



DISABILITY-INCLUSIVE SOCIAL PROTECTION RESEARCH IN NEPAL

A national overview with a case study from Tanahun district



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Abbreviations

ADB	Asian Development Bank
aOR	Adjusted odds ratio
CBR	Community Based Rehabilitation
CDO	Chief District Officer
CI	Confidence Interval
DDC	District Development Committee
DHO	District Health Office
DPOs	Disabled People's Organizations
DPWA	Disabled Protection and Welfare Act
ICED	International Centre for Evidence in Disability
ILO	International Labor Organization
INGO	International Non-Governmental Organization
LMIC	Low- and middle-income countries
MoE	Ministry of Education
MoFALD	Ministry of Federal Affairs and Local Development
MoWCSW	Ministry of Women, Children and Social Welfare
NFDN	National Federation of the Disabled-Nepal
NGO	Non-governmental Organization
NR	Nepalese Rupees
OR	Odds ratio
SDG	Sustainable Development Goals
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disability
UNICEF	United Nations Children Fund
VDC	Village Development Committee
WCDO	Women and Children District Office
WHO	World Health Organization

1 Background

Social protection is increasingly used by governments in low- and middle-income countries (LMICs), as a tool for alleviating poverty, enhancing living conditions and reducing inequalities. While a “social protection floor” of basic guarantees for all has been championed as key to meet the Sustainable Development Goals (SDGs), it is also recognised that additional interventions or targeted outreach may be needed for certain individuals or groups who face higher risks of poverty and other forms of marginalisation [1, 2].

Box 1: Disability and poverty

Poverty and disability can be considered to operate in a cycle, with the one re-enforcing the other. In LMICs in particular, conditions associated with poverty such as lack of access to healthcare, inadequate water and sanitation, malnutrition and poor or unsafe living conditions, increase the risk of being born with or acquiring a disability [3, 4]. In turn, disability can lead to exclusion from work, education and healthcare, as well as high healthcare and other expenses, which can further exacerbate both economic and more multidimensional forms of poverty [5-7].

In a systematic review of 150 studies on disability and economic poverty in low and middle income countries, over 80% found that disability increased the risk of poverty and vice versa [8]. This relationship was consistent across regions/countries and impairment types, and was evident in both adults and children. Many studies also found links between disability and multidimensional forms of poverty – such as poorer access to education, healthcare and employment.

People with disabilities are defined in the United Nations Convention of the Rights of Persons with Disabilities (UNCRPD) as including those who have “long-term physical, mental and intellectual or sensory impairments which in interaction with various contextual factors may hinder their full and effective participation in society on an equal basis with others” [9]. As the estimated 1 billion people living with disabilities globally are significantly more likely to be living in poverty (see Box 1) and face a wide range of social, economic and cultural forms of exclusion, they are more likely to need and potentially benefit from social protection [7]. In addition to a needs-based argument, the right to inclusion in all aspects of society – including in social protection – on an equal basis with others is well-established in international treaties such as the Universal Declaration of Human Rights (Article 25) and the UNCRPD (Article 28) [9].

Inclusion of people with disabilities in social protection may be through mainstream schemes (where they are not explicitly specified as intended beneficiaries but may be implicitly targeted due to higher levels poverty and other types of marginalisation) or through disability-specific programmes (i.e. where disability is an explicit condition of eligibility). Across all types of schemes, however, evidence is lacking on whether people

with disabilities are accessing available programmes and whether participation in social protection leads to the intended outcomes of alleviating poverty, supporting resilience and promoting greater social participation.

From the limited evidence available, there is concern that both mainstream and disability-specific programmes are not reaching and meeting their intended outcomes for people with disabilities [10]. Specific barriers to participation across programmes may include: inaccessibility of administration and service procedures and centres, discriminatory attitudes among administrations, certain conditions attached to receipt of benefits (e.g. school attendance), eligibility thresholds that do not consider extra disability-related costs and limited awareness of the availability of and eligibility for programmes [11]. Additionally, disability assessments to determine eligibility for targeted schemes often use medical model criteria, which may be biased against certain impairments, do not adequately capture the impact of social and environmental factors on functioning and are reliant on specialised resources which may be limited in many LMIC settings [10, 11]. Furthermore, benefits tend to focus more on providing a basic level of subsistence, rather than targeting sources of exclusion and disability-related extra costs; consequently, some evidence suggests that social protection does little to promote more far-reaching participation and equal opportunities for people with disabilities, thereby contributing to exclusion and marginalisation from society [10].

To explore in more depth the degree to which social protection systems are meeting their intended goals of poverty alleviation, development of stronger livelihoods and the reduction of inequalities for people with disabilities, we have conducted research in Nepal, which is part of a two-country study on disability-inclusive social protection systems (see “Disability-Inclusive Social Protection Research: Evidence from Vietnam”, for Vietnam findings). Nepal was selected as a study site for this research as it was identified as having a strong social protection system that has made concerted efforts to address the needs of people with disabilities. Nepal has numerous programmes targeted to people with disabilities that seek to target a diverse range of drivers of poverty and marginalization, such as the Disability Allowance (an unconditional cash transfer programme), scholarships for education and discounts for transportation and healthcare. This research explores the degree to which people with disabilities are accessing and benefiting from these and other programmes.

2 Study Aims

The overall aims of this study are (1) to assess the extent to which social protection systems in Nepal address the needs of people with disabilities; and (2) to identify and document elements of good practice, as well as challenges, in the design and delivery of social protection for people with disabilities. As most social protection programmes in Nepal are targeted to various groups considered to be a high risk of poverty or marginalisation (e.g. orphans, widows), the research mainly focuses on disability-specific schemes, as they are relevant to a higher proportion of people with disabilities.

Specific objectives of the research include:

- (1) To describe the overall social protection landscape in Nepal, with an emphasis on the Disability Allowance and other disability-targeted schemes.
- (2) To explore the need for social protection among people with disabilities in Nepal.
- (3) To measure access of people with disabilities in Nepal to the Disability Allowance and other social protection schemes.
- (4) To explore the experience of recipients in applying for and using the Disability Allowance.

3 Methods

3.1 Study components and their objectives

This research was comprised of three components:

- **National policy analysis:** to describe the current social protection system in Nepal, namely the Disability Allowance and other disability-targeted programmes, and assess the degree to which it is responsive to the needs of people with disabilities.
- **Quantitative research:** to measure the need for and access to social protection among people with disabilities, and explore the experiences of Disability Allowance recipients in applying for and using the grant.
- **Qualitative research:** to explore people with disabilities' knowledge of the Disability Allowance and their experience of accessing and benefiting from the scheme.

3.2 Study setting

While the policy analysis presents a broad overview of disability and social protection across Nepal, the qualitative and quantitative components provide a more in-depth exploration of the functioning of the system in practice by focusing on one district.

The district of Tanahun, part of Province No. 4 in the Hills region of Nepal, was selected as the setting for this research. Since one of the purposes of this study is to identify elements of good practice in disability-inclusive social protection, Tanahun was selected after consultation with stakeholders as it has a strong network of Disabled People's Organisations (DPOs) and disability-support services as well as a relatively well-functioning social protection administration. Tanahun is a predominantly rural district with a population of 323,288, according to the 2011 census [12]. It also has one of the highest proportions of external migration [13].

As Tanahun was identified by stakeholders as having a relatively well-functioning social protection system, lower levels of poverty and adequate availability of disability-related services, the results from this study may not reflect the situation across all of Nepal. However, this study setting was selected to allow the best opportunity to identify good practices in disability-inclusive social protection. As such, it should be viewed as a case study of the strengths and challenges in the Nepali system when it is working relatively well, rather than reflective of the situation across the entire country.

3.3 Study component methodologies

A mixed-methods approach, combining quantitative and qualitative data collection in Tanahun with a policy analysis at the national level, was used to meet the study objectives. The use of mixed-methods combines the strengths of each methodology, while offsetting some of the limitations inherent in each.

3.3.1 Component 1: National Policy Analysis

A national policy analysis was conducted, in order to describe the overall social protection landscape in Nepal and highlight the strengths and weakness of the system in addressing the needs of people with disabilities. Given that there were few broader mainstream schemes, the focus was predominantly on disability-targeted schemes.

To achieve these objectives, the following methods were undertaken:

- **Literature review** to identify the relevant legal frameworks, policies and programmes in Nepal as well as existing research on this issue. This included relevant publications on social protection, national and international legislation, policy instruments, national laws and rules, monitoring and evaluation documents, and academic and grey literature in both English and Nepali. Literature was identified through key informant provided documents and online searching.
- **Consultative workshop** of stakeholders working in disability and social protection in Nepal. The workshop was held in August 2016 in Kathmandu and brought together more than 50 key stakeholders from government agencies, non-governmental organizations (NGOs), international NGOs (INGOs), and DPOs.
- **In-depth interviews** with fifteen key stakeholders at national level within responsible Ministries, United Nations agencies, NGOs, and DPOs to explore perceptions of the impact of major policies and programmes related to social protection for people with disabilities as well as the challenges they face.

3.3.2 Component 2: Quantitative Research

The quantitative part of this study consisted of three components:

- Population-based survey of disability across Tanahun district;
- Case-control study of people with disabilities identified during the population survey and age-sex-cluster matched controls without disabilities; and
- Survey of recipients of the Disability Allowance, identified both from the survey and from official registers.

3.3.2.1 Population-based household survey

A population-based survey was conducted to estimate the prevalence of disability in the general population, identify participants for the nested case control and compare household-level indicators between households with and without members with disabilities.

Sampling frame: Data from the 2011 National Census were used as the sampling frame. A two-stage sampling strategy was employed based on methodology used in other surveys [14]. In the first stage, probability-proportionate-to-size sampling was used to select clusters in Tanahun. Clusters were wards of “Village Development Committees” (VDC) (average size:

750 people), the smallest administrative unit in Nepal. In total, 30 wards were randomly selected. In the second stage, modified compact segment sampling was used to select households within clusters to be visited. With this method, maps of each selected cluster were obtained and divided into equal segments of approximately 50 households (200 people) with the assistance of community stakeholders or staff at the VDC offices. One segment was then randomly selected, and households were visited systematically beginning from a random start point, until the sum of members aged 5+ across households reached 200 people. This method has been used widely for rapid population based surveys [14-16].

Selection criteria: All households in the sampled areas were invited to participate. Household membership was defined based on the following question, from the most recent Census: “How many people, including yourself, normally live (at least 3 months of year) in this household and share a kitchen?” All members of selected households aged five years and older were screened for disability using the Washington Group Extended Set Questionnaire^a (see Box 2) [17]. These tools were translated into Nepali using recommended protocol [18].

Box 2: Disability identification: Washington Group Extended Set Questionnaire

Disability was identified using an accepted modification of the Washington Group Extended Set of Questions on Disability, an internationally recognised, validated instrument that provides robust and internationally comparable estimates of disability [19]. The Washington Group Questions focus on an individual’s ability to function within their everyday environment, rather than focusing on the presence of medical diseases or disorders. This approach is more in line with conceptualisations of disability espoused by the World Health Organization (WHO)’s International Classification of Functioning, Disability and Health (ICF) and the UNCRPD [19]. In the extended set version of the Washington Group questions, there are two modules, one for children (5-17) and one for adults (18+) [17, 20].

Both modules focus on difficulties with activities (e.g. seeing, hearing, walking or climbing stairs, remembering or concentrating, self-care and communicating). For most questions, the responder can choose one of four options: no difficulty, some difficulty, a lot of difficulty or cannot do at all. For the purpose of this study, people who answered “cannot do at all” or “a lot of difficulty” for at least one question were considered to have a disability. The types of activities covered in the child and adult modules are broadly similar, although there are some age-specific domains. For example, depression and anxiety questions were only asked to adults, with each measured through two questions on frequency and intensity of symptoms, with a disability cut-off set as experiencing strong symptoms daily.

To determine eligibility for Nepal’s disability-targeted social protection programmes, assessments focus predominately on the degree of support needed in everyday life. Consequently, the study definition cut-offs (e.g. “a lot of difficulty” in one or more activity) is broadly in-line with social protection eligibility criteria.

^a In contrast to research in Vietnam, which used the Washington Group Short Set Questionnaire.

Procedures: Questionnaires were administered in Nepali by trained data collectors using computer tablets. Data were collected on the household's composition, the disability status of each member, socioeconomic indicators and the participation of members in a range of social protection programmes. Each household member answered the disability screening questions themselves, if they were available at the time of the visit. If they were unavailable, the household head answered on their behalf as a proxy. The remainder of the questions were asked to the head of household or another adult member who had detailed knowledge about the household.

3.3.2.2 Case-control study: Exclusion and needs for social protection

A nested case-control study was conducted to compare the living situation between people with and without disabilities.

Selection criteria: Cases were any male or female, aged 5 years and above, who had been identified as having a disability based on the Washington Group questions during Phase 1. For each case identified, one *control* without disabilities was selected as a comparison. Controls were also drawn from the population-based survey and were the same sex, similar age (± 5 years) and living in the same cluster as the case. Controls could not be from a household that included a member with a disability.

Variables studied: The case-control questionnaire included sections on: education, employment, health and knowledge of and participation in a range of social protection schemes.

Box 3. Indicators of living circumstances

As a key goal of social protection is to reduce poverty and improve living circumstances, a variety of indicators were used to measure individual and household living conditions across questionnaires. These indicators were derived from data collected in both the household and case control surveys. Most are measures of *relative* well-being compared to others in the study sample.

At the household-level, we used the following measures of economic well-being:

- *Household income per capita:* total income from all sources.
- *Self-rated wealth:* subjective ranking of the household's wealth relative to neighbours.
- *Socioeconomic status:* derived from principal component analysis of ownership of durable assets and livestock, divided into quartiles. Assets were selected based on the 2011 Demographic Health Survey in Nepal and feedback from local partners.
- *Living below the international poverty line:* whether the household lives below \$1.90 per person per day, purchasing power parity (i.e. using an exchange rate that accounts for the cost of living in Nepal, rather than the market exchange rate)
- *Food insecurity:* defined using the Demographic Health Survey's tool.

All household level analyses were adjusted by the household's size, location (rural/urban) and dependency proportion (proportion of the household comprised of children, adults 65+). This adjustment helps control for the effect of area of residence, large households

and ones with few economically active members, which may all independently impact living circumstances.

At the individual level, we used a variety of measures of well-being, including:

- *Access to education*: school enrolment, attainment.
- *Health*: any serious health event in the last 12 months, healthcare spending.
- *Livelihoods*: employment status, wages.

All individual-level analyses were adjusted for age, sex and area of residence.

Procedures: The case-control questionnaire was administered in Nepali by a trained data collector. For children below 16 years (age of consent) and people with impairments that severely limited their ability to understand/communicate, a carer answered on their behalf as a proxy. In these instances, input from the child/person with a disability was still sought whenever possible.

3.3.2.3 Disability Allowance questionnaire: Experiences of recipients

Study design: A survey was given to recipients of the Disability Allowance to learn about their experience in applying for and receiving the grant and the perceived impact of participation.

Selection criteria: All people with disabilities who had reported during the case control or household survey that they were currently receiving the Disability Allowance received this questionnaire. An additional 91 people living in the selected cluster but not the sampled segment were selected from the registers of Disability Allowance.

Variables studied: The Disability Allowance questionnaire included sections on the application process, benefits received and self-reported impact of participation.

Procedures: The Disability Allowance questionnaire was administered by trained data collectors. For children below 16 years (age of consent) and people with impairments that severely limited their ability to understand/communicate, a carer answered on their behalf as a proxy. In these instances, input from the child/person with a disability was still sought whenever possible.

3.3.2.4 Data analysis

All quantitative data were collected on computer tablets, using questionnaires created with Open Data Kit (ODK). These mobile data entry forms were pre-coded and had built-in consistency checks to reduce recording errors. Forms were uploaded through a secure server at regular intervals throughout data collection. Data was checked for errors both manually and using STATA 14. Data were analysed using STATA 14.

Household survey: We calculated the prevalence of disability, both overall and by type of functional limitation. A socioeconomic status index was created through principal component analysis of household ownership of assets. Multivariate regression (logistic or

linear) was used to compare socioeconomic indicators between (1) households with and without members with disabilities and (2) households with members with disabilities who were and were not receiving the Disability Allowance. Analyses were adjusted for household size and dependency proportion. Additionally, extra costs were calculated according to the Standard of Living approach described by Zaidi et al [21]. With this methodology, standard of living is measured through asset ownership and is assumed to be positively correlated with log of income; extra costs of disability are then calculated as the additional income needed to support the same standard of living as a similar household without disabilities, controlling for other factors which may introduce variation [22]. This approach has been used in a range of contexts, including in LMIC settings, to estimate extra costs of disability [22].

Box 4. A Note on Statistical Tests

Odds ratio (OR): an odds ratio measures how strongly the presence of one characteristic (e.g. disability) is associated with another variable (e.g. poverty). It is calculated by measuring the likelihood of an outcome occurring in a group that has the characteristic of interest compared to its likelihood in a group that does not have the characteristic. Odds ratios can be adjusted for other characteristics, such as sex and age, which may also be associated with the outcome of interest. Adjusting by these other characteristics gives us a better estimate of the true relationship between the characteristic and outcome of interest. For example, if we give an odds ratio of 4.3 when comparing poverty between people with and without disabilities, this means that people with disabilities are 4.3 times as likely as people without disabilities to be living in poverty. After adjusting for age and sex, the odds ratio reduces to 3.8: this is a more accurate estimate of the influence of disability on poverty than $OR=4.3$, since it is controlling for these other factors (older age, being female) that are also associated with poverty.

Confidence intervals (CI): a confidence interval is used to indicate the precision of a study measurement (e.g. mean, OR). For a given level of certainty (normally set to 95%), confidence intervals provide a range of values around the sample's estimate that are likely to contain the "true" value of that measure across the entire population. For example, if the prevalence of disability in our sample size is 2.5% (95% CI: 2.1-2.9%), that means we are 95% confident that the "true" prevalence in the entire population is between 2.1-2.9%.

p-value: p-values are used as an indicator of statistical significance. Typically, values of $p \leq 0.05$ indicate statistical significance: this means that there is a less than 5% chance the observed estimate occurred by chance. The smaller the p-value, the greater the confidence that the observed effect is genuine.

Case control: To explore differences between people with and without disabilities in areas such as health, employment and education, conditional logistic regression was used. If conditional regression was not possible due to incomplete matching between cases and controls, multivariate regression was undertaken, controlling for the matching variables of

age and sex. For comparisons between people with disabilities who are and are not receiving the Disability Allowance, multivariate logistic or linear regression was also used.

Disability Allowance questionnaire: responses about application experience, use of the Allowance and self-reported impact were tabulated by frequency.

3.3.3 Component 3: Qualitative Research

Qualitative interviews were carried out with people with disabilities who were and were not recipients of the Disability Allowance, to understand their knowledge of the programme and their experience of accessing and benefiting from the scheme. District- and community-level stakeholders, including disability service providers, representatives of DPOs and decision makers/administrators responsible for social protection and related services, were also interviewed to understand the ways in which the planning and implementation of social protection programmes includes or excludes people with disabilities.

Research tools: Six sets of in-depth interview guidelines were used to collect information from different categories of study participants: (1) VDC/Ward and District Level Officials, (2) adults with disabilities receiving the Disability Allowance, (3) adults with disabilities not receiving the Disability Allowance, (4) caregivers of children with disabilities receiving the Disability Allowance, (5) caregivers of children with disabilities not receiving the Disability Allowance, and (6) DPOs and NGOs at the district level. The tools were developed and tested at the field site one week before the main data collection period began. The issues covered included:

- The process of disability certification
- The process for accessing and receiving the Disability Allowance
- The benefits received from these and any other social protection programmes
- Experiences of participation in DPOs or other organisations
- Experiences in terms of work, education and vocational training
- Experience in terms of health services and rehabilitation

Data collection: Data were collected by a team of three social researchers while the quantitative survey was being carried out. A purposive sample of 35 persons with disabilities were identified from amongst respondents identified as having a disability in the population-based survey. They were chosen so as to reflect variation in terms of sex, age (children, adult, old age), geography (rural/urban), type of impairment and possession of disability card. Among the 35 people with disabilities, 28 were disability cardholders and the rest did not hold a disability card. A total of 13 district- and community-level stakeholders were also interviewed.

Data analysis: After the completion of the interviews, the supervisors transcribed them during the fieldwork. A thematic approach was used to analyse findings.

3.4 Consideration of intersectionality

This research focused predominantly on the influence of disability in understanding need for, access to and use of social protection entitlements among people with disabilities. Still, efforts were made to explore the intersection between disability and other sources of

marginalisation. For example, all analyses were disaggregated by sex and age group where adequate numbers or sufficient variation in responses allowed for statistical testing. Differences in experiences among particular groups of respondents – for example, people living in poverty or in rural areas – were explored as they emerged organically from the research.

However, it is acknowledged that further research is needed to probe more in-depth into how disability overlaps with other types of marginalisation and its impact on both participation and inclusion in social protection.

3.5 Ethics

This study was approved by the Ethics Committee at the London School of Hygiene & Tropical Medicine in London, UK and the Nepal Health Research Council. Informed written consent was obtained from all study participants before beginning any interviews. For children below 16 (age of consent) and people with impairments that severely limited their ability to understand/communicate, a carer answered on their behalf as a proxy. In these instances, input from the child/person with a disability was still sought whenever possible and appropriate. Individuals who reported unmet health needs were referred to available local services.

PART A:

*National Overview of Disability
& Social Protection Provisions*



Overview

Part A describes the national policy framework for social protection and disability in Nepal. It analyses key policies and programs related to social protection for people with disabilities in terms of implementation progress, achievements and challenges so as to highlight the strengths and weakness of the system in addressing the needs of people with disabilities.

4 Disability Policy in Nepal

4.1.1 Data on disability

It is widely acknowledged that there is a lack of good quality data on disability in Nepal, which constrains policy formulation and programme planning on disability. A prevalence of disability of 31.9% was reported in the World Health Survey using the same data and methodology that produced the global average figure of 15% worldwide in the World Report on Disability (2011). In comparison, the 2001 national census reported an extremely low prevalence of disability of 0.45%. In the Population Census of 2011, which relied upon self-reporting of disability through a list of eight types of impairments, this rose to nearly two percent (1.94%) of the total population of Nepal. As these figures indicate, the estimates reported by different studies vary widely and there is no consensus on the prevalence of disability. In 2012, the Nepalese Supreme Court issued a directive ordering the government to conduct a national survey of disability to collect better quality data, but to date no action has been taken on this issue.

4.1.2 Policies and legislation on disability

To guide implementation of these constitutional rights, several acts, policies and directives have been enacted. Most notably, the Disabled Protection and Welfare Act 1982 (DPWA) - the first overarching legislation related specifically to people with disabilities in Nepal – remains the key legal framework governing the provision of services to people with disabilities at the village, district and national level. Many of the current disability-targeted social protection entitlements (see section 5) are outlined in the DPWA.

In addition, the Government of Nepal has prepared several short- and long-term policies and plans focused on improving the quality of life of people with disabilities. The most important of these was the first National Policy and Plan of Action on Disability 2063 (2006). The purpose of the Plan was to protect the rights and to promote the empowerment of people with disabilities [23]. To meet these objectives, seventeen priority sectors were identified including national coordination, information and research, public awareness and advocacy, training and employment, transport, education, and health, rehabilitation, poverty alleviation, assistive devices and support services [23].

Finally, in addition to national legislation, Nepal has ratified a variety of international conventions, charters, and declarations related to disability. Nepal was party to the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1992) and, most significantly, in 2010 it ratified the United Nations Conventions on the Rights of Person with Disabilities.

4.1.3 Key implementing bodies

At the national level, the Ministry of Women, Children and Social Welfare (MoWCSC) assumes overall responsibility for all policies and programmes related to persons with disabilities. Key tasks of MoWCSC include gathering national statistics on disability as well as managing programmes on disability prevention and inclusive access to education and healthcare. MoWCSC also coordinates the delivery of rehabilitation services in partnership with NGOs. In addition to MoWCSC, other ministries manage activities specific to their expertise. For example, the Ministry of Education (MoE) is responsible for the design and

delivery of education for children with disabilities, including the scholarship scheme, a key disability-targeted social protection entitlement (section 5.3.1). Similarly, the Ministry of Federal Affairs and Local Development (MoFALD) manages the majority of social assistance schemes (including the Disability Allowance) in conjunction with MoWCSC.

At the local level, each district has a Chief District Officer (CDO) who is the focal person for ensuring the rights of people with disabilities are protected in their catchment area. Key local implementing bodies for social protection include the Women and Children's District Office (WCDO), which oversees applications for disability-targeted social protection schemes. Similarly, the District Education Office manages all applications and decisions on the disability educational scholarships.

In addition to government bodies, NGOs and DPOs are active in the delivery of services and implementation of disability policies. For example, delivery of community-based rehabilitation (CBR) at local level is primarily undertaken by NGOs with government funding at the district level. A 2012 mapping found more than 50 NGOs and INGOs and 297 DPOs are working with or for people with disabilities across the country [24, 25]. Notably, the National Federation for the Disabled, Nepal (NFDN), is an umbrella group that works with MoWCSC to provide assistive devices, livelihood training and awareness-raising about how to access key services, including social protection entitlements. The NFDN and other DPOs are regularly consulted by the government regarding disability-related policies and programmes indicating their good representation in decision-making at various levels. Still, many DPOs lack human resources capacity to provide appropriate consultations. Therefore, there is a need for building consultation and advocacy capacity.

5 Disability-Targeted Social Protection

There has been a gradual expansion of social protection measures for various sections of the population in Nepal, particularly in terms of social assistance. Almost all social protection entitlements in Nepal are targeted to specific groups, including people with disabilities, older adults, widows and members of ethnic minorities or Dalits (lowest caste in Nepal).

Regarding disability-targeted schemes, the Government of Nepal has specified several social protection provisions for people with disabilities. These include entitlements for: 1) social assistance, 2) education, 3) healthcare, 4) transportation, and 5) vocational training and employment. The benefit packages people with disabilities are eligible to receive is dependent on the outcome of a disability assessment.

5.1 Determining eligibility for disability-targeted social protection

5.1.1 Disability assessment criteria

In order to receive social protection benefits, an individual must first undergo an assessment of disability and receive a disability card. In Nepal, people with disabilities are classified into four categories of severity, based on the following criteria:

- Red – “complete disability” – difficulty in performing daily activities, even with the help of others.
- Blue – “severe disability” – difficulty to perform daily activities without the help of others.

- Yellow – “moderate disability” – ability to perform daily activities and participate in social life if environment is barrier-free, and appropriate training and education are provided.
- White – “mild disability” – ability to perform daily activities and participate in social life if environment is barrier-free.

Overall, the language used in defining and categorising disability is in line with the UNCRPD and ICF, in that it focuses on activity limitations and participation restrictions and considers the impact of individual characteristics (e.g. education, availability of support) as well as environmental factors in increasing or decreasing the impact of impairment. However, guidance documents on how to categorize individuals into the four categories– namely the Disability Identification Card Distribution Guideline 2008 – are vague. Consequently, in practice there is a large degree of subjectivity to the assessment. The lack of clarity may lead to an overreliance on medical assessments, as when the Committee cannot decide on a classification, they will request that the applicant go before a clinician for an additional evaluation.

5.1.2 Application process

The Women and Children District Office (WCDO) is the focal point in the provision of disability identification cards. Typically, in each district there is one representative at the WCDO – the District Social Welfare Officer – who manages this process.

To apply for a disability card at the WCDO, an individual or his/her caregiver must first receive a recommendation letter from their respective VDC^b to confirm the applicant’s identity and place of residence. In addition to this letter, applicants also need to provide the following documentation to the WCDO: birth certificate, citizenship certificate, photograph, land ownership certificate or school certificate. Some of these documents may be difficult for applicants to produce. For example, while Nepal has made birth registration a priority in recent years, older adults or people living far from administrative centres may not have ready access to these documents. In addition to these documents establishing identity, applicants should also provide a recommendation from a registered disability-related organization, when available, and a certified copy of any medical documentation related to their disability.

Once an application has been reviewed by the WCDO, an individual is supposed to appear before the Disability Identification Committee for an assessment. This Committee operates under the CDO and involves members such as the planning officer of District Development Committee (DDC), District Health Office, WCDO and one representative from NFDN or a registered DPO.

Applying for a disability identification card is not typically a straightforward process. In most cases, people will have to travel to the district capital to submit their application and may have to make additional visits to appear before the Disability Identification Committee or for a medical evaluation if necessary. This stands in contrast to other social assistance

^b Village Development Committees (VDCs) are one of the smallest administrative area in Nepal. Several VDCs fall under a District Development Committee (DDC).

schemes in Nepal where the whole application process is managed at the level of the VDC. This discrepancy is particularly problematic given that many people with disabilities may have limited mobility and live in remote areas without transportation links. Further, the need to approach unknown officials at the district-level presents challenges for many people with communication or intellectual impairments, or may discourages people who fear that they may be treated poorly because of stigma related to their disability.

To improve the accessibility of the application process, several adaptations have been made. First, if an applicant has a very severe disability and is unable to apply for the card in person, they can seek a recommendation from a DPO based in their district to override the need for an in-person assessment. Second, in several districts, the majority of assessments are being completed by the WCDO at the time the application is submitted, limiting the involvement of the Disability Identification Committee to complex cases. Bypassing an assessment from Disability Identification Committee streamlines the process, reducing the need for an additional visit and, since the Committee meets infrequently, speeding up the process. Finally, mobile camps are increasingly being organised where application, assessment and registration can occur simultaneously. These camps are particularly useful for reaching people living in areas far from WCDO offices.

Based on the registration information maintained by districts, there were 198,788 cardholders registered nationally for fiscal year 2014/15; the breakdown by card type can be found in Table 1 [26]. Given the limitations of the national data on disability, it is not possible to determine programme coverage. However, as Nepal’s population is almost 29 million, even using the 2011 Census prevalence of 1.9% - which has been widely acknowledged as a severe underestimate – coverage would be 37%, so it is certain that many people with disabilities did not receive a disability identification card.

Type of identity card	Disability cardholders for fiscal year 2014/15		
	Male	Female	Total
Red (complete disability)	20,678	15,922	36,600
Blue (severe disability)	22,458	31,772	54,220
Yellow (moderate disability)	22,650	32,736	55,386
White (mild disability)	15,880	22,592	38,472
Unspecified type			14,110
Total			198,788

Table 1. National provision of disability identification cards for 2014/15

5.2 Social assistance: the Disability Allowance

The Disability Allowance has been in place since 1996. Only individuals who hold red (‘completely disabled’) or blue (‘severely disabled’) disability identification cards are eligible for the Disability Allowance. From fiscal year 2016/17, red cardholders received a cash benefit of NR 1000 (US\$19) per month, while blue cardholders received NR 600 (US\$6) per month. White and yellow cardholders are not eligible for the Allowance and are only entitled to benefits such as discounted transportation, tax exemptions, employment quotas and – importantly in the case of children – education scholarships.

Several changes have been made to Disability Allowance policies in recent years. First, following a 2012 Supreme Court decision, the Allowance amount provided to red cardholders doubled from NR 1000 to NR 2000 beginning in the 2016/17 fiscal year. Still, the

amount is less than half of the rate of NR 5,000 [US\$48] recommended by the Supreme Court. Additionally, there was formerly a quota for the number of blue cardholders who could receive social assistance, but following a decision of the Ministry of Finance, which was applied for the 2015/16 fiscal year, this limitation was removed. As a consequence, the number of Disability Allowance recipients nearly doubled for 2015/16 (Table 2). Again using the very conservative 2011 Census prevalence, coverage of the Disability Allowance would be 12% of all people with disabilities.

	Fiscal Year			
	2012/13	2013/14	2014/15	2015/16
<i>Fully Disabled Persons (red card)</i>	22,138	25,492	27,203	30,912
<i>Partially Disabled Persons (blue card)</i>	6,774	6,863	6,375	31,408
Grand Total	28,912	32,355	33,578	62,320

Table 2. Number of Disability Allowance recipients per fiscal year

To register for the Disability Allowance, red and blue disability cardholders must file a separate application to their VDC, along with the following documents: two copies of passport size photo, a certified copy of Nepali citizenship and a copy of the disability card provided by the WCDO. If the application is approved, the VDC will issue a social security allowance card (logbook). To receive the allowance itself, the recipient must present the disability card along with the log book at their VDC at the time of collection. An individual is supposed to re-register for the Allowance each year.

Allowance allotments are paid on a quarterly basis. In most cases, beneficiaries collect their allotments in person at the VDC; however, for people with very severe disabilities, the allotments may be collected by a proxy or through home visits by VDC staff. Recently, the government has piloted a system of depositing the allowance directly into the bank accounts of beneficiaries. While this system enables more efficient distribution for some beneficiaries, its potential for scale-up may be limited as beneficiaries must have an account with an authorised bank (Nepal Rastra Bank).

As for all social assistance schemes in Nepal, annual national budgetary allocations for the Disability Allowances are determined using a bottom-up approach. First, the VDCs prepare a budget based on the number of Disability Allowance beneficiaries of each card level in its catchment area. Next, all VDC budgets are compiled at the DDC and then the aggregate budgets across DDCs determines the national budget provided by the Ministry of Finance for a given fiscal year. Disbursement of funds follows the reverse order.

As national budgets are created and disbursed annually, potential and current beneficiaries must apply or reapply by December to receive the Disability Allowance in the next fiscal year. Consequently, it is common for there to be a delay in up to a year between registration for the Allowance and receipt of the first instalment. Beginning in the 2016/17 fiscal year, additional deadlines have been added, to shorten the time from registration to Allowance receipt. However, this adjustment is very recent, so little is known on how widely it is followed and whether it adequately reduces lag times.

A further challenge regarding implementation is the lack of human and capital resources at the VDC for managing the Disability Allowance. In many hill and mountain areas, these challenges are exacerbated by transportation difficulties that may see the Allowance being distributed only once or twice a year. Further, as well as enrolling people, VDC staff are also

supposed to curate the beneficiary list by renewing everyone on the list annually to ensure that they are still eligible or have not died. However, given the significant workload involved, the renewal policy guidelines are not always applied so ineligible or deceased people may remain on the list.

A final but important concern with the Disability Allowance is that it is widely acknowledged that it is insufficient to cover the basic living costs of people with severe disabilities who require continuous or significant support, although the amount for the allowance has been increasing over time.

5.2.1 Other disability-targeted forms of social assistance

People who participate in contributory social insurance can receive compensation and/or a regular allowance if they acquire a disability due to work-related accidents [27]. As participation in social insurance is restricted to civil servants, military personnel and some formal sector employees, coverage under this programme is relative limited.

5.3 Entitlements for education, transportation, health and work

Once an individual receives a disability identification card, they are entitled to a variety of additional benefits. In contrast to the Disability Allowance, which is only available to red and blue cardholders, these other benefits are available to all disability cardholders.

5.3.1 Educational supports

Education for all children in Nepal is free until Grade 8, but there are still indirect costs (e.g. fees for school supplies, uniforms, to register for exams) that may be prohibitive for families living in poverty. Furthermore, children with disabilities attending school may face additional costs, such as for transportation, assistive devices or boarding. To offset some of these costs and increase the enrolment of children with disabilities, the Government provides scholarships for students with disabilities (who have a disability card) between Grades 1 to 8 [27]. The scholarship system was set up in 2004 and has expanded significantly in the interim, in terms of both coverage and benefits. Applications and decisions for the educational scholarships are managed by the District Education Office.

Educational scholarships are provided according to the severity of the disability and the difficulties the student faces in accessing school (see Table 3). There are four categories (A, B, C, and D), receiving 30,000/25,000, 5,000, 3,000, and 1,000 rupees per year respectively based on 10 months of schooling [28]. Although a disability card is a precondition for receiving a scholarship, the four levels do not correspond to the four colours of cards because factors like distance from the home to school are considered.

Originally, only children attending one of the 360 “resource schools”^c nationally were eligible for the scholarship. Now, any child with disabilities is provided with the payment, regardless of where they receive their education. While in most cases the family is supposed to receive the scholarships funds directly, if a child boards at school (category A), the school receives the scholarship instead. However, for all scholarship categories, funds are channelled through

^c A class in a school where students with disabilities are given direct and specialized instruction.

schools; consequently, in practice the funding may not necessarily reach families, as it is widely acknowledged that the process is not well understood so schools may attempt to retain the money.

Category	Eligibility	Amount (per month, for 10 months of year)
A	Students with disabilities who board at the school, residential provision	NR 3000 [US\$29] (mountain districts) NR 2500 [US\$24] (hill, Terai districts)
B	Students with disabilities who require assistive devices and personal assistance while in school, non-boarding	NR 500 [US\$5]
C	Students with disabilities who use assistive devices or transportation to commute between home and school	NR 300 [US\$3]
D	For all other school-going children with disabilities, non-boarding	NR 100 [US\$1]

Table 3. Categories of disability for education scholarships

In addition to provisions for basic education, people with disabilities can receive supports for continuing education. Benefits include free tuition at Tribhuvan University, scholarships for technical education and vocational training and provisions such as extended time on exams and classroom assistants. However, at present, very few students with disabilities are likely to benefit from these provisions, as drop-out rates post primary are high: in 2013 there were 107,612 children with disabilities enrolled in Grades 1-8, but only 5,129 in Grades 9-10. This trend is partially reflective of trends across the country, as after Grade 8, tuition at public schools is no longer provided by the Government.

5.3.2 Transportation

In order to improve the independence of people with disabilities, the Government has mandated transportation providers to offer discounts. The most important of these are:

- 50% reduction in land transport fare
- Reservation of seats in public transportation
- 50% reduction in internal flight air ticket fare
- Exemption of tax to import special four-wheeler scooter made for people with disabilities

5.3.3 Health, rehabilitation and assistive devices

Basic health services at health posts are free of charge for all Nepali citizens, although there are charges for medicines and services at tertiary facilities. The Government recently issued an expanded list of 70 drugs that all disability cardholders can receive free of charge, but these are primarily general medicines (e.g. does not cover drugs for psychosocial impairments, specific conditions such as epilepsy). Furthermore, even with discounted costs, drug availability is often a major problem at government health facilities. Disability cardholders can also receive some additional services at tertiary facilities free of charge (e.g. waivers of registration fees, services such as X-rays). Governments also reserve two beds in hospitals with over 50 beds for people with disabilities.

Availability of disability-specific health services is a major issue. Specialist services are largely concentrated in Kathmandu, with limited outreach work. There are usually fees for hospital-based rehabilitation therapy and corrective surgery. Additionally, while the Disability Action Plan 2066 advocates for the provision of assistive devices at no or subsidized cost, there is no budgetary allocation from the Government directly to the health sector for these devices/services. Instead, most people with disabilities who cannot afford assistive devices remain reliant on DPOs, NGO or other charitable sources.

5.3.4 Employment and vocational training

Entitlements in employment and vocational training for all disability cardholders include:

- 5% quota for people with disabilities in public sector jobs
- Tax breaks and other incentives for private sector employers to hire people with disabilities
- Free vocational training from approved sources (typically Council for Technical and Vocational Training, cottage and small industries division and offices, DDC, district agriculture office, and DPOs)
- Discount on income tax; retirement pensions available 7 years earlier for civil servants with disabilities

While these entitlements have been valuable for recipients, uptake remains low for several reasons. Vocational training – as well as the formal sector jobs covered by quotas and employer incentives – are based primarily in urban centres, limiting access for people with disabilities living in rural settings. Additionally, job quotas/incentives for employers are underused, due to downstream barriers such as lack of education and training among people with disabilities, as well as potential discrimination by employers. Even when quotas and incentives are used, they tend to promote the hiring of people with disabilities who are already educated and who have mild impairments, thus doing little to improve access to work for individuals who likely face the greatest barriers to employment. Finally, most of these benefits apply to formal sector employees, while most employment across Nepal – including among people with disabilities – is in the informal sector.

6 Non disability-targeted social protection provisions

Most social protection entitlements in Nepal are targeted to specific groups deemed to be at high risk of poverty or other forms of marginalisation, including people with disabilities. People with disabilities may also be eligible for programmes targeted to other groups, if they meet their eligibility criteria. Additionally, social insurance schemes are open to any individual engaged in formal employment.

6.1 Social assistance

For social assistance, the Government of Nepal through MoFALD provides cash transfers for certain target groups (see Table 4). Importantly, people cannot be beneficiaries of multiple social assistance programmes. Consequently, an individual who receives the Disability Allowance is ineligible to concurrently receive social assistance through any of the other programmes, even if they meet the eligibility criteria.

Some people with disabilities may choose to forgo the Disability Allowance in favour of a different social assistance scheme, particularly if it provides a higher rate. For example, “blue” disability cardholders who are over 70 years (or 60 if they live in the Karnali zone or are of the Dalit caste^d) can receive NR 1000/month with the Old Age Allowance instead of NR 600/month with the Disability Allowance. In addition to higher rates, applications are more straightforward for some of these other schemes. Notably, the Disability Allowance is the only social assistance scheme where the application is conducted at district-level; all others are processed solely at the local VDC. Furthermore, determining eligibility is often less subjective than for other schemes: for example, eligibility for the Old Age Allowance can be determined through proof of age, rather than the more complex disability assessment.

Programme	Eligibility	Amount
Old Age Allowance	All citizens over 70; over 60 if Dalit or living in Karnali zone	NR 1000 [US\$10]/month
Single women/Widow allowance	Single women 60 years or older; widows of any age	NR 1000 [US\$10]/month
Child protection allowance	Under 5 children (2 per mother) for all in Karnali zone and Bajura, Bajhang districts; for Dalit children under 5 across Nepal	NR 200 [US\$2] per month per child
Endangered indigenous peoples	All individuals who are deemed to be part of an indigenous groups	NR 1000 [US\$10]/month (endangered indigenous groups) NR 500 [US\$5]/month (non-endangered indigenous groups)

Table 4: Social assistance programmes in Nepal

The restriction to only receiving one type of cash assistance does not acknowledge additional financial needs stemming from multiple risk factors for poverty and deprivation. In this regard, older adults with disabilities may be particularly affected, given that disability prevalence increases with age [7]. While older adults may receive the Old Age Allowance to help cover lost earning potential and other age-related expenses, older adults with disabilities cannot also receive the Disability Allowance to cover additional disability-related expenses. They will therefore have to contend with additional disability-related costs from the same allotment.

6.2 Educational supports

Scholarships are available for other target groups who have traditionally been excluded from education, namely girls living in poverty, those living in the Karnali zone and Dalit children. The amount provided through these scholarships vary, but is typically much less than the amount provided in the disability-targeted education scholarships.

^d Karnali Zone is one of the poorest and most remote regions of Nepal, which is also has few transportation links. Dalit is the lowest caste in Nepal, with most members facing political, social and economic exclusion.

6.3 Social insurance

Nepal has various social insurance schemes, all of which are targeted to formal sector employees. Given that 90% of the labour force in Nepal works in the informal sector – which is likely even higher for people with disabilities – the vast majority of Nepali citizens are not eligible for these benefits [29].

6.3.1 Pensions

A non-contributory pension is available to public sector employees who retires after 20 years of employment (16 for employees in the army, 13 for people with disabilities). Pension amounts depend on the period of service and the employees' salary,^e and are dispersed in equal monthly instalments. Pensions are paid for through the Government's revenue or the public sector employer [29].

In addition, a contributory pension ("Employee Provident Fund") is required for all public sector workers; at private sector businesses with at least ten employees, participation is voluntarily [29]. Under this scheme, employees contribute 10% of their salary to their pension, which is matched by their employer. Finally, a third type of pension ("Citizen Investment Trust") is available to all formal sector workers, regardless of the size of the business they work for, or if they work on a permanent, temporary or contractual basis [29]. For this programme, only the employee contributes (equivalent to the lesser of a third of their salary or NR 300,000 annually), with no involvement from the employer. However, contributions are exempt from income tax to encourage employees to save for retirement.

6.3.2 Other forms of social insurance

Various laws in Nepal outline provisions for maternity and sickness leave and for injury, disablement or death due to work-related accidents. These benefits are restricted to public and private sector employees (in businesses with at least 10 employees). It is generally acknowledged that enforcement of these policies is low.

6.4 Healthcare

For all Nepali citizens, some basic healthcare at lower level health posts and a list of 60 prescription drugs are provided free of charge. Still, many other medications and services at higher level health centres are not covered. As mentioned in section 5.3.3, people with disabilities are entitled to some additional healthcare benefits. Older adults aged 70 and above can access additional health services free of charge, up to a ceiling of NR 4,000 (US\$38) per year [29].

A contributory national health insurance programme for formal sector employees was being piloted in 2016, but is limited to the Kailali, Baglung and Ilam districts [29].

^e Determine as total years of services, multiplied by salary in the last year, divided by 50

Box 5. Social protection policies: challenges and examples of good practice

Examples of good practice

- Nepal offers a wide range of social protection entitlements to people with disabilities aimed at improving access to health, education and work, as well as protecting against poverty.
- Nepal has continually sought to improve the content and delivery of social protection benefits for people with disabilities. This includes doubling the amount of social assistance allotments, removing quotas on the number of beneficiaries and increasing the number of deadlines for processing applications.
- DPOs, such as NFDN, regularly are consulted by the Government and involved in the implementation of disability-related policies and programmes (including social protection), which promotes the inclusion of people with disabilities themselves in the decision-making process.
- DPOs are also actively involved in the disability assessment process, when possible. There are many DPOs across Nepal, and while coverage is generally high, not every district has an active DPO.

Areas for improvement

- The restriction to only receiving one type of cash assistance does not acknowledge additional financial needs stemming from multiple risk factors for poverty and deprivation. This limitation particularly affects older adults, as disability becomes more prevalent with increasing age.
- Applications for the disability card are conducted at district-level, which can be cumbersome particularly for people living in rural areas or in poverty or who have mobility limitations. For other social assistance programmes, applications are conducted at the VDC, which is much more geographically and financially accessible.
- Assistive devices, rehabilitation and other disability-specific healthcare are not covered under either disability-targeted or general healthcare entitlements. Although DPOs and NGOs are involved in the provision of some of these services, their coverage is limited, meaning many people with disabilities will either have to pay out of pocket or forgo needed health services.
- Many benefits (e.g. social insurance, entitlements to improve access to employment) in both disability-targeted and general schemes are limited to employees in the formal sector. Consequently, the vast majority of Nepali citizens – particularly people with disabilities – are ineligible to receive them.
- While disability card classifications are mostly based on functioning, criteria for assessment are fairly subjective.

PART B

Disability-Inclusive Social Protection in Practice: Evidence from Tanahun



Overview

Part B draws on evidence from qualitative and quantitative research conducted in Tanahun district. It provides a more in-depth exploration of the functioning of the system in practice, focusing on the need for, access to and use of the Disability Allowance, as well as other forms of social protection among people with disabilities.

7 Need for Social Protection among People with Disabilities

There is mounting global evidence that people with disabilities experience a greater need for social protection due to increased likelihood of poverty and exclusion in areas such as health, education and labour. Nepal’s social protection framework for people with disabilities acknowledges and seeks to address these diverse drivers of poverty and marginalisation. While specific aims of social protection in Nepal have not been formally outlined, they are meant to “maintain a degree of equity among citizens” and ensure all citizens are able to “live a decent life” [29].

To explore the need for social protection, data from the quantitative research was used to estimate the prevalence of disability in Tanahun and compare living conditions between people with and without disabilities.

7.1 Prevalence of disability

Prevalence of disability provides an indication of the number of people who may be eligible for social protection. After screening 5,692 individuals for disability across 1,469 households, 214 people were identified as having a disability according to the study definition (“a lot of difficulty” or “can’t do” key daily life activities, daily depression/anxiety symptoms), giving a prevalence of disability of 3.8% (3.4-4.4%). (Table 5). A much higher proportion – 17.2% (16.2-18.2%) – reported “some difficulty” or more in at least one domain. By household, 13.9% (12.2-15.8%) had a member with a disability.

		n	Prevalence (95% CI)	aOR (95% CI) [†]
<i>Overall Prevalence of Disability</i>		214	3.8% (3.3-4.3%)	-
<i>Sex</i>	Female	102	3.2% (2.6-3.9%)	Reference
	Male	112	4.5% (3.7-5.3%)	1.4 (1.0-1.7)*
<i>Age Group</i>	5-18 years	26	1.5% (1.0-2.1%)	Reference
	19-40 years	38	2.0% (1.5-2.7%)	1.4 (0.9-2.3)
	41-60 years	68	5.6% (4.5-7.1%)	4.1 (2.6-6.4)*
	61-75 years	46	7.3% (5.5-9.6%)	5.3 (3.3-8.7)*
	76+ years	36	19.6% (14.4-26.0)	16.2 (9.5-27.6)*
<i>Location</i>	Urban	51	3.3% (2.5-4.3%)	Reference
	Rural	162	3.9% (3.4-4.5%)	1.1 (0.8-1.5)
<i>Caste/ ethnicity</i>	Other castes	168	3.7% (3.2-4.3%)	Reference
	Dalit	39	3.7% (3.2-4.3%)	1.1 (0.8-1.7)
	Muslim	7	6.6% (3.2-13.3%)	1.9 (0.9-4.3)
<i>Income quartiles (monthly, per capita)</i>	1 st (wealthiest)	33	2.3% (1.7-3.3)	Reference
	2 nd	46	3.2% (2.4-4.3)	1.3 (0.8-1.7)
	3 rd	53	4.3% (3.3-5.5)	1.7 (1.1-2.5)*
	4 th (poorest)	82	5.1% (4.1-6.3)	2.0 (1.4-3.3)*

*Statistically significant

[†]Adjusted by household size, mean age, dependency proportion and percent female

TABLE 5: Prevalence of disability by key characteristics

Prevalence of disability was slightly higher in men, even after adjusting for age. This finding was mirrored in the 2011 census [30], and likely reflects very high rates of external labour migration among Nepali men [31]. Prevalence also increased significantly with age, ranging

from 1.5% (1.0-2.4%) for children up to 19.6% (14.4-26.0%) for adults over 75. Prevalence of disability was related to poverty, with household prevalence in the poorest income quartile double the prevalence in the wealthiest. This may indicate that poverty is either a cause or a consequence of disability. Though prevalence was slightly higher in rural areas, the difference was not statistically significant. Similarly, there was no difference in prevalence between Dalits compared to other castes and while prevalence was higher among Muslims, the difference was not statistically significant.

7.2 Economic poverty

Protecting households against poverty is a core aim of social protection, which is often defined in terms of basic income security [32].

However, in Tanahun households with members with disabilities were significantly poorer than households without members with disabilities (Table 6). Households with a member with a disability had a per capita monthly income that was on average more than a quarter less than that earned by households without a member with a disability. Consequently, households with members with disabilities were 70% more likely to be living below the international poverty line (US\$1.90 per person per day, purchasing power parity) [33]. There were no statistically significant differences in poverty measures based on the sex or age group of the person with a disability, although people living in rural areas were more likely to be living in poverty (aOR=2.7, 95% CI: 1.2-4.6).

Characteristics	Households with members with a disability (N=198)	Households without members with a disability (N=1,265)	
Poverty Markers			Coefficient (95% CI)^β
<i>Median monthly household income per capita (NPR)</i>	3,349 [US\$32]	4,771 [US\$46]	-27.1% (-36.1% to -16.9%)
	N (%)	N (%)	aOR (95% CI)^γ
<i>Lives below the international poverty line (US\$1.90, PPP)^α</i>	65 (31.9%)	264 (20.9%)	1.7 (1.2-2.4)*
<i>Self-rated wealth</i>			
Average/rich	130 (65.7%)	1,035 (81.8%)	Reference
Very poor/poor	68 (34.3%)	230 (18.2%)	2.4 (1.4-4.3)*
<i>Socioeconomic status</i>			
1 st (wealthiest)	33 (16.7%)	317 (25.1%)	Reference
2 nd	35 (17.7%)	318 (25.1%)	1.1 (0.7-1.9)
3 rd	48 (24.2%)	310 (24.5%)	1.5 (0.9-2.5)
4th (poorest)	82 (41.4%)	320 (25.3%)	2.5 (1.5-4.2)*
Extra costs of disability	% income		Amount (NR)
<i>Household level extra cost</i>	33.5%		7,008 [US\$67]

*Statistically significant

^β Exponentiated regression coefficient, using log transformed income, which illustrates the percent difference in income per capita among household with members with disabilities compared to households with no disability, after taking into dependency proportion and location.

^α Uses 2012 purchasing power parity (PPP) conversion factor of 41.94 NPR to USD [34].

^γ Typically adjusted by household size (except per capita income), dependency proportion, location (rural vs. urban)

^φ Socioeconomic status was derived through principal component analysis of household ownership of assets

TABLE 6: Comparison of economic poverty between households with and without members with disabilities

In addition to poverty, people with disabilities frequently encounter additional disability-related expenses (e.g. extra transport, medical and rehabilitation costs, purchase of assistive devices). Consequently, for a given level of income, households with disabilities may experience lower standards of living compared to households without members with disabilities, who do not have to contend with these expenses. These “extra costs” of disability were estimated to be 33.5% of household income. This means that on average, the per capita income of a household with a member with a disability would need to increase by 33.5% – the equivalent of US\$67 per month – in order to enjoy the same standard of living as a household without members with a disability. It is important to note that this calculation only takes into account what households with disabilities are *currently spending* on disability-related costs; it does not necessarily represent the amount required for full coverage of the range of disability-related expenses needed to promote full and equal inclusion. In fact, given the findings in the ensuing sections, it is highly likely that potential disability-related expenditures would be much higher, if people could afford (or access) them.

7.3 Health

Ensuring access to healthcare has been highlighted in international guidelines as a central directive of social protection [32]. Financial accessibility is key component, as costs associated with accessing healthcare can increase risk of poverty – either directly, through high out of pocket spending or indirectly, due to losses in productivity from poor health. Nepal has acknowledged the importance of equitable and affordable healthcare access in its social protection frameworks, which it is beginning to address through general and disability-specific entitlements such as free access to some basic services and medications.

Indicators	Cases (n=209)	Controls (n=209)	aOR (95% CI) [†]
Health status			
<i>Self-rated health</i>			
- Average to very good	52 (24.9%)	182 (87.1%)	Reference
- Weak/very weak	157 (75.1%)	27 (12.9%)	17.3 (8.5-35.2)*
Had a serious health condition in the last 12 months	32 (15.3%)	24 (11.5%)	1.4 (0.8-2.6)
Healthcare financing			
Lacks financial protection coverage in health [‡]	50 (23.9%)	30 (14.4%)	2.1 (1.2-3.7)*

*Statistically significant

[†]Adjusted for age, sex and cluster or location (rural/urban)

[‡]Also adjusted for household size, percent female, dependency proportion and mean age

[‡] From the WHO’s monitoring of the SDGs for financial protection, which defines lack of financial protection as 25% of household income spent on healthcare [35]

TABLE 7: Comparison of health indicators between people with and without disabilities

Still, evidence from Tanahun indicates that people with disabilities may face barriers in accessing needed healthcare, leading to lower health status (Table 7). For example, people with disabilities were significantly more likely to rate their health as poor compared people without disabilities: almost three-quarters considered their health as “weak” or “very weak” while over half of their peers without disabilities considered their health as “above average”.

Financial accessibility of healthcare was also a key challenge for people with disabilities. Almost a quarter of households with members with disabilities spent over 25% of their income on healthcare, which is considered by the WHO as putting these households at a high risk of healthcare spending induced poverty [35].

While Nepal has no specific social protection entitlements covering the provision of assistive devices, rehabilitation or other forms of disability-specific healthcare, it is acknowledged that access to these services are key for improving health, independence and overall well-being among people with disabilities. As such, they are promoted by the WHO and others as a basic healthcare need that should be covered in a country's package of health services [36]. Still across Nepal, access is limited to out of pocket spending or charitable donations from DPOs or NGOs. Unsurprisingly then, in Tanahun awareness of these specialised health and rehabilitation services among people with disabilities varied was overall low (Table 8). Amongst those aware of the various service, need was high but frequently unmet.

	Heard of service/device	Need service/device	Ever received/used	Currently receiving/using
Medical rehabilitation	83 (39.7%)	59 (71.1%)	37 (62.7%)	7 (11.9%)
Assistive devices	141 (67.5%)	64 (45.4%)	26 (40.6%)	14 (21.9%)
Counselling	46 (22.0%)	26 (56.5%)	5 (19.2%)	1 (3.9%)

TABLE 8: Access to specialist health and rehabilitation services among people with disabilities (n=209)

There was no difference by sex in terms of either health status or health financing, while usage of rehabilitation and assistive devices was too low to disaggregate.

7.4 Education

The Constitution of Nepal guarantees that “every citizen shall have the right to basic education”, which includes compulsory and free education up until Grade 8 [37]. Social protection entitlements in education are designed to increase enrolment and academic success of children typically excluded from schooling, such as children with disabilities.

However, in Tanahun, children with disabilities were less likely to go to school compared to their peers without disabilities, all of whom were currently enrolled (see Table 9). Reported reasons for not attending were mostly directly related to the child's disability, with school accessibility and discrimination cited most frequently. Even when children with disabilities did attend, they were more likely to be in a lower grade than their peers.

Indicators	Cases (n=23)	Controls (n=23)	aOR[‡]
Currently enrolled	13 (56.5%)	23 (100%)	n/a
Not in same grade as other children	7 (53.8%)	22 (95.7%)	6.7 (1.4-32.2)*
Missed school in the past month	10 (76.9%)	11 (47.8%)	4.5 (0.9-23.3)

*Statistically significant

‡ Adjusted for age, sex and cluster or location (rural/urban)

Table 9: Access to education, children with and without disabilities (5-17)

Adults with disabilities also had poorer educational outcome: they were twice as likely to have never attended school compared to adults without disabilities and had lower levels of

educational attainment (Table 10). Not surprisingly then, reading ability was much lower among adults with disabilities.

<i>Indicators</i>	<i>Cases (n=186)</i>	<i>Controls (n=186)</i>	<i>aOR (95% CI)[‡]</i>
Never attended school	108 (58.1%)	93 (50.0%)	1.9 (1.0-3.4)*
Highest Education			
- No school/some primary	134 (72.9%)	117 (62.9%)	Reference
- Primary (completed)	41 (21.4%)	48 (25.8%)	0.5 (0.3-1.0)
- Secondary and higher	11 (5.7%)	21 (11.3%)	0.3 (0.1-0.8)*
Reading ability			
- Can read well	45 (24.2%)	79 (42.5%)	Reference
- Can read a little	36 (19.4%)	38 (20.4%)	2.5 (1.2-5.0)*
- Cannot read at all	105 (56.5%)	69 (37.1%)	5.5 (2.6-11.3)*

*Statistically significant

[‡]Adjusted for age, sex and cluster or location (rural/urban)

TABLE 10: Comparison of education indicators between adults with and without disabilities (18+)

Among adults,^f women with disabilities were much more likely to have never enrolled in school (aOR=5.7, 95% CI: 2.7-11.7), have less than a primary school education (aOR=5.8, 95%CI: 2.6-13.0) and not be able to read (aOR=3.5, 95% CI: 1.8-6.7), compared to men with disabilities. Similar trends held for older adults with disabilities, while living in a rural area did not affect any education measures. These trends are mirrored in people without disabilities, indicating a universal disadvantage in education due to sex and older age.

7.5 Livelihoods

Nepal's social protection policy for people with disabilities outlines several types of entitlements to promote the development of stronger livelihoods, including vocational training and quotas for employees with disabilities. Social assistance may also function as income support for individuals who are unable to maintain a sustainable livelihood, due to unemployment or underemployment or – for a minority – incapacity to work.

In Tanahun, people with disabilities were much less likely to be working^g compared to their peers without disabilities (Table 11). Most people with disabilities cited reasons for not working as directly related to their impairments, namely that they were incapable of work (60.9%) or that they had been denied a job due to their disability (17.2%). In comparison, the main reasons for not working among people without disabilities were childcare/household duties (30.2%) or due to retirement/continuing education (30.2%). When controlling for level of education, the odds of not working reduced slightly but were still statistically significant (aOR=2.6, 95%CI: 1.6-4.1), indicating that barriers other than low levels of education impede people with disabilities from working.

^f There were too few children to disaggregate findings by sex.

^g "Working" defined as having engaged in any livelihood-supporting activity, except domestic work, in the last 12 months.

Indicators	Cases (n=193)	Controls (n=193)	Cases to controls aOR (95% CI) ^γ
Livelihoods (Ages 15+)			
Did not work in the last 12 months	146 (75.6%)	48 (24.7%)	3.0 (1.8-4.9)*
Works irregularly (not year-round) [⋄]	23 (46.9%)	30 (32.6%)	2.3 (1.1-4.8)*
			Coefficient[Ⓛ], (95% CI)
Number of months worked in a year [⋄]	8.4	9.4	-1.3 (-2.5 to -0.3)*
Average monthly salary (NR), if paid cash	6,130	9,334	-3395 (-6369 to -421)*

* Statistically significant

[⋄]Among people who worked in the last 12 months

^γAdjusted for age, sex and cluster or location (rural/urban)

[Ⓛ]Regression coefficient, which illustrates the difference in months worked or monthly salary that can be attributed to disability, after taking into account other factors that may explain differences between cases and controls

Table 11: Comparison of employment indicators between people with and without disabilities (age 15+)

When people with disabilities did work, they earned a third less on average, were engaged in less stable work and worked one month less per year on average. Compared to men with disabilities, women were less likely to work and earned less when they did, these differences did not achieve statistical significance given the low numbers of people with disabilities engaged in work (n=48).

Almost half of all households with members with disabilities experienced food insecurity, with over a third facing moderate to severe shortages (Table 12). Overall, households with members with disabilities were three times as likely to experience food insecurity compared to households without members with disabilities. The predominant reason for food insecurity across all households was financial problems, listed in three-quarters of food insecure households. Coping strategies for households facing food insecurity were similar across case and control households, with about two-thirds having to take out a loan or sell off productive assets. Although necessary for short-term survival, these strategies can lead to long-term poverty traps.

Indicators	Cases (n=208)	Controls (n=208)	aOR (95% CI) ^γ
Household food security (all ages)			
Faces any food insecurity	102 (48.8%)	55 (26.4%)	3.0 (1.9-4.8)*
Level of food security			
- Secure	107 (51.2%)	174 (73.6%)	Reference
- Mild insecurity	24 (11.5%)	11 (5.3%)	3.4 (1.5-7.9)*
- Moderate insecurity	52 (24.9%)	29 (13.9%)	3.6 (1.8-7.0)*
- Severe insecurity	26 (12.4%)	15 (7.0%)	2.3 (1.2-4.5)*
Sold assets or took out a loan to cope with food insecurity	65 (63.7%)	34 (61.8%)	1.1 (0.6-2.2)

* Statistically significant difference

^γAdjusted for age, sex and cluster or location (rural/urban)

Table 12: Comparison of food insecurity between households with and without members with disabilities

There was no difference in a households' likelihood of experiencing food insecurity based on the sex of the member with a disability or whether they lived in a rural area. By age group, the gap between people with and without disabilities was highest for children and working-age adults: 70% of children and 50% of working age adults with disabilities experienced food insecurity. While 38% of older adults experienced food insecurity, there was no significant differences compared to older adults without disabilities. As older adults are typically not expected to be working, and generally require less diversion of time to caregiving from working-age adults compared to young children, this lack of a difference may reflect the presence of existing familial or community arrangements.

Box 6. Summary: Need for social protection among people with disabilities

Nepal's social protection entitlements aim to "maintain a degree of equity among citizens" and ensure all citizens are able to "live a decent life" [29].

In considering these aims of social protection, people with disabilities with disabilities faced a high need for social protection. For example, people with disabilities and their households faced high levels of poverty and food insecurity, as well as barriers from participating in activities that could strengthen their livelihoods such as education and work. Furthermore, people with disabilities experienced poor health and high costs from accessing healthcare. For all of these measures, people with disabilities experienced absolute deprivation, as well as high inequalities compared to people without disabilities.

8 Access to Social Protection

Given our findings of high poverty, broad-ranging deprivation (poor health, low access to education and decent work) and significant inequalities compared to people without disabilities, there is a high level of need for social protection among people with disabilities in Tanahun. Research from other areas of Nepal indicate similar trends across other districts [38]. While social protection is not the only intervention for addressing these needs, Nepal's disability-targeted social protection entitlements have been designed to begin to tackle both economic and more multi-dimensional forms of poverty.

In order to potentially benefit from social protection, people with disabilities must first be accessing available programmes. In this section, we explore coverage and uptake of key entitlements, and how the application process functions in Tanahun.

8.1 Application process for disability-targeted social protection

As mentioned in Part A, to receive social assistance and other benefits, people with disabilities must undergo a disability assessment to determine their level disability. As a first point in process, applicants must gather a proof of residence letter from their VDC. Key stakeholders in Tanahun, as well as nationally, reported that it is likely VDC officials perform a 'gatekeeping' role in agreeing to provide a letter, even though the purpose of the letter is only to provide proof of residence in that VDC, not to make any assessment of disability. For example, one interviewed VDC secretary reported that they would not provide a letter on request if they did not think the person had a disability.

In Tanahun, DPOs – specifically, the Resource Centre for Rights and Development of People with Disabilities (RECED), the representative DPO of the district – have a strong involvement in the disability card process beyond the role specified in national policy. For example, RECED provides the disability card application form as well as assistance to fill it in, and they also give a recommendation to the WCDO about the individual. The value of the RECED’s role was recognized by all the officials interviewed in the district. The WCDO, for example, explained that the purpose of giving RECED a formal role in the process was not only to facilitate access to the card certification process but also so that people with disabilities recognize it as “their” DPO, so that they can be member of it and get access to facilities and services provided by it.

While the standard procedure nationally is for an individual to submit their application to the WCDO once they have gathered the requisite documentation, many applicants in Tanahun are directed to pre-emptively seek medical documentation (if they don’t have it already). RECED often recommends this avenue if a condition is not considered ‘obvious’ (for example, someone with a hearing impairment but who is not profoundly deaf), as it is likely to lead to difficulties during the disability assessment, which may then lead to either inaccurate classifications or delays if the WCDO or Disability Identification Committee later requests a medical assessment. From the quantitative study, it appears that seeking a medical assessment is a very common part of the application as over 80% of Disability Allowance recipients had received one.

In order to receive a medical assessment, the applicant must go to the district hospital or a higher-level facility in Pokhara (major city in neighbouring district). For example, anyone with a hearing impairment will have to go to Pokhara because there is no ear, nose and throat (ENT) specialist in Tanahun. There is no financial support available to cover the costs of this process, although people may in some cases have the fee waived at the health facility at the discretion of the staff. For people with psychosocial impairments, there is now a psychiatric out-patient clinic at the district hospital, which is organized fortnightly by Koshish, which also provides medical certification.

While national guidelines specify that assessments will be completed by the Disability Identification Committee, in Tanahun, for straightforward cases the WCDO will make an assessment and may issue the card straightaway. As the Disability Identification Committee meets infrequently, limiting their involvement can streamline the process. With the WCDO conducting assessments, key informants reported that the disability card is usually obtained within a day or two of applying, which was validated by most of the qualitative respondents. Almost all respondents reported that they were treated well by the staff at various offices when they went through the process.

However, some challenges in the application process remain. In the quantitative survey with Disability Allowance recipients, the majority of respondents indicated that they faced problems getting to and around application offices, understanding the application process and gathering necessary documentation (Table 13). On average, respondents reported almost three trips to receive a disability card.

Characteristic	N (%)
Average number of trips to receive card	2.7 (SD=0.11)
Experienced difficulties during the application process:	
- Getting to application office (or other application points)	75 (63.0%)
- Accessibility of facilities or application points	74 (62.2%)
- Understanding the application process	72 (61.5%)
- Gathering the necessary documents for the application	72 (61.5%)
- Communicating with staff/officials	54 (45.4%)
- Attitudes of staff	47 (32.8%)
- Meeting application deadlines	59 (49.6%)
- Receiving disability assessment	58 (48.7%)
- Paying for transport	58 (48.7%)

Table 13: Experiences during the application process for the disability card, among Disability Allowance recipients (n=119)

These challenges in applying for the disability card were mirrored in the qualitative interviews. The process, with its need for multiple documents and visits, is particularly inaccessible for people who are illiterate or living in rural areas. Furthermore, difficulties understanding procedures can lead to delays and frustration. For example, a father found it very difficult to get a card for his daughter, who is blind and has a hearing impairment. He says he needed to go to Pokhara three times and Damauli four times, as he was told “*this thing or that thing was missing or would not do.*”

In some cases, the process can be so daunting that it dissuades individuals from starting an application. For example, the mother of a girl aged 15 who has learning and communication impairments, has heard that the “dumb,” and “lame” are getting the Disability Allowance. She is aware of the disability card process, and recognises its value, but they have not applied for it:

“[My husband] does not think what our daughter will do after we die. I had told him it would be light [easy] for us if she gets a card and allowance. We don’t receive it because my husband is a simpleton. I had told him far earlier, but he did not listen. I did not go as I am not educated.”

To improve the accessibility of the process, several strategies have been employed. Most notably, outreach camps are occasionally conducted to reach people with disabilities who live far from the WCDO. The 2008 Guidelines require that each district has outreach programs of this kind, although the Chair of RECED noted that Tanahun was the first district to conduct outreach camps and did so even before the Guidelines came into force. Generally, camps are conducted by local community-based organizations in partnership with RECED and the WCDO. Officials from the District Health Office also reported being involved. According to the chair of RECED, funding is either provided by the concerned VDC or the MoWCSW. For example, a week-long outreach camp was conducted in all 9 wards of the then Khairenitar VDC in 2013 by the Pentecost Advocacy Society. During the camp, a total of 144 people with disabilities were identified and were given cards within the week. The WCDO, however, has mixed opinions regarding the outreach camps stating that while they were initially effective, they have now “cut off” outreach camps as most people have

already been reached and that those that are left out should come on their own as it is too expensive to organize outreach programs for a few people.

Finally, to promote greater awareness of the disability card and its benefits, the Government of Nepal and DPOs have been undertaking various outreach activities. In Tanahun, FM radio was the most widely cited method, as RECED airs a weekly awareness programme about disability. It discusses issues related to disability, including the process for acquiring a disability card. Additionally, a social mobilizer at each VDC is responsible for encouraging people with disabilities to apply for a card. Teachers also play an important role, partly because the government provides scholarships for children with disabilities so schools encourage parents to make a card for their child. Peer education is also an important avenue for raising awareness. For example, a father whose son has both visual and hearing impairment, with a red card, has advised three of his neighbours to apply for disability cards; they now all have cards and receive the Disability Allowance.

Case study: challenges in applying for the disability card

The uncle of a 25-year-old woman with a “mental disability” (as written on the card) suggested that she apply for a card. The uncle applied for a recommendation from the VDC secretary. With the document, the girl’s mother first went to a government hospital and then to the VDC secretary. Then she went to the DPO in Damauli (capital of Tanahun) and then got her daughter checked at the government hospital in Damauli. At the WCDO, she was told to come the next day as the “big person” (officer) who would make the card had gone to a meeting in another VDC. When she pleaded with them that she had suffered a lot and asked what needed to be done to make the card, she felt that *“they hated me a lot.”* The mother went again the next day and was told that the official had gone to a meeting in another town. *“I requested, ‘Don't do such a thing, sir. I am alone, no one at home. I have left cattle at home, sir. In this planting season of Jesth (May/June), don't do this, please make it. Please do what you are authorized to do.’”* She was worried about the *ghaiya* (upland rice) she had planted, maize sown, and hungry cattle so she kept her daughter at a sister's, who lived closer to Damauli, and returned home, telling the sister to go to the office with the child to finalise the application. It took another 4 days for the sister to make the card. The mother says *“my sister told me that our karma (fate) is such; when one sister's karma is bad, another's also gets bad.”*

8.1.1 The disability assessment

As explained above, assessment of disability is conducted by a combination of WCDO staff, the Disability Identification Committee and/or a medical expert. Guidelines for categorizing each person into one of the four card types is outlined in the Disability Identification Card Distribution Guideline 2008. To assist in the decision-making, RECED can provide a recommendation for the application. The application form also includes questions on self-reported type and severity of the disability, any difficulties the person faces because of their disability (e.g. in doing daily chores, working), and the need for assistive devices.

Key informants involved in the process noted that for visible or obvious cases of disability—such as physical impairments, blindness, severe cognitive or intellectual impairments, and deafness— assessments were straightforward. However, various forms of intellectual,

communication and developmental impairments as well as certain psychosocial impairments were seen to present a challenge for the classification process. Staff at *Koshish*, a DPO working on psychosocial disability, reported that most people with psychosocial impairments were denied a higher-level card even if the condition was severe. As a result, almost none of their clients had a red card. However, more recently *Koshish* reported that they have been collaborating with RECED to improve understanding of psychosocial impairments among assessors for more accurate categorisation.

Additionally, key informants noted challenges in providing assessments to older adults who become disabled as part of the ageing process. For individuals involved in the disability assessment and older adults with disabilities alike, it is a common perception that functional limitations among older people are part of the “natural” ageing process and are not considered to be a disability. Additionally, as people over 70 usually receive the Old Age Allowance, and as people primarily equate the disability card with the allowance rather than other benefits (such as transportation discounts), older people and their families may not be interested in getting a card even where they are aware that they can do so. This is especially the case given that the Old Age Allowance can be applied for directly through the VDC, whereas the Disability Allowance cannot.

Furthermore, while an individual is not entitled to multiple social assistance benefits, multiple individuals in a single household may receive allowances. However, there were some reports that officials take into account the receipt of other allowances in the households when they make determinations of disability level, and thus eligibility for social assistance. For example, a man aged 32 and his 11-year old son both have psychosocial impairments. The father has a red card but the son only has a yellow card. The grandparents of the child reported that their grandson was denied a red or blue card by officials who told them that members of the same family should not get multiple allowances.

Generally, people with disabilities and their families were not knowledgeable about the eligibility criteria used to make categorizations, even if they had cards. Lack of understanding about the assessment criteria can lead to dissatisfaction among recipients, particularly if an individual is placed in a category that is ineligible for the Disability Allowance. Most people relate the disability card to the Disability Allowance, so people frequently expected to get some sort of allowance if they received a card. Lack of awareness about the assessment criteria and the benefits attached to each category can lead to resentment. For example, the wife and daughter-in-law of a 62-year-old man, who has mobility and communication impairments, felt discriminated against by being given a yellow card. They compared his condition with others, saying:

“We have heard that those who have little difficulty speaking are getting the allowance; we have heard that those who cannot move get 2,000 rupees; and those who can walk a little and cut grass get 1,200.”

Similarly, the father of a man, aged 49, who has mobility and communication impairments, blames it on himself for not having *afno manchhe* (one’s acquaintance in power or position). This point was also mentioned by some of the key informants. For example, staff at *Koshish*

felt that those who are “clever” and literate go to the district and get the type of card they wish, but those who have greater needs often do not get it.

All key informants agreed that dissatisfaction with the category of cards people receive is a problem, although they were not very sympathetic in some cases. For example, one District Development Committee staff member felt that no one is satisfied and that people would go as far as describing someone as a “*mad person*” in the medical report just to get the 1000 rupees. Others were more understanding. For example, one VDC secretary noted that people are dissatisfied not because they think the severity of disability has been wrongly assessed, but because they need help to look after themselves and the amount they receive is not sufficient to cover these costs.

8.1.2 Additional application for social assistance

People who receive a red or blue disability card are entitled to receive social assistance; however, they must make a separate application to their VDC to enrol. There is an annual application deadline during 16th-30th November so that applications are received in time for the next fiscal year. Officials involved in the process indicated that it tends to take a year after submitting the card to the VDC to begin receiving the allowance. Furthermore, key informants noted that not all people who have an eligible disability card were aware of the need to submit it to the VDC or of the limited application period.

From the quantitative survey, all but one of the red or blue disability cardholders received the Allowance, indicating very high uptake of this benefit among individuals who had already gone through the disability card process. As was mentioned in the qualitative interviews, most individuals apply for the disability card with the primary purpose of receiving the allowance, so the incentive to complete the process is high. Also mirroring the qualitative study, about half of Disability Allowance recipients in the survey had begun to receive allotments within a year after registering for the disability card (Table 14). However, the remaining half had to wait over a year, due in large part to the one-time a year registration deadlines.

Characteristic	N (%)
Wait time to receive Disability Allowance after receiving card	
- Less than 6 months	18 (15.4%)
- 6 months to 1 year	44 (37.6%)
- 1-2years	35 (29.9%)
- More than 2 years	20 (17.1%)
Average number of trips to complete application	1.9 (SD=0.10)

*N.B.: Missing 2 cases

Table 14: Experiences during the application process for the Disability Allowance, among Disability Allowance recipients (n=119)

From the 2016/17 fiscal year onwards, the government has announced plans to shorten the time lag between applying for the allowance and receiving it. Under the new system, someone who applies for the allowance at any time in the fiscal year will receive it in the next fiscal period of the year (i.e. the next time the allowance is distributed). If this process is implemented effectively, it will be a significant improvement on the existing system.

One additional challenge affecting receipt of the Disability Allowance is in the transition of the 1,170 people with disabilities in Tanahum who were previously receiving the Disability Allowance through the system in place prior to the current four-coloured card process introduced in 2006. Some of these people have not come to get a new card and the policy does not allow people to get the allowance using the “old” card.

Box 7. Application process: challenges and examples of good practice

Examples of good practice

- At least in Tanahun, there is a strong involvement of DPOs in the application process. This involvement not only helps applicants navigate the process, but it encourages further linkages between people with disabilities and the DPO moving forward.
- In Tanahun and other districts, limiting the involvement of the Disability Identification Committee to “complex cases” streamlines the assessment process, reducing the time and number of visits needed to receive a disability card.
- Outreach camps greatly improve the accessibility of the application process, as they are conducted closer to applicants’ homes and all steps are completed simultaneously.
- Psychosocial health providers have been working with assessors to improve their understanding – and thus decision-making on card level categorisation – for people with psychosocial impairments.

Areas for improvement

- There was a low level of awareness among applicants on how disability categories are determined. This can lead to frustration among applicants if they feel they have been put in too low a category.
- The majority of applicants reported challenges getting to application points, understanding the application process and gathering necessary documentation.
- Most applicants required medical documentation of an impairment, which is both cumbersome to obtain and leads to a more medical approach to assessing disability.
- Assessors face challenges classifying people who have certain forms of intellectual, communication or developmental impairments or who experience disability as a result of ageing. Consequently, they may be placed in a lower card level, or not receive a card at all.
- VDCs sometimes act as a gate-keeper during the application process, dissuading individuals from applying even though they do not have the directive or the capacity to take on this role.

8.2 Coverage of social assistance

From our survey in Tanahun, 69 (32.1%) of the people identified as having a disability in the household survey had a disability card, of whom 31 people reported receiving the Disability Allowance (14.5% of all people with disabilities). All but one of the red or blue disability

cardholders received the Allowance. No people with lower level disability cards and only one person not categorized by the Washington Group questions as having a disability was receiving the Allowance, indicating inclusion errors are very low.

In addition, 16 people with disabilities had previously received the Allowance, but did not anymore. Of these previous beneficiaries, the majority (n=11) had not reapplied, mostly because they lacked information about, or documentation for, the reapplication process. The remainder had completed the reapplication process, but had been denied.

As well as the Disability Allowance, people with disabilities lived in households receiving other forms of social assistance (Table 15). Overall, over half the households with members with a disability were receiving some form of social assistance compared to 27.1% of households without a disabled member.

Programme	Households with members with disabilities (n=198)	Households without members with disabilities (n=1,265)	aOR (95% CI) [‡]
<i>Any type of social assistance</i>	105 (53.0%)	343 (27.1%)	2.4 (1.7-3.4)*
Disability Allowance	24 (12.1%)	1 (<0.1%)	
Old Age Allowance	62 (31.3%)	217 (17.2%)	
Single Woman/Widow Allowance	27 (13.6%)	107 (8.5%)	
Child grant	2 (1.0%)	30 (2.4%)	

[‡]Adjusted by household size, dependency proportion and location

*Statistically significant

TABLE 15: Participation in other social protection programmes

The Old Age Allowance was the main type of social assistance accessed by all households. Among people included in the case control who were eligible for this cash transfer (aged 70 years of age and older), there was no significant difference in coverage between people with and without disabilities as it was universally high (89% vs 79% coverage, respectively). Similarly, although absolute numbers were much smaller, people with disabilities accessed the Single Women (over 60)/Widows' Allowance in similar proportion to people without disabilities.

8.2.1 Coverage of the Disability Allowance by recipient characteristics

People with disabilities who were receiving the Disability Allowance did not differ from non-recipients in terms of sex, but coverage did differ by age (Table 16). Coverage for the allowance was highest among adults 19-40 (67.1% coverage) and children (47.7%) but then decreased with increasing age. As individuals may only receive one type of social assistance, this trend reflects a substitution away from the Disability Allowance towards the Old Age Allowance, as almost 90% of people with disabilities aged 70 and older were receiving the latter. Given the relative ease of the application process for the Old Age Allowance – which is conducted locally and has objective, readily assessable eligibility criteria – it is not surprising that the Old Age Allowance is more regularly accessed by this group.

The vast majority (86.1%) of people with disabilities had difficulties in multiple areas. Those with multiple functional limitations had on average five times the odds of receiving the Allowance compared to people with only one area of difficulty, with likelihood of receiving the Allowance increasing with each additional difficulty.

	Receiving Allowance (n=128)	Not receiving Allowance (n=180)	aOR (95% CI) ^a
General characteristics			
Female	53 (44.5%)	82 (45.0%)	1.0 (0.6-1.6)
Location			
- Urban	34 (25.8%)	98 (74.2%)	Reference
- Rural	85 (22.5%)	293 (77.5%)	1.0 (0.6-1.6)
Age group			
- 5-18 years	21 (47.7%)	23 (52.3%)	Reference
- 19-40 years	55 (67.1%)	27 (32.9%)	2.2 (1.1-4.7)*
- 41-60 years	30 (34.5%)	57 (65.5%)	0.6 (0.3-1.2)
- 61-75 years	12 (22.2%)	42 (77.8%)	0.3 (0.1-0.7)*
- 75+ years	1 (2.9%)	33 (97.1%)	0.03 (0.004-0.3)*
Number of functional difficulties ^b			
- One domain	21 (19.4%)	87 (80.6%)	Reference
- Two domains	42 (45.7%)	50 (54.4%)	3.8 (1.9-7.4)*
- Three domains	25 (56.5%)	20 (43.5%)	5.9 (2.5-13.7)*
- Four or more domains	36 (78.3%)	10 (21.7%)	14.4 (5.5-37.2)*

^a Adjusted by age, sex

^b Domains included physical (difficulties walking, with upper body function or fine dexterity), sensory (hearing/seeing), communication, cognitive (remembering, learning and understanding) and self-care

* Statistically significant

Table 16: Characteristics of Disability Allowance recipients compared to non-recipients with disabilities

Almost all respondents reported receiving the instalments in the amounts and frequency specified in under the pre-2016/2017 guidelines for their card level. As previously noted, although the higher allotment amounts are supposed to have gone into effect, there appears to be a lag time in implementation.

8.3 Uptake of other social protection entitlements

Disability cardholders (of any colour) can receive a range of benefits other than the Disability Allowance, which is available only to the red and blue cardholders. From the quantitative survey, uptake of linked benefits was low (Table 17). Public transportation discounts were the most commonly utilized, with lower level disability cardholders more likely to report using this benefit. Similarly, though few children with disabilities accessed educational scholarships, lower level cardholders were more likely to receive them. School enrolment was very low among child cardholders (6/23, 26.1%), which helps explain why few used the scholarships.

Usually, when receiving the disability card at the WCDO, verbal information is provided about the benefits of the card. From the qualitative study, most respondents acknowledged that they were told about benefits other than the Disability Allowance, especially discounts in public transportation and in government health centres. However, a few respondents

claimed that they had not been told about this properly. For example, a 51-year-old man says he did not know about the benefits, including the allowance, and was told nothing when receiving the card. *“I made the card, kept it in my pocket, and returned.”* He kept the card at home for more than three years (he received it in June 2010) as he *“did not know [he] would get benefits.”*

	Linked benefits			
	Transportation discounts	Education discounts (≤ 17) ^h	Discounted healthcare	Vocational training (≥ 18)
All cardholders (n=158)	40 (25.3%)	3/23 (13.0%) ^h	18 (11.4%)	8/135 (5.9%)
Disability Card level				
Red (most severe) (n=61)	11 (18.0%)	0/13 (0%)	7 (11.5%)	1/48 (2.1%)
Blue (n=65)	16 (24.6%)	2/6 (33.3%)	7 (10.8%)	6/57 (10.5%)
Yellow (n=19)	9 (47.4%)	1/2 (50%)	3 (15.8%)	0/17 (0%)
White (least severe) (n=13)	4 (30.8%)	0/0 (0%)	1 (7.7%)	1/13 (7.7%)
<i>p-value</i>	0.08	0.07	0.90	0.21
Disability Allowance				
Recipient (n=119)	25 (21.0%)	1/19 (11.1%)	14 (11.8%)	7/100 (7.0%)
Non-recipient (n=41)	15 (38.5%)	2/4 (20%)	4 (10.3%)	2/35 (5.8%)
<i>p-value</i>	0.03*	0.02*	0.80	0.37

* Statistically significant

Table 17: Receipt of benefits linked to the disability card, among cardholders (n=158)

8.3.1 Discounted transportation

Discounts in transportation was one of most widely known benefits of the disability card, outside of the Allowance, and was used by about a quarter of cardholders. However, in the qualitative interviews, respondents highlighted that they sometimes faced problems accessing this entitlement. The main reason given for not getting the discount was that bus drivers refused to comply with the card regulations. For example, a 49-year-old woman with a white card, who has communication and mobility impairments, says that bus conductors scold her when she asks for a discount. Similarly, the mother of a woman aged 43, with mobility and intellectual impairments, said that she was denied a discount by the bus conductor who said they would lose money if disabled passengers filled up their vehicle.

Case study: Challenges accessing linked benefits

A woman, aged 25, with an intellectual impairment, has never received a discount while travelling. Last year, when she went to Pokhara her mother told the bus conductor that her daughter was disabled. The conductor asked, *“Where is it written that she is disabled?...She was disabled when this card was made but she won’t always get a discount.”* He did not give her a discount and on the return journey she was told a similar thing. When getting the blue card, she had thought she would get many things, but now she feels it is not beneficial.

^h Among children who were attending school, 50% (3 of 6) were receiving a scholarship.

The WCDO organizes meetings with transportation owners' organizations to discuss the need to honour the transportation discounts. Still, a key informant attributed the reluctance to give discounts by bus drivers to their lack of awareness and their focus on profit. Since the road transportation system is privately owned, it is very difficult to enforce government rules. As a result, even where people with disabilities do know about this benefit, many do not want to have to fight for a small sum of money, as the discount amount is small for short routes and they may only travel on long routes occasionally.

8.3.2 Educational scholarships and supports

The most widely recognised educational benefit is the disability scholarship. However, across Tanahun, there were only 59 students with disabilities receiving this benefit. Within the quantitative survey, only 13% (3/23) of children with disabilities received scholarships, with lower level cardholders were more likely to receive them. Low uptake of scholarship is linked to low school enrolment, as only half of all children with disabilities were in school. Of note, while there are no formal exclusion criteria, some officials stated that the scholarships were not intended for children with disabilities who were red cardholders, as "they will not be going to school".

Availability of suitable schools may also be a barrier to utilising scholarships. Although scholarships can be applied in either mainstream schools or schools with resource centres, only the latter provides specialised instruction or supports (e.g. Braille, sign language, teaching aids) to students with disabilities. From 2012 data, there are a total of 27 schools with resource centres, 10 of which have boarding facilities in Tanahun. Most of these resource schools are in the district capital Damauli or other urban areas. These included four schools for the deaf or hard of hearing; five for children with intellectual impairments; and one disability child centre, in Khairenitar. Across Tanahun, there are currently a total of 87 students (33 girls and 54 boys) in resource schools. Still, the DEO admits there is room for improvement in many resource schools: many are congested, with insufficient boarding facilities and teachers require additional training. The amount provided in category A scholarships (NR 25-30,000 [US\$239-286] over 10 months) was perceived to be insufficient in meeting both the boarding and educational costs for a child.

Other barriers to attending school even with the availability of scholarships included perceptions that a child with a disability was not capable of learning, which was particularly pronounced at even an institutional-level for children with severe disabilities (i.e. red cardholders). Additionally, difficulties in accompanying children to school and fear about the discrimination while at school were barriers to enrolment. Safety was a particular concern for girls with disability:

"No incidents happened, but thinking that somebody would do something bad to her, we did not send her to school. She cannot even say her name. So, thinking it will be difficult for a girl, we did not send her to school." (Siblings of a 13-year-old girl with intellectual impairments)

Still there were examples of caregivers going to impressive lengths to ensure their child receives an education. For example, some parents have migrated to urban areas to access special education schools for their children.

8.3.3 Healthcare entitlements

8.3.3.1 *Discounts on medicines and health services*

Discounts on a list of 70 medications and on hospital service fees are the main entitlement for healthcare available to people with disabilities who hold disability cards (any category). Additionally, people with disabilities can make use of reserved beds in hospitals in theory. However, this provision only applies to hospitals with more than 50 beds and since there are no hospitals of this size in Tanahun, it does not apply for those seeking services within the district.

From the quantitative study, slightly over 10% of disability cardholders had accessed healthcare discounts. A major challenge in accessing these discounts is low availability of medicines and failure of staff to honour the benefits. For example, the mother of a man, aged 25, who has an intellectual impairment, had gone to the district hospital after hearing about the benefits. She paid 10 or 20 rupees for the visit, but *“not a drop [of medicine] was given for free”* and she was instead told by a staff member that a *“disability card won’t do anything in the hospital.”* Similarly, a 51-year-old interviewee who is blind went last year to the district hospital thinking it would cost less than a private facility. He paid 5 rupees for the visit, but felt that the doctor did not do a thorough examination and was told to buy medicine from elsewhere as the hospital was out of stock. He has not been back since.

Some people with disabilities reported a preference for private clinics and pharmacies, due to either negative experiences or difficulties in accessing public facilities. Furthermore, private clinics and hospitals are perceived as providing accessible and quick service. For example, a 25-year-old woman who has an intellectual impairment was taken by her mother to the “medical” because it is difficult to take her to the hospital as she cannot walk and so needs to be carried from their village to the bus.

Overall, while most people did not complain about the way they were treated by government staff at the district hospital, they were not happy with the level of service and did not feel that having a disability card was particularly useful. The shortage of free drugs was also consistently mentioned as another reason to prefer private over government services. As a result, most people did not see the value of having a disability card in terms of accessing discounted government health services at the district level. When travelling further afield for higher level services, people’s experiences seemed to be mixed. Although they always had to cover the cost of transportation, services were often available at a discounted rate, as were drugs. However, this did not seem to consistently applied and – as a result – people were not confident of their right to receive free or discounted health services.

8.3.3.2 *Access to rehabilitation and assistive devices*

Laws and policies call for the provision of free or subsidized assistive devices and rehabilitation services for people with disabilities, but their provision is not institutionalised within the current healthcare system. NGOs, DPOs and charities, however, are active in the provision of these services, particularly assistive devices. Still, many people with disabilities reported that they were not told about how to get assistive devices or rehabilitation

services when receiving the disability card, indicating a need for stronger referral systems to services. Even when individuals do receive a referral, devices are not free. For example, the mother of a man with severe disabilities reported needing to pay 1,000 [US\$9.50] rupees for a wheelchair. Though this is certainly discounted from market value, it is still a high cost for many households who live in extreme poverty.

As provision of assistive devices operates outside the health system and does not have a consistent budget, availability is also a concern. For example, several people complained that they did not receive wheelchairs even though they applied for them a long time ago. According to a key informant, the district last distributed wheelchairs three years ago.

For rehabilitation, Tanahun conducts CBR with funding from MoWCSW, though its reach is limited. For facility-based rehabilitation, the nearest provider is in Pokhara. None of the respondents interviewed had received rehabilitation services or physiotherapy services with government support. However, some had sought rehabilitation services for children on their own in other places such as Kathmandu.

Strides have been made in improving availability of services for psychosocial impairments. As mentioned earlier, the DPO Koshish runs a psychiatric out-patient clinic fortnightly in Damauli that provides individual counselling and access to medications. The reliability of this service helps to ensure regular access to needed treatment.

8.3.4 Vocational training and other employment entitlements

Most employment entitlements (e.g. quotas) are targeted to the formal sector. Among interviewees in the study, who were primarily based in rural areas and had low levels of literacy, these are generally not relevant as most respondents who worked carried out agricultural tasks or household work such as cutting grass, looking after cattle, and cleaning.

Another key entitlement is free vocational training. In the capital of Tanahun, training is provided on IT, beautician services, tailoring, and spice-making. At the VDC-level, some trainings for livelihood activities are provided such as livestock farming and candle-, incense- or *mudha*-making (bamboo-stool making). The trainings aim to promote self-employment and other opportunities for income generation. For all types of vocational training, budgets are a major concern, limiting the reach of these programmes. For example, the WCDO officer reported receiving only around 150,000 rupees (US\$1,432) to cover both vocational training and the provision loans for livelihood purposes for people with disabilities.

Almost all people with disabilities interviewed for the qualitative study knew about trainings, and some had taken part in them. However, to access these trainings, they generally needed to go to Damauli, often staying at the training centre for a few days. Additionally, the available trainings are not always well suited to the individual or the demands of the local economy. Participation in the training did not lead to people with disabilities earning money by making or selling products and no one continued with the activity long-term. As a result, they did not appear to build meaningful capacity or help income generation, let alone contribute to poverty reduction. Nonetheless, they may have increased the confidence of some participants and provided an opportunity for social contact outside of their homes, even if they did not lead to financial independence.

The final entitlement for people with disabilities is for loans for livelihood improvements. The WCDO has a budget of 35,000 rupees for promoting self-employment activities, such as raising livestock. Loans are given through RECED, and usually the amount is NR 10,000, with an interest rate of 1-2% per month. For smaller amounts, no interest needs to be paid. Among interviewees, only a few people reported taking out loans. For example, one female interviewee got a loan for goat-keeping amounting to NR 10,000, with interest at 1.5% per month, and she also went for goat-keeping training. She did not repeat the experience as she felt the whole process was cumbersome (*jhyau*). Similarly, the father of a child with disabilities took a loan of 10,000 rupees for keeping pigs. He has paid back half the amount. He complains that initially he was told it was interest-free, but now he is being made to pay interest. *“They should not have taken interest. They deducted 1,000 rupees as interest.”*

Box 8. Delivery and access to social protection: challenges and examples of good practice

Examples of good practice

- Uptake of some non-disability targeted social assistance programmes was very high. Notably, almost 90% of people with disabilities who were eligible for the Old Age Allowance were receiving it. The relative ease of the application process, which is conducted locally and has easily assessable eligibility criteria, may provide learning for ways to improve the administration of disability-targeted provisions.

Areas for improvement

- Based on our calculated prevalence, coverage in Tanahun (and the rest of Nepal) is relatively low: only 15% of people with disabilities received the Allowance, while 32% have a disability card.
- Awareness and use of entitlements other than the Allowance are low among disability cardholders.
- There is a need to improve compliance among service providers in honouring certain entitlements linked to the disability card, notably for discounts in transportation and healthcare.
- Some benefits are not aligned to best meet the needs of the majority of people with disabilities. For example, vocational training is generally not tailored to match the skills of the individual or the demands of the local economy. Similarly, healthcare entitlements do not include provisions for assistive devices or rehabilitation.
- While social protection may address financial barriers to accessing existing services, the quality and accessibility of the services themselves may still limit use. For example, transportation may be limited or inaccessible, while schools can be far away or do not offer disability-specific resources or instruction.

9 Use of the Disability Allowance and other benefits: satisfaction, self-reported impact and adequacy

The Disability Allowance is distributed three times a year. Usually a day is fixed for receiving the allowance, and people receive a phone call about the date and time from VDC or municipality staff, a disability activist, or a fellow person with disabilities in the community. The Disability Allowance is distributed on the same day as other allowances. I

There were also reports of some flexibility applied by staff in cases where the Allowance recipient faces difficulty reaching the collection point independently. For example, in the disability card, there is a provision for a proxy who can receive the Disability Allowance on behalf of the person if they cannot come themselves. Observations of the card suggest that most people had not filled in the proxy form. Nonetheless, several people reported that family members collected the allowance on behalf of the person with disability.

From the quantitative study, overall more than 80% of recipients were at least somewhat satisfied with the Disability Allowance (Table 18). The majority had no issue with any elements of the collection process and were satisfied with the amount received. The lowest level of satisfaction was in access to other linked services, with almost half indicating dissatisfaction.

	Level of satisfaction				
	<i>Very satisfied</i>	<i>Somewhat satisfied</i>	<i>Neutral</i>	<i>Unsatisfied</i>	<i>Very unsatisfied</i>
The amount you receive from the Disability Allowance	35 (29.9%)	55 (47.0%)	5 (4.3%)	18 (15.4%)	4 (3.4%)
Frequency/regularity of grant instalments	34 (29.1%)	64 (54.7%)	13 (11.1%)	5 (4.3%)	1 (0.9%)
Collection procedures for receiving benefits	37 (31.6%)	55 (47.0%)	17 (14.5%)	6 (5.1%)	2 (1.7%)
Distance to collection site	43 (36.8%)	42 (35.9%)	9 (7.7%)	17 (14.5%)	6 (5.1%)
Access to other linked services/ discounts	17 (14.5%)	30 (25.6%)	20 (17.1%)	34 (29.1%)	16 (13.7%)
<i>Overall satisfaction with the Disability Allowance</i>	36 (30.8%)	58 (49.6%)	4 (3.4%)	15 (12.9%)	4 (3.4%)

Table 18: Level of satisfaction with various aspects of Disability Allowance among recipients

9.1 Spending and self-reported impact

While people with disabilities were grateful to be receiving the Allowance, when asked about the impact of receiving the Disability Allowance, most respondents indicated more modest benefits (Table 19). The greatest reported impact of the Disability Allowance was in the recipient's ability to get medical care, with almost two-thirds of respondents indicating at least some positive impact. About half of respondents reported that the Allowance helped them meet basic food needs. About a third indicated that the Allowance had improved their relationship with other household members. Still, for many categories and responders, receiving the Disability Allowance had had no reported impact.

	Self-reported impact		
	<i>At least some positive</i>	<i>No impact</i>	<i>At least some negative</i>
Basic food needs	58 (49.6%)	56 (47.9%)	3 (2.5%)
Non-food household essential expenses	33 (28.2%)	71 (60.7%)	3 (2.5%)
Non-essential household expenses	36 (30.8%)	78 (66.7%)	3 (2.5%)
Recipient's education, skill development	5 (4.3%)	106 (90.6%)	2 (1.7%)
Education of other children in the household	2 (1.7%)	91 (77.8%)	2 (1.7%)
Ability to get medical care	77 (65.8%)	39 (33.3%)	1 (0.9%)
Recipient's ability to work	16 (13.7%)	97 (82.9%)	3 (2.5%)
Other household member's ability to work	14 (12.0%)	99 (84.6%)	3 (2.5%)
Relationship with other household members	37 (31.6%)	79 (67.5%)	1 (0.9%)
Participation in community	17 (14.5%)	95 (81.2%)	4 (3.4%)
Socialisation with other people with disabilities	14 (12.0%)	99 (84.6%)	3 (2.5%)

Table 19: Self-reported impact of the Disability Allowance among recipients

In three-quarters of households, the Disability Allowance was primarily used for the recipient's personal expenses (Table 23). The main expenditures were for basic needs (food, clothing) and access to general health services, which was also mirrored in the qualitative. Most spending decisions were made by the recipient, either alone or in consultation with other household members, though in over 40% of recipient households another household member was the sole decision-maker.

	N (%)
On whom Allowance is mainly spent on:	
- Recipient's individual expenses	89 (75.6%)
- Household expenses	28 (23.5%)
Who makes spending decisions	
- Recipient	45 (37.8%)
- Recipient in consultation with others	23 (19.3%)
- Someone else	51 (42.9%)
Main items Disability Allowance spent on:	
- Household food expenses	58 (48.7%)
- Non-food household expenses	76 (63.9%)
- General health services	49 (41.2%)
- Clothing	26 (21.9%)
- Care giving support	23 (19.3%)
- Recreation/leisure	8 (6.7%)
- Education	5 (4.2%)
- Rehabilitation, assistive devices, specialist health services	2 (1.7%)
- Transport	0 (0%)

Table 23: Spending decisions

9.2 Adequacy: is social protection meeting the needs of people with disabilities in Tanahun?

Due to high levels of poverty and marginalisation in areas that affect the development of sustainable livelihoods (e.g. lower access to education and decent work, poorer levels of health), there is clearly a high level of need for social protection among people with disabilities in Tanahun, and likely the rest of Nepal. However, among individuals who are accessing social protection, it appears there is still a shortfall in meeting the intended aims of social protection.

There were no significant differences between disability cardholders and non-cardholders on the key indicators of need for social protection discussed in section 7; however, Disability Allowance recipients were worse-off on several measures compared to non-recipients (Table 20). As the Allowance is allocated to people with the most severe disabilities, this group likely has a higher baseline need for social protection.

	Recipients	Non-recipients	aOR (95% CI) [†]
Household below poverty line	50 (42.0%)	50 (29.4%)	1.9 (1.2-3.3)*
Spends more than 25% of income on healthcare	33 (27.7%)	41 (22.5%)	1.3 (0.7-2.4)
Never had gone to school	76 (63.9%)	101 (55.5%)	3.1 (1.7-5.5)*
Not worked in last 12 months	89 (84.8%)	127 (75.6%)	2.3 (1.2-4.7)*
Household is food insecure	52 (43.7%)	85 (46.7%)	0.7 (0.4-1.1)

*Statistically significant

[†]Adjusted for age, sex and rural/urban

Table 20. Comparison of Disability Allowance recipients to non-recipients

While the cash transfer and other benefits may have led to modest improvements in living standards for some recipients, over 40% of Disability Allowance recipients were living below the international poverty line and facing food insecurity. Similarly, a quarter of cardholders had catastrophic health expenditures, indicating that current healthcare discounts are insufficient to ensure financial protection in accessing healthcare. Consequently, social protection benefits at present are insufficient for ensuring all people with disabilities are meeting adequate standards of living, let alone developing stronger livelihoods.

Case study: Adequacy of the Disability Allowance

The insufficiency of the Allowance in promoting independence and relief from poverty was clearly expressed by a 69-year-old female interviewee, who is blind and requires support from a carer: *“What will I buy with 300 rupees? Not enough even to go from here to Damauli. Everything is expensive. I need to take medicine every month; 300 is not even enough for that. ... I cannot say how much I should be given. Old people get 8,000, 4,000, and 10,000 but we who cannot do anything get only 300. Those who are strong and able, get an increased amount, but we who are unable do not get increased amount....I am getting equal to what others get; it won't do asking for more. I consider it okay. Even if it was not given, family members would need to feed us and look after us. It is good that we are given the allowance. It would have been better if I could get the same as others [people getting the old age allowance].”*

The inadequacy of the Disability Allowance was mirrored in the qualitative research. Recipients as well as officials reported that the amount of monthly social assistance is not enough to meet the basic living costs and other needs of people with disabilities. For example, the WCDO officer considers the amount “*absolutely insufficient*” and “*nominal, minimum*”. A staff member at the DDC felt that as the price of everyday goods is very high, the allowance is just a token for “*encouragement*” from the government so that “*the family would love the person with disabilities*”.

With the recent doubling of the amount for fiscal year 2016/17, the amount in each instalment will be significantly higher in future, especially for red cardholders (8000 NR per four months, or 75 USD for red cardholders). Without other livelihood sources, however this amount is still not sufficient to sustain a person over a period of four months. Indeed, in the 2012 Supreme Court case which led to the allotment increase, the recommendation was to raise the rate to NR 5000 [US\$48]/month (NR 20,000 [US\$191] per four month instalment. Looking only at the “extra costs” of disability, which were measured as NR 7,008 [US\$67] per month in the quantitative, even the increase to NR 2000[US\$19]/month for red cardholders would cover only a third of these additional expenses. Given the size of the transfer and the lack of linkages with other services, such as education and vocational training, it is arguably more of a charitable approach at present than an attempt to support and empower people with disabilities to live independent and dignified lives.

Box 9. Use and adequacy of social protection: challenges and examples of good practice

Examples of good practice

- Most recipients of the Disability Allowance reported that they were satisfied with the programme, namely in that they were grateful to be receiving the cash transfer.
- Few Disability Allowance recipients reporting issue with any elements of the collection process. Efforts have been made in Tanahun to improve collection procedures, such as by nominating a proxy for people with mobility limitations.
- Disability Allowance recipients reported that receiving social protection had positive impacts in areas such as meeting basic needs, accessing medical care and improved their relationship with other members of their households.

Areas for improvement

- Many social protection recipients still faced high levels of poverty, food insecurity and barriers to developing stronger livelihoods, meaning that the current content and delivery of social protection is insufficient for many to meet the living costs, let alone develop more sustainable livelihoods.
- Over 40% of Disability Allowance recipients had no input into how the allotment was spent, indicating that its receipt is not necessarily supporting people with disabilities to live independently.

Conclusions & Recommendations



10 Conclusions

Given high levels of poverty and deprivation among people with disabilities (e.g. lower access to education, poorer levels of health and decreased participation in decent work) found in this study, and also reflected in other research in Nepal [38], it is clear that there is a high level of need for social protection among people with disabilities in Nepal.

The social protection system in Nepal includes a wide range of benefits for people with disabilities. Entitlements in health, education and employment, combined with the cash transfer acknowledge multiple elements of potential social and economic marginalisation. Nepal – and the district of Tanahun – have made strides in recent years to improve the provision of social protection and other core services for people with disabilities. Notable policy improvements include removing quotas on the number of Disability Allowance recipients, doubling the Allowance amount and increasing the number of annual deadlines to shorten lag times between application and payment receipt. For implementation of social protection, strengths include a strong involvement of DPOs in raising awareness of available programmes, assisting applicants with forms, and working with the WCDO and Disability Identification Committee on conducting assessments of disability. Additionally, innovations such as outreach camps and shortened assessment procedures have streamlined the application process, reducing the number of visits and improving ease of access.

Still, as with any system, challenges remain. For example, while the disability assessment criteria focus on functioning, guidelines and training on how to implement them are minimal. Consequently, many assessments in practice rely heavily on medical documentation of impairments. There is a concern that certain types of disabilities (e.g. psychosocial impairments, moderate forms of intellectual impairments) are poorly understood, leading to improper categorisation of people with these conditions. Conducting applications at district-level also presents geographic and financial access barriers.

Overall, while social protection may help to improve living circumstances for people with disabilities, at present it is insufficient to ensure people with disabilities meet adequate standards of living. While the increase in the Allowance amount in the coming years will help close the gap, it still does not cover extra costs of disability. While other entitlements, such as for discounted transportation and health services, and supports for education and work, may help address poverty and lead to more sustainable livelihoods, uptake is low. Furthermore, the content and delivery of these benefits could be improved by better aligning them with the needs of people with disabilities and the contexts in which they live (e.g. coverage for rehabilitation/assistive devices, vocational training in employable skills) and enforcing compliance among service providers.

10.1 Strengths and limitations of the study

There are several limitations that should be considered when interpreting the findings of this study. Notably, Tanahun is relatively affluent, has less challenging topography and decent road connections, and was selected to highlight best practices in Nepal's social protection system. Consequently, the results from this study may not reflect the situation across all of Nepal. Additionally, the Washington Group questions used to define disability in

the quantitative surveys may not capture all forms of functional limitations and so will underestimate the overall prevalence of disability. Notably, while the Washington Group asks about depression/anxiety (which is likely to be underreported), other psychosocial may not be captured (e.g. bipolar disorder, schizophrenia); however, the experience of people with these types of disabilities was explored through the policy analysis and qualitative research. Overall, the cases in the study had relatively more severe forms of disability, and so findings may not be generalizable to all people with disabilities. Additionally, while the allotment amounts for the Disability Allowance are due to increase for the 2016/17 fiscal year, at the time of the research (August-October 2016), most recipients reported that they had not yet seen a change in their benefits. Consequently, this research is not able to capture the experience of Disability Allowance recipients under this new policy.

Strengths of the study include the use of mixed methods, which allows for a more comprehensive investigation into our research questions. The use of qualitative and quantitative research in addition to a national policy analysis enables us to corroborate and contrast findings across different methods and respondents, which ultimately both broadens and deepens our understanding of the strengths and weaknesses of social protection provisions for people with disabilities in Nepal. For the quantitative surveys, the study sample was large and population-based, which improves generalisability of results. We also used a variety of tools to measure both need for, access to and use of the Disability Allowance and its linked benefits.

11 Recommendations

The recommendations outlined below are the result of consultation between the London School of Hygiene & Tropical Medicine, Valley Research Group and stakeholders in disability and social protection in Nepal, including representatives from government, NGOs, DPOs and other experts, who were consulted as part of a dissemination workshop in Kathmandu on March 21, 2017.

11.1 For national policy

- Consider ways to update social protection benefits so that they better enable people with disabilities to at least meet basic needs, accounting for both ordinary and disability-related costs. This may include increasing the value of the Disability Allowance allotments in line with the Supreme Court recommendations or targeting some of the drivers of poverty through other programmes (e.g. expansion of healthcare entitlements to target high healthcare costs, better access to and quality of vocational training).
- Streamline the application process for the disability card, for example by empowering the WCDO to conduct assessments independently for non-complex cases. Also, consider conducting applications at VDC-level, as is done for with other forms of social assistance, or planning more mobile outreach camps.
- Align benefit packages with the needs of people with disabilities more effectively, taking into consideration differences in contexts and individual characteristics. For example, vocational training programmes should be better tailored to meet the

needs of the local job market and the skills of the participant. Similarly, more focus is needed on employment in the informal sector, where many people with disabilities, particularly women, work.

- Increase availability, quality and budgets for health and rehabilitation services/assistive devices, vocational training, specialist education resources and disability-friendly infrastructure and information.
- Review criteria for assessing disability to promote better inclusion of people with certain impairments (e.g. of people with psychosocial impairments, disability due to ageing). Also, increase training of assessors to improve their understanding of disability.
- Promote greater inclusion of people with disabilities in the design, implementation and monitoring of all social protection schemes.
- Ensure non-disability targeted programmes are inclusive of people with disabilities. Notably, remove limitations that individuals can only receive one type of social assistance or adapt eligibility criteria and benefit levels to adequately reflect and address overlapping sources of marginalisation.
- Collect statistics on the coverage and use of all disability-targeted social protection entitlements as well as the participation of people with disabilities in non-disability targeted programmes.
- Enact other initiatives that support the development of more inclusive societies. Social protection is one tool for reducing poverty and improving living conditions among people with disabilities, but its benefits will be maximised if barriers to inclusion such as inaccessible built environments, discrimination and lack of quality, affordable healthcare and education are also addressed.

11.2 For implementation in districts

- Increase awareness among people with disabilities about the range of disability-targeted and non-targeted social protection entitlements available. For example, DPOs, as well as NGOs working in disability or social protection, should be trained to engage with their membership to encourage and support applications. In particular, benefits available to lower level cardholders need to be more broadly publicised to encourage applications amongst those ineligible for social assistance as well as increase their uptake among already certified people with disabilities and encourage enrolment of people with less severe disabilities.
- Strengthen referral strategies to link people with disabilities with other services and programmes, including rehabilitation, vocational training and educational programmes. For example, increasing the role of DPOs in the application process could enable them to reach out to a wider range of people with disabilities and increase their awareness of the variety of services they can access.
- Ensure service providers (e.g. in public transportation, healthcare) honour entitlements. Key activities could include improving awareness of these benefits among relevant providers, collecting data on the use of benefits and more rigorously enforcing compliance.

- Increase engagement with DPOs and people with disabilities to ensure their meaningful participation in planning, implementation and monitoring of the Disability Allowance, linked benefits and other forms of social protection.

11.3 For research

- Longitudinal, impact evaluation studies are needed to explore the effectiveness of social assistance, health insurance and other social protection provisions in promoting the economic and social inclusion of people with disabilities. Measuring changes pre- and post-enrolment, and at different time points over the duration of support, can determine more fully if social protection improves living circumstances and well-being for people with disabilities.
- Identify best practices and tools for assessing disability, including for psychosocial impairments and in young children, in the context of social protection eligibility. Evaluate the consequences of different approaches in terms of human and material resources required, experience of the applicant and resulting coverage for different subgroups (e.g. by impairment type, age groups, sex). Additionally, explore and trial monitoring strategies that governments can implement to make use of information collected during the disability assessment process to better understand support needs of people with disabilities and plan adequate policy responses.
- Conduct similar research across other districts in Nepal (particularly in the more inaccessible mountain areas) and internationally to explore how the need for and access to social protection varies in different contexts. Analyses on the strengths and challenges of other social protection systems in responding to the needs of people with disabilities would broaden a currently limited evidence base.
- Across all research, disaggregate data to account for the heterogeneity of experiences of people with disabilities, due to factors such as sex, age, impairment types. Explore in targeted research the impact of intersectionality on need for, access to and use of social protection.
- Conduct research focusing on the inclusion of people with disabilities in large-scale mainstream schemes and consider the merits and disadvantages to targeted or mainstream approaches to social protection for people with disabilities.

11.4 For donors

- Mainstream disability across all programmes. For example, include indicators on disability (disaggregated by sex, age group, impairment type and other characteristics) in monitoring and evaluation frameworks to ensure projects are disability-inclusive in terms of access and impact.
- Support more research on disability and social protection to improve the evidence-base in this field. In particular, impact evaluations of existing programmes and trials of new interventions are needed to establish “what works”. This could include consideration of contexts where disability-specific approaches are appropriate or effective, and those where an approach of improving the inclusiveness of and access to mainstream services is appropriate.

- Work with governments and other stakeholders to promote and enact evidence-based policy for disability-inclusive social protection.
- Advocate for full inclusion of DPOs and people with disabilities within all stages of policy and programme development, for social protection or otherwise.

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