

Key Findings

of the National Survey on Person with Disabilities in Ethiopia

April 2026



KEY POINTS

- Disability prevalence is not a **fixed number**; it varies significantly depending on how disability is defined and the thresholds applied. Evidence from Ethiopia's 2025 National Survey of Persons with Disability shows prevalence ranging from 0.7% to 20%, depending on **measurement criteria**. These variations have critical implications for **universal design, social protection, targeted services, and international reporting**. Policymakers must align disability definitions with policy objectives to ensure inclusive, efficient, and equitable interventions.
- **Disability thresholds (definitions):**
 - **Broad:** At least one domain with "some difficulty" or worse.
 - **Moderate:** At least two domains with "some difficulty" or one domain with "a lot of difficulty" or worse
 - **WG-recommended:** Any domain with "a lot of difficulty" or "cannot do at all".
 - **Strict:** Any domain coded "cannot do at all".
- **Resulting Individual Prevalence Rates:**
 - **20%** report some difficulty (broad threshold),
 - **5.8%** report a lot of difficulty or worse (moderate/WG threshold) and
 - **0.7%** cannot do at all in at least one domain (strict threshold).
 - Based on the Washington Group recommended threshold, the prevalence of disability is **5.8%** for the overall population which represents approximately **6.3 million** individuals with disabilities across all demographic groups in Ethiopia.
 - **3.6%** of children (below 18 years of age) have disabilities compared with **7.2%** of adults (18 and above)
- **Household prevalence rate:** Nationally, 20% of households have at least one member with a disability based on the Washington Group Recommended threshold (definition 3). **Fifty-five percent** of households have at least one person with some difficulty in a functional domain. This implies infrastructure planning should account for the fact that more than half of the households have a person with some difficulty in at least one functional domain, necessitating inclusive design principles in public spaces and facilities.

ABOUT THE SUMMARY

This summary is based on findings from National Survey on Persons with Disabilities in Ethiopia, April 2026, which was made possible with the financial support of UK Aid- FCDO (Foreign, Commonwealth & Development Office of Ethiopia) and technical support of Policy Studies Institute, UNICEF and Inclusive Development Partners.

BACKGROUND

The Ethiopian National Survey of Persons with Disability (2024/25) screened 40,311 individuals using internationally recognized tools. The survey covered a total sample size of 9,200 households (3,385 urban and 5,815 rural households). This approach ensured a minimum of 500 households per region, including those regions with smaller population. Data collection was conducted from October 21, 2024 to December 8, 2024.

- WG-CFM for children aged 2–17
- WG-SS for adults aged 18 and above

The survey is nationally representative, with results disaggregated by age, sex, wealth quintile, and region. It provides robust evidence on how measurement choices directly influence disability statistics and policy relevance.

Disability prevalence depends not just on age or income, but also on how disability is defined. Changing the threshold changes the count.

- BroadThreshold: At least one domain with “Some difficulty” or worse
- ModerateThreshold (Definition 2): At least two domains with “some difficulty” or one domain with “a lot of difficulty” or “Cannot do at all”
- Moderate Threshold (Definition 3): “A lot of difficulty” or “cannot do at all” in any 1 domain
- StrictThreshold: “Cannot do at all”

Each threshold serves a different purpose:



Universal design: Use broad threshold (Definition 1)

Universal design requires the use of a broad disability threshold (*“some difficulty” or worse*) to capture the widest range of functional limitations within the population. This approach ensures that data used for planning and decision-making are reliable and inclusive, reflecting the diversity of needs across society. By applying universal design principles in assessments and learning environments through Universal Design for Assessment (UDA) and Universal Design for Learning (UDL). They are designed from the outset to enable equitable participation for all individuals, including persons with disabilities¹. This includes proactively reducing learning and participation barriers by providing assistive materials such as braille textbooks, audio devices and sign language as well as investing in accessible infrastructure, including ramps, tactile pathways, auditory signals, and wheelchair-accessible public buildings, transport systems, and urban spaces.



Social Protection: Use moderate threshold (Definition 2 or 3)

For social protection, applying a moderate disability threshold (*At least two domains with “some difficulty” or “a lot of difficulty” or worse*) is appropriate to identify individuals facing significant and sustained economic exclusion. This threshold captures persons whose functional limitations significantly affect their ability to access education, employment, and basic services, thereby increasing their risk of poverty and dependency. Applying this definition supports more accurate targeting of social protection interventions toward those with the greatest need, while maintaining administrative feasibility.

¹ World Bank. 2023. Toolkit: Using Principles of Universal Design for Assessment (UDA) to Design Accessible Learning Assessments. Washington, D.C: World Bank Group



Cross-country comparison: Use WG-recommended threshold (Definition 3)

For international comparability, the Washington Group recommends defining disability as reporting *“a lot of difficulty”* or *“cannot do at all”* in at least one of the six core functioning domains. This threshold helps identify people at high risk of exclusion from physical, informational, attitudinal, or institutional barriers, making it useful for SDG data disaggregation. Evidence from cognitive and field testing across multiple countries shows that respondents interpret the response categories *“a lot of difficulty”* and *“unable to do”* more consistently across cultural contexts and population sub-groups, enhancing cross-national reliability and comparability. Individuals captured at this level of difficulty face a substantially higher risk of non-participation in education, employment, and social life if environmental barriers persist. In contrast, the interpretation and implications of *“some difficulty”* vary more widely across countries, limiting its suitability for standardized international comparison.



Targeted support: Use strict threshold (Definition 4)

Using the strict threshold *“cannot do at all”* focuses on a smaller, more severely limited subgroup of persons with disabilities who experience profound functional limitations that substantially restrict participation in daily life without assistance. This subgroup often has the highest risk of exclusion, dependency, and intensive support needs, making them especially vulnerable and appropriate targets for specialized support programs.

Why does this matter?

Different policy objectives require different disability definitions, and the chosen threshold directly shapes who is identified, prioritized, and reached. Broad thresholds support inclusive systems by informing universal design in education, infrastructure, and services, ensuring that diverse functional needs are considered early. Moderate thresholds help target social protection by identifying those facing persistent socioeconomic barriers, enabling better allocation of disability specific cash transfers and services. Strict thresholds focus on people with severe functional limitations who require intensive, specialized support. Using the Washington Group-recommended thresholds strengthen global accountability by ensuring comparability across countries, improving SDG and CRPD reporting, and enhancing the credibility of Ethiopia’s national disability statistics for planning and benchmarking.

UNDERSTANDING WASHINGTON GROUP SCREENING QUESTIONS

- The study uses the Washington Group (WG) screening questions to estimate the prevalence of disability in Ethiopia. The WG screening set of questions was developed based on the International Classification of Functioning, Disability, and Health with the participation of national statistics offices in over 130 countries and territories.
- The WG tool is intended to be used to (1) identify persons with various degrees of limitations in basic activities regardless of nationality; (2) compare levels of participation in employment, health, and family life with those without a disability; and (3) monitor the effectiveness of programs and policies to promote wider participation and inclusion.
- The study used adapted a methodology that included a cross-sectional, interview-based household survey instrument comprised of three questionnaires that collected data on households, individuals with disabilities, and individuals without disabilities.
- WG had six sets of questions with four possible responses shown below to collect data on six different domains of functional limitations (seeing, hearing, mobility, cognition, self-care, and communication). This version is widely known as the Washington Group Short Set (WG-SS).
- Taking the example of one domain such as hearing, the person or the caregiver depending on the age is asked if the person or child uses a hearing aid? If yes to this question, follow up questions include:

When using his/her hearing aid, does (name) have difficulty hearing sounds like people's voices or music? Would you say (*name*) has:

1. no difficulty,
2. some difficulty,
3. a lot of difficulty or
4. cannot do at all?

Similar questions are also asked for the other domains (such as vision, walking etc.) listed in the below table.

- WG has developed additional versions of the tool to address the needs of children of different ages, capture other functional limitations such as anxiety and depression, and include children under different screening contexts (by caregivers at home or by teachers at school). These other versions are the child functioning module (CFM), the CFM teacher version (TV), and the extended set (ES).
- **Threshold:** Prevalence estimates do not need to be a single number. Apart from disaggregated levels of disability prevalence by demographic and socioeconomic factors, disability prevalence can also be calculated at various thresholds depending on the purpose of data collection, reporting, and use. The WG recommends analyzing prevalence using four different levels of thresholds/definitions, summarized in the table below.

<i>Threshold/Definition Levels</i>	<i>Definition</i>
Definition 1 (Broad)	At least one domain/question is responded “some difficulty” or “a lot of difficulty” or “cannot do at all”
Definition 2 (Moderate)	At least 2 domains/questions are responded “some difficulty” or any 1 domain/question is responded “a lot of difficulty” or “cannot do at all”
Definition 3 (Moderate)	Any 1 domain/question is responded “a lot of difficulty” or “cannot do at all” (Note: the cut-off recommended by WG)
Definition 4 (strict)	Any 1 domain/question is coded “cannot do at all”

Table 1. WG tools to measure prevalence rate

<i>WG Tool</i>	<i>WG-SS</i>	<i>CFM</i>	<i>CFM-TV</i>	<i>WG-ES</i>
Types	Social model/ functioning			
Purpose	Prevalence rates and disaggregation by disability status			
Data collection method	Self-report for adults, subjective assessment when responding for child	Subjective assessment	Subjective assessment	Subjective assessment
Interviewer/ administrator	Non-medical			
Year of tool development	2002	2011	2019	2009
Child age range	5-17	2-17	5-17	18+
Respondent	Parent/ caregiver	Parent/ caregiver	Teacher	Person
Vision	X	X	X	X
Hearing	X	X	X	X
Walking/mobility	X	X	X	X
Self-care	X	X		X
Communication/ comprehension	X	X	X	X
Learning		X	X	
Cognition	X	X	X	X
Remembering		X	X	X
Concentration		X	X	X
Routine		X	X	
Behavior		X	X	
Friends		X	X	
Upper body				X
Pain				X
Fatigue				X
Affect (anxiety)		X	X	X
Affect (depression)		X	X	X

Source: Macon and Dunn (2024)

2. DISABILITY PREVALENCE

Disability prevalence is reported at both the household and individual levels to capture different dimensions of how disability affects the population. At the household level, prevalence refers to the percentage of households that include at least one member with a disability defined as having at least a lot of difficulty in one or more functional domains. This measure highlights the broader reach of disability within family units, even when individual-level rates may seem relatively low. This threshold is internationally preferred as it is consistently understood across contexts and effectively identifies individuals at higher risk of exclusion and limited participation (Washington Group on Disability Statistics, 2016).

Disability prevalence at the household level

Disability prevalence at the household level

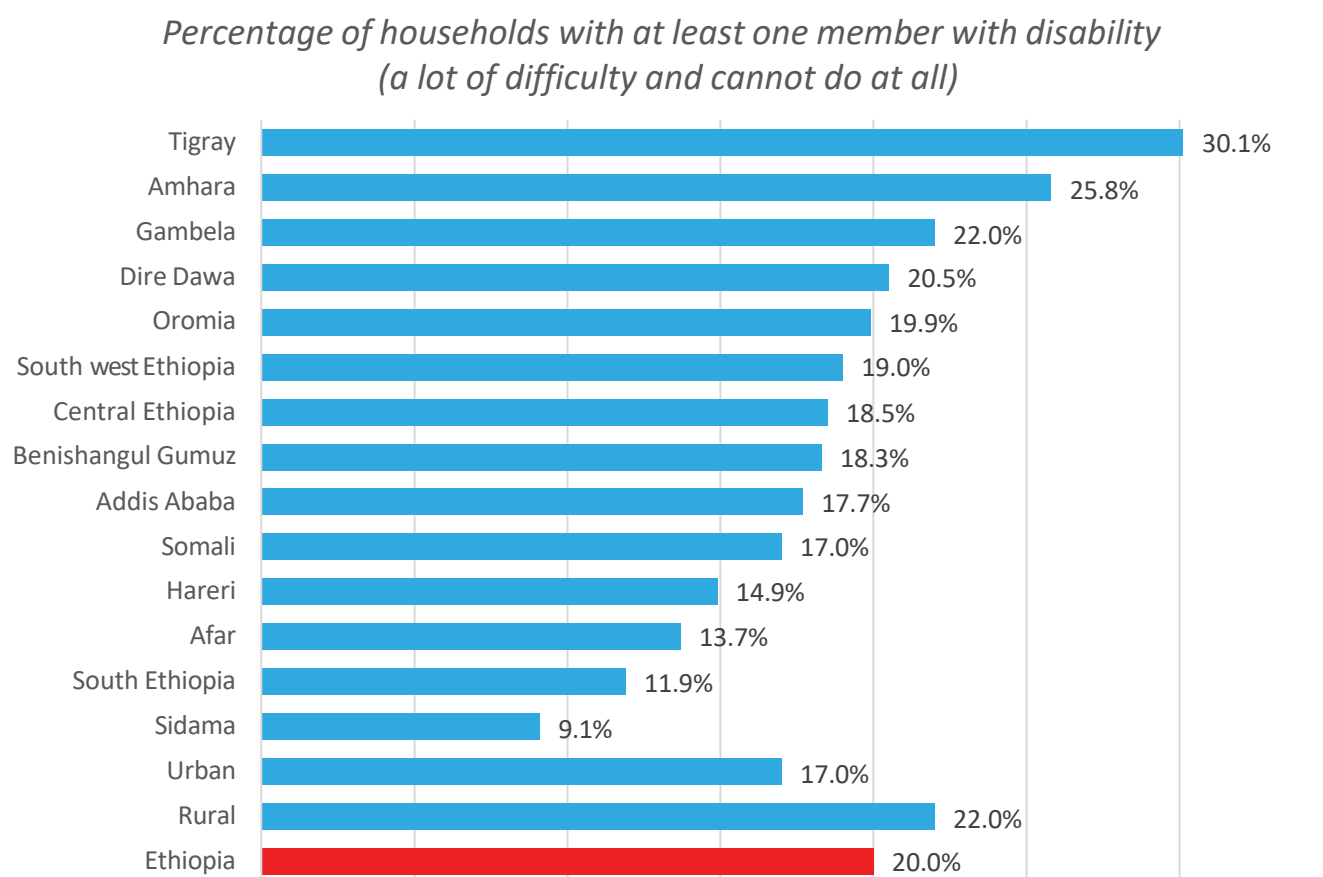
Percentage of households having at least one member of the household with a disability which **reports “a lot of difficulty” or cannot do at all** in any functional domain as per the Washington Group’s recommended threshold (Definition 3).

Nationally, 20% of households have at least one member with a disability based on the Washington Group Recommended threshold (definition 3). More than half (55%) of households have at least one person reporting at least some difficulty (including people reporting a lot of difficulty and cannot do at all) in at least one functional domain. A smaller yet critical subset of the population faces even greater limitations; 3.02% of households include at least one member who reports “cannot do at all” in one domain.

Patterns by background characteristics

- Disability prevalence is significantly higher in rural areas (22%) than in urban areas (17%).
- Tigray exhibits the highest prevalence (30%) and Sidama the lowest (9%). Amhara (25.8%), Gambela (22%) and Dire Dewa (20.5%) also have prevalence above the national average. (see figure 1)
- Regional differences are evident in households where at least one person is unable to perform activities (**‘cannot do at all’**) in a given domain, with Benishangul-Gumuz having the highest rate (5.79%) and Addis Ababa the lowest (0.75%).

Figure 1. Households with a person with disabilities by urban/rural and region



An 11-Year-Old Struggling to Be Understood



Samuel lives in an urban kebele of Dire Dawa. Born prematurely as a twin, he has persistent speech and communication difficulties. Although doctors report no physical impairment, he struggles to express himself verbally and to process sounds from a distance. His frustration often manifests as anger when others cannot understand him.

At 11 years old, Samuel remains in Grade 1, while his twin brother is in Grade 5. His teachers observe that he writes well and copies accurately from the blackboard, yet his inability to read aloud or speak clearly has stalled his academic progress. Despite this, his mother hesitates to enroll him in a specialized school, fearing stigma and further marginalization.

During observation, Samuel could not respond clearly to spoken questions but showed strong visual comprehension. When interviewers used gestures, he immediately understood and responded, drawing objects accurately when meaning was communicated visually. His case demonstrates that disability is not always a lack of ability, but a mismatch between individual needs and the way services are delivered. Without early assessment, speech therapy, or inclusive learning support, children like Samuel risk being mislabeled as incapable, when in reality they require adapted communication methods and targeted educational support. This is an example of a child with “a lot of difficulty in hearing” and communication.

Note: The details of this human-interest story, including the individual’s name and photograph, have been de-identified to protect their privacy.

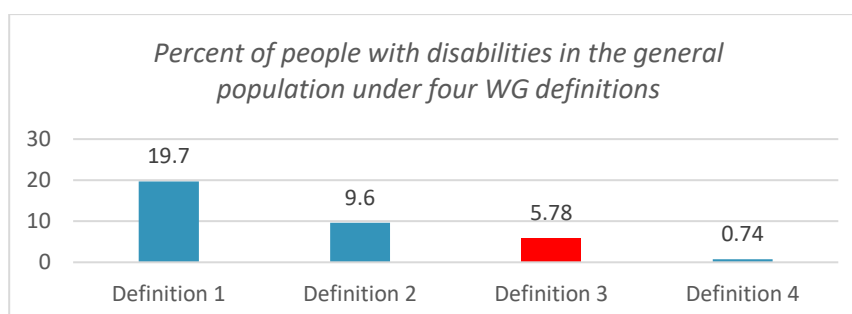
Disability prevalence at the individual level

Disability prevalence at the individual level

Percentage of individuals who themselves report having “a lot of difficulty” or cannot do at all” in any functional domain as per the Washington Group’s recommended threshold (Definition 3).

The overall prevalence of disability in the population is 5.78% according to the Washington Group recommended threshold (definition 3). The figure below gives the prevalence of disability at the individual level under the four different definitions proposed by the WG.

Figure 2. Prevalence of Disability individual Level



Patterns by background characteristics

- Disability prevalence for all age groups is slightly higher in rural areas (5.97%) compared to urban areas (5.18%). The prevalence rate for adults (18 and above) in rural areas (7.61%) is significantly higher than in urban areas (5.97%). Among younger age groups, the differences between rural and urban settings are marginal for children aged 2-17.
- When disaggregated by age disability prevalence increases with age, rising from 2.46% among children aged 2-4, 4.1% among children 5-17, and 7.19% among adults aged 18 and above. These trends suggest that disability prevalence increases with age, likely due to health risks, chronic conditions, and age-related functional limitations.
- The overall prevalence of disability is nearly identical between males (5.77%) and females (5.79%), indicating that disability affects both genders at comparable levels. However, age specific differences emerge. Among children aged 2–4, disability prevalence is higher among females (3.06%) than males (1.91%). In contrast, among school aged children (5–17 years), prevalence is slightly higher among males (4.28%) compared to females (3.92%).
- Disability prevalence among children aged 2-4 years shows regional variation across Ethiopia (see the full report for details), suggesting geographic disparities in early childhood health, development, and reporting. Tigray stands out with the highest prevalence at 4.23%, significantly above the national average of 2.5%. Other regions with above-average prevalence include Oromia (3.17%) and Central Ethiopia (2.90%). In contrast, Sidama reports the lowest prevalence at just 0.17%, far below the national average. While these low rates may suggest better early childhood health in some areas, they may also reflect underreporting, lack of awareness, or gaps in screening practices for disability among young children.
- The prevalence of disability among children aged 5 to 17 varies across Ethiopian regions (see the full report for details). Amhara records the highest prevalence in this age group at 7.41%, followed by Tigray (6.64%) and Gambela (5.32%), all well above the national average of 4.10%. Notably, these are also regions where adult disability rates are relatively high, suggesting a continuity of risk factors in these regions. On the other end of the spectrum, Central Ethiopia (1.76%), Sidama (2.13%), South Ethiopia (2.26%), and Somali (2.51%) report the lowest prevalence of disability in this age group.

Table 2. Percent of persons with disability in the general population by age range, gender, urban/rural, and functional limitation

	Age: 2-4	Age: 5-17	Age: 2-17	Age: 18 and above	All ages
Ethiopia	2.46	4.10	3.75	7.19	5.78
Rural	2.43	4.09	3.75	7.61	5.97
Urban	2.53	4.14	3.77	5.97	5.18
Male	1.91	4.28	3.77	7.22	5.77
Female	3.06	3.92	3.74	7.15	5.79

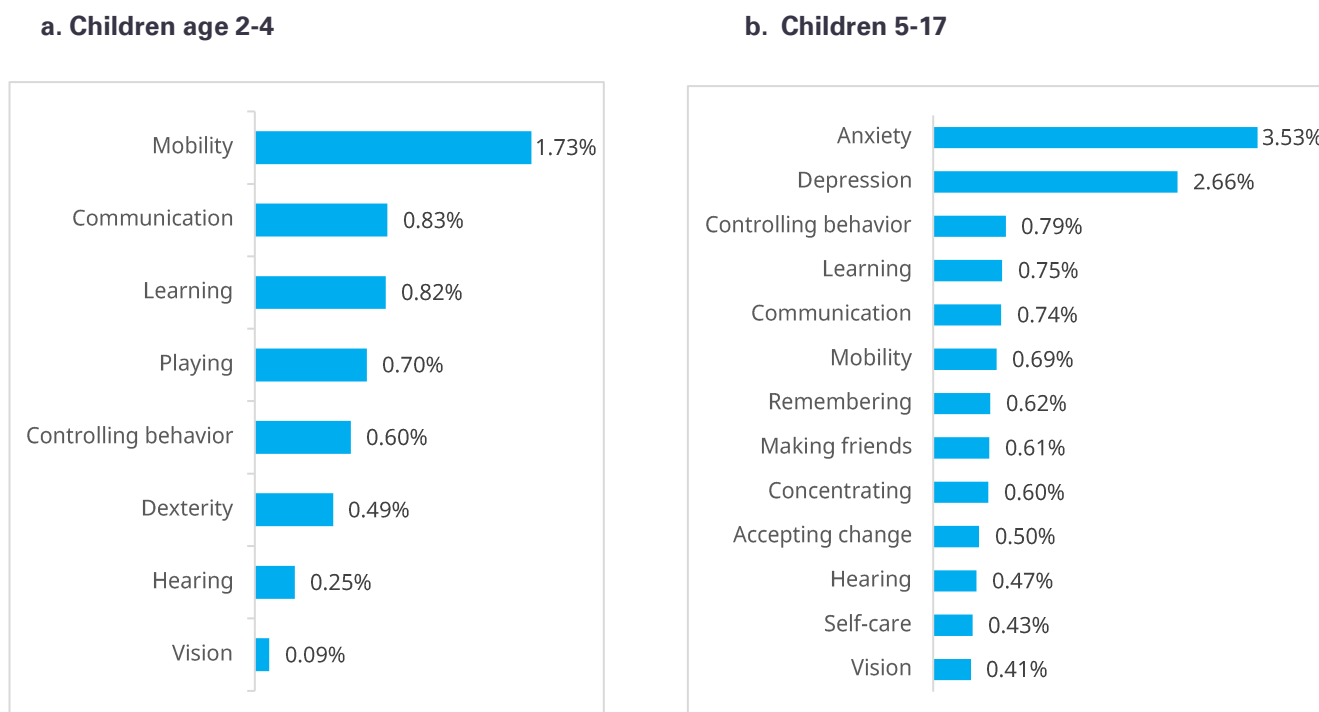
Prevalence of functional limitations

The types of functional limitations also vary by age. Among the youngest age group (2-4 years), mobility (1.73%), communication (0.83%), and learning difficulties (0.82%) are the most reported challenges (see figure 3a). The prevalence rate for multiple disabilities (reporting functional limitations in more than one domain) was 0.82% for this age range.

Among children aged 5–17, the least common functional difficulties are vision (0.41%), self-care (0.43%), and hearing (0.47%). In contrast, mental health–related conditions become more

prominent, with anxiety (3.53%) and depression (2.66%) showing the highest reported prevalence in this age group (see Figure 3.b). The prevalence of multiple disabilities (reporting of functional limitations in more than one domain) for children age 5-17 was 1.53%. For adults, disability prevalence is more often associated with mobility limitations (3.38%), vision (2.64%), remembering/concentrating (1.76%), and hearing (1.36%).

Figure 3. Prevalence of disability by functional domain



Causes of disability

The most reported cause of disability is illness or disease (51%), followed by accidents (13%), aging (7%), and congenital conditions (7%). Conflict-related disabilities disproportionately affect males in urban areas (9%) compared to females (1.3%), while malnutrition (3.6%) is more commonly reported among females, with urban females being nine times more likely to report malnutrition as the cause of disability than urban males.

EDUCATION

Education is recognized as a fundamental right in Ethiopia's Constitution and reinforced by global commitments that promote inclusive and equitable learning for all children. Despite these strong policy foundations, substantial disparities persist for children with disabilities, reflecting both structural and systemic barriers within the education system. Literacy outcomes illustrate this gap clearly: only half of persons with disabilities report being able to read and write, compared to 79 percent of those without disabilities. These inequalities emerge early, as children with disabilities are 24 percent less likely to be enrolled in school, with the disadvantage widening to 30 percent in rural areas where access barriers are more pronounced.

Participation challenges extend beyond enrollment. Students with disabilities experience higher absenteeism, missing an average of four days per month, nearly twice the rate of their peers without disabilities. Gender and location further intersect with disability, with urban males and rural females with disabilities reporting the highest rates of missing school.

Multiple barriers hinder regular attendance. Long distance to school or the absence of a school nearby affects 21 percent of students with disabilities, compared to 12 percent of those without disabilities. Physical inaccessibility remains a significant obstacle for 14 percent of students with disabilities, far exceeding the 2.4 percent reported among students without disabilities.

Denial of enrollment affects 6 percent of students with disabilities, reinforcing the need for stronger enforcement of anti-discrimination policies. Additionally, 14 percent cite the lack of appropriate teaching and learning aids as a barrier, compared to just 2 percent of other students. In urban areas, insecurity further compounds exclusion, with 46% of urban males with disabilities identifying conflict or violence as the primary reason for being out of school.

Marima: A 15-Year-Old Girl Left Outside the Education System



Marima lives in Gendeneser kebele, a rural area where basic services are sparse. Born blind, she has never attended school. The nearest school is far from her home, and there is only one school equipped to teach children with visual impairments in the wider area far beyond her family's reach. Braille materials, trained teachers, and assistive devices are unavailable locally.

Despite her blindness, Marima is not dependent. She can dress herself, eat independently, move around her home, and speaks two languages fluently. Yet her days are marked by isolation. She has no friends, no access to radio or television, and spends most of her time indoors. While her siblings attend school, she remains behind, not because of inability, but because support systems do not extend to where she lives. Her mother does not report discrimination from the community. Instead, she expresses uncertainty, she does not know what kind of support her daughter is entitled to or how to access it.

Although the household is enrolled in a national safety-net program, no disability-specific assistance is provided. "If support were available," the mother says, "she could be productive."

When interviewers first met Marima, she appeared withdrawn, anxious, and neglected compared to her siblings. Yet as the conversation progressed, her demeanor changed. She became more relaxed, smiled, and engaged openly revealing not incapacity, but untapped potential. Her case highlights how strict definitions that focus only on the most severe limitations risk overlooking children who could thrive with relatively modest investments in inclusive education and community-based services.

Note: *The details of this human-interest story, including the individual's name and photograph, have been de-identified to protect their privacy.*

Recommendations to Strengthen Inclusive Education Policies

- 1. Strengthening enforcement of antidiscrimination policies in school enrollment:** Ensure full implementation of Article 24 of the CRPD, the National Plan of Action of Persons with Disabilities, and ESDP V by establishing clear reporting, redress, and accountability mechanisms for cases of denial of admission.
- 2. Expand investment in accessible school infrastructure:** Align school construction and renovation with Ethiopia's Building Proclamation No. 1356/2024 by ensuring ramps, accessible latrines, safe pathways, tactile signage, and classroom layouts that accommodate diverse learners.
- 3. Improve availability and quality of teaching and learning materials:** Increase budget allocation for assistive devices, adapted textbooks, and low-cost learning aids, and integrate universal design for learning (UDL) principles into curriculum development.
- 4. Scale up teacher training on inclusive practices:** Integrate pre-service and in service training on disability-inclusive pedagogy, classroom accommodation, early identification of learning needs, and communication strategies for students with sensory, intellectual, or psychosocial disabilities.

5. **Strengthen early identification and referral systems:** Build partnerships between schools, health facilities, and community workers to systematically identify children with disabilities, refer them for assessments, and ensure follow-up support services.
6. **Expand school level support services:** Deploy itinerant teachers, sign language interpreters, inclusive education coordinators, and school counsellors in underserved districts, prioritizing rural areas where gaps are largest.
7. **Enhance safety and protection measures in urban areas:** Work with local authorities to mitigate risks related to violence and insecurity that disproportionately affect urban students with disabilities.
8. **Promote community engagement to reduce stigma:** Implement targeted awareness campaigns with parents, caregivers, and community leaders to address negative attitudes and encourage enrolment and retention of children with disabilities.
9. **Strengthen data systems for monitoring inclusion:** Integrate disability disaggregated indicators into EMIS and ensure regular monitoring of enrolment, attendance, learning outcomes, and barriers to participation using Washington Group-aligned tools.

3. HEALTH AND NUTRITION

The health and nutrition situation of persons with disabilities shows deep and persistent inequalities when compared with persons without disabilities. Overall, persons with disabilities were **28 times more likely** to describe their health as *very bad*, highlighting a severe gap in perceived and experienced health outcomes.

Regional differences further demonstrate these disparities. The **Harari Region** recorded the highest contrast in self-reported health status, where persons with disabilities were **more than 13 times more likely** to describe their health as *bad or very bad* compared with persons without disabilities. This suggests that access to appropriate health services and living conditions varies greatly across regions and disproportionately affects people with disabilities.

Regarding the causes of health problems, **more than half** of persons with disabilities attributed their condition to **illness or disease**, while **13%** reported that accidents were responsible. A smaller proportion (**4%**) cited conflict-related causes, and **11%** stated that they did not know the cause of their health problem. These findings show that most disabilities are linked to preventable or treatable conditions rather than conflict-related factors.

Barriers to health services remain widespread. An estimated **86%** of persons with disabilities reported facing at least one barrier when seeking health care, compared to **54%** among persons without disabilities. These barriers include physical inaccessibility, communication difficulties, limited availability of services, and financial constraints.

The economic burden of disability is also significant. Total health-related expenditure for persons with disabilities during the previous year was **2.7 times higher** than that of persons without disabilities, and a similar pattern was observed among children with disabilities.

Access to assistive devices remains limited. Only **13%** of individuals experiencing functional difficulties reported using any assistive device. Among users, **52%** obtained devices from the market, while **32%** relied on homemade solutions such as walking sticks.

Age further intensifies inequality: in the **70–80 year age** group, **70%** of persons with disabilities rated their health as *bad or very bad*, compared with **32%** of persons without disabilities.

Malnutrition is a notable cause of disability, particularly among females, suggesting gender-based nutritional disparities, common in international trends. Among urban females, 4.4% reported malnutrition, while only 0.5% of urban males said the same, meaning that urban females are nine times more likely to have a disability due to malnutrition. The disparity between rural males and females is far less at 3.0% and 4.5%, respectively. The impact of medications as a cause of disability is minimal (0.3% overall), but it is slightly higher in rural areas compared to urban settings.

Recommendations for Inclusive Health and Nutrition Service Delivery

Implement disability responsive and nutrition sensitive service standards across all primary health care units, aligned with the National Health Equity Strategy Plan and CRPD Article 25. Integrate routine functional difficulty screening using Washington Group tools and complementary clinical assessments, together with nutrition screening: including MUAC, growth monitoring, and maternal nutrition checks at all service delivery points.

1. Equitable Access to Essential Health and Nutrition Services:

Expand community-based rehabilitation, nutrition outreach, and mobile health–nutrition services, prioritizing rural and underserved areas. Ensure reasonable accommodations: priority queues, accessible infrastructure, adapted communication materials, and simplified nutrition counselling for persons with disabilities. Strengthen financial protection through expanded social health insurance, targeted fee waiver schemes, and removal of indirect costs that limit access to child and maternal nutrition services.

2. Assistive Devices and Nutrition Supportive Technologies:

Increase availability and affordability of assistive devices through local production, reduced import duties, and improved procurement. Establish woreda level repair and maintenance services to ensure continuity of device use. Provide appropriate, compatible devices for children and adults, including feeding and communication aids for children with feeding difficulties.

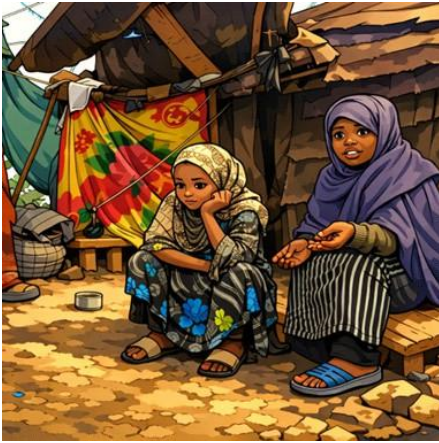
3. Quality of Care and Nutrition Counselling:

Train health workers on disability inclusion, respectful care, early identification of long-term conditions, and integrated nutrition services (IYCF counselling, maternal nutrition, management of wasting). Ensure inclusive growth monitoring, individualized feeding assessments, and adapted nutrition counselling for children with developmental or feeding challenges. Monitor service coverage gaps, waiting times, nutrition outcomes, and expenditure disparities to advance universal health coverage.

4. Child Focused Actions:

- Strengthen early identification through routine screening, newborn checks, developmental assessments, and integrated nutrition screening.
- Improve child friendly, disability inclusive health and nutrition services, with targeted outreach to rural areas and stronger financial support for families with children at risk of malnutrition.
- Expand access to communication, mobility, feeding, and learning support devices. Improve disability inclusive child health and nutrition data to track progress toward SDG 3.8 and nutrition targets.

Hanan: A 13-Year-Old Girl Whose Disability Is Emerging



Hanan lives in an urban neighborhood and attends a nearby primary school. Unlike the other cases, her disability is recent. Over the past four months, she has developed vision problems that make it difficult to see the blackboard or read at home. She compensates by sitting closer to the front and using extra light, but her learning has already begun to suffer.

Her mother has not taken her to a health facility, not due to neglect, but because the family cannot afford care. Hanan's father is seriously ill and partially paralyzed, consuming the household's limited resources. Although a supporting organization assists with the father's treatment, it cannot extend help to Hanan

Hanan describes feeling isolated at school, withdrawing from friendships and social activities. She believes her vision problems began during the period of emotional distress when her father was hospitalized. At night, she often cries to sleep. Her only request is simple: a medical check-up and eyeglasses.

Following the interview, local authorities immediately linked the family to health services and registered Hanan for disability support. Her case underscores the importance of **early identification** because without timely intervention, a manageable impairment can quickly become a long-term educational and social disadvantage.

Note: The details of this human-interest story, including the individual's name and photograph, have been de-identified to protect their privacy.

4. WASH

Use of piped water in rural areas was higher for households *without* a person with disabilities (52%) compared to households *with* a person with disabilities (47%), while households *with* a person with disabilities were more likely to use a tube well or borehole (20% versus 16%, respectively). Differences appear within various regions as well, with the general trend being that households with persons with disabilities use less improved sources of drinking water.

Similarly, households *with* persons with disabilities were less likely to have flush toilets or pit latrines and more likely to use a bush or field. Differences are more pronounced when examining urban and rural settings. Two-thirds (67%) of rural households *with* a person with disabilities reported using a pit toilet and 75% of rural households *without* a person with a disability said the same.

Recommendations

- 1. Design and upgrade WASH facilities using universal design**, ensuring accessible routes, ramps, handrails, clear signage, and safe pathways across schools, health centres, and community infrastructure.
- 2. Scale disability-inclusive menstrual health and hygiene (MHH)** by providing adapted materials, privacy solutions, and caregiver friendly instructions tailored to girls and women with disabilities.
- 3. Enhance community engagement** with accessible communication materials: Braille, audio, pictorial guides, and sign language to address stigma and improve hygiene practices.
- 4. Establish robust disability inclusive M&E systems** to track accessibility, identify barriers, and document innovations.

5. **Align national WASH strategies with disability policies**, including Disability Inclusion Policy and strategy, to ensure sustainable financing and institutionalization of inclusive WASH.

5. SOCIAL PROTECTION

The National Disability Survey highlights substantial gaps in social protection access and participation for persons with disabilities. Overall access to government services and programs is limited for both groups. Only 22% of persons with disabilities reported having social security coverage, compared to 16% of persons without disabilities, indicating weak social protection systems nationwide.

Disability allowance coverage is particularly low. Of the 2,062 persons with disabilities identified in the survey, only 77 individuals (1.5%) reported receiving any disability allowance. Among these, 22 were urban residents and 55 were rural residents, while 45 were male and 32 were female. Of the 77 beneficiaries, 46 received support from NGO/INGOs. For services and benefits beyond disability allowances, local government institutions were the primary providers, followed by NGO/INGOs, accounting for 45% of support in rural areas and 54% in urban areas.

Access to transportation and information remains a major barrier. A higher proportion of persons with disabilities (24%) reported that accessible transportation has “always” been a problem compared to persons without disabilities aged 5 years and above. Similarly, 25% of persons with disabilities reported always having difficulty accessing information, compared to 16% of persons without disabilities. Regional disparities are evident, with the highest difficulty reported in Southwest Ethiopia (61%) and the lowest in South Ethiopia (44%).

Participation in social and political activities is consistently lower among persons with disabilities; with 41% to 60% reporting they “never” participate. Key barriers include lack of physical accessibility and reasonable accommodation. Participation in organizations of persons with disabilities (OPDs) is very limited, with 86% reporting they “never” participate, including 91% of urban females and 84% of urban males.

Recommendations

1. **Mainstream disability in PSNP design and targeting:** Ensure persons with disabilities are systematically identified and prioritized in PSNP targeting, including those with severe functional limitations.
2. **Adapt PSNP conditionalities and public works:** Introduce flexible and alternative modalities to public works requirements, including direct support, reasonable accommodation, and accessible work environments.
3. **Expand benefit adequacy and coverage:** Increase access to cash and in-kind transfers for persons with disabilities, providing reasonable additional allowance for persons with disabilities.
4. **Strengthening linkages with services:** Integrate PSNP with health insurance, assistive devices, rehabilitation, and information services to reduce exclusion and improve participation outcomes.

6. CHILD PROTECTION

The study did not include data on child protection issues such as child marriage, FGM and violence against children, or birth registration. However, identifying children with disabilities who are at risk of or affected by violence remains essential for prioritizing targeted interventions. The following recommendations outline key actions for inclusive child protection programming.

Recommendations for Inclusive Child Protection Programmes

- 1. Address Barriers Across All Child Protection Services:** Ensure identification and removal of physical, communication, digital, attitudinal, and institutional barriers that limit access for children with disabilities. This aligns with guidance on inclusive system strengthening, which highlights accessibility measures and barrier reduction as foundational steps.
- 2. Apply a Rights Based and Disability-Inclusive Framework:** Anchor programming in the *Convention on the Rights of the Child* and the *CRPD*, ensuring equal protection, effective remedy, and participation for children with disabilities across all interventions.
- 3. Strengthening Inclusive Child Protection Systems:** Integrate disability inclusion into national child protection systems, ensuring aligned policies, processes, and accountability mechanisms.
- 4. Enhance Participation and Consultation:** Engage children with disabilities and their caregivers meaningfully in programme design, monitoring, and review. Collaborate with Organizations of Persons with Disabilities (OPDs) to ensure lived experiences inform solutions.
- 5. Ensure Accessible Communication and Information:** Provide child protection information and services in multiple accessible formats (e.g., Braille, sign language, Easy Read, captioned multimedia), enabling informed access to support.
- 6. Integrate Inclusive Case Management Systems:** Adopt integrated case management systems that accommodate the needs of refugees, displaced children, and children with disabilities without parallel structures.
- 7. Strengthening Community-Based and Family Support Systems:** Support community structures to prevent and respond to violence and harmful practices and reinforce alternative care systems that uphold the rights of children with disabilities.

7. EMPLOYMENT AND FINANCIAL INCLUSION

Persons with disabilities face significantly lower labor market outcomes than persons without disabilities. Unemployment among persons with disabilities is 40%, compared to 27% among those without disabilities, with wider gaps in urban areas. Full-time employment is substantially lower at 4.59% for persons with disabilities versus 12% for persons without disabilities, with rural females with disabilities recording the lowest rate at 1.23%. Persons with disabilities are also underrepresented in service industries (8% compared to 21%). While 85% of employed persons with disabilities remain in jobs for five years or more, they face major barriers in accessing initial employment opportunities.

Structural barriers continue to limit employment for persons with disabilities, particularly women. Lack of reasonable accommodation, inaccessible workplaces, transportation challenges, and discrimination disproportionately affect urban females with disabilities. Transportation gaps are pronounced: rural females without disabilities are four times more likely to use public transportation than rural females with disabilities, and among urban females the difference is 2.4 times. Financial exclusion further compounds disadvantage, as only 41% of persons with disabilities have a bank account compared to 50% of persons without disabilities. Rural females with disabilities face the highest exclusion, with only 27% reporting access to banking services.

Recommendations

- 1. Enforce and incentivize inclusive employment.** To effectively implement workplace inclusion initiatives under Ethiopia's Proclamation No. 568/2008, a dual strategy of enforcement and incentivization must be adopted. The Ministry of Labor and Skills (MoLS) can strengthen enforcement mechanisms by establishing a dedicated Disability Employment Compliance Unit, tasked with conducting annual audits of public and private sector workplaces to monitor adherence to provide the right to employment for persons with disabilities as per the proclamation, and toward introducing and enforcing quotas.
- 2. Expand targeted employment programmes for persons with disabilities.** Prioritize job matching, skills training, and employer incentives to reduce the high unemployment gap, with specific focus on urban areas and women with disabilities. Develop sector specific strategies and employer engagement to increase representation of persons with disabilities in service sectors where they are currently underrepresented
- 3. Mandate reasonable accommodation and workplace accessibility.** Strengthen enforcement of accessibility standards, inclusive recruitment practices, and provision of assistive devices to address structural barriers limiting employment entry.
- 4. Improve accessible and affordable transportation options.** Invest in disability inclusive public transport and last mile connectivity, especially for rural and urban females with disabilities who face severe mobility constraints.
- 5. Expand financial inclusion initiatives.** Introduce tailored banking services, mobile financial access, and awareness campaigns to close the bank account ownership gap, especially for rural females with disabilities who face the highest exclusion.

8. WELL-BEING

Persons with disabilities experience markedly lower individual, social, and family well-being than persons without disabilities. They are three times more likely to never feel safe (15%), comfortable with their appearance (30%), or that life is meaningful (20%), and seven times more likely to never feel capable of caring for their health and hygiene (14%). They are also 2.5 times more likely to always feel sad (26%). Social isolation is pronounced, especially among rural women with disabilities. Within families, adults with disabilities are two to four times more likely to report that their opinions never count, their living conditions are unequal, and positive family interactions are absent.

Well-being disparities vary by gender, location, age, and employment. Urban males with disabilities are more likely to never feel respected by the community (23%) than urban females with disabilities (10%). Women caregivers of children with disabilities show the lowest well-being: rural women are twice as likely to feel sad all the time (43%), while urban women feel least safe (17%) and are far less socially engaged. Employment is associated with higher respect among adults with disabilities in primary and secondary sectors. Regional gaps are widest in South Ethiopia, and older women with disabilities report the poorest outcomes across multiple well-being indicators.

Recommendations

- 1. Integrate mental health and psychosocial support (MHPSS)** into disability, health, and social protection programs, with targeted outreach to women, older adults, and caregivers of children with disabilities.

2. **Strengthen community inclusion and anti-stigma initiatives**, particularly in urban settings and high-risk regions, to improve respect, safety, and social participation for persons with disabilities.
3. **Support caregivers, especially women**, through respite care, peer-support groups, and livelihood assistance to reduce emotional distress and social isolation.
4. **Promote inclusive employment and decent work**, as employment is linked to higher well-being and community respect for persons with disabilities.
5. **Ensure family-centered interventions**, including awareness and counseling, to improve intra-household inclusion, decision-making, and living conditions for persons with disabilities.

9. CONCLUSIONS AND RECOMMENDATIONS

This study aimed to measure the prevalence of disability in Ethiopia and examine the living conditions and wellbeing of persons with disabilities in comparison to persons without disabilities. The findings highlight persistent, interconnected barriers that limit access to education, health services, livelihood opportunities, social participation, and essential services such as banking, transportation, and information. These constraints collectively contribute to poorer living standards and reduced wellbeing among persons with disabilities.

Disability prevalence varies significantly across regions, age groups, residence, and wealth status. At the household level, 20% of households have at least one member with a disability, rising to one in three households in Tigray. Individual-level prevalence stands at 5.8%, slightly higher in rural areas (6.0%) compared to urban areas (5.2%). Prevalence increases sharply with age, from 2.5% among young children, 4.5% among school-aged children, to 7.2% among adults, reaching 52% among those aged 80 and above. Regional differences are substantial: Tigray (9.1%) and Amhara (8.3%) report the highest prevalence, while Sidama (2%) has the lowest. Disability is strongly associated with socioeconomic status; individuals in the lowest wealth quintile report a prevalence of 8.7%, compared to 4.3% in the highest quintile.

Children with disabilities face substantial barriers in accessing quality education. They are 24% less likely to be enrolled in school and have a literacy rate of 50% compared to 79% among peers without disabilities. Girls and rural children with disabilities experience the lowest educational outcomes. Despite these challenges, families spend nearly the same amount on their children's education, with significantly higher costs for rent or hostel accommodation. Yet fewer than 9% of persons with disabilities receive any form of allowance or support, underscoring the need for targeted financial assistance.

Poorer educational outcomes and access may contribute to difficulties in accessing information and banking services. Persons with disabilities are less likely to have a bank account (41% vs. 50% for those without disabilities), with rural females with disabilities facing the highest financial exclusion (26%). Only 6% of persons with disabilities reported accessing the internet compared to 9% among persons without disabilities in Ethiopia.

Health outcomes reveal even deeper disparities. Persons with disabilities are 28 times more likely to describe their health as "very bad" and spend nearly three times more on health services. Although illness and disease are leading causes of disability, nine in ten face barriers when seeking health services. Only 13% use assistive devices, many rely on market purchases or homemade devices, increasing financial strain and risk of poverty.

Livelihood outcomes are equally concerning. Unemployment affects 40% of adults with disabilities compared to 27% of adults without disabilities. Among urban women with disabilities, unemployment reaches 64%. Barriers include lack of workplace accommodations and inaccessible environments. Only one in five persons with disabilities has any form of social security, with half relying solely on community-based health insurance.

Exclusion extends into social, political, and civic life. Persons with disabilities participate far less in community events, cultural activities, and civic engagements. Almost 86% have never engaged with organizations of persons with disabilities, often due to lack of information or availability. These cumulative disadvantages affect overall wellbeing, with persons with disabilities reporting lower feelings of safety, respect, and life satisfaction.

Recommendations

- Strengthen disability inclusion through a **multi-sectoral national approach**, led by an inter-ministerial committee coordinating health, education, social protection, employment, transport, and finance. Institutionalize **disability-responsive budgeting**, requiring ministries and regions to allocate dedicated funds for accessibility, assistive devices, and inclusive service delivery, supported by capacity building for planners and budget officers.
- Expand **disability-targeted social protection**, including pensions, cash transfers, and livelihood linkages, with revised eligibility criteria and disability-indexed benefits. Improve **health screening, diagnosis, and referral systems** by integrating disability services into the Essential Health Services Package and ensuring coverage through CBHI, alongside subsidies for low-income households.
- Enhance **facility accessibility and inclusive care capacity** through universal design standards, infrastructure upgrades, and mandatory disability-sensitive training for health workers. Strengthen access to **assistive devices and rehabilitation**, with standardized benefits, sub-sidized costs, and improved supply chains. Mandate **priority health services** for persons with disabilities through fast-track systems, dedicated appointment slots, and grievance mechanisms.
- Advance **inclusive education** by scaling teacher training, ensuring accessible school environments, providing assistive materials, and integrating disability-disaggregated data into EMIS. Improve **inclusive employment** through strengthened enforcement of Proclamation No. 568/2008, workplace audits, quotas, tax incentives, and tailored vocational training.
- Invest in **accessible infrastructure, rural inclusion programs**, and **conflict-sensitive regional support** for Tigray and Amhara to ensure equitable progress nationwide.
- Future research should deepen understanding of disability through a mix of qualitative and quantitative approaches. Qualitative studies—using interviews, focus groups, and case studies are needed to capture lived experiences, sector-specific barriers, and positive examples across education, health, employment, and social inclusion. Additional surveys focusing on less prevalent disability types will enable more refined disaggregation and targeted policy design. Child-focused surveys in education and health should be prioritized to address the unique challenges faced by children with disabilities.

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