status of health care for people with disabilities in Latin America and the Caribbean, (2) rigorous evidence on the effectiveness of health care interventions for people with disabilities, and (3) the priorities of civil society concerning research on health policy for persons with disabilities.

Box 3.1 The Global Burden of Poor Health (Not Disability!)

The Global Burden of Disease is an annual study conducted by the Institute of Health Metrics and Evaluation and supported by the World Health Organization. It is one of the main analytical products informing health policy around the world. The study's purpose is to estimate the national and regional "burden" posed by different conditions on society based on three measures, in turn providing a framework for prioritizing health interventions:

- **Years of life lost (YLL)** are the years of life lost due to premature mortality. They are calculated by multiplying the total deaths associated with a given condition by the standard life expectancy at the average age of death of persons with that condition.
- **Years lived with disability (YLD)** are the total number of years that a person lives with a disability due to a specific condition. They can also be understood as the quality of life lost due to disability. They are calculated by multiplying the prevalence rate for a given condition by the product of the average duration of that condition and a disability weight. The weighted term is intended to represent the severity of the given condition based on how it affects quality of life.
- **Disability-adjusted life years (DALYs)** are the healthy life years lost due to a condition. It is calculated by summing YLL and YLD.

It is worth noting that capturing disability in YLD and DALY calculations has been deemed controversial. The main criticism is that the methodology measures the consequences of health conditions, rather than disability, while using the "disability-adjusted" terminology has unintended consequences. The disability weight for each condition is set through surveys where people are asked to rate which conditions they consider to impact quality of life the most severely. The values of the weights are developed based on this process—assigning values from zero to one—and the desirability of different conditions is evaluated. This is a representation of a range of severity, spanning from conditions with no effect on quality of life, to conditions so severe that one year lived with them is mathematically equal to death. Inadvertently equating disability with death promotes the notion that the lives of persons with disabilities are not worth living. This can result in the lives of persons with disabilities being devalued in policymaking, even though DALYs were never meant to be used as statistical values for life (Mont 2007). Additionally, the surveys used to set these weights are often not representative of persons with disabilities. Studies find that people without disabilities perceive a more negative impact of health conditions associated with disability on quality of life than persons with disabilities that have those conditions (Mont 2007). These unintended pitfalls could be avoided if the literature on the burden of disease moved away from YLD and DALYs to years lived with a health condition (YLH) and health-adjusted life years (HALYs), so that disability is no longer directly equated to disease and low quality of life. It is also essential that persons with disabilities be included in data collection efforts used to estimate the burden of various illnesses and conditions.

The Health Care Needs of Persons with Disabilities

While disability does not imply illness, on average, persons with disabilities have higher medical needs than their counterparts without disabilities, especially in low- and middle-income countries (Kuper and Heydt 2019; Kuper et al. 2014). These higher health needs on average stem from reasons specifically related to the nature of the disability. Persons with disabilities often require medical services to access and learn how to use assistive devices (e.g., wheelchairs, prostheses, hearing aids, or glasses), besides other rehabilitation services. Additionally, for some, their disability is associated with underlying health conditions requiring medical treatment and/or medication, to improve quality of life and reduce the risk of morbidity or mortality. Further, since disability is highly associated with older age (see Chapter 1), persons with disabilities are more vulnerable to age-related conditions (WHO and World Bank 2011). Further, some persons with disabilities are more susceptible to premature aging, and, hence, to developing age-related conditions at a younger age; for instance, among adults in their 40s and 50s, the incidence of Alzheimer's is significantly higher among those with Down Syndrome (Zigman et al. 2004; Holland et al. 1998; McGlinchey, McCallion, and McCarron 2020).

In some parts of Latin America and the Caribbean, food insecurity and poverty rates are higher among persons with disabilities than their counterparts without disabilities (see Chapter 5). This puts persons with disabilities at an increased risk of experiencing adverse health outcomes. In some Latin American and Caribbean countries, persons with disabilities living in poverty may also be at an increased health risk due to inadequate access to water and sanitation compared with their counterparts (Duryea, Pinzon and Pereira, forthcoming). In addition, low household income can constrain investments in health. These conditions can put persons with disabilities at a disproportionate risk of illness relative to their counterparts without disabilities.

Environmental barriers also compound the risk of persons with disabilities being excluded from health services. People with disabilities may face significant barriers in accessing medical treatment given that public infrastructure is often inaccessible, especially in the health and transportation sectors. Indeed, no Latin American and Caribbean country has laws recognizing the right to reasonable accommodation in health services, and only four countries (Brazil, Bolivia, Colombia, and Mexico) have norms establishing an obligation to have accessible health infrastructure. In other words, in most Latin American and Caribbean countries, doctors' offices, clinics, and hospitals are not specifically obligated to comply with accessibility norms, even though some may have general building codes on accessibility. Even where accessibility-related construction codes exist, access to public facilities continues to be a struggle for people with disabilities, because the requirements of the laws are not described in coherent language, and regulations such

as building codes are inconsistent, impeding the implementation of universal access (García Mora, Schwartz Orellana, and Freire 2021). Persons with disabilities may struggle to access important medical information due to the inaccessibility of public health campaigns (e.g., not providing information in easy-to-read formats, large print, an accessible digital format, or with sign language interpretation or closed captions); yet, only Chile, Peru, Venezuela, and Mexico legally require that public health information and communication be accessible (Bregaglio Lazarte 2021). Challenges in accessing timely medical care puts persons with disabilities at increased risk of functional decline and developing complications and comorbidities.

Limited studies suggest that, in high-income countries, the prevalence of noncommunicable diseases is higher among persons with disabilities than among people without disabilities. However, these studies are limited to a few countries under specific conditions (MBI and CHAI 2022). Much more analysis is needed, including for Latin America and the Caribbean.

A lack of accessibility in public spaces, including streets and workplaces, puts people with disabilities at an increased risk of accidents. Several studies find that persons with disabilities are at an increased risk of fall-related injuries, occupational injuries, and nonoccupational injuries (Shi et al. 2015; Lee et al. 2008). A review of studies from the United States, Australia, Great Britain, and Sweden found that disability significantly increases the risk of road traffic injuries, presumably due to street and road inaccessibility (Schwartz et al. 2022). The inaccessibility of public spaces may also put persons with disabilities at an increased risk of low levels of physical activity. It is unsurprising, therefore, that research from the United States finds that some persons with disabilities, especially adults with developmental disabilities, are at an increased risk of chronic health conditions related to sedentarism, including high blood pressure, cardiovascular disease, and diabetes (Havercamp, Scandlin, and Roth 2004).

People with disabilities also face significant attitudinal barriers and exclusion, putting them at an increased risk of abuse and neglect. In the United States, documented incidents of violence against persons with disabilities have been 4–10 times higher than those against persons without disabilities (Marge 2003). Administrative data from Peru showed over 3,500 reported cases of violence against persons with disabilities in 2023, representing approximately 2.1 percent of all reported cases; most of these cases correspond to instances of violence against women (71.1 percent) (Ministerio de la Mujer y Poblaciones Vulnerables del Perú 2023). These data only consider the number of reported cases. The figure is likely much higher for persons with disabilities who are abuse and neglect victims. For instance, an analysis of a survey on violence against women in Colombia showed that 72 percent of women with disabilities who have been married or have lived with a partner, suffered at least one type of violence (psychological, physical, sexual, or economic) from their partner during their lives; the percentage is 67 percent

for women without disabilities (Marques Garcia Ozemela, Ortiz, and Urban 2019). In Costa Rica, the results of the 2018 National Disabilities Survey indicate that 38.1 percent of men with disabilities and 61.9 percent of women with disabilities had been the object of violence or sexual abuse (INEC 2019). Given that persons with disabilities in Latin America and the Caribbean are at an increased risk of violence, their higher likelihood of developing abuse-related conditions (e.g., sexually transmitted diseases), violence-related injuries, and trauma-related mental health conditions (e.g., post-traumatic stress syndrome, depression, and anxiety) is quite probable.

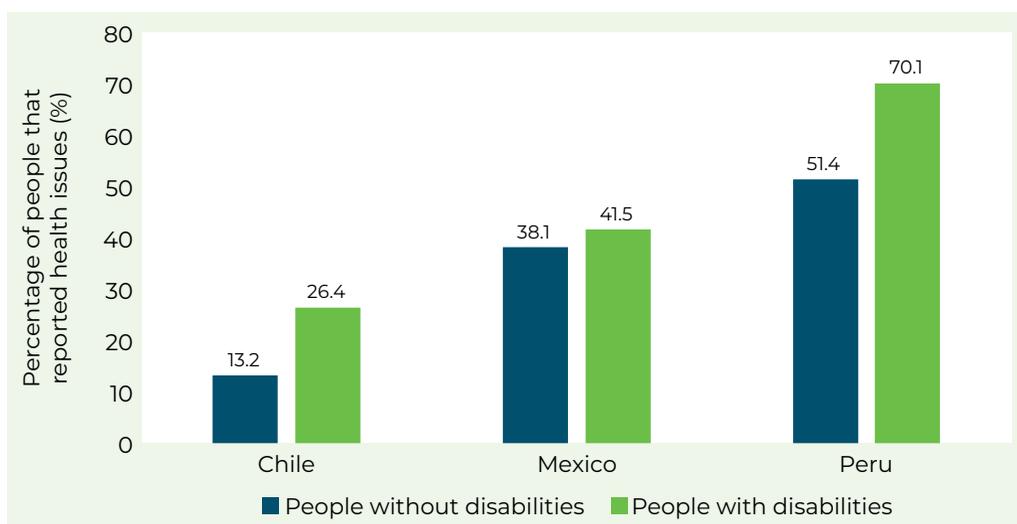
Additionally, studies from Australia, the United States, Canada, and Rwanda have shown that people with disabilities are at an increased risk of engaging in health-risk behaviors such as smoking, alcohol consumption, and recreational drug use (Schulz et al. 2022; Rimmer and Rowland 2008; Woodcock and Pole 2007). These behaviors may directly stem from psychological distress and abuse-related trauma, as well as, generally, exclusion from social participation.

Some data also suggest a higher probability of persons with disabilities experiencing mental health conditions. For instance, Emerson and Llewelyn (2023) estimate differences in prevalence rates of mental health conditions among children with and without disabilities in 44 countries using the most recent round of Multiple Indicator Cluster Survey data. They rely on parental reports of signs of anxiety and depression to estimate prevalence rates. They find that young people with disabilities are two and a half times more likely to be reported by their parents as showing daily signs of anxiety and depression (Emerson and Llewelyn 2023). Overall, they estimate that approximately 20 percent of young people with frequent anxiety or depression also have a disability. If we consider the results from Emerson and Llewelyn (2023) for Latin American and Caribbean countries only (Argentina, Costa Rica, Dominican Republic, Guyana, and Honduras), then we find that, on average, children and youth with disabilities are 3.08 times more likely to experience anxiety, 3.62 times more likely to experience depression, and 4.23 times more likely to experience comorbid anxiety and depression. There is a dearth of comparable data concerning adults with disabilities, but one might expect a similar pattern.

It is therefore unsurprising that data from Latin America and the Caribbean also show that people with disabilities have higher medical needs. Analysis of household survey data from Chile, Mexico, and Peru suggests that persons with disabilities experience health issues more often than their counterparts without disabilities. For example, data from Chile reveal that 26.4 percent of people with disabilities reported experiencing a medical issue within the past three months, compared with 13.6 percent of their counterparts without disabilities. Similar patterns are evident in Mexico and Peru (see Figure 3.1). Further, results from Chile's disability survey also suggest that 70.7 percent of adults with disabilities have three or more illnesses or long-term conditions, compared

with only 25.4 percent of adults without disabilities; among children, the difference is also large—35.3 percent of children ages 2–17 have three or more illnesses or long-term conditions, compared with only 4.5 percent of children without disabilities (Rozas Assael et al. 2023). The 2018 disability survey in Costa Rica shows that 63.9 percent of adults with disabilities consider their health as being in regular to very bad condition, compared with only 18.9 percent of adults without disabilities (INEC 2019). These results are consistent with the wider global trend showing that persons with disabilities have higher health care needs.

FIGURE 3.1 | Percentage of People that Had a Medical Issue in the Reference Period, by Disability Status



Source: IDB staff calculations based on data from household surveys from Chile (2022), Mexico (2022), and Peru (2022).

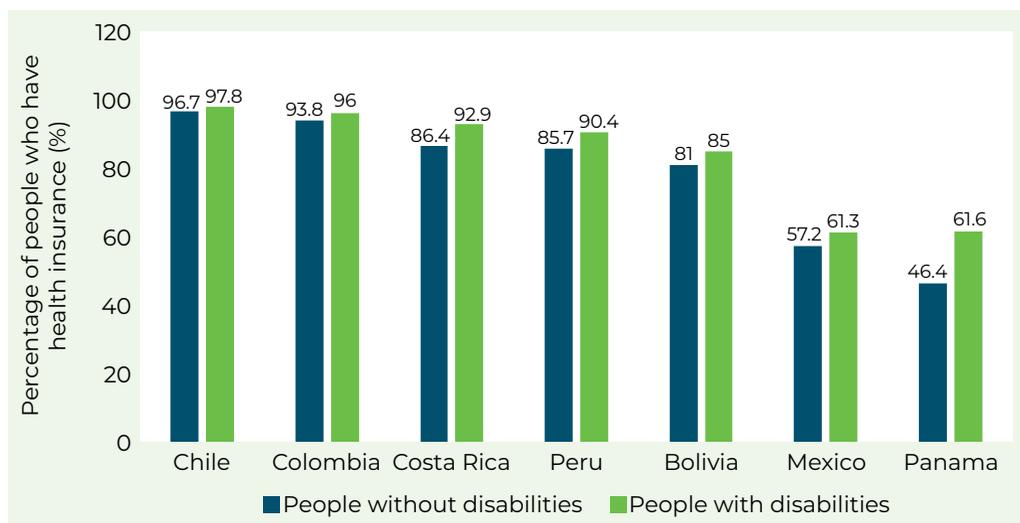
Note: The reference period differs across countries. In Chile, individuals are asked about any health issues they experienced in the past three months. The reference period in Peru is the past four weeks. In Mexico, individuals are asked to report historical health issues, and responses range from 1955 to 2022. Therefore, the analysis focuses on individuals who reported their most recent health issue between June and December 2022.

Unmet Needs as a Question of Accessibility and Quality, Not Coverage

Studies from outside the region suggest that the higher health care needs of people with disabilities are often unmet (Kuper and Heydt 2019). Conversely, in Latin America and the Caribbean, while overall coverage is low in some countries, persons with disabilities do not seem to be systematically excluded from health care coverage (see Figure 3.2). This might be the result of individuals with disabilities seeking health insurance because of their health needs, and of government initiatives to expand health care coverage for poor and vulnerable groups.

It is important to note that a lack of exclusion from coverage does not guarantee access to high-quality services. Persons with disabilities face particular barriers: specialized health services are limited, the health and transportation infrastructure is often inaccessible, and there is a lack of health workers skilled and trained in engaging persons with disabilities. As noted by Kuper and Heydt (2019), there is a significant global deficit in the number of rehabilitation professionals—including physical therapists, mental health professionals, occupational therapists, and speech-language pathologists—as well as prosthetic and orthotic practitioners. Moreover, health worker training programs rarely include disability-related skills, information, and awareness. For instance, in one review of Pacific countries conducted by the World Health Organization, only 8 percent of medical programs incorporated disability-related information into health care undergraduate training (WHO 2017).

FIGURE 3.2 | Percentage of People Covered by Health Insurance, by Disability Status



Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: Coverage rates include both public and private health insurance, except for Colombia and Panama, which only include public health insurance coverage in their household survey instruments.

Chile's 2022 Disability Survey reveals that 39.6 percent of adults with disabilities report having struggled to access and utilize health care services, compared with 10.6 percent of their counterparts without disabilities. While a large decrease (9.7 percentage points) in the perceived barriers is observed among people without disabilities compared with the 2015 results, a slightly smaller decrease is observed among people with disabilities (only 6.8 percentage points) (Rozas Assael et al. 2023; Servicio Nacional de la Discapacidad de

Chile 2016). In a 2015 national disability survey in El Salvador, 62.7 percent of adults with disabilities reported difficulties in utilizing health care services (CONAIPD 2016). A study using data from Peru's disability survey in 2012 finds that only 43.6 percent of respondents with disabilities in rural areas report the existence of a rehabilitation center near them, compared with 96.2 percent of respondents with disabilities in urban areas. The same study finds the absence of ramps, handrails, elevators, information counters, and adapted bathrooms, as well as difficulties using public bus systems to be associated with a 20–40 percent decrease in the probability of using rehabilitation centers—controlling for age, gender, urban-rural residence, possession of health insurance, and the number of disabilities a person has (Moscoso-Porras, Fuhs, and Carbone 2019). These results may reflect overall dissatisfaction with the quality of health care. However, more research is needed in this area.

Moreover, the research outlined above does not consider differences in seeking and receiving specific types of medical assistance. Analysis of household survey data from Chile also shows disparities in breast and cervical cancer screening, especially among older women. On average, women with disabilities ages 65 years or older in Chile are 13.65 percentage points less likely to have received a pap smear in the past three years compared with their counterparts without disabilities, whereas 19- to 64-year-old women are 2.36 percentage points less likely. Regarding breast cancer screenings, women with disabilities ages 35–64 are 2.73 percentage points less likely to have received a mammogram in the past three years, whereas the difference for women 65 years or older is of 13.65 percentage points.⁴ These results are consistent with the results from high-income countries showing that women with disabilities demonstrate 0.78 (95 percent confidence interval [CI]: 0.72–0.84) lower odds of attending breast cancer screening and 0.63 (95 percent CI: 0.45–0.88) lower odds of attending cervical cancer screening compared with women without disabilities (Andiwijaya et al. 2022). In other words, as with cervical and breast cancer screenings, there may be specific medical services for which persons with disabilities face specific access barriers.

There are also concerns regarding the affordability of health care for persons with disabilities. Individuals with disabilities are less likely to be employed and have lower wages (see Chapter 4). Further, household survey data from Bolivia, and expenditure survey data from Argentina, suggest that the households of persons with disabilities spend significantly more on health than households without persons with disabilities. Household survey analysis in Bolivia finds that households of persons with disabilities spend 82 percent more on health than households without persons with disabilities. A study in Argentina finds that health care expenditures are 24–30 percent higher among households of persons with disabilities relative to households without persons with disabilities

4 These estimates were calculated by the authors.

(depending on the model specification used), and that these households are also significantly more likely to experience catastrophic health expenditures (see Box 3.2). Moreover, households of persons with disabilities spend significantly more on health, even though they are significantly more likely to have public health insurance coverage (see Box 3.2). This suggests that although persons with disabilities are not systematically excluded from coverage schemes, public, free health care does not cover all the health care needs of persons with disabilities.

Box 3.2 Higher Health Expenditures among People with Disabilities in Argentina

There are only a few studies estimating the extra costs of disability in developing countries. Puentes (forthcoming) uses data from Argentina's household expenditure survey to estimate the additional expenditure for households with and without members with disabilities. To avoid confounding disability and older age, Puentes only considers households with members 60 years of age or younger.

Puentes (forthcoming) finds that, depending on the specification used, Argentinian households that have a member with a disability bear additional disability-related costs that are 25–49 percent of the expenditure of households that do not have a member with a disability. While the study considers several categories of household expenditure, health care costs are the only category with large significant differences in spending. Indeed, health expenditures were found to be 24–30 percent higher among households of persons with disabilities relative to households without members with disabilities, depending on the specification used. Most of these extra costs can be attributed to differences in spending on pharmaceutical products and outpatient care. Households of persons with disabilities were also significantly more likely to experience catastrophic health expenditures—understood as spending that constituted 10–25 percent of the overall household expenditure. For the 10 percent threshold, the likelihood increases from 12 percent to 16 percent for households of members with disabilities. For the 25 percent threshold, the likelihood more than doubles, increasing from 2 percent to 5 percent. These households were also less likely to have private insurance and more likely to be covered by public health coverage schemes, suggesting that public insurance schemes do not cover all health care needs of persons with disabilities. Finally, the author also finds that the percentage of health-related spending in the overall household budget was higher among wealthier households with members with disabilities compared with less wealthy households with members with disabilities. It may be the case that poorer households prioritize spending on other goods, such as food and shelter, and may not be able to afford necessary health care goods and services.

Policy Landscape

Governments in Latin America and the Caribbean have developed several health policies that consider disability. Some of these policies focus on universal access to health facilities and services, while others address health needs that are more common among people with disabilities. In this section, we discuss the range of programs.

Making Health Care Institutions and General Health Care Services More Accessible

Overall, systematic efforts to ensure accessibility of health care infrastructure, services, and public health campaigns in Latin America and the Caribbean are generally limited, although, in some countries, ministries of health provide grants to health institutions to make their facilities or services more accessible. However, these examples appear to represent isolated, often small-scale initiatives. Indeed, there are no large-scale initiatives to make health care facilities more accessible.

Multiple ministries of health have developed guides for health professionals on how to treat and interact with patients with disabilities. For instance, Colombia's Ministry of Health and Social Protection created a comprehensive manual for inclusive service provision for the organizations and agencies associated with the ministry, including hospitals. The manual covers aspects related to physical accessibility, online and mobile accessibility, and inclusive customer service, including the use of proper terminology (Ministerio de Salud y Protección Social de Colombia 2021). Yet, it is unclear to what extent health professionals in Colombia and other countries receive active training on these kinds of manuals.

During the pandemic, demand for virtual services increased exponentially, prompting several governments to expand in this area. In some countries, contact systems for emergency and customer services introduced alternative forms of contact, such as WhatsApp or sign language interpretation relay services, helping deaf or hard-of-hearing persons access services. For instance, Chile makes sign language interpretation available through video relay, enabling deaf or hard-of-hearing persons to use *Salud Responde*, the Ministry of Health's phone line, where public health doctors, nurses, and other health workers are available to answer questions related to health and health services (Ministerio de Salud de Chile 2024).

Identifying and Screening for Disability and Health Care Needs

Disability health programs hinge on the identification of disability and any associated health care needs. Indeed, the timely identification of disability-related conditions is critical to enable persons with disabilities to identify and access interventions (medical and otherwise) that can help them integrate into society, prevent further functional decline, and prevent the development of serious medical conditions associated with certain disabilities. At least 16 Latin American and Caribbean countries have mandatory neonatal screening programs implemented at the national level (see Table 3.1). Most of these countries focus on biochemical profiling using newborn blood samples and tandem mass

spectrometry.⁵ Many of the deficiencies and congenital diseases that can be identified using biochemical profiling are associated with the development of intellectual or physical disabilities. Further, at least nine Latin American and Caribbean countries have universal neonatal hearing screening programs, and six countries have universal neonatal vision screening programs (see Table 3.1).

TABLE 3.1 | Types of Screenings Included in Universal Neonatal Screening Programs in Latin America and the Caribbean

Country	Hearing	Vision	Cardiac	Biochemical											
				AA	BD	CAH	CF	CH	FAO	G6PDD	GAL	Hbpx	MSUD	OA	PKU
Argentina	✓	✓	✓	✓	✓	✓	✓	✓				✓		✓	✓
Bolivia						✓	✓	✓							✓
Brazil	✓	✓	✓		✓	✓	✓	✓				✓	✓		✓
Chile	✓			✓	✓	✓	✓	✓	✓			✓			✓
Colombia	✓	✓	✓					✓							
Costa Rica	✓	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓
Ecuador						✓		✓				✓			✓
El Salvador								✓							
Guatemala						✓	✓	✓				✓			✓
Honduras						✓	✓	✓				✓			✓
Mexico	✓		✓		✓	✓	✓	✓				✓			✓
Nicaragua								✓							
Panama	✓	✓	✓			✓	✓	✓		✓	✓	✓			✓
Paraguay							✓	✓							✓
Peru	✓	✓	✓			✓	✓	✓							✓
Uruguay	✓	✓	✓	✓		✓	✓	✓	✓				✓	✓	✓

Source: IDB staff with information from Giugliani et al. (2021) and reports and communications from the ministries of health of Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, and Uruguay.

Note: AA = amino acid disorders; BD = biotinidase deficiency; CAH = congenital adrenal hyperplasia; CF = cystic fibrosis; CH = congenital hypothyroidism; FAO = fatty acid oxidation disorders; G6PDD = glucose-6 phosphate dehydrogenase deficiency; GAL = galactosemia; Hbpx = hemoglobinopathies; MSUD = maple syrup urine disease; OA = organic acidurias; PKU = phenylketonuria.

5 Tandem mass spectrometry is a method to identify and measure the amounts of different molecules in a blood sample. It works by first turning the molecules into charged particles, then sorting them by size and charge, followed by breaking them into smaller pieces, and then analyzing these fragments to determine what the original molecules were. This technique provides detailed information about the chemical makeup of a newborn's blood; this can help identify metabolic disorders and potential genetic conditions.

Universal screening programs are also common in Latin America and the Caribbean for preschool and school-age children. Screening for children before entering schools is typically implemented through the ministries of health (see Chapter 2). These programs are critical to ensure that children with disabilities or at risk of developing disabilities have access to the services they may require. Yet, disability is not exclusive to infants and children.

Disability certification programs, which require medical proof of an impairment, help identify individuals with disabilities and their needs (see Chapter 5). The certification can help connect them with appropriate programs. Yet, it is worth noting that the disability certification process is voluntary and, hence, does not provide representative data on the health-related needs of persons with disabilities (see Chapter 5). However, it can be a useful entry point to develop personalized health care plans for those who do become certified.

Improving Coverage and Subsidizing Disability-Specific Health Care Services

Some governments have created targeted health care coverage programs or provide specific benefits for people with disabilities. For instance, Argentina's *Federal Incluir Salud* program provides coverage to noncontributory disability pension holders who lack medical coverage from the National Health Insurance System or Provincial Social Security. In addition to health service coverage, this program offers medical services such as technical aids, biomedical technology items, and food provision for people with disabilities. Brazil has a similar program, known as the Care Network for Persons with Disabilities. The program is operated under the Unified Health System (*Sistema Único de Saúde*), through which persons with disabilities can access a wide array of health services free of cost. Eligible persons with disabilities can access dental care, therapy, rehabilitation, and orthopedic workshops at specialized rehabilitation centers, day centers, and hospitals, or in their homes. Besides providing subsidized health care, these programs in Argentina and Brazil make active efforts to draw people with disabilities to seek out health care through targeted campaigns.

However, these comprehensive programs can imply high costs. Some countries have therefore focused on subsidizing only a select group of health care services, mainly rehabilitation and the provision of assistive devices and prothesis. Countries such as Chile, Colombia, Barbados, and El Salvador have extensive rehabilitation services for people with disabilities. For instance, Chile's National Disability Service (*Servicio Nacional de la Discapacidad, SENADIS*) offers access to rehabilitation services to persons with disabilities who are beneficiaries of the National Health Fund and registered in their corresponding Family Health Centers. The rehabilitation program is thus

free of cost. SENADIS also provides funding to public and private organizations providing rehabilitation. It grants approximately US\$21,500 to each selected project; for 2021, SENADIS funded eight projects (Servicio Nacional de la Discapacidad de Chile 2020).

The provision of assistive devices and prostheses is also common. Argentina, Chile, Ecuador, El Salvador, and Peru have programs that directly provide or subsidize the purchase of devices such as wheelchairs, canes, walkers, crutches, or hearing aids. In Argentina, the program is especially comprehensive. The National Disability Agency not only directly provides devices to persons with disabilities not covered under *Incluir Salud*, but also manages a Decentralized Technical Aids Bank program, ensuring devices are available to provincial government agencies (including health facilities) and the Autonomous City of Buenos Aires. These agencies can present project proposals to distribute assistive devices, receiving a maximum of about US\$12,000 (Agencia Nacional de Discapacidad de Argentina n.d.). Additionally, in countries such as Chile, El Salvador, and Jamaica, programs also fund orthoses and prostheses. For example, Jamaica's Ministry of Health and Wellness, in coordination with the Ministry of Labor and Social Security, created the "New Limb,, New Life" program, where prosthetic legs and arms were financed.

There are also programs focusing on medical conditions often associated with disability. Beneficiaries with disabilities may have a high representation in these programs. This is likely the case in initiatives such as medicine banks for rare and catastrophic illnesses, such as the *Banco de Drogas* in Argentina. Another program, Ecuador's *Bono Joaquín Gallegos Lara*, which aims to support high costs of health care, provides individuals with catastrophic diseases or persons with disabilities with high levels of need with income support in the form of a monthly transfer equivalent to US\$386.88 (PPP, 2024). As of September 2023, the program had 42,736 beneficiaries (Ministerio de Economía y Finanzas de Ecuador 2023).

Other examples of general health care programs relevant for people with disabilities include mobile health and telehealth programs. Indeed, telehealth and mobile health can be important accommodations for patients with disabilities who face considerable obstacles in accessing transportation or health infrastructure. Several Latin American and Caribbean countries have programs of these types, many of which were developed in the context of COVID-19 or to provide access to health services in rural areas. For instance, Bolivia has implemented a telehealth program since 2014 to reach rural communities. The program expanded over 2019–21 amid the pandemic. As of 2021, based on a survey of 1,440 health professionals, telemedicine was used the most in Chile, Peru, and Uruguay among the Latin American and Caribbean countries (Saigí-Rubió et al. 2021). Yet, based on the same survey, up to 82.6 percent of health professionals in Latin America and the Caribbean had not used telemedicine (Saigí-Rubió et al. 2021). In other words, telemedicine systems are still incipient in the region. Yet, these types of programs may be especially relevant for people with disabilities who face significant barriers to accessing health care services in person, because transportation

and public infrastructure are mostly not accessible, and real-time sign-language interpretation can be easily incorporated in the virtual services. It is therefore important to continue promoting these programs, incorporating lessons from initiatives prompted by the pandemic.

Programs with a mental health focus are also especially relevant, given the higher rates of depression and anxiety among people with disabilities (Emerson and Llewellyn 2023). For instance, through the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS) in Brazil, the Ministry of Health coordinates mental health services, which include primary care to short-term hospitalization, besides supervising community-based mental health centers (*Centros de Atenção Psicossocial*). After mental health law in Argentina underwent a legislative reform between 2020 and 2021, the number of people living in hospitals and psychiatric institutions in Buenos Aires declined from 1,810 to 1,391 (Subsecretaría de Salud Mental, *Consumos Problemáticos y Violencias en el Ámbito de la Salud Pública* 2021). These efforts demonstrate an increased commitment to providing community-based mental health services over institutionalization. However, throughout the region, much remains to be done regarding service coverage and quality.

In 2020, the median public expenditure on mental health services for people with and without disabilities in the Americas represented only 3 percent of the overall health budget, and almost half of this budget (43 percent) funded psychiatric hospitals instead of community-based initiatives (PAHO 2023). Resources destined for mental health are insufficient, inefficiently used, and inequitably distributed. It is, therefore, unsurprising that only 18 percent of persons with psychosis in the Americas received treatment in 2020 or that 73 percent of adults with depression in the region did not receive treatment at all (PAHO 2023). Further, 28 percent of all psychiatric hospital stays in the Americas last longer than five years, surpassing all other regions, and raising serious concerns regarding institutionalization (PAHO 2023). These estimates include data from the United States and Canada, where mental health services may be more widely available, and, therefore, it is likely that Latin America and the Caribbean has a lower share of people with psychosis or depression receiving treatment and a higher share on extended hospital stays (effectively institutionalized).

What Does the Evidence Say?

The causal literature on the impacts of health interventions on people with disabilities is generally limited. Most research on health interventions focused on people with disabilities comes from small-scale experiments. In this section, these studies are discussed only when there is an established body of evidence from meta-analysis of multiple studies. Otherwise, as in the other chapters, the focus is on larger experimental and quasi-experimental research, which in this chapter is focused on early identification

and intervention, adult screening programs, and interventions expanding health care coverage.

There is ample evidence supporting early identification and universal screening programs, albeit from high-income countries. Evaluations of universal neonatal hearing screening (UNHS) in the United States, Germany, and other high-income countries suggest that UNHS significantly reduces the age of diagnosis and intervention and leads to improved language and cognitive development (Wolff et al. 2010; Neumann et al. 2006; Yoshinaga-Itano 2004). For example, teenagers from a birth cohort of 157,000 children from southern England who underwent UNHS showed better reading comprehension than children from the same cohort who were not screened at birth (Pimperton et al. 2016). Similar results are obtained in evaluations of vision screenings for newborns. Some preliminary small-scale medical experiments also suggest that early identification and intervention for infants under 24 months (about two years) with autism can have positive effects: increased acceptance by parents, improved treatment implementation, and gains in social communication and developmental skills (Bradshaw et al. 2015).

Universal screening programs in schools are also relevant, especially screening for auditory, visual, psychosocial, or intellectual disabilities. These programs can have significant effects on outcomes for preschool and school-age children (see Chapter 2). Indeed, screening for disability among young children can ensure access to appropriate services within the school system, in turn promoting satisfactory learning and developmental outcomes, especially in communication and literacy. For instance, a meta-analysis by Fuller and Kaiser (2020) of small-scale experiments shows that the greatest gains related to communication outcomes from early identification and intervention for children with autism are observed during their early years, especially at 3.8 years.

Perhaps the most well-known and contentious body of evidence on early identification concerns prenatal screenings for disability-related conditions. In Europe, as of 2015, prenatal screenings combined with selective terminations had resulted in an estimated 54 percent reduction in the live-birth prevalence of Down Syndrome. This reduction varied from 0 percent in Malta to 83 percent in Spain (De Graaf, Buckley, and Skotko 2021). Studies have not shown that prenatal screenings improve health outcomes for children born with Down Syndrome (Steffensen et al. 2023). Further, the impacts of prenatal screening on the prevalence of Down Syndrome are highly contentious in the disability rights community.

While universal screening is the recommended approach to identify disability among infants and children, targeted programs are the most relevant for adults. Among working-age adults, screening programs are the most relevant for implementation at worksites that present occupational hazards potentially leading to disability (for instance, hearing screenings among construction workers or in factories). There are no rigorous evaluations

for programs of these types, which focus on screening for disability among working-age adults.

For older adults, screening initiatives are focused on health conditions that appear while aging. Indeed, early detection of medical conditions can slow functional decline, improve quality of life, and reduce mortality rates for conditions such as Parkinson's or multiple sclerosis (Cobo-Calvo et al. 2023; Liou et al. 2008). Given the positive impacts of early identification of disability or related impairments among older persons, interventions to facilitate screening (e.g., the development of screening questionnaires) or interventions to remind doctors and nurses to screen for relevant conditions can be especially relevant. For example, Zazove et al. (2020) studied the effect of reminding clinicians, through electronic alerts, to ask patients over 55 years about hearing loss in two US health districts. The intervention significantly increased audiology referrals for at-risk patients, by 11.2 percentage points, in one health system and by 4.0 percentage points in another health system, with no significant changes among the control group (Zazove et al. 2020).

Naturally, the effects of early identification and screening programs are contingent on the availability of and access to rehabilitation. In the context of the rise of the disability rights movement in the 1970s, community-based rehabilitation (CBR) emerged as an alternative to traditional rehabilitation services, which were often only available for institutionalized persons or in urban areas. At its inception, the CBR framework promoted rehabilitation in local health clinics or in medical offices such that persons with disabilities could still live in their communities, instead of in institutions. In the early 2000s, disability rights groups and certain multilateral organizations acknowledged that rehabilitation could also occur outside health care settings (for instance, at school and at work) and that the impacts of rehabilitation could likely be enhanced by other types of interventions (e.g., education and social protection programs). Hence, CBR began to be promoted as a more general strategy within general community development for the social inclusion of people with disabilities, with much variation across countries and regions (ILO, UNESCO, and WHO 2004).

Indeed, a meta-analysis conducted by Lemmi et al. (2016) finds that CBR may be effective at improving clinical outcomes, as well as functioning and quality of life, although they note that the quality of many studies is low. For instance, Duarte et al. (2018) find that access to specialized rehabilitation shortened hospital stays and lowered medical costs relative to receiving routine care for people with disabilities who were admitted to three national health service hospitals in England. Evidence from Cambodia suggests that CBR may have effects on quality of life (Powell, Mercer, and Harte 2002).

These studies consider the effects of CBR overall, instead of its individual components. Given that CBR varies widely from country to country, it is not possible to generalize positive results for all CBR programs. Moreover, it is unclear which individual components

of CBR improve rehabilitation outcomes and whether CBR initiatives outperform isolated rehabilitation interventions.

However, a few studies evaluate the isolated effects of rehabilitation, primarily, the provision of assistive devices. A review by Saran, White, and Kuper (2020) finds that the few studies on the effectiveness of assistive devices indicate positive effects. For instance, the Longitudinal Outcomes of Children with Hearing Impairment study conducted in Australia found that providing hearing devices as early as possible to children who were deaf or hard of hearing improved their language performance over time (Ching et al. 2018). Another study, from Ethiopia, showed that providing a wheelchair when needed was significantly associated with increased working hours, income, and a reduction of mendicity (Grider and Wydick 2016). Mortenson et al. (2012) and Labbé et al. (2019) found that assistive technology helps caregivers and family members by reducing some of the physical and emotional effort invested in supporting people with disabilities.

There are a few studies examining the effects of improvements in health care coverage on people with disabilities. For example, Van Gasteren and Enciso (2023) studied the impact of *Seguro Popular*—a universal health insurance program for low-income persons in Mexico—on the progression of disabilities among older adults with chronic degenerative diseases. The study finds that affiliation with *Seguro Popular* slowed the progression of mobility decline and improved functionality in instrumental daily activities. Ford Shah et al. (2012) assessed the impact of the United States' Medicaid Buy-In (MBI) Program in Washington State. They examined the program's impact on employed individuals with disabilities whose incomes exceed the threshold for traditional Medicaid. The MBI Program offers people with disabilities a chance to acquire comprehensive Medicaid coverage. It pays a monthly premium, determined by a sliding income scale. Their results indicate that the MBI in Washington State not only promotes employment but also boosts earnings, reduces reliance on food stamps, and ensures medical coverage. These studies suggest that including people with disabilities in traditional health coverage schemes may be sufficient to address their higher health care costs. However, this is likely to vary by country, based on the implemented health care framework. For instance, Palmer and Nguyen (2012) found that traditional insurance mechanisms in Vietnam do not provide sufficient coverage for people with disabilities.

Key Takeaways

Based on the analysis presented in this chapter, the health care needs of persons with disabilities in Latin America and the Caribbean do not appear to be met. Analysis of household survey data from the region shows that insurance coverage is at the same level for people with and without disabilities across the region. However, the accessibility of health services and the utilization of specific services appear to differ. Further,

data from Argentina, Bolivia, and Peru show that households of persons with disabilities bear greater health expenditures. In most Latin American and Caribbean countries, unmet health care needs are therefore likely related to the accessibility and quality of health care services. More systemic efforts are needed to ensure that health care services and facilities are accessible to persons with disabilities. Some programs are being implemented, including programs to improve the physical accessibility of infrastructure, digital platforms for greater access to information and services (e.g., mobile health and telehealth initiatives), real-time captioning, programs providing sign language interpretation, and training of health care professionals on disability inclusion. However, evidence on these interventions' effectiveness and costs is needed to further guide policy decisions. These interventions and their impacts on people with disabilities must be evaluated rigorously.

There is a limited body of evidence regarding health-related programs; early intervention and universal screenings are the most frequently studied. The existing evidence suggests that early identification and universal screenings are particularly cost-effective strategies to prevent functional deterioration and ensure infants and young children have access to appropriate services. Most countries in the region have neonatal screening programs, yet these vary widely in the conditions they screen for. It is important to support countries in strengthening and expanding their neonatal screening initiatives. Meanwhile, the literature on targeted identification among older adults suggests that these interventions can slow functional decline, improve quality of life, and reduce mortality rates. Interventions to remind clinicians to screen for age-associated conditions are particularly promising.

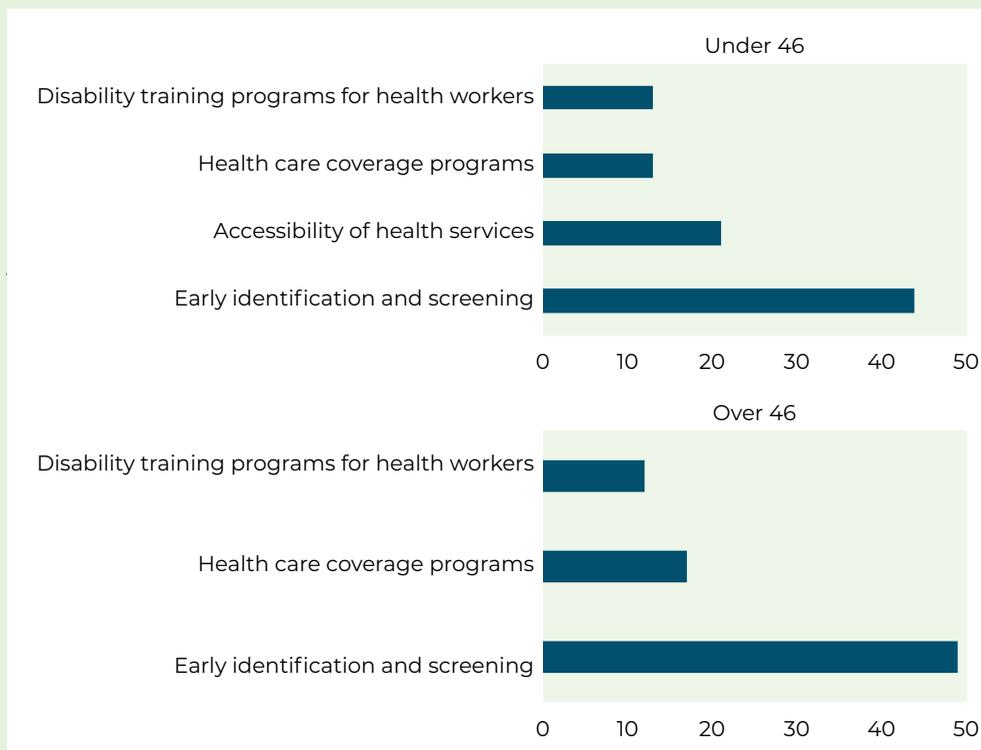
There is some positive evidence in support of rehabilitation services and the provision of assistive devices. While CBR has been proposed as a framework to serve the rehabilitation needs (and other development needs) of persons with disabilities since the 1970s, its implementation varies widely from country to country. Also, there is a lack of rigorous evaluation of CBR. While there is undoubtedly positive evidence on the importance of medical rehabilitation services and the provision of assistive devices, it is unclear whether providing other services alongside these traditionally medical interventions (e.g., in education or related to employment) significantly improves rehabilitation outcomes for beneficiaries with disabilities. There is thus a need for more rigorous evidence in this area.

Finally, a few studies examine the impact of general health programs on people with disabilities. This is particularly relevant for interventions where many beneficiaries are likely to have a disability, as is the case with medicine banks, and mental health and deinstitutionalization initiatives. It is imperative that future health care research on general health care interventions consider these programs' differential impacts by disability status, just as with other equity considerations, such as gender or race.

Box 3.3 Priorities for Health Policy Research

As mentioned in Box 1.3 of Chapter 1, the IDB is conducting an online survey to gauge the perspectives of people in the region, especially people with disabilities and their families, regarding which policies and interventions on disability inclusion should be prioritized by researchers. In this box, we present results from the answers provided up to May 2024.^a While the results are not representative (only 150 responses), given the challenges in surveying people with disabilities, they provide insights that can be evaluated in future initiatives. Within health policy, the top three research priorities, disaggregated by respondent age, are presented in Figure B.3.3.

FIGURE B.3.3 | Top Priorities for Health Policy Research, by Respondent Age Group



Source: IDB staff calculations using results from online survey.

Survey respondents were particularly interested in evaluating early identification and screening programs that allow persons with disabilities to be connected to specific health care services in a timely manner. This is the number-one research priority, regardless of the age of respondents. However, the second and third priorities vary depending on respondent age. For instance, younger respondents identify that the second most important research priority is to evaluate the accessibility of health services, while older respondents consider it more important to evaluate health care coverage programs (that is, programs reducing treatment and medicine costs or ensuring access to insurance).

^a If you would like to offer your opinion on research priorities for the inclusion of people with disabilities, please fill out the survey at the following link through June 2025: <https://accessiblesurveys.com/s2/-NoXa0IViThWvED1daoy>.



Labor Markets

Why It's Important to Promote Inclusion in the Labor Market

Adults with disabilities have the right to participate in competitive, meaningful, dignified work that allows them to contribute to the economic well-being of their households and communities according to Article 27 of the Convention on the Rights of Persons with Disabilities (United Nations 2007). Legislation in several Latin American and Caribbean countries already includes important legal commitments to protecting this right: as of 2021, labor legislation in 14 of the 26 borrowing member countries of the Inter-American Development Bank recognized the right to no discrimination at work based on disability, while 13 countries recognized the right to reasonable accommodations¹ (Bregaglio 2021). But several problematic laws on disability inclusion in the labor market still exist in the region, for example, norms preventing some persons with disabilities from signing a contract or working in the public sector (see Box 4.1). Nonetheless, countries in the region increasingly recognize that participation in the labor market should not be determined by whether a person has a disability, but by their skills. And there is more than a moral case to be made as to why persons with disabilities should be included in the labor market. There is a large economic cost of not fully leveraging the production, consumption, and tax-paying potential of working-age adults with disabilities, who represent over 10 percent of the Latin American and Caribbean population (see Chapter 1). Contreras, Riveros, and Vargas (2019) use data from Costa Rica, Chile, and Mexico to estimate the

1 Reasonable accommodations in the workplace refer to modifications or adjustments to the application or hiring process, the job itself, the manner in which the job is performed, or the work environment that enable a qualified person with a disability to carry out the essential functions of the job and enjoy equal employment opportunities. Accommodations are “reasonable” if they do not impose an undue hardship on the employer.

potential impact of including people with disabilities in the labor market. They find that labor market inclusion represents 2–3 percent of the gross domestic product.²

Labor market inclusion can also reduce government expenditures by decreasing reliance on social protection programs (see Chapter 5). Indeed, if persons with disabilities can raise their income by participating in the labor market, then they will be less likely to rely on cash transfers and other social protection measures to maintain and improve standards of living.

Further, promoting the participation of persons with disabilities in the formal labor market would increase total social security contributions. The economic argument for labor market inclusion is especially appealing in the context of rapid aging in many Latin American and Caribbean countries and the increasing concern that the number of persons receiving contributory or noncontributory pensions will outweigh those contributing to social security.

Box 4.1 The Legal Frameworks Surrounding Employment Leave Room for Improvement

Despite the important legal and moral arguments backing inclusion, legal frameworks in Latin America and the Caribbean are uneven. As of 2021, 14 of the 26 borrowing member countries of the Inter-American Development Bank had legislation prohibiting discrimination against people with disabilities, and 13 countries had legislation requiring the provision of reasonable accommodations (Bregaglio Lazarte 2021). While this is a significant share of countries, there remain many contexts where the labor rights of persons with disabilities still go unrecognized.

Other norms may provide disincentives to participation. For instance, 17 countries have regulations prohibiting the receipt of disability benefits if the beneficiary is working. Further, several countries have well-intended norms with often unintended consequences—for example, quotas (20 countries) and protections against termination (8 countries) (Bregaglio Lazarte 2021). These protections can have unintended or adverse effects; for example, they could result in employees getting reclassified as having a disability, or could even discourage employers from hiring persons with disabilities due to concerns about the potential high costs of terminating them if they do not perform adequately. Evidently, more laws do not necessarily translate into better outcomes, where the spirit of the law might get undone by the behavioral responses of firms and individuals. Not only is it important to supervise compliance, but also to carefully review legal design, with a thought to the expected behavior of actors.

People with disabilities should be given an opportunity to develop their skills so that they can obtain the jobs they want and that match their current skills. This means

2 These estimates are constructed by summing the productivity loss due to not including persons with disabilities in the labor market. They consider the number of persons with disabilities, the average productivity of each country, and a productivity adjustment factor for disability. The productivity adjustment factor considers the disability wage gap and the wages that persons with disabilities could make, considering their observed characteristics.

that they require access to high-quality education, especially at the secondary and tertiary levels. Chapter 2 shows that access to education above primary levels remains a challenge across most of the region, and that in some countries, a high proportion of students with disabilities attend separate special schools, where it is unclear if they receive commensurate instruction. Labor market inclusion involves three important approaches: reducing barriers to employment, upgrading the skills of persons with disabilities through training programs, and refining the alignment of the demand for talent and its supply through labor market intermediation. It is important to provide policy makers with evidence of programs that successfully enhance inclusion. By doing so, countries can move away from potentially adverse policies toward effective interventions. The present chapter considers (1) the status of labor market inclusion for people with disabilities in Latin America and the Caribbean, (2) rigorous evidence on labor market interventions for persons with disabilities, and (3) the priorities of civil society groups concerning research on relevant labor market policy for persons with disabilities.

A Snapshot of Current Trends

Despite the growing interest in promoting the labor market participation of persons with disabilities, there are still gaps between the employment outcomes of people with and without disabilities. As shown in Table 4.1, employment rates (based on the total population³) are consistently higher for persons without disabilities than for persons with disabilities. This disparity varies significantly across the countries analyzed. For instance, in Mexico and Chile, the employment gap is 8.6–10.5 percentage points, whereas in Costa Rica, it expands to 26.9 percentage points. Gender differences also play a role in employment rates; employment rates are consistently lower for women than men, irrespective of disability status. However, the employment gap by disability status is more pronounced among males. In Costa Rica, for example, the gap is 23.1 percentage points for women compared with 32.7 percentage points for men.

Considering the differences in enrollment rates at the secondary and tertiary levels (see Chapter 2) and the employment gap, a substantial share of people with disabilities are neither working nor studying (see Table 4.2). This gap is at least 20 percent larger in all countries for people with disabilities and more than twice as large in Bolivia, Costa Rica, and Peru. As expected, although the share of young women not working or studying is larger, the gap is more pronounced for males.

³ Labor market participation is typically low among people with disabilities. This may be attributed to multiple factors, including the withdrawal of persons with disabilities from the labor force after unsuccessful employment searches, and a lack of necessary accommodations in the workplace. Consequently, to provide a clearer picture of employment among this group, we calculate employment rates based on the total working-age population rather than solely those people actively participating in the labor market.

TABLE 4.1 | Employment Rates (%) by Disability Status

Country	People without disabilities	People with disabilities
Bolivia	79.0	68.0
Brazil	78.3	64.1
Chile	78.4	67.9
Colombia	75.6	62.1
Costa Rica	72.5	41.4
Mexico	79.2	70.6
Panama	76.3	58.4
Peru	83.3	56.4

Source: IDB staff calculations based on household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: Employment rates represent the proportion of individuals ages 25–54 who are employed relative to the total population within that age group. This table does not show differences in employment rates by gender. Yet, gaps in employment are sustained when gender is considered.

TABLE 4.2 | Share of Individuals Ages 18–25 Not Working or Studying, by Disability Status

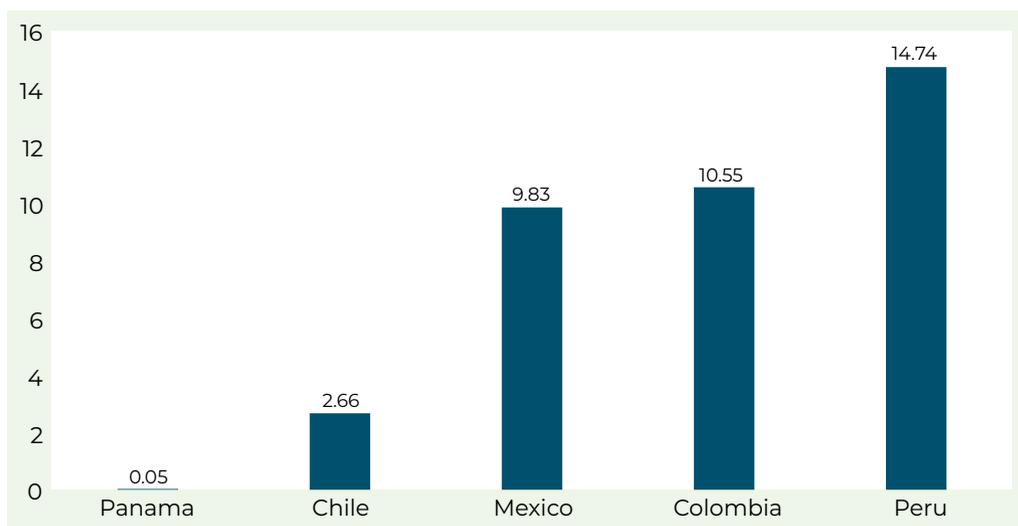
Country	People without disabilities	People with disabilities
Bolivia	15.7	45.4
Brazil	24.6	32.6
Chile	19.2	23.3
Colombia	26.1	40.2
Costa Rica	21.7	46.5
Mexico	19.4	30.1
Panama	22.9	42.5
Peru	21.6	62

Source: IDB staff calculations based on household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022). This table does not show differences in the share of individuals not working and not studying by gender. Yet, gaps by disability are sustained when gender is considered.

While the gap in formal employment is most often notable, its size varies widely among the five countries for which data are available, from nearly negligible to 14.7 percentage points (Figure 4.1). The formality gap is more pronounced in countries with lower levels of overall formality, and is typically larger for female workers.

These differences in formal labor market participation can likely be attributed to multiple factors, including a lack of reasonable accommodations and a lack of accessible jobs. For instance, based on Chile's 2022 disability survey, 19.5 percent of employed workers with disabilities report significant barriers at their jobs that hinder their performance; only 3.4 percent of workers without disabilities report similar barriers (Rozas Assael et al. 2023). Further, the differences in formal labor market participation can also be due to a lack of accessibility and the prevalence of bias in the hiring process. Evidence from correspondence studies in the Organisation for Economic Co-operation and Development countries revealed employers' bias against persons with disabilities. For example, Bjørnshagen and Ugreninov (2021) found that in Norway, individuals who disclosed their wheelchair use in their cover letter were only half as likely to receive a callback for an interview. In Canada, another experiment revealed applicants' disability status to employers and found that applicants without disabilities received twice as many callbacks as their peers with disabilities (Bellemare et al. 2020). Gaps in callback rates across disability status were higher for client-facing roles. In a correspondence study by Ameri et al. (2018) on the US accounting industry, hypothetical curricula vitae (CVs) were randomized across two impairments—paraplegia and high-functioning autism, besides a control group without any impairment. The impact was the same for both types of impairments: interview callback rates were 26 percent lower for CVs disclosing impairment compared with CVs that did not disclose any impairment. Some studies have found that the gap in callback rates across disability status is lower for high skill levels (Ravaud, Madiot, and Ville 1992). Hiring bias is also found in Denmark in experiments that also control for the education and experience of the job candidates (Shamshiri-Petersen and Krogh 2020). They also find that the opportunity to apply for complimentary reasonable accommodations reduces the gap in hiring. While there is no comparable literature in Latin America and the Caribbean featuring correspondence or vignette studies, experiments are underway in Ecuador, Peru, and other countries, given the suspected high bias against applicants with disabilities in the region.

Considering the barriers to accessing formal employment, it is unsurprising that many persons with disabilities turn to entrepreneurship. Persons with disabilities are more likely to be self-employed than their counterparts without disabilities, and less likely to be formal employees in all analyzed countries (see Table 4.3). The figures are striking in countries like Costa Rica and Colombia, where people with disabilities are 9.2–10.1 percentage points more likely to be self-employed; 39.2 percent of workers without disabilities are self-employed in Costa Rica, and 14.0 percent in Colombia—compared with 41.2 percent and 24.1 percent of workers with disabilities. Further, people with disabilities are more likely in general to be unpaid workers, although the differences are less pronounced (see Table 4.3).

FIGURE 4.1 | Gaps in Formal Employment Rates (Percentage Points)

Source: IDB staff calculations based on household surveys from Chile (2022), Colombia (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: We measure formality as the percentage of employed individuals who have signed a contract with their employers. Gaps represent percentage point differences between individuals with and without disabilities.

TABLE 4.3 | Gaps in Work Categories between Workers with and without Disabilities (Percentage Points)

Country	Employer	Self-employed	Employee	Unpaid worker
Bolivia	-1.8	7.3	-5.4	0.1
Brazil	-0.6	4.9	-5.0	0.7
Chile	0.4	5.1	-5.5	0.0
Colombia	-1.3	9.2	-8.8	0.8
Costa Rica	-0.4	10.1	-11.2	1.5
Mexico	4.0	3.7	-8.5	0.9
Panama	0.8	7.8	-8.1	-0.5
Peru	0.8	3.2	-10.9	7.1

Source: IDB staff calculations based on household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

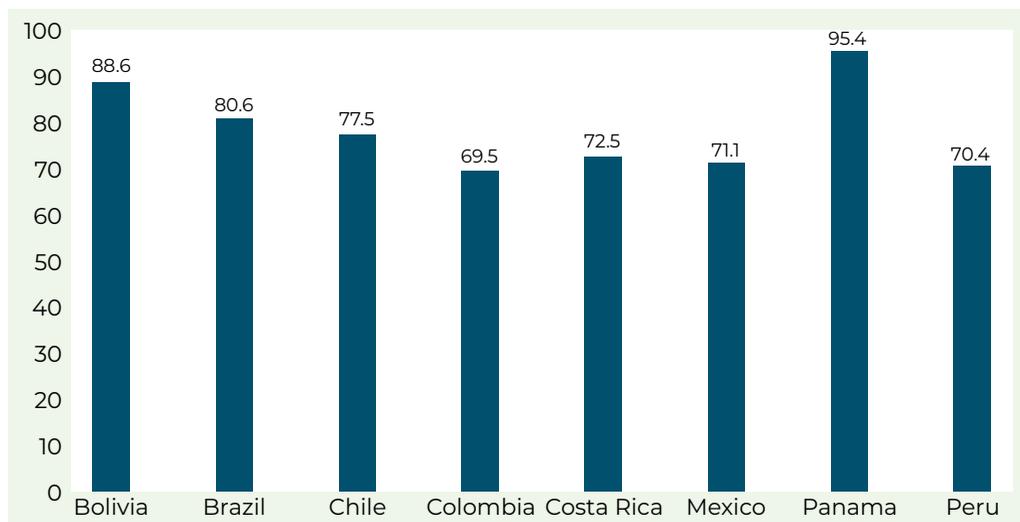
Note: Percentage point differences between workers with and without disabilities.

Because of these differences in the types of jobs performed by persons with disabilities, workers with disabilities earn significantly less than their counterparts without disabilities. The monthly earnings of workers with disabilities range between 70.4 percent (Peru) and 95.4 percent (Panama) of the wages earned by individuals without disabilities,

averaging 78.2 percent across the region (see Figure 4.2). The earnings gap is usually wider for males, although the differences in the gaps by gender are not large—except in Bolivia, where women with disabilities earn 4.3 percent less than women without disabilities, the penalty among men is a striking 14.1 percent.⁴ Additionally, on average, individuals with disabilities work only 2.3 fewer hours per week than individuals without disabilities.⁵ This very small difference in hours worked is far from explaining the differences in monthly earnings.

Further, these estimates do not account for differences in gender, work experience, or education, which could also affect the differences in earnings between individuals with and without disabilities. When these factors are controlled for, the average wage gap across the eight countries in Figure 4.2 is reduced significantly, to 11.7 percent. In monetary terms, this means that people with disabilities earn approximately 88 cents for every dollar made by persons without disabilities of the same gender and with similar work experience and educational background.

FIGURE 4.2 | Ratio of Earnings of Workers with Disabilities to Workers without Disabilities



Source: IDB staff calculations based on household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: Wages of workers with disabilities, earned from their main occupation, as a percentage of the wages of workers without disabilities.

4 Authors' calculation using data from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

5 Authors' calculation using data from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Box 4.2 Impacts of the COVID-19 Pandemic and Flexible Work Arrangements

The COVID-19 pandemic drastically changed the way we work. Before the pandemic, only a few Latin American and Caribbean countries, including Brazil, Colombia, Costa Rica, and Peru, had laws regulating telework (Alaimo et al. 2022). The pandemic allowed the private and public sector to see that many jobs can be done remotely and that there are many benefits to allowing flexible work. As a result, most countries in the region now have laws regulating telework, and increasingly more countries are recognizing and protecting other forms of flexible work, such as the possibility of accumulating work hours (banked hours), working longer hours on certain days to reduce the work week (compressed work week), or averaging work hours over periods longer than a week (work cycling) (Alaimo et al. 2022).

Flexible work arrangements can also be particularly appealing for workers with disabilities. Indeed, modalities such as remote work can be considered a reasonable accommodation, as it mitigates the need for workers with disabilities to confront accessibility barriers while commuting to work, besides confronting inaccessibility at work itself. Further, certain medical needs are more easily managed at home, and given that persons with disabilities have higher medical needs on average (see Chapter 3), this may be another reason that flexible work arrangements may be beneficial for workers with disabilities.

Yet, workers with disabilities continue to face difficulties in accessing flexible work modalities. Data from the United States show that although telework increased during the pandemic for the overall working population, this did not benefit workers with disabilities to the same extent. Before the pandemic, 5.5 percent of persons with disabilities worked from home in the United States, compared with 4.4 percent of those without disabilities (Schur, Ameri, and Kruse 2020). But during the pandemic, 36 percent of workers without disabilities teleworked, compared with only 25 percent of workers with disabilities (Kruse et al. 2022).

These gaps in access to teleworking are related to the differences in the types of employment between people with and without disabilities. Kruse et al. (2022) report that 34 percent of workers with disabilities in the United States have jobs that can be done entirely remotely, compared with 40 percent of those without disabilities. During the pandemic, therefore, workers with disabilities were less likely to be in jobs that offered the option of telework, and were thus more likely to be laid off; indeed, unemployment rates among persons with disabilities rose sharply during the pandemic in the United States (Schur, Ameri, and Kruse 2020).

Far more limited data are available on how the COVID-19 pandemic affected telework among workers with disabilities in Latin America and the Caribbean. However, there are some data available for Costa Rica (see Figure B4.2). Analysis of Costa Rican household survey data from 2015 to 2022 reveals that, as in the United States, telework increased dramatically during the pandemic, yet the increase was less pronounced for workers with disabilities (Costa Rica, Instituto Nacional de Estadística y Censos 2015–2022).

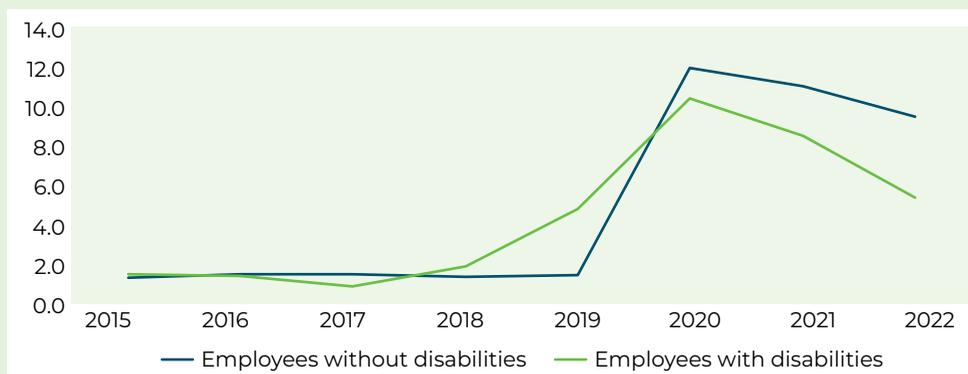
Further, the marked decline in teleworking since 2021 has been slightly steeper for employees with disabilities than for those without disabilities. It is unclear whether teleworking will continue to decline at steeper rates among employees with disabilities in countries such as Costa Rica. However, it is possible that teleworking for employees with disabilities is less likely to be considered a possible permanent work arrangement post-pandemic.

It is therefore important to support telework as an important possible reasonable accommodation for workers with disabilities, even while understanding that most workers with disabilities will not benefit from immediate possibilities to telework.

(continued on next page)

Box 4.2 Impacts of the COVID-19 Pandemic and Flexible Work Arrangements *(continued)*

FIGURE B.4.2 | Percentage of Workers Teleworking in Costa Rica, by Disability Status, 2015–2022



Source: IDB calculations based on household surveys from Costa Rica (2015–2022).

Note: We exclude employers, self-employed workers, and unpaid workers from the analysis, such that the percentage is that of formal employees working, by disability status.

Policy Landscape

While governments in the region seek to promote the labor market participation of persons with disabilities through various policy packages, the main approach has been to encourage public and private firms to hire workers with disabilities, and most often through quotas. As mentioned earlier, 20 Latin American and Caribbean countries have legislated employment quotas in the private and/or public sectors (Table 4.4). Quota requirements range from 0.5 percent to 5 percent of employees, depending on the country.

Meanwhile, incentive programs are becoming more prevalent (Table 4.5). These programs seek to promote the employment of persons with disabilities by helping to bring down the employment costs to employers for hiring them. For instance, Uruguay has a traditional wage subsidy program that provides an employer with a monthly subsidy conditional on hiring a new employee with a disability. A subsidy is also provided in Argentina, which on one hand workers receive directly, incentivizing unemployed persons with disabilities to look for jobs. Argentina’s program also incentivizes employers to hire persons with disabilities by granting deductions on income tax and social security contributions. Across countries, such programs typically do not run longer than a year, thus continuously incentivizing new hires.

Initiatives to provide companies and public institutions with certifications or “inclusion seals” recognizing their commitment to disability inclusion are also increasingly

(continued on next page)

common in the region. Often, these programs are accompanied by training in recruiting, hiring, and retaining employees with disabilities. Firms are then evaluated on their hiring practices, the accessibility of their facilities, and compliance with quota requirements. Upon passing the evaluation, firms receive their “seal,” which they can use in their recruitment materials, thus signaling to job seekers with disabilities that they are inclusive workplaces. Argentina, Chile, Mexico, the Dominican Republic, and the capital cities of Quito and Bogota have public programs to train and recognize inclusive firms and public offices.

TABLE 4.4 | Disability Quota Schemes in Latin America and the Caribbean

Public/Private sector	Country	Smallest binding firm size	Percentage (%)		
			Public	Private	
Only public	Bahamas	>100	1		
	Colombia	All	0.5–2		
	Costa Rica	All	5		
	Paraguay	All	5		
Only private	Uruguay	All		4	
Both	Argentina	All	4		
	Bolivia	All	4	2	
	Brazil	>50		1–5	
	Chile	>100	1		
	Dominican Republic	>25	5	2	
	Ecuador	>25		4	
	El Salvador	>25		4	
	Guatemala	All		2–5	
	Haiti	>1,000		2	
	Honduras	>20		2–4	
	Panama	>50		2	
	Peru	Public: All Private: >50		5	3
	Nicaragua	>50		2	
	Venezuela	All		5	

Source: Bregaglio Lazarte (2021) and government websites.

However, even with wage incentives, quota policies, and firms ensuring positive signaling through “seals,” employers may face difficulty finding applicants with

disabilities with the necessary skills for given jobs. Persons with disabilities struggle to access school-to-work and tertiary education programs (see Chapter 1); this puts them at a disadvantage in terms of skill accumulation. Some governments have, therefore, developed programs to help workers with disabilities upgrade their technical skills while gaining exposure to employment opportunities. Models vary widely from country to country.

TABLE 4.5 | Disability Labor Subsidy Programs in Latin America and the Caribbean

Country	Eligibility requirements					Maximum payments per worker per year	Maximum subsidy per worker				
	Firm		Contract		Worker		% Monthly minimum wage (2023)	Monthly value (US\$, PPP 2023)	% Yearly minimum wage (2023)	Yearly value (US\$, PPP 2023)	
	Public/private	Firm size	Max. salary	Hours/week	Gender						
Subsidy to workers with tax benefits to employers											
ARG	Public	Any	Any	≥40	Any	12	10.9	120.51	10.9	1,446.09	
				<40			12.8	70.89	12.8	850.64	
	Private			≥40			21.2	233.93	21.2	2,807.12	
				<40			26.9	148.86	26.9	1,786.35	
Subsidy to employers											
URU	Private	Any	Any	Any	Women	12	1.3	296.28	1.3	3,555.36	
					Men			1.2	259.25	1.2	3,110.99
					Any, with dependents			1.5	333.31	1.5	3,999.73

Source: Authors' calculations and government websites.

^a In this wage subsidy program in Chile, the value of the subsidy for returning hires is lower than for new workers. At maximum, it equals 45 percent of the monthly minimum wage, which is 11 percent of the yearly minimum wage. ARG = Argentina; CHL = Chile; PPP = purchasing power parity; URU = Uruguay.

For instance, in Brazil and Mexico, persons with disabilities can access vocational rehabilitation services through the Ministry of Labor. The services include career counseling, counseling for reasonable accommodations, and specific skill training. Brazil also has an apprenticeship program, through which employers can hire persons with disabilities as apprentices. The apprentices are registered in a professional learning program facilitated by the program *Aprendizagem Profissional* (Ministério do Trabalho e Emprego do Brasil 2022). Chile's *Fórmate para el Trabajo* program allows adults with disabilities to access technical training courses run by the Ministry of Labor. Participants are also enrolled in health insurance and can receive small transfers every time they attend a

class. The transfers cover transportation and the costs associated with child or elder care (approximately US\$10 per day) (Ministerio del Trabajo y Previsión Social de Chile n.d.). Persons with disabilities working in sheltered workshops in Argentina can request a grant from the Ministry of Labor to purchase the tools they need to start their own practice and cover the costs of becoming certified in a specific trade (Gobierno de Argentina 2022c). Also, Argentinean nonprofits can request grants from the Ministry of Labor to fund short-term technical skill training programs for people with disabilities in various areas, from carpentry to baking. Training is short term (3–8 months) and can only last 15–20 hours per week; this is to prevent these from functioning as sheltered workshops and potentially abusing the productive capacity of persons with disabilities (Gobierno de Argentina 2022a). Evidently, there is no consistent policy response to promoting the skills accumulation of persons with disabilities.

Finally, the most common policy responses targeting both workers and employers are labor market intermediation initiatives, which aim to articulate the demand and supply of talent. Public employment services typically offer job counseling services and digital job search platforms. Argentina, Bolivia, Colombia, El Salvador, Mexico, and Panama have programs that not only help job seekers with disabilities access employment opportunities through public employment services, but also provide additional support. For instance, in Argentina, persons with disabilities who approach public employment offices, can receive counseling on disclosure and reasonable accommodations (Gobierno de Argentina 2022b). In El Salvador and Panama, the ministries of labor organize job fairs for persons with disabilities as part of labor intermediation strategies (Ministerio de Trabajo y Desarrollo Laboral de Panamá n.d.). While most countries do not report data on the percentage of persons with disabilities among public employment services' beneficiaries, data are available for Bolivia and Colombia. In 2022 in Bolivia, 247 participants in the public employment service were identified as having a disability; they represented 3.2 percent of all participants. Yet, it is unclear what percentage in participants attained employment (Ministerio de Trabajo, Empleo y Previsión Social de Bolivia 2023). In 2023 in Colombia, 4,036 workers who attained employment through the public employment service had a disability; they represented 0.4 percent of all persons placed in jobs through the program (Ministerio del Trabajo de Colombia 2024). Therefore, while these policies are promising, it is unclear to what extent they attract and support job seekers with disabilities.

It is worth noting that many Organisation for Economic Co-operation and Development member countries provide funding and technical assistance to provide reasonable accommodations in the public sector. Specialized offices provide guidance to employers on providing reasonable accommodations in the workforce. Technical consultation is often available to the private sector and local governments as well. Services typically include the provision of assessments of worker needs and of the workplace environment.

Funding for reasonable accommodations may be restricted to workers in certain sectors (the federal government in the US case) or be more widespread. For example, the Australian government provides funding for adjustments through its Employment Assistance Fund, which covers purchase of technology and equipment, and modification of infrastructure. While Latin America and the Caribbean has a legal framework to provide reasonable accommodations in the workforce, it is without the technical and financial assistance to implement this approach.

Finally, even though workers with disabilities are more likely to be self-employed, few countries have programs that consider the specific needs of entrepreneurs with disabilities. One exception is Argentina's *Programa de Empleo Independiente* (PEI) program, under which the selected applicants are given training and funding to start their own business. The beneficiaries are trained in business management and strategy, market analysis, and are supported in identifying providers. While the program is not exclusively for entrepreneurs with disabilities, it aligns with a disability-specific program for unemployed adults with disabilities, *Promover la igualdad de oportunidades de empleo* (Ministerio de Trabajo, Empleo y Seguridad Social de Argentina 2017). It is unclear how many beneficiaries of the PEI have a disability. However, an initiative of this type may be promising to support entrepreneurs with disabilities.

What Does the Evidence Say?

There is a large body of evidence focused on observing subsequent shifts in employment for people with disabilities compared with those without disabilities following the enactment of antidiscrimination legislation and quotas. The majority of the research on antidiscrimination laws examines the effects of the US Americans with Disabilities Act (ADA); a few additional studies consider other legislation from high-income countries. Besides prohibiting employment discrimination, the ADA requires employers to provide “reasonable accommodations” for employees with disabilities, provided these adjustments do not impose “undue hardship” on the business. Initial studies indicated that the ADA may have had a negative impact shortly after its implementation, lowering employment. For instance, Acemoglu and Angrist (2001) find that, depending on the model specification, weeks worked declined by approximately 2–3 weeks (10–15 percent decrease) among men with disabilities in the initial years following the ADA's enactment; results are similar for women with disabilities. They attribute these results to an estimated 6–10 percent increase in the cost of hiring workers with disabilities, due to new legal provisions compelling employers to provide reasonable accommodations. They note that these costs are likely to decline over time. DeLeire (2000) finds similar results, estimating a 7.2 percent employment rate decline among men with disabilities due to the ADA, but also finding that these effects were shouldered only by persons

with certain types of disabilities (mostly physical, intellectual, or psychosocial). A similar situation was observed in the United Kingdom, according to Bell and Heitmueller (2009), where the Disability Discrimination Act of 1995 seemed to initially hinder rather than help prospects for persons with disabilities, lowering employment rates by 5–8 percentage points, depending on the model specification. These outcomes are potentially due to uncertainty around the litigation costs associated with firing persons with disabilities, low levels of awareness, and a lack of financial support to fund reasonable accommodations.

More recent studies offer a more nuanced view. Houtenville and Burkhauser (2004) replicate Acemoglu and Angrist's 2001 study but use a more long-term definition of disability (a condition lasting two work periods versus only one) and do not find evidence of negative employment effects (Houtenville and Burkhauser 2004). Similarly, Jolls and Prescott (2004) find an approximate 10 percent decline in employment among persons with disabilities resulting from the ADA; yet, this decline was temporary, dissipating after 1993. Further, Houtenville and Burkhauser (2004) argue that the observed decline in employment among workers with disabilities is likely due to the take-up of social security disability insurance, which was expanded during the same period and has been shown to have had adverse effects on the employment of people with disabilities (Autor and Duggan 2003).

Other researchers have pointed out that the observed employment decline among people with disabilities after the enactment of antidiscrimination legislation may be artificial (Bound and Waidmann 2002; Hotchkiss 2004). Notably, Hotchkiss (2004) argued that the employment decline due to the ADA was not because people left the workforce, but rather, a result of an increase in unemployed people self-identifying as having a disability—attracted by the possibility of higher disability benefits after the ADA. Indeed, Jolls (2004) mentioned that the ADA has fostered greater educational engagement among people with disabilities, potentially influencing their employment prospects. Beegle and Stock (2003) found that state-level antidiscrimination statutes following ADA did not affect employment rates. These results suggest that, in general, antidiscrimination legislation has neutral effects, especially once overarching antidiscrimination norms are already in place.

Some studies even find positive effects of antidiscrimination legislation on employment outcomes, especially for persons with less severe disabilities. For instance, Kruse and Schur (2003) find that the ADA's impact varies based on the definition of disability that is used to estimate its effects. Negative impacts are observed when a restricted definition of disability is employed, whereas a positive effect is noted when the definition is, according to the authors, more appropriately aligned with the legislation. Similarly, Button (2018) found that when California broadened its disability discrimination law to less severe disabilities, the probability of being employed rose by 3.8 percentage

points among persons with disabilities. Further, Jolls and Prescott (2004) leverage a difference-in-difference design to evaluate the effects of different components of the ADA. They show that the decline in employment was associated with the requirement to provide accommodations rather than the prohibition of discrimination. These results suggest that antidiscrimination legislation can positively affect the labor market participation of persons with mild to moderate disabilities. Any negative effects are short term and most likely concentrated among workers with more severe disabilities, who may require more substantial accommodations and support. This implies that programs to fund reasonable accommodations may be particularly relevant to mitigate any negative effects of new antidiscrimination legislation.

Quota laws have also been evaluated extensively for high-income countries; yet existing evidence presents a varied picture of these laws' effectiveness. Some studies find moderate positive effects; for instance, in Japan, Mori and Sakamoto (2018) find that for every firm size increase of 100 workers, the number of workers with disabilities increases by 0.013 workers as a result of a quota program. In Spain, quota evaluations show that there is a 1.4 percent increase in the percentage of workers with disabilities in the firms subject to the quota (Malo and Pagán 2014). In Austria, evaluations of the quota system are slightly more positive; showing a 12 percent increase in the employment of persons with disabilities (Lalive, Wuellrich, and Zweimüller 2013). Positive effects are also found in Chile, where Duryea, Martínez A., and Smith (2024) find a 15–20 percent rise in the employment of people with disabilities in the firms subject to the disability quota. However, there is also extensive evidence of the adverse effects of quotas. Wagner, Schnabel, and Kölling (2001) and Verick (2004) find quotas in Germany inconsequential in affecting employment rates. Barnay et al. (2019) find that the disability quota in France has neutral effects in the public sector, with large negative effects in the private sector, where it resulted in employment decline by 13 and 19 percentage points, respectively, two and five years after its implementation. Further, in the study mentioned previously, Lalive, Wuellrich, and Zweimüller (2013) find that as many as 64 percent of workers classified as having a disability, for compliance with the quota requirement, were already employed by their respective firms before they received their disability status. Similarly, Duryea, Martínez A., and Smith (2024) find that 42 percent are reclassified workers. Therefore, quotas do not always have positive outcomes, and when they do, these results should be interpreted with caution since they may be the result of employees' reclassification rather than true employment gains.

Given the small effects due to quotas, some studies have evaluated interventions that seek to improve quota performance. Overall, these studies suggest that increasing the perceived risk of noncompliance improves quota efficiency. For instance, De Araújo et al. (2022) found that the quota in Brazil had no significant effects when it was first implemented in 2007, but had a positive effect in 2016, when it led to an

increase in the employment of persons with disabilities by approximately two workers per firm. They attribute the delayed positive effect to the greater enforcement of quota compliance over time. Evidence from Brazil also shows that increasing the number of inspections to verify quota compliance improves quotas' employment impacts (Szerman 2022; De Souza 2023). Evidence from Austria and Hungary suggests that increasing noncompliance-related fines makes quotas more effective (Krekó and Telegdy 2022; Wuellrich 2010). Further, studies in Chile and Peru find that compliance can be encouraged with emails informing companies about the quota stipulations, reminding them of the risk of noncompliance (Bosch et al. 2021; Duryea, Martínez A., and Smith 2024). Overall, these studies provide positive evidence of strengthening enforcement of quota compliance.

Evidence on the impact of quotas on firms' outcomes is still incipient. However, the available evidence suggests mixed outcomes. On one hand, there is no evidence suggesting negative impacts due to quotas on firms' performance. Mori and Sakamoto (2018) find that the number of employees with disabilities does not impact a firm's profit. Duryea, Martínez A., and Smith (2024) find that firms are not hurt by the quota in Chile. However, De Souza (2023) finds that the quota in Brazil reduced the wages and employment of workers without disabilities.

The available evidence on interventions targeting employers is limited. There are no evaluations of the wage subsidy programs in Argentina, Chile, and Uruguay for this population. However, there are a few evaluations of wage subsidies in high-income countries outside Latin America and the Caribbean. For example, Deuchert et al. (2017) find a disability subsidy to have neutral employment effects in Switzerland. Similarly, in a correspondence experiment in Belgium, Baert (2016) finds that disclosing entitlement to a disability wage subsidy did not increase the callback rate for applicants with disabilities, regardless of the subsidy amount (20–40 percent). Conversely, Datta Gupta, Larsen, and Thomsen (2015) find that in Denmark, a wage subsidy for workers with disabilities was associated with a 32–39 percentage point increase in employment. They also find that lowering the wage subsidy's value is associated with a significant decrease in the hiring of people with disabilities. Angelov and Eliason (2018) observe that in Sweden, wage subsidies for job seekers with disabilities had mixed effects, slightly reducing exits through disability insurance, but also diminishing the chances of securing unsubsidized employment. Clearly, the evidence on disability wage subsidies is limited and inconclusive. Further, evidence is needed in contexts where the informal sector represents a substantial share of employment.

Given companies' insufficient awareness of legal frameworks and inclusion practices, inclusion-related employer training programs are presumably important in promoting the employment of persons with disabilities. However, there are no rigorous evaluations of programs of these types.

Direct employment services vary widely, from highly supported employment programs, to more light-touch interventions such as vocational rehabilitation and case management programs. Case management programs traditionally focus on helping individuals navigate government services—in this case, related to employment. Vocational rehabilitation often includes case management, but also supports persons with disabilities in accessing employment in the private sector. Through vocational rehabilitation persons with disabilities can have access to job preparation and training (at times even including funding for tertiary education), career counseling, counseling on reasonable accommodations, and job placement services (Duryea, Martínez A., and Pereira 2023). While the literature on these types of programs is limited and mostly from high-income countries, overall, the evidence suggests positive impacts on labor market outcomes.

In general, vocational rehabilitation and case management programs have had positive outcomes. Case management programs, which help job searchers with disabilities navigate government services, have been found to have significant positive effects on the employment of persons with psychosocial disabilities (Dieterich et al. 2017). Vocational rehabilitation has received overall positive evaluations considering specific populations, especially when supporting youth with disabilities during school-to-work transitions (see Chapter 2). Yet, the effects of vocational rehabilitation on older working-age adults are less clear. For instance, Dean and Dolan (1991) estimate the impact of vocational rehabilitation on earnings in the United States and find that positive effects are concentrated only among women, instead of all participants. A recent study finds that a vocational rehabilitation program in the United States positively impacts employment rates but negatively affects earnings for program applicants with physical, cognitive, and psychosocial impairments (Dean et al. 2014). This contrasts largely with the widespread positive effects often observed among youth (see Chapter 2). Those who do not tend to benefit from vocational rehabilitation may require more involved approaches.

Supported employment and similarly complex interventions have been developed in high-income countries to target persons with disabilities who fall through the cracks of vocational rehabilitation programs. Indeed, supported employment is an approach that focuses on persons with disabilities who were previously regarded as “incapable of work” and addresses the high support needs for them to obtain and hold jobs. Most commonly, these programs have been developed targeting persons with psychosocial and intellectual disabilities. Besides the traditional vocational rehabilitation services, supported employment often includes individual placement services, on-the-job mentoring, and subsidies for employers who often have positions reserved for programs.

While the evidence is still incipient, these more involved programs have positive evaluations, mostly from high-income countries. For instance, evaluations from the United States, Canada, Australia, Sweden, Switzerland, and other high-income countries have consistently shown supported employment programs to have boosted employment for

persons with mental health conditions and psychosocial disabilities (Bond, Drake, and Becker 2008; Drake et al. 2016; Kinoshita et al. 2013; Luciano et al. 2014). This is consistent with the results of Zhang et al. (2017) in China, who find that persons with schizophrenia who participated in an integrated supported employment program were more likely to be employed and have longer job tenures than those assigned to receive only individual placement and traditional vocational rehabilitation. Further, Fogelgren et al. (2023) evaluate a Swedish program where a caseworker is assigned to help workers with disabilities search for jobs, maintains close contact with employers and the employee, and is ready to do the participant's job at the workplace when needed. This program was associated with a 10 percentage point increase in employment relative to regular vocational rehabilitation. These results suggest that more involved direct employment services may be especially relevant in closing the gaps among those who would not benefit from traditional vocational rehabilitation.

Key Takeaways

Individuals with disabilities have lower labor market participation rates, and those employed have lower monthly earnings relative to their counterparts without disabilities. These disparities partly stem from variations in accumulated productivity, as evidenced by differences in educational levels, as discussed in Chapter 2. Discrimination, lack of systems to fund and provide reasonable accommodations, and inaccessible transportation systems and job sites likely also contribute to employment gaps among people with and without disabilities.

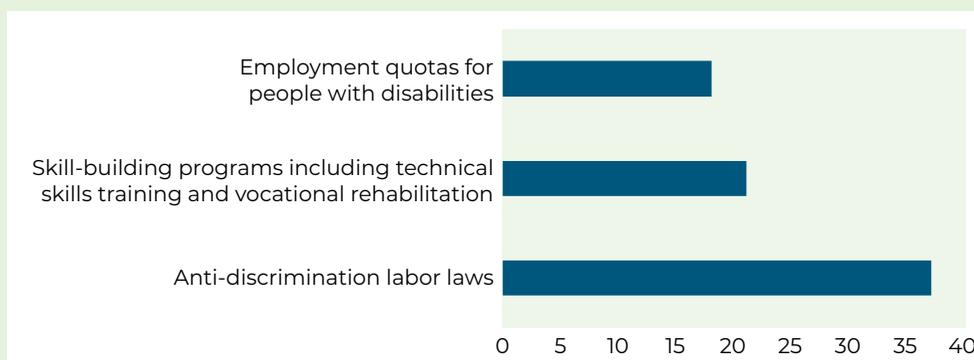
The region's policy response has focused on establishing legislative regulations, including employment quotas for individuals with disabilities. The emerging evidence from the region indicates a positive, albeit limited, impact of quotas. Results from other regions also show heterogeneous effects. This heterogeneity may be linked to unstudied factors, such as the level of the quota and other regulations and labor market conditions. On the other hand, there are no rigorous studies of the impacts of laws that make it more difficult to fire workers with disabilities, despite concerns about generating disincentives for hiring them. Evidence on other policies intended to encourage hiring, such as wage subsidies for people with disabilities, is limited and inconclusive. More active labor market policies for individuals with disabilities, including intermediation through public employment services, vocational rehabilitation, case management, and supported employment, have shown a limited but generally positive impact in evaluations outside Latin America and the Caribbean. Well-executed policies in Latin America and the Caribbean could support the inclusion of people with disabilities in the region. However, the quality of these interventions must be closely monitored and adapted to the region's needs, and further evidence is required to refine these policies under specific conditions.

There is no rigorous evidence on the impacts of programs to train and certify employers as inclusive workplaces. However, these programs can boost the employment of workers with disabilities by reducing discrimination and promoting funds for reasonable accommodations within companies. Given that these types of programs are increasingly being implemented in Latin America and the Caribbean, their evaluation is important.

Box 4.3 Priorities for Employment Policy Research

As mentioned in Box 1.3, the IDB is conducting an online survey to gauge existing views in the region, particularly those of people with disabilities and their families, on what disability inclusion policies and measures should be prioritized in research agendas. This box presents the results of the responses received as of May 2024.^a While these results are based on only 150 survey responses and are therefore not representative, they can provide insights for future initiatives, particularly given the challenges associated with surveying people with disabilities. Within employment policy, the top three research priorities are given in Figure B.4.3.

FIGURE B.4.3 | Top Priorities for Employment Policy Research



Source: IDB staff calculations using results from online survey.

For survey respondents, there are two research priorities in employment policy that relate to evaluating the effects of employment legislation: anti-discrimination legislation (the most mentioned) and quota policies (the third most mentioned). This is an interesting result considering the small share of respondents who work for pay in private or public entities (17 percent). The second most frequently cited priority is skill-building programs, including technical skill training and vocational rehabilitation.

^a If you would like to offer your opinion on research priorities for the inclusion of people with disabilities, please fill out the survey at the following link through June 2025: <https://accessiblesurveys.com/s2/NoXaOIVThWvED1daoy>.

Finally, it is important to recognize the predominance of informality in the region, for workers both with and without disabilities. Workers with disabilities are significantly more likely to be self-employed, and in some countries, they are also slightly more likely to be employers. This suggests that, given the barriers to accessing formal employment,

many workers with disabilities turn to entrepreneurship. Therefore, it is important that countries in the region consider the needs of persons with disabilities in programs promoting the development of small and medium enterprises as well as trade and technical vocational training focused on entrepreneurship. The evidence on interventions focused on promoting inclusion in the informal sector is vastly limited. Additionally, the high prevalence of informality makes the scope of formal sector policy responses to inclusion more limited, even though they may have positive evaluations in other contexts, as discussed in this chapter.



5

Social Protection



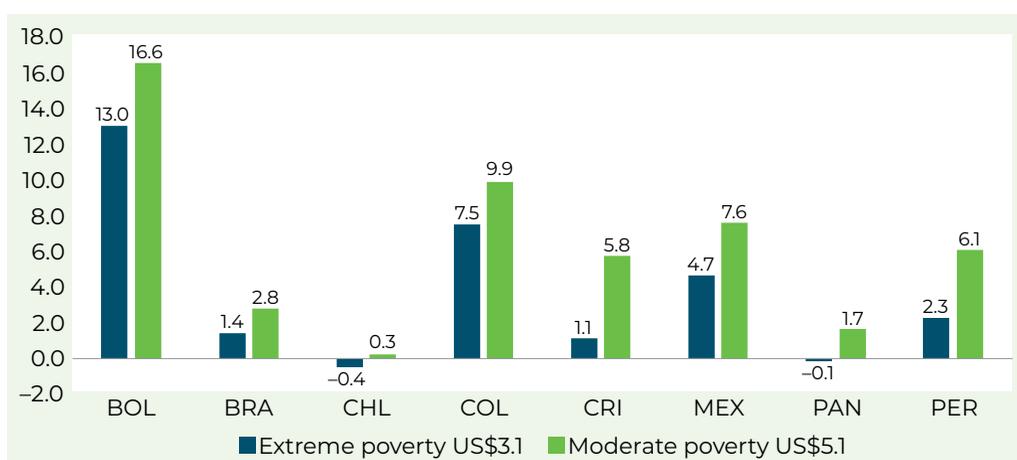
Social Protection Policies: Critical for Inclusion and Autonomy

Social protection programs aim to reduce poverty, vulnerability, and social exclusion by providing support to individuals and households in need. There is a strong moral argument for ensuring that social protection programs are inclusive and accessible to persons with disabilities. Like everyone, people with disabilities should be able to access poverty reduction and cash transfer programs, emergency food programs, in-kind transfers, housing programs, care programs, and other social protection programs. As shown in the previous chapters, people with disabilities have lower earnings, education levels, and employment rates, which may make them especially likely to benefit from social protection initiatives. Additionally, some social protection programs actively target people with disabilities to address barriers and needs that are not covered through other government programs.

A commitment to the right of access to social protection is established in Article 28 of the Convention on the Rights of Persons with Disabilities (CRPD) (UN 2007). The article explicitly encompasses a wide range of programs, including, but not limited to, poverty reduction programs, retirement benefits, and public housing programs. Most Latin American and Caribbean countries, having ratified the CRPD, also have national legislation that recognizes equal rights of people with disabilities to income support and/or social security (Stang Alva 2011). A significant number of such countries have laws recognizing the rights of people with disabilities or establishing social protection programs for them, such as the right to receive fiscal benefits and tax exemptions (16 countries), assistive technology (13), disability cash transfers (12), discounts on public transport fees (12), public housing and mortgage support (12), as well as recognition of the right to receive care (3) (Vásquez Encalada and Pereira 2023). Nonetheless, many countries are still working to achieve compliance with these legal frameworks and ensure that their social protection systems move away from a charity-based approach to one based on promoting the autonomy and self-determination of people with disabilities.

There are also economic reasons why social protection is of crucial importance in promoting the social inclusion of persons with disabilities. When education, labor market, health, and other policies promote skill acquisition and inclusion in quality jobs, the need for income support through social protection programs diminishes. At the same time, social protection programs can have an economic return, such as enabling families with members with disabilities to invest in the education of the next generation. Moreover, even with the most inclusive education and employment policies, persons with high support needs may require social protection policies to ensure self-determination and adequate living conditions.

FIGURE 5.1 | Percentage Point Differences in Poverty Rates between Households with and without Members with Disabilities



Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: The gap in extreme and moderate poverty between households with and without persons with disabilities is expressed as the difference in poverty rates among households with at least one member with a disability minus households without persons with disabilities. The calculations use per capita household income using the US\$3.1 2011 PPP threshold for extreme poverty and US\$5.1 2011 PPP for moderate poverty. Per capita household income includes labor and nonlabor income, including social transfers or subsidies, which include cash transfers, noncontributory pensions, and other government transfers.

A Snapshot of Regional Trends

Given limited resources, most social protection programs in Latin America and the Caribbean to date have been targeted to poor households. A considerable share of people with disabilities are poor. However, estimates of extreme poverty rates (household income under US\$3.1 per day) using recent household surveys for eight countries do not vary systematically based on disability status, in contrast to previous research using 2002–04 data for four countries in the region (Mitra, Posarac, and Vick 2013).¹ In five of eight countries, rates of extreme poverty are less than 3 percentage points higher among

¹ This is calculated using per capita household income, at the threshold of US\$3.1 PPP a day. The threshold for moderate poverty is US\$5.1 2011 PPP a day.

households of people with disabilities than those without people with disabilities. In the remaining three countries, poverty rates are 4.7 percentage points higher. However, as shown in Figure 5.1, when considering a slightly higher threshold (household income under US\$5.1 per day), moderate poverty rates are consistently higher among households of persons with disabilities; differences exceed 5 percentage points in five of the eight countries and are under 3 percentage points in the other 3 countries. Overall, these results suggest that people with disabilities are more likely to be poor than their counterparts without disabilities, although the difference in experiencing extreme poverty is less pronounced when considering extreme poverty lines.²

People with disabilities are also more likely to experience poverty relative to their counterparts without disabilities when analyzing the income distribution in different countries. Indeed, households with members with disabilities are more likely to be in the lowest quintiles of the income distribution. People with disabilities are less likely to be formally employed and have lower earnings than their equally educated and experienced counterparts without disabilities (see Chapter 4). This contributes to the differences in the distribution of monetary household per capita income between households with and without persons with disabilities (see Table 5.1). Indeed, households of people with disabilities are overrepresented in the bottom 40 percent of household incomes, whereas their counterpart households, with no members with disabilities, are overrepresented in the top 40 percent of household incomes. Moreover, households with members with disabilities are also overrepresented in the third income quintile, meaning they are more vulnerable to falling to the bottom quintiles compared with households without members with disabilities.

TABLE 5.1 | Average Per Capita Household Income Distribution by Disability Status (8 countries)

Income quintile	Percentage of households (%)	
	Without members with disabilities	With members with disabilities
Q1	17.3	24.8
Q2	18.6	23.3
Q3	19.1	19.7
Q4	20.5	17.9
Q5	24.6	14.3

Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: The calculations use per capita household income. Shown are the averages of the quintiles for the eight countries studied.

2 Given the large share of older persons among the population with disabilities, we examined the relationship with age, and find that the poverty gaps across disability status vary when households with members 55 years or older are excluded from the analysis, but not in systematic ways. In Bolivia and Mexico, the gaps by disability are smaller when these households are excluded, whereas the inverse is true in Brazil, Chile, Costa Rica, Panama, and Peru (Figure 5.1). In Colombia, the age composition of the household does not seem to be related to differences in poverty rates.

These results suggest that while people with disabilities are not more likely to experience extreme poverty in all the countries, they are more likely to be moderately poor than their counterparts without disabilities and are less likely to be in high-income households. However, poverty cannot be summed up only with monetary income measures; poverty also implies a lack of access to education, health care, and basic living standards. This is the conceptual framework behind the multidimensional poverty index (MPI), which aggregates deprivations in 10 different measures (Alkire and Jahan 2018).³ Some recent analyses suggest that differences in multidimensional poverty are not large between people with and without disabilities in the region. While earlier analyses did highlight some differences in multidimensional poverty across disability status in the region (Pinilla-Roncancio 2018), studies using more recent surveys and a larger sample of countries have found few gaps. Analysis using demographic and health surveys for 11 lower- and middle-income countries over 2010–2014 (Pinilla-Roncancio and Alkire 2021) found that people living in households with members with disabilities did not experience higher levels of multidimensional poverty or deprivation than people living in households without members with disabilities, including in four surveys from Latin America and the Caribbean.

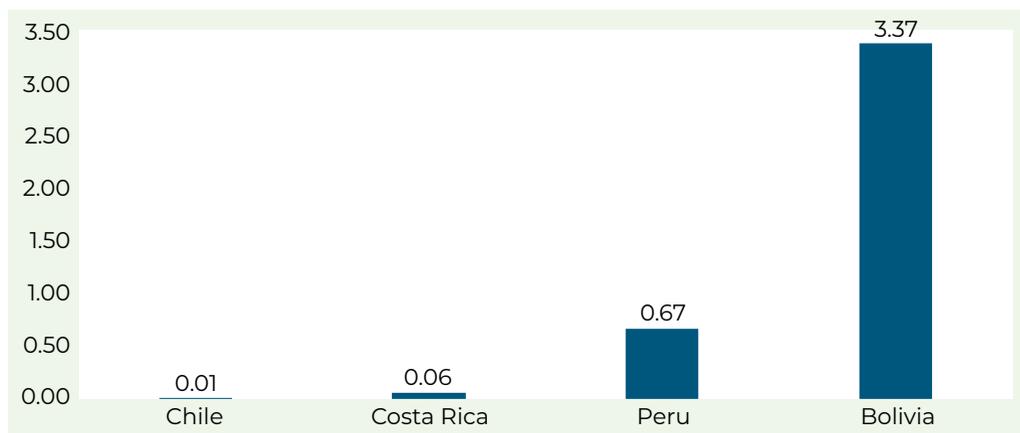
While it is not possible to calculate multidimensional poverty using the data in this report, there are other measures that can be used to explore differences in the standard of living between people with and without disabilities.⁴ For instance, empirical analyses have found that for persons with disabilities, costs of living are higher due to the additional expenditures needed to reach the same standard of living as their counterparts without disabilities (World Health Organization and the World Bank 2011). In other words, families that have a member with a disability need more income to attain the same standard of living as families that have no members with disabilities. Disability status is associated with additional costs for goods and services for health care, assistive devices, and adaptation of homes (Mitra et al. 2017). Analyses of recent expenditure data for Argentina found that persons with disabilities had higher expenditure levels for health but not for other expenditures (see Box 3.2 in Chapter 3). While the higher costs of disability are not typically reflected in measures of poverty, monetary income, or multidimensional poverty in the region, they may contribute to other differences in living conditions across disability status.

3 The MPI is constructed using two indicators from the health (undernourishment and child mortality), two indicators of the education dimension (completion of at least six years of schooling among household members who should have completed primary schooling and school attendance among children up to the age when they should complete eighth grade), and six indicators associated with standard of living (lack of access to electricity, sanitation, drinking water, adequate housing, and cooking fuel; and lack of access to at least one key household asset such as a radio, a television, a telephone, or a computer). Alkire and Jahan (2018) contains more information on how the MPI is constructed.

4 It is not possible to compute the MPI using the household surveys used in this report, because the surveys do not include questions on undernourishment, child mortality, and school attendance—three of the indicators used in the MPI.

For instance, in some countries, households of people with disabilities are slightly more likely to meet key conditions of inadequate housing. Figure 5.2 shows the percentage point difference in moderate to severe deprivation between households with and without members with disabilities across several of these key aspects. Households are considered to be moderately to severely deprived if three or more of the following conditions hold for them: the household is overcrowded; lacks electricity; lacks adequate sanitation systems; lacks a safe water source; lacks adequate fuel for cooking; or its roof, walls, or flooring are constructed with nonpermanent materials. In Chile, Costa Rica, Peru, and Bolivia, households of people with disabilities are 0.01–3.37 percentage points more likely to meet three or more of the above conditions (see Figure 5.2). When a different number of deprivations is used for the threshold, the differences are still under 4 percentage points across all countries. In countries that have achieved near-universal access to basic utilities—mainly electricity, adequate water and improved sanitation systems—differences are by definition lower. However, in countries where universal access to these types of services is yet to be achieved, differences between households with and without members with disabilities are likely to be more pronounced. This should be further evaluated in other Latin American and Caribbean countries, especially those where universal access to basic utilities has not been achieved.

FIGURE 5.2 | Percentage Point Differences in Households with and without Members with Disabilities that Experience Moderate to Severe Deprivation in Housing Conditions



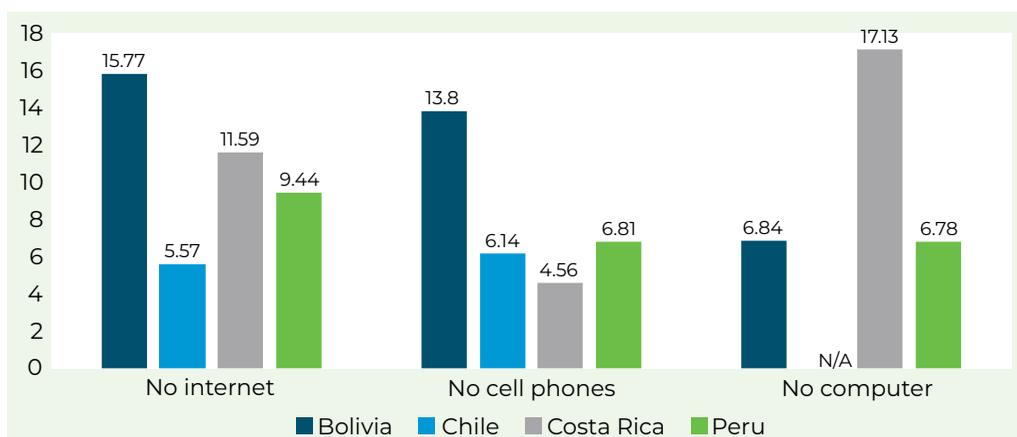
Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Chile (2022), Costa Rica (2022), and Peru (2022).

As seen in Figure 5.2, the differences in housing deprivations appear to be small. However, they are greater for some housing conditions. For example, in Chile, Costa Rica, and Peru, households of members with disabilities are less likely to be overcrowded than households without members with disabilities, and they are not significantly more likely

to lack access to electricity, sanitation, and water. However, in Bolivia and Peru, households of members with disabilities are over 5 percentage points more likely to have their floors, walls, or roofs constructed with nonpermanent materials.

The largest differences between households with and without members with disabilities relates to indicators associated with online connectivity. In Bolivia, Chile, Costa Rica, and Peru, there are large percentage point differences in access to the Internet, cell phones, and computers between households with and without members with disabilities (see Figure 5.3). Evidently, the challenges are unique to each country when ensuring the same standard of living for people with disabilities and their families relative to their counterparts without disabilities.

FIGURE 5.3 | Percentage Point Differences between Households with and without Members with Disabilities in Access to the Internet, Cell Phones, and Computers at Home



Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Chile (2022), Costa Rica (2022), and Peru (2022).

The topic of food insecurity among people with disabilities has been studied in high-income countries (Schwartz, Buliung, and Wilson 2019; Brucker and Coleman-Jensen 2017) but far less in Latin America and the Caribbean. Assessment of food insecurity involves considering multiple dimensions of food consumption, including food access, utilization, and stability (Salazar 2023).⁵ A recent paper examines the relationship between disability status and food insecurity in three Latin American countries—Bolivia, Chile, and Mexico (see Table 5.2). After controlling for households' geographic

⁵ Access refers to the availability of physical and financial resources for households to obtain food. Utilization refers to the food quality to attain an adequate nutritional status and live a healthy life. Stability refers to the ability to maintain constant access and availability to nutritious and quality food. Food availability refers to the food supply at the national or local level. It is the fourth characteristic of food security. The household surveys do not provide information along this dimension, however.

residence and demographic information, all the measures of food insecurity are significantly higher for people with disabilities than for people without disabilities in all three countries (Senra, Duryea, and Pereira, forthcoming). Disability status is associated with an 8–19 percentage point increase in the likelihood of experiencing food insecurity, depending on the model.

TABLE 5.2 | Percentage of People with Food Insecurity by Disability (%)

Insecurity measure	Bolivia		Chile		Mexico	
	People with disabilities	People without disabilities	People with disabilities	People without disabilities	People with disabilities	People without disabilities
Access	32.6	23.9	23.2	17.9	32.7	23.5
Stability	50.6	43.2	39.7	34.8	46.5	37.6
Utilization	37.6	29.4	36.3	29.5	42.8	31.8

Source: Senra, Duryea, and Pereira, forthcoming.

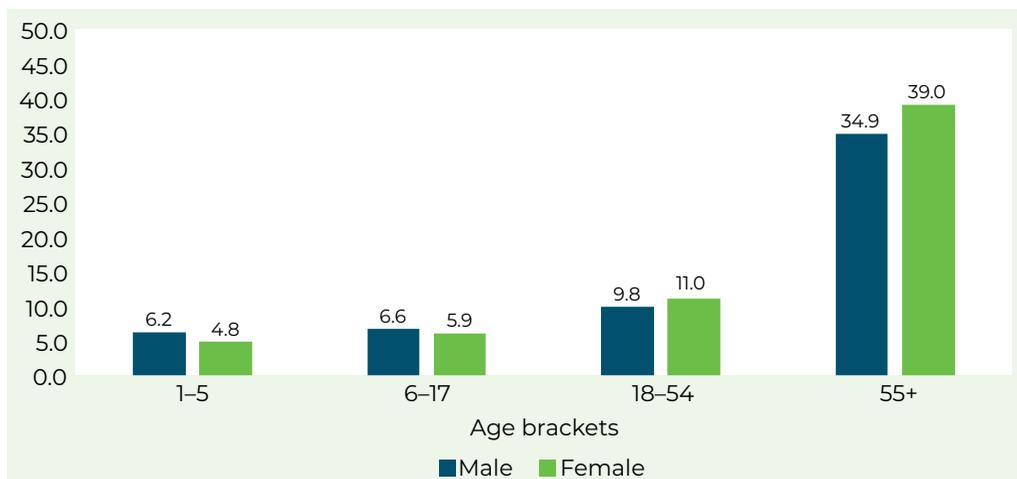
Demographics of people with disabilities are also relevant for social protection policy. Women make up a larger share of the overall population with disabilities in the region, although this is not the case at all ages. Age-specific prevalence rates are typically higher for men than women among those younger than 18, based on the average of the age-specific rates among the eight countries analyzed (Figure 5.4). The higher prevalence rates for women at older ages and their higher survival rates at these ages contribute to the overall greater number of women with disabilities than men in the overall population.

This is relevant since many social protection programs, for example, retirement pensions and care policy, target older adults. Retirement pensions base eligibility primarily on age, while different care policy packages include an assessment of dependency. Governments have thus created programs specifically for people who are dependent, whether they are of old age or not. Yet, it is important to recognize that disability and functional dependency are related but distinct concepts. Not everyone with a disability is functionally dependent, and not everyone with a functional dependency has a disability.⁶ Under the social model of disability, disability is defined by the interaction between a permanent impairment and external barriers. Strictly speaking, individuals who do not have a permanent impairment do not have a disability, even if they have functional limitations in daily life. All infants meet the criteria for dependency, even if

6 Activities of daily living, such as being able to eat, dress, and groom on one's own, are indicators of functional status and the ability to care for oneself without assistance. The inability to perform activities of daily living results in a functional dependence on other individuals or assistive devices.

they do not have functional limitations, as do many older persons; however, since neither infancy nor old age is considered an impairment, these individuals do not necessarily have a disability.

FIGURE 5.4 | Average Prevalence of Disability across Gender and Age Groups (8 countries)



Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

At the same time, many people with disabilities, particularly those with high support needs, are functionally dependent and rely on unpaid family members to assist with daily activities. Data from Mexico and Chile indicate that 14–37 percent of people with a severe disability are helped by another person at home in everyday tasks such as eating, bathing, or dressing. Women provide the bulk of unpaid care for family members with disabilities needing support. In Peru and Chile, over 95 percent of people with disabilities receiving assistance reported being assisted by family members or friends, and only about 5 percent of those providing assistance received any remuneration for the tasks performed. In Chile, 9.8 percent of adults have disabilities and are also functionally dependent. Approximately 60 percent of this population receive personal assistance, with the lion's share, 85 percent, coming from another household member. Of the household members providing assistance in Chile, 70 percent are women, primarily daughters, wives, or mothers (Ministerio de Desarrollo Social y Familia de Chile n.d.). In Mexico, unmet need for assistance was documented; one-third of older persons with severe disabilities had an unmet need.⁷

⁷ The statistics presented in this paragraph are based on authors' calculations using data from disability surveys in Peru (INEI 2012), Mexico (Centro de Investigación en Evaluación y Encuestas del Instituto Nacional de Salud Pública de México 2010), and Chile (Ministerio de (Servicio Nacional de la Discapacidad de Chile 2016).

More information is needed on the demographic characteristics and living conditions of people with disabilities in large-scale residential institutions in the region, for example, psychiatric hospitals, orphanages, and prisons, whether publicly or privately run.⁸ In most countries, these institutions are not included in censuses or other surveys. The conditions in these facilities are not monitored systematically, partly because many are run by nongovernmental organizations. While some countries have established standards and quality indicators for such organizations (for instance, by limiting the number of people per institution), it is not evident that they are monitored or enforced. Reports on specific institutions in the region have found abusive conditions as well as a lack of specific mechanisms to challenge involuntary commitments (Ríos-Espinosa 2018; Rodríguez 2015).

Policy Landscape

Including a disability perspective in social protection can be understood as operating along a continuum of two related tracks: the universal approach and the disability-specific approach. While the universal approach emphasizes ensuring that all social protection programs are inclusive and accessible to people with disabilities, the disability-specific approach involves programs for closing the gaps in well-being between people with and without disabilities and may offer specific or differentiated services for people with disabilities. Many disability-specific programs also target families with low income; they require instruments to identify disability and poverty status to prove eligibility. In this section, we explore the main policies and programs offered under the social protection umbrella.

Universal Access

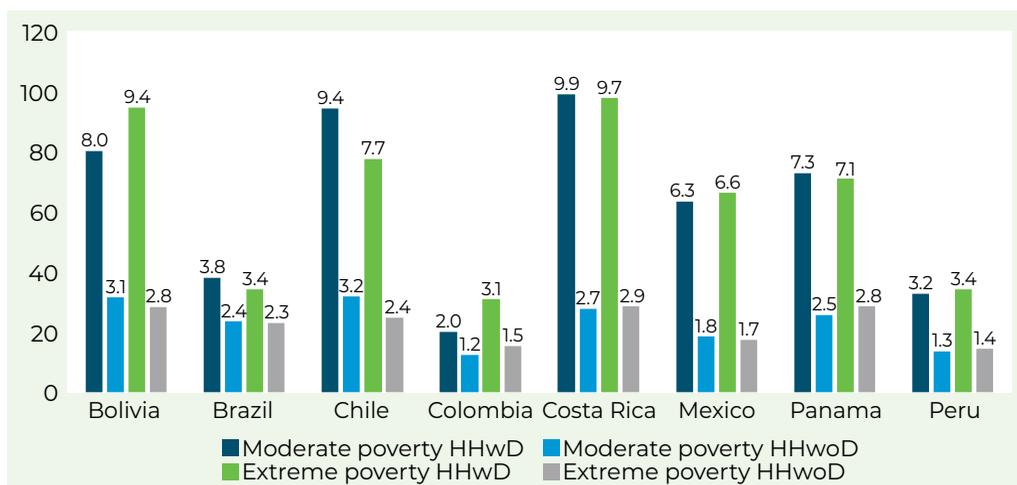
While efforts tend to be fragmented rather than systematic, some of the most common initiatives to make social protection programs accessible and inclusive in the region involve training and building awareness of front-line workers on disability frameworks and inclusive practices, as well as interventions to make programs more accessible. This involves not only ensuring that establishments are physically accessible, but also, ensuring the provision of accommodations in the delivery of services, such as by providing real-time sign language interpretation or providing information and application processes in accessible formats. While many countries have building codes that govern the accessibility of new construction projects and the upgrade of older buildings, standards

⁸ While we do not have good measures of the number of children and adults with disabilities living in institutions, reports to the CRPD find many of these institutions in the region with individuals who have been denied the opportunity to live in the community.

enforcement is low. In general, scarce information is available on the accessibility of social protection infrastructure and services. This itself hinders the use of these programs.

Some insight is available on the utilization of one of the region's largest social protection programs—cash transfer programs. These are included under a larger group of social protection strategies designed to reduce monetary poverty by increasing consumption and to break the inter-generational transmission of poverty by promoting human capital accumulation. Researchers have examined whether cash transfer programs are inclusive of people with disabilities, specifically, whether families with a member with a disability are less likely to receive a conditional cash transfer subsidy. Empirical evidence for Bolivia, Chile, Costa Rica, and Mexico indicates that traditional cash transfer programs do not disproportionately exclude households with members with disabilities, controlling for households' observable characteristics (Duryea, Pinzon, and Pereira, forthcoming). While these results do not discount the need for disability-specific programs and features, they are encouraging regarding the universality of program benefits in these countries.

FIGURE 5.5 | Percentage Point Decreases in Poverty Rates due to Cash Transfers Received by Households with and without Members with Disabilities



Source: IDB staff calculations based on data from household surveys from Bolivia (2021), Brazil (2022), Chile (2022), Colombia (2022), Costa Rica (2022), Mexico (2022), Panama (2022), and Peru (2022).

Note: The calculations use per capita household income using the US\$3.1 2011 PPP threshold for extreme poverty and US\$5.1 2011 PPP for moderate poverty. Social transfers or subsidies include cash transfers, noncontributory pensions, and other government transfers. HHwD = Households with persons with disabilities; HHwoD = Households without persons with disabilities.

Further, preliminary data analysis suggests that cash transfers have an especially important role in reducing poverty among people with disabilities. There is a decisive pattern in the link between receiving cash transfers and experiencing lower levels of poverty, with the reductions being two to three times larger for households with people with disabilities (see Figure 5.5). In the eight surveys analyzed, reductions in extreme poverty

rates range from 3.1 to 9.7 percentage points among households with people with disabilities as a result of receiving cash transfers, while for households without people with disabilities reductions in rates range from 1.4 to 2.9 percentage points as a result of receiving government transfers.⁹ Similarly, reductions in moderate poverty rates range from 2.0 to 9.9 percentage points for households with people with disabilities and from 1.2 to 3.1 for households without people with disabilities. Bolivia, Chile, Costa Rica, Panama, and Mexico show especially large differences in poverty rate reductions by disability status associated with cash transfer incomes (see Figure 5.5). These results suggest that cash transfers are reaching households with people with disabilities, who are overrepresented in the lowest quintiles of the income distribution (Table 5.1).

It is essential to highlight that the eligibility for many transfers (including those specifically for people with disabilities) ends at age 65. At this age, individuals without a formal retirement pension in some countries in the region receive a basic transfer through another set of widely implemented social protection programs—noncontributory retirement pensions. These pensions are not targeted specifically to people with disabilities. However, given that persons with disabilities are less likely to be employed in the formal sector (see Chapter 4) and hence have lower rates of contributions to the contributory system, they likely disproportionately benefit from these programs. There is a solid and growing pool of evidence regarding the impact of noncontributory retirement pensions on reducing poverty and improving the well-being of older persons in the region (Bando, Galiani, and Gertler 2020, 2022; Galiani, Gertler, and Bando 2016). The impacts of these same programs on people with disabilities warrant further investigation.

Disability-Targeted Approaches

Disability Certification and Poverty Targeting

While access to overall social protection programs is key, Latin American and Caribbean countries have recognized that persons with disabilities may have additional social protection needs not covered within traditional programs. Several countries have hence developed disability-targeted approaches to social protection that complement mainstream programs.¹⁰ Eligibility for disability-specific social protection programs—regardless of whether they are providing income subsidies, services, or assistive devices—typically requires a certification of disability status and means testing of poverty. Challenges with accessing and navigating the disability certification process hinder access to social pro-

9 The analysis of the effect of government transfers considers all monetary transfers from the government, with anti-poverty transfers and non-contributory pensions typically comprising the largest shares.

10 It is important that these programs complement, rather than duplicate, broader social protection strategies. Administrative costs may be lower if disability benefits are provided within wider social protection programs rather than as stand-alone programs. The Tekoporá conditional cash transfer program in Paraguay is an example of this, as it provides additional benefits to households with people with disabilities.

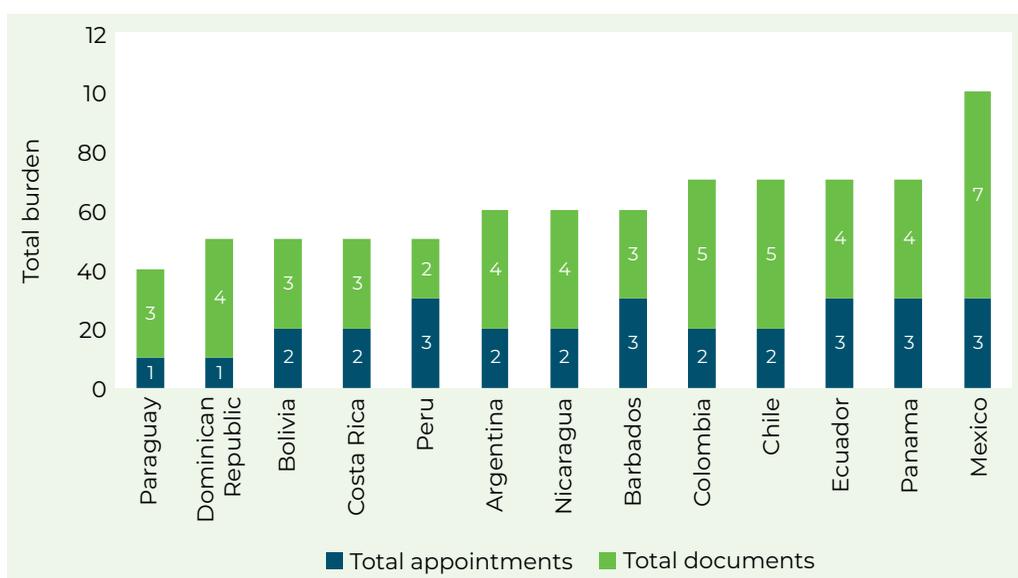
tection as well as other programs for people with disabilities that require certification. Further, in many countries, the instruments used to target poverty and disability are not the same across all programs. This introduces gaps in coverage and generates high transaction costs associated with redundant application processes.

Certification processes vary widely throughout the region, yet most certifications start with an assessment of an impairment. In some countries, the certification process is entirely based on the results of medical examinations and is summarized in an official medical report, often completed by an approved public sector doctor. On the other hand, many countries are transitioning to an evaluation of disability that also considers how the medical diagnosis interacts with external factors and thus aggravates or alleviates the limitations experienced by the person with a disability. Some of these countries, for example, Argentina and Colombia, use internationally validated tools such as the International Classification of Functioning, which aims to evaluate the limitation of a person's participation in key life activities (Gobierno de Argentina n.d.c; Mayor's Office of Bogota n.d.). Other countries use other methods to factor in the limitations to social participation experienced by persons with disabilities. In Chile, for instance, in addition to the medical report, applicants must also present a support network report and a community performance assessment report; both of these must be completed by specific government agencies (Servicio Nacional de la Discapacidad de Chile n.d.). By considering social and environmental barriers in the qualification process, for example, as done in Argentina, Colombia, and Chile, the qualification of disability is more likely to represent the true state of the disability to the extent that it limits the participation and well-being of people with disabilities, and not just from a medical perspective. However, implementing these more comprehensive processes for qualifications of disability is complex, often requiring coordination between multiple professionals and training them to implement assessment tools. Further, this transition also involves developing more robust information systems to store and analyze qualifications.

As part of the certification process, applicants typically must submit many documents such as any results and reports from medical examinations and proof of citizenship or residence, in addition to the application form; yet the number of required documents varies by country. Some countries, for example, Argentina, Ecuador, and Peru, require applicants to be physically present while an evaluator (either an individual or a board) reviews all submitted documents and comes to a decision regarding whether a disability certification will be issued (Gobierno de Argentina n.d.c; Gobierno del Ecuador n.d.; Gobierno del Perú 2024). During this review, the submitted documents are typically used to estimate a degree of disability. If the percentage or degree of disability passes a required threshold, the disability identification is conferred. In many countries, applicants receive the disability identification immediately after the evaluation; in some, they must return on a later date.

Evidently, the processes and requirements for certification vary widely from country to country and can take more time or less. These variations in the number of appointments and the number of documents required to receive a disability identification imply differences in the transaction burden associated with applying for certification. As shown in Figure 5.6, there is no clear relationship between the number of appointments and the number of documents required for certification. This suggests that processes can be simplified to reduce the transaction burden in many countries, especially given that most countries require recertification after a certain number of years.

FIGURE 5.6 | Transaction Burden of Disability Certification Processes



Source: IDB staff calculations using data from official government websites as cited under References.

Moreover, the differences in the transaction burden of disability certification systems have important implications for the ease with which persons with disabilities can become beneficiaries of social protection programs that require disability certification. For this reason, several countries are exploring ways to ease access to the application process itself. For instance, Panama is extending certification services beyond cities to more remote areas and investing in the interoperability of information systems to further reduce fragmentation. On the other hand, during the COVID-19 pandemic, many countries allowed disability certification applications to be completed online and some still allow online applications. For instance, in Barbados, Chile, Colombia, Costa Rica, and Paraguay, all or part of the process can still be completed online (Barbados Council for the Disabled 2022; Servicio Nacional de la Discapacidad de Chile n.d.; Servicio Nacional de la Discapacidad de Paraguay n.d.; Mayor's Office of Bogota n.d.; CONAPDIS n.d.). In

Chile, applicants do not have to pick up their identifications in person; rather, they receive it through postal mail (Servicio Nacional de la Discapacidad de Chile n.d.). Finally, most countries offer disability certification free of cost; the exception is Mexico, which requires applicants to pay the equivalent of US\$4.50 (Gobierno de México n.d.).

Disability certification is usually one of two main requirements for social protection programs. Applicants to social protection programs typically must also fall under a pre-determined poverty threshold. In the past two decades, Latin American and Caribbean countries have gained extensive knowledge on poverty-targeting systems through the design and implementation of conditional cash transfer programs. The successes and errors of these programs have been well documented (Robles, Rubio, and Stampini 2019), and they have been used to develop similar programs targeting specific population groups, for example, people with disabilities. While many countries have developed poverty registries using information on households' conditions and assets (known as proxy-mean methodology), few algorithms take into consideration the higher expenditures needed in households with persons with disabilities.

Disability Cash Transfers

Several countries in the region have implemented transfer programs specifically for people with disabilities. These programs can be classified based on their primary objectives: those addressing the higher costs associated with living with a disability, those catering to persons with high support needs, those designed for income replacement, and those aimed at children with disabilities.¹¹ Each category serves a distinct purpose in alleviating the financial burdens faced by individuals with disabilities. Table 5.3 shows the programs in each category, along with their average transfer amounts and number of beneficiaries.

TABLE 5.3 | Disability Cash Transfer Programs in Latin America and the Caribbean

Type	Country	Program	Acronym	Average monthly transfer value (US\$, PPP 2024)	Number of beneficiaries
Type I: Programs for addressing the higher costs of disability	Bolivia	Bono mensual para las PcD	BO_BD	96.90	4,551 (Dec. 2021)
	Costa Rica	Pobreza y Discapacidad	CR_PD	376.18	1,926 (Mar. 2023)

(continued on next page)

¹¹ Various countries have maintained program names that use language that is considered outdated if not offensive, for example, the many versions of *pensión por invalidez* or “pension for invalids.”

TABLE 5.3 | Disability Cash Transfer Programs in Latin America and the Caribbean *(continued)*

Type	Country	Program	Acronym	Average monthly transfer value (US\$, PPP 2024)	Number of beneficiaries
	Ecuador	Pensión para Personas con Discapacidad	EC_PPD	111.11	79,949 (Mar. 2023)
	Ecuador	Pensión toda una vida	EC_PTV	222.22	1,482,451 (Jan. 2024)
	Mexico	Pensión para el Bienestar de las PcD Permanente	MX_PB	150.00	NA
	Paraguay	Tekoporã (for mild-moderate disabilities)	PY_TM	58.88	NA
	Type II: Programs for persons with high support needs	Costa Rica	Promoción de la Autonomía Personal de las PcD	CR_PAP	815.22
	Ecuador	Bono Joaquín Gallegos Lara	EC_JGL	533.33	42,027 (Mar. 2023)
	Panama	Programa Ángel Guardián	PA_AG	186.05	19,462 (Dec. 2023)
	Paraguay	Tekoporã (for severe disabilities)	PY_TM	108.70	NA
	Peru	Programa CONTIGO (Pensión para PcD severa y situación de pobreza)	PE_PC	80.65	107,027 (Dec. 2023)
	Type III: Programs for income replacement	Argentina	Pensión no contributiva por invalidez	AR_PI	319.45
	Brazil	Prestação Continuada de Assistência Social, Benefício assistencial à pessoa com deficiência (BPC)	BR_BPC	517.22	5,894,761 (Apr. 2024)
	Chile	Pensión Básica Solidaria por Invalidez	CH_PS	450.89	195,118 (Mar. 2024)
	Trinidad and Tobago	Disability Assistance Grants	TT_DA	439.02	21,828 (Sep. 2023)
	Uruguay	Pensión por invalidez	UY_PI	398.19	61,101 (Dec. 2022)
	Type IV: Programs for children with disabilities	Chile	Subsidio para Menores de 18 con discapacidad mental	CH_SDM	225.45

(continued on next page)

TABLE 5.3 | Disability Cash Transfer Programs in Latin America and the Caribbean *(continued)*

Type	Country	Program	Acronym	Average monthly transfer value (US\$, PPP 2024)	Number of beneficiaries
	Guatemala	Subsidios Familiares	GT_SF	123.76	3,002 (Dec. 2023)
	Argentina	Asignación familiar por hijo con discapacidad	AR_AFD	225.96	57,576 (Sep. 2023)
	Trinidad and Tobago	Disability Assistance Grants for Minors	TT_DAM	365.85	3,483 (Sep. 2023)

Source: Duryea, Pinzón, and Pereira, forthcoming.

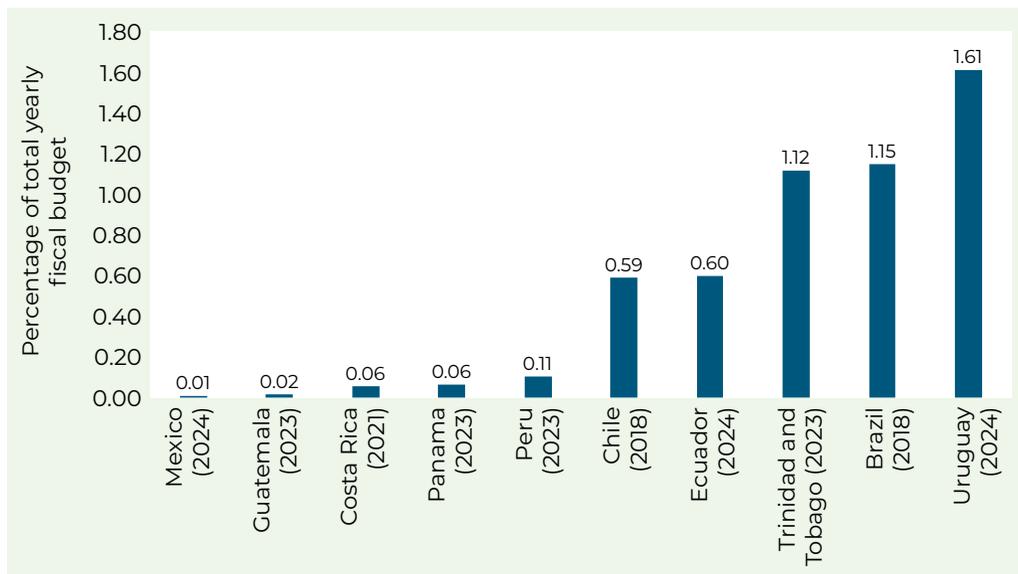
Note: NA = not available.

As can be seen in Table 5.3, transfer levels vary considerably across countries. Disability pension programs tend to have particularly high monthly subsidies relative to other programs; the values range from US\$319 a month to US\$517 across five countries. However, it is worth highlighting that transfer values are especially high under a few programs for persons with high support needs. Presumably, this is related to the higher costs associated with ensuring personal assistance during a part of these programs. This is discussed in more depth below.

The fiscal impact of disability transfers is contingent on the number of beneficiaries as well as the transfer amount. This results in varying levels of government expenditure. For countries with available data, these expenditures demonstrate considerable variation. In Mexico, disability transfers account for a minimal 0.01 percent of the total government budget. This reflects a relatively small beneficiary base or smaller transfer amounts. Conversely, in Uruguay, such transfers constitute 1.61 percent of the government budget, indicating either a higher number of beneficiaries or more substantial transfer amounts (see Figure 5.7). This disparity underscores the diverse fiscal commitments to disability support across different national contexts. Further, with the ongoing demographic transition, it is important to consider how aging will affect the potential beneficiaries and budgets for these programs.

Finally, while monetary cash transfers are more popular in the region, a couple of countries have social protection programs to distribute assistive devices such as screen readers, prostheses, smart canes, or wheelchairs. These programs are often poverty targeted and managed by the national disability councils (CONADIS or SENADIS) in each country. For example, persons with disabilities in the Dominican Republic can request assistive devices for free from the National Council on Disability (Consejo Nacional de Discapacidad [CONADIS n.d.]). Several countries have similar programs, which, however, tend to be small in scale. Larger-scale programs tend to be coordinated directly through the health system (see Chapter 3).

FIGURE 5.7 | Total Budgeted to Disability Transfers as a Percentage of the Total Government Budget



Source: Duryea, Pinzon, and Pereira, forthcoming; Astudillo and Pessino, forthcoming.

Notes: The above estimates are based on the budget for the following programs in the respective countries: Brazil—Benefício de Prestação Continuada (BPC); Costa Rica—Pobreza y Discapacidad, Promoción de la Autonomía Personal de las Personas con Discapacidad; Chile—Pensión Básica Solidaria de Invalidez, Subsidio para menores de 18 con discapacidad mental; Ecuador—Bono Joaquín Gallegos Lara, Pensión toda una vida; Mexico—Pensión para el Bienestar de las Personas con Discapacidad Permanente; Panama—Ángel Guardián; Peru—Programa Contigo; Trinidad and Tobago—Disability Assistance Grants; and Guatemala—Subsidios Familiares.

Care Policy

Considering the aging of the population in the region and the disproportionate burden shouldered by women performing unpaid care work (Fabiani 2023), governments are building systems to address the burgeoning need for care across diverse populations. Indeed, some countries, such as Uruguay and Chile, have even built care systems to coordinate, finance, and facilitate interoperability among the vast array of programs and are increasing their investments in this area. As of 2019, the budget for the Uruguayan care system represented 0.2 percent of gross domestic product (Salvador 2019). In Chile, the government increased the budget allocated to care policy by 20 percent in 2024 (Gobierno de Chile n.d.). However, even in these countries with more advanced coordination of care policies, programs with a disability perspective are in a much more emergent phase in the region compared with caregiving services for children, older persons, or caregivers themselves, which have been the primary focus of these policies.

There are three types of services for people with disabilities with functional dependence that are especially relevant and increasingly implemented: personal assistance programs, center-based care programs, and assisted living programs. These services aim to work together to support persons with disabilities exiting institutions (such as

psychiatric hospitals), those at risk of being admitted to the same institutions, or those at risk of experiencing homelessness. It is also worth noting that emerging public programs often emulate programs run by organizations of people with disabilities and nonprofits, which have historically been the primary providers of these services. The governments of several countries are hence leveraging public-private partnerships with organizations of this type to scale up services.

Personal assistance refers to the human support provided to persons with disabilities to specifically promote their autonomy and support them in performing activities of daily living (Vásquez Encalada and Pereira 2023). Like traditional caregiving, persons with disabilities may require full-time personal assistance or assistance only during some hours of the day or week. These programs can provide respite to family caregivers. However, the personal assistance paradigm is different from traditional caregiving in that it allows persons with disabilities to decide what support they need, when they receive it, and how they receive it. For instance, while a traditional caregiver may decide what a person eats and when, a personal assistant would ask a person with a disability what they want to eat, they would help the person with the disability prepare their own food, and, if the person with the disability asks for it, would help them feed themselves. Given that being a personal assistant requires a certain degree of objectivity, some persons with disabilities prefer that the personal assistant not be one of their own family members, especially when it concerns receiving support in sensitive areas such as finance, relationships, or health. However, most people with disabilities receive support from their family members.

In the region, personal assistance programs are typically directly tied to disability cash transfers for persons with high support needs. Indeed, to address the high costs faced by people with disabilities with high support needs, some countries, such as Ecuador, Panama, Paraguay, and Peru, have provided a higher level of cash transfers than for people without disabilities or people without functional dependency (Dur-yea, Pinzon, and Pereira, forthcoming). These programs, labeled as Type-II in Table 5.3, assume that a transfer can be used to hire the services of a personal assistant, but they do not provide referrals; this often results in people with disabilities and their families struggling to find providers. The impact of these programs on the well-being of caregivers or of people with high support needs has not been evaluated. Uruguay's approach differs in important ways. Mainly to support personal assistance for people with disabilities with functional dependence, Uruguay provides a voucher¹² that can be used to support up to 80 hours a month, depending on the needs. In Costa Rica, the program Promoción de la Autonomía Personal de las Personas con Discapacidad provides access

12 Under many disability transfer programs, payments are transferred directly to the bank accounts of family members, disregarding the rights of people with disabilities to direct the use of these resources for their own care.

to a personal assistant and emphasizes the legal capacity of people with disabilities with high support needs to make decisions regarding their own care (Duryea, Pinzon, and Pereira, forthcoming). The disability agency assesses the support needs, designs an individual support plan, and provides a personal assistant and other resources to ensure independent living. In contrast to Uruguay's program, beneficiaries are not limited in the number of hours of personal assistance they can receive (Duryea, Pinzon, and Pereira, forthcoming). Notwithstanding, scaling up this program beyond 200 beneficiaries has proved challenging.

In some countries, an alternative to personal assistance has been providing care and support at day centers. Several governments and non-profits have invested in initiatives of these types. Indeed, Chile, Colombia, Costa Rica, Ecuador, and Uruguay are among the countries with day programs (Vásquez Encalada and Pereira 2023). These programs can often combine rehabilitation, recreation, or training programs for people with disabilities and older functionally dependent persons. They enable unpaid caregivers to pursue their interests while their family member receives services at the day center, returning home once the center closes. However, the challenge of accessible transportation is often an obstacle, and programs are often segregated between those with and without disabilities. These programs are hence being deployed more commonly in urban areas and high-income countries, where transportation services are more accessible.

Finally, assisted living focuses on persons with disabilities who need continuous care and support that cannot be adequately provided by family members or other personal assistants, or at day centers. Persons with disabilities in assisted living programs often have left large-scale residential institutions and do not have the skills to live independently. These individuals are thus given the option of living in group homes with 8 to 20 other people with disabilities, where they receive continuous care and support. The smaller number of residents and potentially greater freedom are what in principle differentiate these homes from traditional large-scale residential institutions. Further, the purpose of many such homes is to aid in skill development so that persons with disabilities can achieve autonomy and eventually live independently and participate in their communities. However, it is unclear whether these programs effectively safeguard sanitary conditions and basic human rights, including the right of residents to their own decision-making in day-to-day life, starting with the decision to enter these homes in the first place. Argentina, Brazil, Chile, Paraguay, Peru, and Uruguay support assisted living models, yet it is unclear how widespread these programs are (Vásquez Encalada and Pereira 2023). Overall, the scope of personal assistance, center-based day programs, and assisted living programs in the region is limited and is not evaluated rigorously. Further, it is unclear to what extent these programs monitor for conditions of abuse and neglect; this is imperative given that caregivers and personal assistants are often involved in very

private and intimate matters, which can place people with disabilities at risk of physical or financial exploitation. There is a need to systematically compare care policy models that yield good results and are economically viable, considering the region's fiscal situation.

Tax Exemptions and Other Waivers or Discounts

Several countries in Latin America and the Caribbean provide tax exemptions and discounts to persons with disabilities to reduce the costs of the consumption of goods and services. As mentioned above, at least 16 of the 26 borrowing member countries of the Inter-American Development Bank (IDB) have laws establishing fiscal benefits beyond subsidies for persons with disabilities (Vásquez Encalada and Pereira 2023). By far, Ecuador has the largest number of benefits of this type and is also the only country where certified persons with disabilities are exempt from value-added tax on all purchases (Asamblea Nacional de la República del Ecuador 2012).¹³ Yet, multiple countries in the region have similar schemes and have established various fiscal benefits and discount programs for persons with disabilities. For instance, Argentina, Brazil, and Ecuador provide persons with disabilities with exemptions on income taxes (Astudillo and Pessino, forthcoming; Asamblea Nacional de la República del Ecuador 2012).

However, the most common fiscal benefits concern exemptions and reductions of customs tariffs for the importation of select goods. Multiple countries, including Argentina, Chile, Ecuador, Mexico, Peru, Panama, and Uruguay, provide exemptions from tariffs for the importation of adapted vehicles ((Astudillo and Pessino, forthcoming; Asamblea Nacional de la República del Ecuador 2012; Gobierno de la República de Panamá 2016; Gobierno del Perú 2017). In Ecuador, Panama, and Uruguay, persons with disabilities are also exempt from import taxes on assistive devices, prostheses, orthoses, and medications that are not produced domestically (Asamblea Nacional de la República del Ecuador 2012; Gobierno de la República de Panamá 2016; Astudillo and Pessino, forthcoming).

Further, several countries provide additional discounts to persons with disabilities. In Brazil, persons with disabilities cannot import adapted vehicles exempt from taxes, but they can access a 50 percent discount on the domestic purchase of vehicles (Astudillo and Pessino, forthcoming). Also in Brazil, the beneficiaries of the Benefício de Prestação Continuada (BPC) program, a poverty-targeted subsidy for people with disabilities or older adults, can receive a reduction of up to 65% of electricity bill payments ("Tarifa Social") (Agência Nacional de Energia Elétrica n.d.). In Ecuador, persons with disabilities are entitled to a discount of up to 50 percent on water, sewage, electricity, landline telephone, cell phone, and Internet payments (Asamblea Nacional

¹³ Uruguay exempts persons with disabilities from paying value-added tax as well, but only in the consumption of health-related goods and services (Astudillo and Pessino, forthcoming).

de la República del Ecuador 2012). Argentina, Brazil, Ecuador, and Peru allow persons with disabilities to access public transportation for free or at a discounted price, even though many transportation systems are not accessible (Astudillo and Pessino, forthcoming; Asamblea Nacional de la República del Ecuador 2012; Gobierno del Perú 2017).¹⁴ Ecuador and Brazil also allow discounts of up to 50 percent or 80 percent, respectively, on booking prices for persons with disabilities to travel with private companies (for example, flight bookings) (Astudillo and Pessino, forthcoming; Asamblea Nacional de la República del Ecuador 2012). In Brazil, Ecuador, and Peru, persons with disabilities can access cultural and sporting events and facilities (such as concerts, sporting competitions, or museums) for free or at discounted prices (Astudillo and Pessino, forthcoming; Asamblea Nacional de la República del Ecuador 2012; Gobierno del Perú 2017).

Housing Supports

Social protection systems play a key role for the reduction of poverty and contribute to ensuring access to adequate housing. Further, as countries increasingly strive to de-institutionalize persons with disabilities, especially those with psychosocial disabilities, countries have also recognized the need to develop housing alternatives that promote independent living. It is thus unsurprising that the legislation of at least 12 of the IDB's 26 borrowing member countries includes measures to promote access to adequate housing among people with disabilities and their families (Vásquez Encalada and Pereira 2023).¹⁵ These measures can be categorized under three groups: prioritization within general public housing initiatives, housing subsidies to adapt or build homes with accessibility considerations, and assisted living programs for persons exiting institutions or those at risk of being institutionalized or experiencing homelessness.

The first measure focuses on including persons with disabilities and their families within overarching public programs that aim to help people purchase, build, or improve their homes. For instance, in Bolivia, at least 4 percent of public housing managed by the Housing State Agency (Agencia Estatal de Vivienda de Bolivia 2024) must be assigned to people with disabilities and their families. In 2023, 615 families with members with disabilities were placed in public housing, representing 4.9 percent of all public housing beneficiaries (Agencia Estatal de Vivienda de Bolivia 2024). In the Dominican Republic, 5 percent of public housing built through the Happy Family Plan (Plan Familia Feliz) had been assigned to families with members with disabilities as of May 2024. The initiative leverages public-private partnerships to build low-cost housing, whereby first-time homeowners contribute only 2–5 percent of the home's value (Gobierno de la República

¹⁴ In the case of Peru, the public transportation discount applies only to persons with severe disabilities, who can access public transportation free of charge.

¹⁵ Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, Panama, Peru, the Dominican Republic, Uruguay, and Venezuela.

Dominicana 2024). Between June 2021 and May 2022, Colombia's Ministry of Housing disbursed 79 housing subsidies to households with members with disabilities, representing 3.2 percent of all subsidies disbursed (Ministerio de Vivienda, Ciudad y Territorio de Colombia 2022). These kinds of initiatives show countries' efforts to ensure that people with disabilities have equal access to public housing programs. However, they are still limited in scope.

Some countries have recognized that traditional public housing subsidies and supports may not be sufficient to ensure adequate housing with respect to home accessibility. As a result, they have created programs specifically to adapt or build homes with accessibility and universal design considerations. For instance, the maximum value of Costa Rica's national housing subsidy is almost US\$7,000 higher for households with members with disabilities compared with those without. This allows these households to request a higher subsidy amount to provide specific housing adaptations, for example, the installation of wider doors, ramps, or handles in bathrooms (INVU n.d.).

What Does the Evidence Say?

Rigorous research on the effects of social protection programs on persons with disabilities is very common in high-income countries yet largely limited in low- and middle-income countries. Indeed, in a review of evidence on disability for low- and middle-income countries published between 2000 and 2018 using a rapid assessment criterion, the topics of social protection were recognized as among the least studied (Saran, White, and Kuper 2020). This overall trend also holds for Latin America and the Caribbean. However, important conclusions can be drawn for the region based on available evidence.

As mentioned above, difficulties with accessing and navigating the disability certification process hamper access to social protection programs. Reducing barriers to disability certification is expected to increase applications and may also have impacts on well-being through eligibility for programs.

Overall, studies from the United States have suggested that simplifying certification processes yields positive results. For instance, Deshpande and Li (2019) find that applications from persons with disabilities who are less educated and from persons with moderately severe disabilities decrease disproportionately due to the closing of offices where paperwork for filing disability applications is received in the United States. Foote, Grosz, and Rennane (2019) studied the impact of streamlining, via an online system, the application process for disability certification required to receive disability-specific cash transfers (Social Security Disability Insurance [SSDI] and Supplemental Security Income [SSI]) in the United States. The online system lowered the transaction costs of traveling to the field offices to apply for benefits. The reduction in transaction costs was found to boost applications and appeals significantly. In Latin America and the Caribbean, many

applications for disability certifications and programs were reformulated to make digital application possible during the peak of the COVID-19 pandemic; however, no studies have rigorously evaluated the effects of these changes.

Regarding cash transfers and income support, research has mostly focused on determining whether these programs disincentivize people with disabilities from working (Autor and Duggan 2003; Bound 1989, 1991; Gruber 2000). Applications for disability subsidies have been shown to respond to labor market conditions; applications decline when conditions are better. Those earning low wages are more responsive to these fluctuations (Autor and Duggan 2003). Research in the United States, Canada, and Europe has focused largely on workers who accessed contributory pensions through disability insurance. These studies have found negative effects on the probability of employment and earnings of beneficiaries. For instance, Maestas, Mullen, and Strand (2013) found that receiving disability insurance in the United States reduced employment by 28 percentage points, although not for persons with severe disabilities. Also for the United States, Gelber, Moore, and Strand (2017) found that an additional disability insurance dollar reduced the earned income by 20 cents.

Given the large size of Latin America and the Caribbean's informal sector, noncontributory disability pensions play a larger role than in high-income countries. While noncontributory disability pensions are distinct from disability insurance, given there are no previous work requirements or minimum tax contributions, they often have similar conditionalities regarding whether beneficiaries can work if they are enrolled in a program, and both provide beneficiaries with income support. Therefore, noncontributory cash transfers and disability insurance programs might be expected to have similar effects. Yet, the impacts of cash transfers on the labor market participation of people with disabilities has not been studied rigorously in Latin America and the Caribbean, despite the widespread adoption of disability cash transfers. One exception is Britto et al. (forthcoming), who finds that the disability noncontributory pension in Brazil's BPC program reduces formal employment by only 0.2 months per year—a much smaller effect on formal employment than observed in disability insurance studies in high-income countries. However, this does not consider the effects on informal employment, which are more difficult to measure.

Further, while labor market disincentives are important, they are not the only potential outcomes of disability cash transfers and income support programs. Indeed, recent studies have found that these programs have important effects on quality of life. For instance, Britto et al. (2023) find improvement in households' financial status due to enrollment in the BPC program in Brazil. Autor et al. (2019) find that, while earnings fall with disability insurance in the United States, consumption expenditure increases 16 percent, suggesting large positive welfare effects. Deshpande, Gross, and Su (2021) examined the effects of being approved for SSI and SSDI on the measures of financial stability. They find that

three years following application to SSI and SSDI, the probability of being in foreclosure among homeowners falls by 2 percentage points and the probability of selling one's home falls by 3 percentage points. Gelber et al. (2023) also find positive effects of SSI and SSDI with regard to mortality rate reduction, especially among low-income beneficiaries. In the Netherlands, similar disability insurance was also found to have important impacts on mortality reduction, although only among women (García-Mandicó et al. 2020). Moreover, using a regression-discontinuity approach, Deshpande and Mueller-Smith (2022) show that removing disability income support in the United States at age 18 substantially increases the probability of incarceration by 20 percent over the next 20 years. Those losing the disability income support may switch to illegal income-generating activities, such as theft, burglary, and prostitution, and are less likely to have earnings from employment. The paper demonstrates that providing disability income support has potential long-term economic benefits, with the measured savings to taxpayers from the lower incarceration at similar levels to the cost of the disability income support program. Programs in Latin America and the Caribbean should likewise be evaluated to assess whether they have similar impacts on quality-of-life indicators, including consumption expenditure, financial stability, mortality, crime, and incarceration.

Receiving disability benefits has also been shown to have important, albeit mixed, intergenerational effects. For instance, using Dutch administrative data, Dahl and Gielen (2021) found that children whose parents had their disability benefits reduced, were less likely to be receiving disability benefits in their own adulthood, more likely to complete secondary school, less likely to have been arrested, and have higher earnings. In Canada, however, parents' receipt of larger disability transfers when their child was between the ages of 5 to 15 was found to increase the child's scores on standardized math exams and improve the probability that the child attends post-secondary education (Chen, Osberg, and Phipps 2019). Deshpande (2020) finds that removing youth with disabilities from SSI at the age of 18 significantly reduced their younger siblings' earnings in adulthood, by about US\$5,000 annually.

Regarding in-kind transfers of assistive devices, causal studies have been scarce or underpowered. As discussed in Chapter 3, only one small study has carefully examined the effect of addressing the unmet need for a wheelchair. The results of this study, in Ethiopia, suggest that the provision of a wheelchair to those with an unmet need increased work hours and income, and reduced mendicity (Grider and Wydick 2016). The body of evidence on the effect of providing corrective glasses to students with vision disabilities is an important exception to the overall knowledge gap, yet these studies focus primarily on the effects on learning (see Chapter 2).

Finally, there is a significant lack of causal research on the impacts of care policies and programs, tax exemptions and discounts, or housing supports programs on persons

with disabilities. As these programs gain prominence and popularity in the region, it is important to build a body of evidence with regards to these interventions.

Key Takeaways

Social protection continues to be an area with a deep evidence gap. There are key policy areas in which the dearth of evidence, including for high-income countries, is concerning. This includes the training of frontline workers and the benefits of assistive technologies. Burgeoning care policies across the globe aim to respond to the unmet need for personal assistance and provide respite to unpaid family caregivers. However, there is currently little to no rigorous evidence on these programs' impacts to guide policy makers in deciding which programs to scale up.

Surprisingly, research in Latin America and the Caribbean has not examined the impact of efforts that have been shown to be important outside the region, for example, reducing the transaction costs of applications to disability programs. This is despite efforts in the region to expand the geographic coverage of administrative offices and make application platforms more digitally accessible. This includes the improvement of disability certification processes. Likewise, while there is an emerging knowledge base documenting that disability subsidies have positive quality-of-life outcomes in high-income countries—from reduced mortality to financial stability to reduced crime—rigorous studies on their impacts in Latin America and the Caribbean remains limited, despite the substantial budgetary expenditures they represent in much of the region. Similarly, the incidence and effectiveness of the many tax exemptions provided to people with disabilities has not been studied, nor the effects of different care and housing initiatives. Mobilizing more research funding is necessary given that the list of what is needed far exceeds available funds. It is critical that the disability community plays a key role in the prioritization process and actively engages as investigators, reviewers, and communicators.

Box 5.1. Research Priorities for Social Protection Policy

As mentioned in Box 1.3 of the Introduction to this volume, the IDB is conducting an accessible online survey to gauge the perspectives of people in the region, especially people with disabilities and their families, regarding what policies and interventions on disability inclusion should be prioritized for research. In this box we present results from answers given up to May 2024.⁹ While the results are not representative (only 150 responses), given the challenges in surveying people with disabilities, the results of this survey can provide insights that can be evaluated in future initiatives.

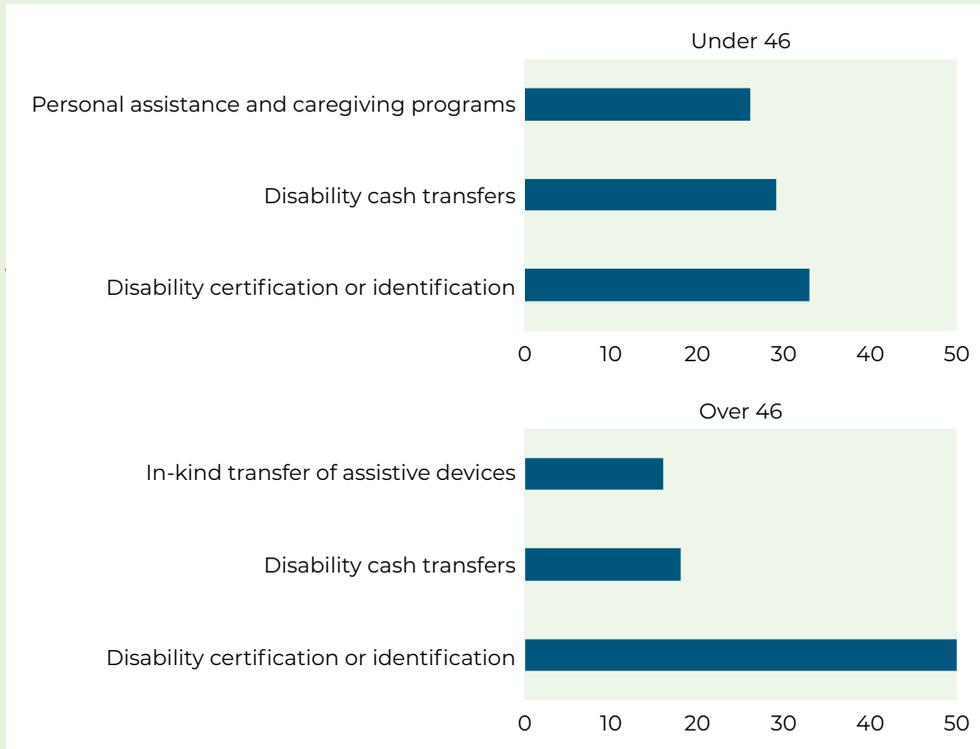
The top three research priorities for social protection policy, disaggregated by respondent age, are presented in Figure B.5.1.

(continued on next page)

Box 5.1. Research Priorities for Social Protection Policy *(continued)*

Unsurprisingly, regardless of respondent age, the two main research priorities in social protection concern the most widespread programs in the region: disability certifications and disability cash transfers. On the other hand, research on personal assistance and caregiving programs appears to be the third-most-important priority among younger respondents, while older respondents are more interested in evaluating in-kind transfer programs for assistive devices.

FIGURE B.5.1 | Top Priorities for Social Protection Policy Research



Source: IDB staff calculations using results from online survey.

^a If you would like to offer your opinion on research priorities for the inclusion of people with disabilities, please fill out the survey at the following link through June 2025: <https://accessiblesurveys.com/s2/-NoXaOIViThWvED1daoy>.

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