Governments across the Europe and Central Asia (ECA) region have committed to reducing the number of children living in poverty by 2030 (Box 1). Successfully achieving Agenda 2030 rests on an inclusive approach to sustainable development to ensure that no one, including children with disabilities, is left behind (UNDESA 2019). Disability is intertwined with both monetary and multidimensional poverty with lifelong consequences for children with disabilities. Lower rates of education, poorer health, and limited participation in the labour market and society means that children with disabilities are more likely to experience chronic poverty and social exclusion throughout their lives.

In the region, parents continue to be encouraged to place children with developmental delays or disabilities in state institutions (UNICEF, 2015b). Ensuring that children with disabilities stay with their families, are able to reach their full potential and are included in society requires a holistic suite of supports. Inclusive, well-coordinated and accessible social protection systems are crucial for addressing poverty and the social vulnerabilities that children with disabilities face. This brief summarises a mapping of different social protection programmes, specifically cash transfers, social health protection, and assistive technology available for children with disabilities in the ECA region.

**Inclusive Social Protection Systems for Children with Disabilities**

in Europe and Central Asia

1 UNICEF’s Europe and Central Asia region covers 21 countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Kazakhstan, Kosovo (UNSCR 1244), Kyrgyzstan, Moldova, Montenegro, North Macedonia, Romania, Serbia, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan.

2 According to WHO “Assistive technology is an umbrella term covering the systems and services related to the delivery of assistive products and services. Assistive products maintain or improve an individual’s functioning and independence, thereby promoting their well-being. Hearing aids, wheelchairs, communication aids, spectacles, prostheses, pill organizers and memory aids are all examples of assistive products.”

3 However, it is important to emphasise that social protection in ECA provides support to children with disabilities through many other avenues not covered in this brief. These other schemes are by no means any less significant and indeed are equally important to the ecosystem of coverage for children with disabilities.
**Box 1: SDG1 and children with disabilities**

**TARGET 1.2**

By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.

**Indicator 1.2.2**

Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.

**TARGET 1.3**

Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.

**Indicator 1.3.1**

Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable.

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The concept of inclusive social protection for children with disabilities in Europe and Central Asia

Disability is intertwined with poverty. Families raising children with disabilities are more vulnerable to poverty due to disability associated costs and the lost earning opportunities from having to care for their children (UNICEF, 2012a; UNICEF, 2005). Data on this issue for the ECA region is scarce, but what is available indicates that households with a disabled member are more likely to be poor or food insecure than those without (UNDESA, 2019; UNICEF, 2005; Braithwaite and Mont, 2009). The additional expenses related to care can be substantial and may crowd out spending that would otherwise raise the household’s living standard. In Bosnia and Herzegovina, the additional direct cost to a family with a person with a disability (not necessarily a child) has been estimated at 14 per cent (Braithwaite and Mont, 2009). Additionally, those with disabilities tend to have higher healthcare needs and are at greater risk of financial catastrophe and impoverishment due to higher health spending; people with disabilities are twice as likely to have catastrophic health expenditures than their peers (The Lancet, 2019). The link between disability and poverty can disproportionately affect girls and women, particularly those from ethnic minorities (UNICEF, 2013b).

Carefully designed social protection schemes have the potential to provide a much-needed level of protection and support to children with disabilities and their families. UNICEF defines social protection as a “set of policies and programmes aimed at preventing or protecting all people against poverty, vulnerability and social exclusion, throughout their life cycles, with a particular emphasis towards vulnerable groups” (UNICEF, 2019c). A disability-sensitive social protection system is one that is responsive to the needs of children with disabilities, taking into account the different risks, inequalities and barriers they face based on different levels of functioning (ILO and IDA, 2019). It supports a continuum of care for a child with disabilities at each stage of the lifecycle, considering the variations and implications in each phase of childhood, and particularly during transitions from one phase to another. A disability-sensitive social protection system is also participatory and responds to the different dimensions of exclusion, such as discrimination, stigma, traditional social norms, and limited access, assets and visibility. Children with disabilities are reached by social protection systems through their inclusion in mainstream schemes4 and by disability-targeted benefits and services5. Different components of disability-sensitive social protection systems are present throughout the region.

- **Social assistance programmes** are redistributive schemes that include direct social transfers (both cash and in-kind), subsidies, public works and tax benefits. All countries in the region have **disability-targeted benefits** for children. Disability-targeted benefits should be viewed as supplemental to mainstream social assistance schemes such as child grants, because

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4 All social protection programmes should be designed, implemented and monitored in a way that ensures the inclusion of persons with disabilities, with particular attention to removing barriers and avoiding adverse effect (ILO and IDA, 2019).

5 Adequate disability-specific programmes should be developed to provide the support and benefits required by persons with disabilities that are not met through mainstream programmes (ILO and IDA, 2019).
they are intended to offset the additional costs faced by families (See Box 2 for discussion on estimating additional costs) and/or compensate for caregivers’ lost wages. Several countries in the region provide subsidies or fee waivers to children with disabilities to facilitate access to services. These include subsidised transportation to school in Serbia and Moldova and scholarships to attend secondary school in Bulgaria. Tax-benefit systems are a relatively underutilized component of social protection systems in ECA; however, there is evidence of their use. For instance, tax allowances are available to parents of a child with disabilities in Ukraine.

- **Social insurance** refers to transfers which rely on individuals’ monetary contributions. While social insurance programmes in all countries provide protections for formal sector workers in the case of disability, only a few provide coverage to parents of children with disabilities. In North Macedonia, for example, a contributory scheme provides for salary reimbursement where an employee is caring for a disabled child.

- **Social care services** are a set of complex interventions undertaken to meet the social needs of a person/family to overcome difficult life circumstances and to prevent social exclusion. Examples of social care services include respite care for carers of children with disabilities in Belarus, and home-based social support for children with disabilities in Kazakhstan.

- **Universal health coverage** that provides adequate financial protection is critically important for children with disabilities given their extensive health-related needs. Benefits packages should include access to primary health services, specialized medical interventions, treatment and rehabilitation, together with assistive technology to enable children with disabilities to function independently and with dignity.

- **Active labour market policies (ALMP)** help to connect people to employment. Many people with disabilities are capable of work but are not able to due to various barriers to employment. ALMP can support people with disabilities through mainstream or targeted anti-discrimination legislation, wage subsidies, workplace accommodations, sheltered employment, training and placement services. The current programmes in ECA tend to be under resourced and do not adequately support the integration of vulnerable populations, such as young people with disabilities, into the labour market.

This brief is based on a mapping of key social protection programmes, specifically social cash transfers and universal health coverage, including assistive technology, available for children with disabilities in ECA.

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**Box 2: Estimating the Cost of Disability**

Disability often leads to increased costs for households. Costs are generally categorised as either indirect or direct. Estimating the costs of disability are essential for designing appropriate interventions and setting the benefit levels. In the case of children with disabilities, indirect costs are those related to parents taking on additional caring responsibilities in lieu of economic activity. Direct costs can be categorized as “enhanced costs” or “specialized costs”. Enhanced costs are expenses that all households have but households with children with disabilities may need to spend extra, such as heating, healthcare and/or transportation. Specialized costs are disability specific, such as assistive devices, therapy or rehabilitation. Several contextual factors influence the level of direct costs: type and severity of disability, household composition, level of income, availability of goods and services, along with others. By estimating the extra costs, disability adjusted poverty lines can be developed to provide a deeper understanding of the situation of households with disabilities. They are also useful for assessing the adequacy of benefits, both mainstream and disability-specific. The different approaches for measuring direct costs are:

1. **Goods and services used (comparative approach)** estimates the costs of different goods and services used by a person with disabilities and compares it to spending of individuals without disabilities. This approach is limited as it assesses actual expenditures which may be constrained by a number of factors (availability of goods and services and income level), rather than the actual costs associated with disability.

2. **Goods and services required (subjective approach)** requires estimating what additional expenditures are needed to enable a person with disabilities to fully participate in society. The limitation to this approach is that respondents would need to be fully aware of all goods and services in order to provide correct estimates.

3. **Expenditure equivalence approach (standard of living)** is predicated on the idea that households with a disabled member require a higher level of income to reach the same standard of living as households without a disabled member. Different measures can be constructed to assess the extra costs incurred by households with a disabled member. A composite measure of non-disability related goods, activities and assets can be used to compare the differences in the standard of living between disabled and non-disabled households at the same income level. Another measure is “material hardship” and can include indicators for the inability to meet essential expenses (rent, utility bills), inability to obtain medical care, and food insecurity. While the first two approaches require in-depth interviews, this approach uses data available in household surveys. Depending on data availability costs can be estimated for different levels or severity of disability.

*Source: Mitra, et al., 2017; Stapleton, et al., 2008*
Countries across the region have obligations regarding children with disabilities under international law, with all 21 countries in the region having signed or ratified the Convention on the Rights of Persons with Disabilities (CRPD), and 14 having ratified both the CRPD and its optional protocol⁶. Even where ratification has occurred, however, domestic implementation of international obligations, through the development of disability-inclusive policies and legal frameworks, remains of crucial importance for combating social exclusion and poverty. Countries across the region have introduced several domestic laws and policies which pertain to social protection and children with disabilities. Given the multi-sectoral nature of the issue, the extent of social protection coverage for children with disabilities is usually addressed by multiple laws and policies in any given country, not all of which are necessarily coherent.

Nearly all 21 countries have a specific disability policy (though no countries have a dedicated policy focused on children with disabilities). Many strategies have an emphasis on inclusion, rights and international commitments relating to persons with disabilities. Some countries, for example Albania, have a disability policy or action plan that includes a pillar explicitly referencing children. However, there is variation across the region. The focus of strategies in some countries (Tajikistan and Kyrgyzstan) is on ‘rehabilitation’ rather than inclusion, and the emphasis of Turkmenistan’s plan of action is on employment for persons with disabilities. While active labour market programs play an important role within a social protection system, particularly for adolescents transitioning from school to work, these documents suggest the medical approach (further discussed in the next section) remains a core theme in many disability policies.

While social protection benefits and/or services are enshrined in legislation in the vast majority of countries, only around one in three countries has an overall social protection strategy or action plan which covers the entire population. The lack of a single social protection strategy is not necessarily problematic. However, a coherent approach to social protection which clearly delineates areas of institutional responsibility and inter-sectoral coordination will greatly assist efforts to collaborate across disciplines and improve access to services such as health or education. Social protection strategies are more common in European and Western Balkans countries compared to Central Asia and the Caucasus.

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⁶ The optional protocol has been signed or ratified by: Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Croatia, Georgia, Kazakhstan, North Macedonia, Moldova, Montenegro, Romania, Serbia, Turkey and Ukraine.
Defining disability

As a precondition to receiving benefits and services countries in the region require children with disabilities receive a certification of disability. The definition of disability adopted has implications for how disability is assessed, and eligibility determined for services and benefits. The CRPD recognizes that “disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others”. However, the majority of countries (14 out of 217) continue to define disability in medical terms. The medical model views disability as a ‘defect’ that needs to be fixed. Consequently, the role of social protection for children with disabilities is seen as compensating for the ‘loss’ of capability. Children with disabilities are often sent to specialised schools or placed in institutions with the aim of ‘fixing’ or ‘curing’ them (United Nations General Assembly, 2015). In contrast, the bio-psycho-social model – an approach that views disability as the interaction between health conditions (long-term physical, mental, intellectual or sensory impairments) and contextual barriers – leads to a significantly different range of benefits and services (WHO and World Bank, 2011). The bio-psycho-social approach promotes active citizenship, social inclusion and community participation for children with disabilities, while dependence and segregation – including in specialised institutions – are avoided.

The medical approach allows little room for consideration of the child’s individual characteristics, abilities and immediate environment. Children without a formal diagnosis or assessment, but who experience difficulties in functioning, are unlikely to qualify for an assessment until their condition reaches a more severe stage. This is especially the case for ‘invisible’ disabilities such as developmental delays, intellectual disabilities or autism. It is common for young children aged under three years to not be formally assessed and registered as having a disability. The medical approach therefore precludes early identification and early intervention and limits the opportunity for access to early intervention services that could prevent and/or reduce disability (see Box 3 on the importance of early detection) (UNICEF ECARO, 2018a). The medical model also results in rehabilitation being based on medical diagnosis rather than a functional analysis of a child’s potential and capacities which should be developed to maximise their independence. The medical model leads to undercounting the number of children with disabilities: it is estimated that there 5.1 million children with disabilities in ECA, but only 1.5 million are actually registered in national systems (UNICEF ECARO, 2018a). As such millions of children with disabilities are prevented from accessing social protection benefits and/or services.

The International Classification of Functioning, Disability and Health (ICF) – which takes the bio-psycho-social approach, is increasingly being adopted in ECA, though implementation of this progressive approach is often problematic. For example, while Kosovo8 and Romania have aligned their definition of disability with ICF; there is evidence to suggest that legal or policy changes are not always implemented in practice. The shift from adopting to implementing the ICF is very challenging. It requires substantial institutional changes, including establishing multi-disciplinary assessment teams; introducing new assessment methodologies, instruments and equipment; and recruiting professionals with a distinct set of skills. These are consistently lacking in the region. Moreover, translating the results of a bio-psycho-social assessment into a multi-agency individual support plan as part of an integrated approach to social protection presents many hurdles, especially when services are lacking. Another concern is the use of conflicting or inconsistent definitions of disability across different legislation, such as in Kyrgyzstan; this could undermine the coherence of an integrated social protection system which is premised on a multi-sector approach.

Box 3: The importance of early detection and intervention

UNICEF promotes a holistic, lifecycle approach to providing support to children with disabilities with a focus on early identification and intervention. The periods of pregnancy, birth and early years are critical for the detection of disabilities and developmental difficulties. Children develop along a continuum, progressing from one milestone to the next. While all children develop at different rates, failure to reach milestones within a certain timeframe can indicate development disorders or certain impairments. Systems of early identification involve a wide range of actors from different sectors for the early identification; assessment and early intervention planning; and provision of services for children with disabilities. Families of children with disabilities require support such as counselling, early childhood development programmes, and specialized services to prevent poor caregiver interaction, institutionalization, violence, abuse and neglect, and limited access to programmes and services. Through the regular monitoring and screening of all children’s development, issues can be identified, and children can be provided with interventions to effectively address emerging (and prevent further) disabilities and delays. Intervention should take place at the earliest possible age. An approach which waits to assess whether the delay will progress into a disability must be avoided as this implies the loss of valuable time that could have been used to mitigate the effects of the disability.

Source: UNICEF and WHO, 2012

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7 The medical model remains prevalent or widely used in Albania, Armenia, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Kazakhstan, Kosovo (UNSCR 1244), Kyrgyzstan, North Macedonia, Montenegro, Tajikistan, Turkey, Ukraine and Uzbekistan.

8 All references to Kosovo in this report should be understood to be in the context of United Nations Security Council resolution 1244, 1999.
**Data on Children with Disabilities**

The CRPD obliges Governments to collect and disaggregate data on persons with disabilities in order to formulate and implement appropriate policies and programmes. The mapping revealed that many countries across the region have a significant gap when it comes to collecting disaggregated data amongst children with disabilities. In Uzbekistan, for instance, regular surveys do not disaggregate data regarding children with disabilities by type of impairment, age, gender or region (UNICEF, 2019b). The situation is similar in Serbia and Turkmenistan (UNICEF, 2017b; UNICEF, 2015a).

There are, however, some emerging promising practices from which other countries in the region can learn. In Kosovo, for example, the census disaggregates based on age, type of impairment and gender (UNICEF, 2017c), and in Albania there is some disaggregation in relation to rural and urban areas (UNICEF, 2018a). The availability analysis and data has been increasing over recent years due the efforts of a number of partners. Situation Analyses on children with disabilities are being undertaken by UNICEF and research is being conducted by academic institutions and NGOs, amongst other stakeholders. UNICEF, in partnership with the Washington Group, has developed a disability module based on the ICF conceptual framework to assess child functioning across a range of areas. The module is intended to be incorporated into national surveys and censuses. At least nine countries in the region have agreed to include it in the sixth round of UNICEF’s Multiple Indicator Clusters Surveys (MICS6). Additionally, some countries in the region (e.g. Kosovo, Turkmenistan, Belarus) have included disability benefits within the MICS6 module on social transfers.

Administrative data on cash benefits and public residential care are often the most up-to-date information on the number of registered children with disabilities, though there are significant limitations to this data. Countries are working to create more comprehensive administrative systems. Serbia has established a ‘Registry of Children with Disability’ based on a functional assessment and ICF. This will allow for the collection of data on children with disabilities which can be used by various sectors, including the social protection system. In Bosnia and Herzegovina, a real-time database is maintained with the capacity to disaggregate detailed information regarding recipients of the disability pension (UNICEF, 2017d). UNICEF also maintains the TransMonEE database which monitors the situation of children in the region, including a range of indicators on children with disabilities across different dimensions of child wellbeing (e.g. education, social protection, child protection).

**Social Protection Systems**

**Social assistance**

Every country in the region provides some level of social assistance for children with disabilities. Allowances for children with disabilities are mainly provided at a flat rate and on a monthly basis. Most countries provide allowances to children from birth up until the age of 18, although the age limit has been adjusted upwards from 16 in several countries only in recent years. Turkmenistan and Uzbekistan continue to retain an age cut-off of 16 years of age, reflecting a narrow approach to disability which focuses on capacity to work.

Various approaches are taken to set the benefit level of social assistance provided for children with disabilities. Transfer levels are often linked to national benchmarks such as the old age pension, minimum wage or minimum subsistence level. Some countries (Kazakhstan and Bulgaria) use medical assessments to determine a varying level of allowances. In Albania, the level of allowance differs by disability, with a variation of approximately 10 percent according to whether the child is blind, paraplegic/quadriplegic or has mental, physical or sensory disabilities. Blind children also receive a higher allowance in Kosovo. Georgia and Turkey are the only two countries in the region where social assistance for children with disabilities is means-tested based on their caretakers’ income levels. Although there is significant variation across the region in the Euro value of allowances for children with disabilities (monthly allowances range from 27 Euro in Tajikistan to 475 Euro in Bulgaria), a comparison using national costs of living would be required in order to quantify local purchasing power. In addition, some countries provide support through in-kind schemes.

Sixteen out of 21 countries in the region provide social assistance for caretakers. These are predominantly monthly cash transfers (e.g. Moldova), with some countries providing support through alternative means such as reimbursement for utilities (e.g. Tajikistan). A flat rate is common in many countries, although the transfer level varies according to the assessed level of disability of the child in Romania, Serbia and Ukraine.

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9 Belarus, Bosnia and Herzegovina, Georgia, Kosovo, Kyrgyzstan, Montenegro, North Macedonia, Serbia, Turkmenistan, Ukraine, Uzbekistan.

10 From 16 years of age, children with disabilities in Turkmenistan and Uzbekistan are eligible for social assistance based on assessment of disability according to capacity to work.
Turkmenistan and Kosovo have health schemes which include some countries (Tajikistan, Armenia, Azerbaijan, Croatia, Kyrgyzstan, North Macedonia, Albania, Bulgaria, Romania) with national health systems. Most countries have a national health care, which is at the core of UHC, when coverage policies do not include some groups, the range and accessibility of services is limited, and co-payments are required for services (WHO, 2019a). Legal and policy frameworks in the region provide relatively strong support for children with disabilities through national health systems. Most countries have a national health insurance scheme. Some countries (Tajikistan, Turkmenistan and Kosovo) have health schemes which are currently funded and operated by the state, but which are gradually moving towards universal health insurance. Irrespective of the governance and financing arrangements, all countries have committed to providing free healthcare to children with disabilities (by virtue of being either children or persons with disabilities – two categories which receive favourable treatment). This includes access to health services without the need to make financial contributions, and reduced co-payments for out-patient medication. No co-payments are required for children with disabilities in Armenia, Azerbaijan, Croatia, Kyrgyzstan, North Macedonia, Montenegro and Ukraine.

However, inclusivity in national frameworks does not necessarily translate to implementation of legal or policy commitments. Secondary research undertaken for the mapping revealed extensive qualitative evidence that children with disabilities were required to make informal out of pocket payments. Research also suggests that specialist services required by children with disabilities – such as physiotherapy, audiology and speech therapy – are not always available in ECA (UNICEF, 2018c). Available evidence therefore indicates that many health systems in the region are not yet providing the promised level of support to children with disabilities. Turkmenistan has a state-run healthcare system and has moved towards definitions of disability which incorporate the extent of participation in society and activities that people can undertake. That said, however, the medical model of disability has continued to dominate public and private discourse about disability in Turkmenistan, with a child’s condition being seen mainly as an illness that needs treatment (UNICEF, 2015a). Universal Health Coverage and Financial Protection

Children with disabilities often have higher health-related needs and may require regular access to primary, secondary and tertiary healthcare as well as other specialised services in order to reduce disability and optimize functioning. Ensuring that health systems not only include but prioritise children with disabilities is essential to achieving universal health coverage (SDG3.8). Health systems fail to provide financial protection, which is at the core of UHC, when coverage policies do not include some groups, the range and accessibility of services is limited, and co-payments are required for services (WHO, 2019a). Legal and policy frameworks in the region provide relatively strong support for children with disabilities through national health systems. Most countries have a national health insurance scheme. Some countries (Tajikistan, Turkmenistan and Kosovo) have health schemes which are currently funded and operated by the state, but which are gradually moving towards universal health insurance. Irrespective of the governance and financing arrangements, all countries have committed to providing free healthcare to children with disabilities (by virtue of being either children or persons with disabilities – two categories which receive favourable treatment). This includes access to health services without the need to make financial contributions, and reduced co-payments for out-patient medication. No co-payments are required for children with disabilities in Armenia, Azerbaijan, Croatia, Kyrgyzstan, North Macedonia, Montenegro and Ukraine.

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Assistive technology

All countries in the region provide an entitlement to some form of assistive technology. However, the minimum entitlement is always a mobility-related device such as prosthetics, wheelchairs or crutches. The second most-supported category of assistive device in the region is hearing, with about half the countries providing some form of hearing device. The provision of devices for the remaining three categories of assistive devices – vision, communication and cognition – is negligible. Although an assessment of needs is undertaken to determine the appropriate assistive technology (this occurs in at least nine countries according to the mapping), this does not guarantee that the technology or device provided is tailored to the needs of the child. In Belarus, for example, persons with disabilities are provided with prosthetic and orthopaedic devices and technical means of rehabilitation. But the equipment tends to be standardised and no choice is available (European Commission, 2009). The situation is similar in Tajikistan where, despite efforts by the Government to improve access to assistive technology, beneficiaries continue to receive low quality, inappropriate or ill-fitting products that often end up rarely used or discarded (WHO, 2019b).

In most countries, assistive technology is nominally provided free of charge through the health care system. Countries with more mature universal health insurance systems (e.g. Albania, Croatia, Romania) provide assistive technology through that scheme. Other countries in the region, particularly those that continue to use state-funded and operated health care, provide assistive technology in-kind. In addition to providing the equipment, the Government of Tajikistan also covers transport, accommodation and meals for people with disabilities and their caretaker if travel is required to obtain the assistive products (WHO, 2019b). Means-tests are applied in the region, and formal financial contributions or co-payments are only required in Turkey, Serbia and Ukraine. However, out-of-pocket payments are required for many devices in Uzbekistan.

The proportion of children with disabilities who are able to exercise their entitlement to assistive devices is unknown. No country in the region appears to record the number of children with disabilities provided with assistive devices. This makes it impossible to assess whether needs are being met. In addition, the use of the medical model in assessing both eligibility and needs for assistive technology is likely to result in many children with disabilities not receiving the required support.
Integrated Social Protection Programmes

There is limited evidence in the region on integrated approaches to social protection programming for children with disabilities. Fragmented provision of benefits and services can negatively impact families raising children with disabilities, particularly low-income families who struggle with balancing household responsibilities, caring duties and work. The widespread provision of social assistance presents an opportunity to link cash transfers with other programmes, such as in health services, social services, early childhood development or parenting programmes. But the role of social protection in facilitating such integration has not yet been fully developed. That said, there are some emerging examples of promising initiatives which adopt an integrated approach. In Bosnia and Herzegovina (Brcko District), a social protection officer is assigned to the family of a child with disabilities to assist with decisions relating to accommodation needs and special care allowance. In Armenia, a one stop shop approach has been introduced which includes case management and intersectoral collaboration to support families and children based on their specific needs – including children with disabilities (Box 5).

Evidence on Effectiveness

Robust evidence about the impact of social protection programmes on children with disabilities and their families is limited. Some Situation Analyses of Children with Disabilities drew on qualitative research and suggested that social assistance transfer levels are too low to be effective. But there is a clear need for analysis on whether mainstream and disability-targeted social assistance programmes are achieving their objectives. Further analysis – both quantitative and qualitative – is needed to understand the coverage and adequacy of social protection, including social assistance, for children with disabilities, to shape reforms of social protection systems. There is also limited evidence about social protection systems strengthening initiatives, such as Management Information Systems, government coordination, and robust monitoring and evaluation frameworks, which can be beneficial for children with disabilities. Analysis of integrated social protection systems in the region would also generate useful knowledge regarding the importance of referral pathways, including with social work and social services.

Box 5: Integrated social protection for children with disabilities and other vulnerable children and families in Armenia

In Armenia, UNICEF has been supporting the Government’s efforts since 2010 to create a more integrated, proactive and holistic social protection system. A ‘one window’ approach has been introduced to support families and children – including children with disabilities – based on their specific needs. The Integrated Social Services approach brings together multiple benefits and services and provides tailor-made support to children and their families to help address economic and social vulnerabilities to poverty and deprivation. It provides cash (such as disability allowances, pensions, family benefits, maternity benefits and others) and non-cash benefits (e.g. social support, labour market programmes, case management) through co-location of different service providers in Integrated Social Centres which are distributed across the country. A case management system has been introduced, including the appointment of professional case managers who are responsible for identifying the needs of the most vulnerable families and children, and mobilizing available resources to respond to those needs in a customized way. In 2017, more than 338,000 beneficiaries received services through 18 Integrated Services Centres.
Recommendations

Definition of disability

Strengthen ongoing efforts to introduce – and implement – the ICF definition of disability across the region. Introducing the ICF system requires a transformation of the entire system – starting with reformed assessment structures and methodologies; revised social care and support services; updated health, education and employment services; and new funding mechanisms. Technical and financial support to introduce the ICF model should be accompanied by a sustained, sustainable and multi-sector strategy to build the skills, capacity and knowledge of those in or integrated with the social protection system, such as government officials, social workers, educators and health practitioners, including those who develop or implement relevant policies.

Evidence: data and research

Continued investment in disaggregated data collection and analysis to help understand and address equity issues amongst children with disabilities. Where possible the Washington Group of Questions should be incorporated into national surveys, including the Multiple Indicator Cluster Survey (MICS), to gather better and highly disaggregated information on children with disabilities. Consideration should also be given to dedicated disability surveys, which can gather comprehensive information on disability characteristics and in particular would shed light on neglected equity issues, such as gender. Dedicated surveys could also provide valuable information such as prevalence, health conditions associated with disability, use of and need for services, quality of life, opportunities, and rehabilitation needs (UNICEF, 2012b). Alongside this, efforts should be made to strengthen administrative data systems, such as Management Information Systems or social registries (as in Serbia). The dearth of research across the region on children with disabilities and social protection needs to be addressed. Disability related issues should be incorporated into systems assessments (such as CODI) and impact evaluations.

Policy and legal frameworks

Give emphasis and visibility to children with disabilities in policy frameworks. There is a need to increase the prominence of children with disabilities in the various strategies, policies and action plans that relate to issues such as disability, social protection, child rights, health, education and early childhood development. Moreover, such policies should adopt a social and human rights perspective, rather than the medical approach.

Strengthen legal and policy frameworks to ensure clarity, coherence and integration regarding children with disabilities. This is particularly the case with respect to the assessment of disability, where legislative amendments to introduce more progressive definitions of disability have not been consistently adopted. Comprehensive and integrated legislation and policies are critical to ensuring that all children with disabilities can access a wide range of appropriate benefits and services, including assistive technologies.

Develop overarching social protection strategies for the population as a whole, including children with disabilities. While most countries across the region have a significant range of social protection initiatives which have been introduced and strengthened over time, only a few have developed an overarching vision and set of detailed objectives. A carefully designed and implemented social protection strategy enables prioritisation of scarce human and financial resources. It can facilitate a more coherent and integrated approach, including giving sufficient emphasis and visibility to children with disabilities, amongst other vulnerable groups.

Social assistance and integrated social protection systems

Disability benefits should be set at an adequate level to prevent and mitigate poverty. Governments should take into consideration disability related costs when designing social assistance programmes (both mainstream and disability targeted). Estimating the extra costs associated with disability at the household or individual level would provide decision-makers and other stakeholders with the necessary evidence for assessing the adequacy of benefits and proposing adjustments if necessary. These estimates can be disaggregated by the severity classification (mild, moderate, severe or multiple) and age.

Integrate social assistance schemes with services to drive improved outcomes for children with disabilities. Leverage existing social assistance programmes to develop integrated initiatives – in particular cash and care for children with disabilities in ECA. Defining clear referral pathways, strengthening social workforce and implementing case management can more effectively and efficiently support households to access the benefits and services they need.

Significant investment is required to strengthen the systems which underpin the provision of social assistance. The priorities for systems strengthening need to be analysed and developed on a country by country basis. But there appear to be clear opportunities in areas such as data management (e.g. through the development of Management Information Systems); monitoring and evaluation frameworks (to enable decision makers to track and analyse program implementation); and government coordination (to promote coherence and collaboration across sectors, within social protection, and vertically between national and sub-national authorities). The rewards of effective systems strengthening would extend to all social assistance beneficiaries, including children with disabilities.
Universal Health Coverage
Up to date knowledge and evidence on provision of support to children with disabilities by healthcare systems are required to inform reforms to achieve universal health coverage. There is a need to better understand the extent to which health systems are meeting the needs of children with disabilities, specifically which services children with disabilities are entitled to receive and the extent to which they can access those services. This includes the mainstream health care services as well as specialised, targeted services. Costs for health services often present a major barrier to access, and it is critical to quantify the amount of formal and informal out-of-pocket payments which carers of children with disabilities are required to contribute. A foundation of evidence would inform subsequent advocacy on a basic package of services to be provided to children with disabilities, whether free of charge or otherwise, as part of universal health coverage.

Assistive technology
Detailed in-country analysis is needed to better understand the supply and demand sides of assistive technology in ECA. In line with the CRPD, governments need to provide affordable assistive technologies to all children with disabilities who could benefit from them. Yet the lack of information makes it challenging to identify priorities and entry points for assistive technology within social protection systems in ECA. More comprehensive research (such as the situation analysis of assistive technology in Tajikistan) would allow government and other stakeholders to assess how assistive technology can support children with disabilities, the types of technology currently available and existing barriers to accessing assistive technologies.

Support the provision of assistive technology for children with disabilities as part of a comprehensive national social protection floor. The high costs of acquiring and maintaining some assistive technology mean that affordability is often a crucial factor for both the end user and government. Careful analysis and planning will be required by governments to assess the requisite level of funding and the necessary social protection instruments to ensure assistive technology is accessible to all children with disabilities. A systems approach is also crucial to address common challenges such as lack of production and servicing. A number of technologies are being developed with a user-centric design in mind. Linkages with innovation and R&D in assistive technologies for children may both reduce associated costs and increase impact on children’s well-being.

Non-government stakeholders – including the private sector – have a significant role to play. The private sector can involve children with disabilities and their families in the development and design of assistive technologies. Companies should also collaborate in research and analysis with government and other non-government actors to help align their support for children with disabilities through social protection. UNICEF and other stakeholders can draw on international experience to support systems-building to ensure supply, quality and service. This includes technical or financial assistance to ensure that sufficient personnel are properly trained such that technologies can be used, maintained, updated and repaired. Lack of awareness by children with disabilities or parents that assistive technologies exist is another widespread problem that non-government stakeholders can help to remedy.

11 3D printed lightweight prosthetic sockets for children missing a lower limb; brain-computer interface (BCI) technology that allows users to operate a computer with their thoughts; lightweight and affordable wheelchairs designed for children; special readers that allow children and young people with visual impairments to use smartphones; specialized speech recognition technology, and many more were presented at the interactive exhibit on assistive technologies to assist children with disabilities co-organized by UNICEF in Geneva on 5 March 2019.
### A Checklist for Inclusive Social Protection for Children with Disabilities

#### Evidence

**Poverty Analysis**
- Is disaggregated data on children with disabilities and their families routinely collected through household surveys (e.g. HBS/MICS/DHS) or census?
- Do poverty assessments (e.g. MODA/MPI) examine the situation of households with children with disabilities?
- Is it possible to assess the extra costs of disability based on available data? Can a disability-adjusted poverty rate be developed?

**Systems Assessments**
- Are children with disabilities mainstreamed within assessments of social protection systems (e.g. CODI)?

#### Monitoring and Evaluation (Policy/Programme)

- Do policy and programme monitoring frameworks allow for disaggregation by disability?
- Have social assistance programmes (mainstream and disability targeted) been evaluated in terms of their effectiveness on poverty reduction and improving wellbeing outcomes for children with disabilities? How does the impact of the programme on CWD compare to those without disabilities?
- Are DPOs included in the monitoring and evaluations of policies and programmes?

#### Policy and legal frameworks

- Which ministry/government body is responsible for the design and implementation oversight of disability policy? Do they have the necessary evidence to design appropriate policies to address the risks and vulnerabilities faced by CWD?
- Do policy and legal frameworks adopt the ICF model of disability?
- To what extent are children with disabilities considered within national poverty reduction and sector policies?
- Are disability policies comprehensive, covering all stages of life and including a variety of programmes to address risks and vulnerabilities at different stages in the lifecycle (from preventative to rehabilitation)?
- Do social protection policies take into consideration the specific needs of CWD and their families?
- Are disability benefits considered legal entitlements?
- Are there legal provisions on anti-discrimination and reasonable accommodations?
- Are DPOs included in national dialogue processes for formulating or revising national social protection strategies?
- Are the resources allocated to the social protection system sufficient to cover a comprehensive mix of benefits and services for all children with disabilities?
- What is the incidence of catastrophic spending on health and the out-of-pocket share of total spending on health?
- What is the cost per child of providing institution-based services compared to community-based services?

#### Programme

**Programme Design**
- Which ministries/agencies are responsible for disability-related services according to the law/policy?
- Do the programme objectives, design and delivery promote the inclusion and participation of children with disabilities? Do they support children with disabilities remaining with their families?
- Is the programme designed and delivered in a way that fosters the choice, control and autonomy of persons with disabilities?
- To what extent are programmes for families with children with disabilities integrated? Do social assistance programmes facilitate access to social services, national health insurance, active labour market programmes, etc.?
- Do programmes allow for families raising children with disabilities to access multiple programmes (e.g. can a household receive a mainstream poverty-targeted benefit and a disability grant simultaneously?)
- To what extent is the responsibility for disability programming decentralized to local authorities? What is the role of local authorities in planning, designing, financing and implementing programmes?
- Are DPOs included in the design and implementation of the programme?

**Programme Coverage**
- What percentage of programme beneficiaries are children with disabilities (for mainstream social protection programmes)?
- What percentage of children with disabilities are covered by disability-targeted programmes? Are there inclusion and exclusion errors?
- What are the profiles of participants with disabilities (e.g., demographic characteristics, type of impairment)?
- Are there disparities (geographic, urban/rural) with respect to coverage?
### Adequacy of benefits
- What is the adequacy of benefits (mainstream or disability-targeted)? How are transfer levels set? Do benefit amounts take into consideration the extra costs associated with disability?

### Eligibility
- Are eligibility criteria for disability targeted schemes based on ICF? What is the process to be certified as disabled? Does the process create barriers for families with disabilities to be certified and apply for social protection programmes?
- To what extent are eligibility criteria harmonized across different social protection programmes?
- Do conditions of eligibility, particularly for mainstream schemes, result in the exclusion of children with disabilities? Do conditions of eligibility create unintentional barriers?

### Administration

#### Physical Accessibility
- Are there physical barriers that limit the access of children with disabilities to the programme (e.g. are application processes onerous requiring multiple trips to collect documents? are government buildings fully accessible (ramps, elevators, specialized rest rooms, etc)? can families apply online?)?
- Can a family representative apply, enrol and receive benefits on behalf of a person with disabilities?
- Are social workers provided with the necessary resources to provide support (training, transport, specialized materials)?

#### Communication and Social Accessibility
- Is the information on the programme (including eligibility conditions, admission procedures, and complaint and appeal procedures) accessible to all persons with disabilities (e.g. in appropriate formats such as Braille)?
- Is the programme staff trained to provide support to children with disabilities?

#### Information Data Systems
- Is there a national registry for persons with disabilities (including children)?
- Do Information Management Systems allow for the consolidation of disability-related data from different programmes and schemes?

Adapted from Mitra, 2005; UNICEF, 2019c; ILO and IDA, 2019
References


WHO (2019b) Assistive Technology in Tajikistan: Situational Analysis. Copenhagen: WHO Regional Office for Europe. Available at: https://apps.who.int/iris/handle/10665/312313

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