POLICY PAPER

TOWARDS A BETTER FUTURE: STRENGTHENING GENDER-RESPONSIVE AND DISABILITY-INCLUSIVE TRANSFORMATIVE CARE AND SUPPORT

SPECIAL PROCEDURES
UNITED NATIONS
HUMAN RIGHTS COUNCIL

UN WOMEN

FOR ALL
WOMEN
AND GIRLS

Produced by UN Women in collaboration with the United Nations Special Rapporteur on the Rights of Persons with Disabilities, New York, April 2026.

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Cover photo: UN Women Rwanda

Layout design: Ikromjon Mamadov

This publication was made possible thanks to funds from the Global Disability Fund however it does not necessarily reflect the official position of the Fund.

Leveraging knowledge exchange, innovation, and coordination, the publication was also benefited from ongoing relevant UN and non-UN joint thematic programmes, projects, and initiatives across regions.

Please cite this publication as: UN Women. 2026. Towards a Better Future: Strengthening Gender-Responsive and Disability-Inclusive Transformative Care and Support. New York: UN Women HQ.

TOWARDS A BETTER FUTURE: STRENGTHENING GENDER-RESPONSIVE AND DISABILITY-INCLUSIVE TRANSFORMATIVE CARE AND SUPPORT

Disability Inclusion and Intersectionality Series
UN Women
New York, 2026

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EXECUTIVE SUMMARY

Advancing and strengthening gender-transformative and disability-inclusive care and support systems is fundamental to the full and effective enjoyment of human rights. It also is a prerequisite for achieving the Sustainable Development Goals (SDGs) including SDG 5, under which is Target 5.4. “Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate”.

Efforts to transform care and support systems must actively and systematically advance non-discrimination and gender equality across society. Achieving this requires identifying who is excluded or discriminated against, understanding how and why, and recognizing those experiencing multiple and intersecting forms of discrimination. It also requires pinpointing inequalities in care and support outcomes and opportunities, as well as patterns of discrimination in laws, policies and practices. The goal is to prioritize these efforts to support the hard-to-reach and make the invisible visible.[1]

This policy paper provides key insights into the intersection of gender and disability as it relates to care and support systems. It highlights that advancing comprehensive care and support systems is essential to promoting gender equality and upholding the rights of those providing and those receiving care and support, particularly persons with disabilities. Care and support systems should adopt an intersectional and human rights–based approach and promote shared responsibility across genders and among households, families, communities, the State and the private sector. Recognizing that needs evolve across life stages, care and support systems must incorporate a life-course approach.[2]

Current data systems rarely capture how care and support needs evolve over the life course, both for those providing and those receiving care and support , at the intersection of gender and disability, including when long-term care and support are required. When data methodologies integrate this perspective, care and support policies, programmes and services can reflect and respond to when, how and why support needs change.

Key principles that underpin the transformation of care systems are: human rights-based, State accountability, universality, transformation and leaving no one behind.[3] Advancing gender equality, disability inclusion and the rights of persons with disabilities – whether they provide or receive care and support – requires challenging and addressing the unequal social organization of care and support in a way that is consistent with human rights. The 6R Framework (Recognize, Reduce, Redistribute, Reward, Represent and Resource) can contribute to this end.[4]

Autonomy, independent living, legal capacity and individualized, community-based support are essential to reorganizing care and support systems that advance the rights of persons with disabilities, which under the Convention on the Rights of Persons with Disabilities (CRPD) are legal obligations of States. Care and support systems guided by these principles are essential to guaranteeing persons with disabilities the full and effective enjoyment of broader sectoral rights.

INTRODUCTION

Globally, women and girls undertake a disproportionate share of unpaid care, often at high costs to their human rights and gender equality.[5] Compared to men, women spend 2.5 times as many hours per day in unpaid care work.[6]

Women also make up a large portion of the paid care work sector, often in low-paid, informal or precarious work.[7] This reduces women's and time and opportunities for education, decent paid work and political participation, and contributes to occupational segregation by pushing women into low-paid and precarious jobs. Over the life course, these effects are observed on social protection coverage, earnings and the ability to build savings and achieve income security. These persistent gender disparities limit women's autonomy and impede progress towards realizing the Sustainable Development Goals, including SDG 5, on gender equality and women's empowerment.

In most countries, data are limited on the extent to which care and support policies are disability-inclusive.[8] Urgent policy action and investments are needed to design evidence-based care and support systems that recognize the life course dimension of unpaid care and support, particularly by or for children and for persons with disabilities, whether as providers or receivers of care and support. The Beijing Declaration and Platform for Action recognizes the intersectionality of gender and disability, highlighting the particular barriers faced by women and girls with disabilities, and calling for actions to ensure their full and effective participation.[9] It emphasizes the equal sharing of family care and support work by men and women, and advocates for the promotion of the harmonization of paid and unpaid work, as well as recognizing and valuing unpaid care and domestic work through public services, infrastructure and social protection policies, also reflected in Target 5.4 of the SDGs.[10]

It is important to recognize that women experience a disproportionate responsibility for care and support work compared to men. The unequal social organization of care and support is a major driver of poverty and gender inequality as it restricts women's time and opportunities to access education, decent jobs, participate in public life, and enjoy rest and leisure. Around 708 million women worldwide are outside the labour force due to unpaid care work.[11] This has significant consequences, especially for women with disabilities. Persons with disabilities, and especially women with disabilities, often also provide care and support to their family and community, yet these roles are frequently overlooked and persons with disabilities are further invisible in policymaking and incorrectly perceived as passive care recipients with limited autonomy in care. They are subjected to intersectional forms of discrimination due to their gender and disability status and continue to be at a disadvantage in most spheres of society and development.

Available data suggest that the gap is stark compared with men without disabilities: women with disabilities are three times more likely to have unmet needs for healthcare, three times more likely to be illiterate, two times less likely to be employed, and two times less likely to use the Internet.[12] In countries that lack such data, policies may be imprecise. They may result in persons with disabilities, including children with disabilities, being incorporated into broad care policies that do not address their specific needs, or in the creation of small-scale, disability-specific programmes that are too narrow.[13] To ensure a holistic gender-responsive and disability-inclusive care and support policy environment, it is crucial to consider persons with disabilities,[14] and recognize them as rights holders and having agency.

BOX 1

Definitions of care and support

Care and support are complementary and interconnected concepts that enable participation in society with dignity and autonomy.

Care refers broadly to all the activities that sustain daily life, human well-being and the sustainability of communities and the planet. It encompasses care for oneself and for others, including the provision of support and assistance to those who require it to enable their participation in society with dignity and autonomy.[16] Care work includes both paid and unpaid activities, comprising direct care for people (physical, emotional, psychological and developmental) as well as indirect care activities, such as cooking, cleaning and household management.[17]

Support, as articulated under the Convention on the Rights of Persons with Disabilities (CRPD), refers to assistance provided to those who require it to enable individuals to carry out daily activities and participate fully in society. Support is grounded in autonomy, dignity and respect for the will and preferences of the person concerned. It recognizes that both receiving and providing support are universal human experiences, and that support must enable participation,[18] inclusion and independent living.

For the purposes of this policy paper, the terminology "**care and support**"[19] is used to emphasize the centrality of support in advancing autonomy, dignity and inclusion of persons with disabilities. "Care" or "support" are used when citing evidence and research that focus only on one or the other.

A transformative gender-responsive and disability-inclusive care and support system is characterized by investing in robust, gender- and disability-disaggregated data; establishing and implementing legal and policy frameworks for accessible care and support; financing inclusive care and support services; delivering on inclusive education and social protection services; and strengthening mechanisms that guarantee the participation of women and girls with disabilities and their organizations in care and support policy processes. It also requires investments in accessible physical infrastructure and assistive and digital technologies; measures to support unpaid caregivers through services, income and social protection; actions to challenge discriminatory social norms around gender, disability and care; and the promotion of decent work for care and support workers, including fair pay, social protection, safe working conditions and opportunities for training and professionalization, including for persons with disabilities. Such investments are not optional; they are central to fulfilling States' obligations to provide access to care and support for providers and recipients alike, particularly for persons with disabilities as rights holders, and as set out in international human rights law.

Effective inclusion initiatives require cross-sectoral and multi-stakeholder coordination. Disability-inclusive care and support systems must "enable independent living and autonomy of persons with disabilities, while redistributing and valuing unpaid care and support provided predominantly by women and girls and progressing deinstitutionalization."[15]

BOX 2

Gender-responsive and disability-inclusive care and support as it relates to human rights

Care and support are interconnected to gender equality and human rights. The CRPD established the concept of **support**[20] for persons with disabilities and provides a comprehensive framework for implementing care and support systems.[21] In addition, the jurisprudence of some human rights treaty bodies addresses the importance of **care** in connection with the enjoyment of other human rights.

Support is closely interconnected with the rights of persons with disabilities to equal recognition before the law and legal capacity (CRPD Art. 12), living independently and being included in the community (CRPD Art. 19), and respect for home and the family (CRPD Art. 23). The Convention on the Rights of the Child (CRC, Art. 18) supports parents in their care responsibilities and the right of children to be heard, including in matters related to the care and support they receive or provide.

CRPD Committee General Comment No. 5 (2017) on living independently and being included in the community (Art. 19) and guidelines on deinstitutionalization, including in emergencies (2022),[22] allow for informal family support with the express consent of the individual with the disability.[23] The Committee further emphasizes that support is a cross-cutting obligation under the Convention.[24] The Committee on the Rights of the Child, in its Concluding Observations, has underlined that appropriate care and support are necessary to prevent family separation, protect children deprived of their family environment, ensure an adequate standard of living, support children with disabilities and their families, and avoid violence, abuse and neglect.[25]

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) sets out a framework for equality between women and men. It recognizes the shared responsibility of parents in caregiving for children and calls on States to provide social services that enable the reconciliation of family responsibilities with paid work and public life, while ensuring women's equal access to education, healthcare, employment and social security, among other rights. Both the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) acknowledge in their Concluding Observations that care and support systems are required to achieve gender equality. Further, the CEDAW Committee, highlights the importance of care and support in challenging stereotypes and harmful practices, guaranteeing women's rights to work, social protection, health and education; and the CESCR Committee emphasizes the role of care and support in enabling persons with disabilities and older persons to live in the community, and guaranteeing the rights to work and the social protection of caregivers, and advancing the deinstitutionalization of children with and without disabilities.[26]

Other human rights procedures and mechanisms have addressed the centrality of care and support,[27] and various United Nations intergovernmental bodies like United Nations General Assembly and Human Rights Council, and the International Labour Conference have adopted resolutions on care and support.[28]

At the regional level, the Inter-American Court of Human Rights issued an Advisory Opinion[29] recognizing care as an autonomous human right and as a basic human need required by all at some point in life and emphasizing that guaranteeing this right involves ensuring both the autonomy and independence of those receiving care as right holders and the rights of those who provide it.

1. DISABILITY-INCLUSIVE AND GENDER-RESPONSIVE CARE AND SUPPORT

Underpinning this and the following sections is the understanding that: (a) the structural absence or insufficiency of formal, rights-based State-provided care and support systems, including for persons with disabilities (e.g. individualized support, personal assistance, accessible services, community-based support) is closely interlinked to the gendered gap in care and support; (b) persons with disabilities are rights holders, and they are diverse, meaning their needs for care and support vary; and (c) care and support must contribute to the autonomy, participation and independent living of the person. While some persons may require 24-hour care and support, others can live more independently with the appropriate care and support.

1.1. WHO PROVIDES CARE AND SUPPORT?

Globally, women perform over 76 per cent of total unpaid care work.[31] Women with disabilities, like their counterparts, are also more likely to provide care and support than men.

For women with disabilities, care responsibilities and unmet care needs may increase in times of crisis. Based on data available from 26 rapid gender assessment surveys to measure the impact of COVID-19, the provision of unpaid care work and domestic work during the pandemic increased more among surveyed women with disabilities (54 per cent) than among women without disabilities (49 per cent), men with disabilities (47 per cent) or men without disabilities (44 per cent).[32] The same was true for women with disabilities aged 60 or older.[33]

BOX 3

Colombia: Who provides unpaid care

According to the 2020–2021 Colombia National Time-Use Survey,[30] around 80.2 per cent of the individuals who assist or support persons with disabilities within households on an unpaid basis are women. Women dedicate an average of 7 hours and 44 minutes, compared to the 3 hours and 6 minutes that men dedicate. The Time-Use Survey shows similar patterns in rural and urban areas. On average, women in rural areas spend one hour more on unpaid care and support than women in urban areas. The Time-Use Survey also measured the proportion of persons with disabilities that participate in unpaid care activities. It found that over two-thirds (61.2 per cent) of persons with disabilities in Colombia participate in unpaid activities. For women with disabilities, this rate was more than 20 per cent higher than for men (71.2 and to 49.5 per cent, respectively), and that daily, women with disabilities dedicate an average of twice as much time as men with disabilities (6 hours and 41 minutes, compared to 3 hours and 29 minutes).

While taking on more unpaid care work, more women with disabilities than women without disabilities reported difficulty accessing sanitary and health products, medical care, accessing water and transportation.[34] Those of working age were more likely than their counterparts without disabilities to report lost earnings, and to lose their jobs and earnings.[35] At the same time, fewer women with disabilities, including single women with disabilities and those with children in the household, than their counterparts without disabilities reported receiving cash and in-kind relief.[36]

Available data from 14 countries show that, although in most countries the percentage of women with disabilities receiving care and support was higher than the percentage of men,[37] the percentage of women needing and not receiving it was higher than the percentage of men.[38] Based on a study in Europe, over one-third of persons with disabilities aged 65 years and older reported unmet needs for assistance in daily activities. Women in this group were 18 per cent more likely than men to report unmet needs. Older adults with higher support needs were 89 per cent more likely than those with lower support needs to report unmet needs.[39]

Another important trend emerges from data across countries that are also increasingly investing in collecting through disability surveys data on unmet care needs for persons with disabilities. According to a recent report across nine countries, more than one-third of persons with disabilities receiving support report needing additional assistance. The highest percentages of persons with disabilities needing more support were in Laos (73.6 per cent), India (65.7 per cent), Sri Lanka (64.1 per cent) and Afghanistan (63.2 per cent).[40] Additionally, a significant share of persons with disabilities not receiving any care report that they need it. In countries like Cameroon, Laos and the Philippines, this proportion exceeds 50 per cent of all persons with disabilities.[41] Countries with the highest access to care and support, such as Laos (75.4 per cent) and Tajikistan (71.8 per cent), sometimes paradoxically also have the highest unmet needs – at 73.1 and 50.1 per cent, respectively – suggesting that the expansion of care services has not kept pace with demand[42] of quantity and/or quality. While these data are essential, they do not fully capture the demand and need for care and support and services across the diversity of persons with disabilities.

BOX 4

Addressing care in times of conflict and crisis

Care is a universal and cross-cutting issue across all contexts, including humanitarian settings; yet it continues to be insufficiently recognized, resourced and addressed systematically.

Care considerations should be an integral part of humanitarian action, including in times of conflict and crisis where, generally, the need for care and support increases as care services and infrastructure deteriorate or are destroyed. Care and support must respond to the different dimensions and needs of people who provide and receive care and support, including persons with disabilities and other marginalized populations, as well as new care and support needs that arise in these contexts. To be effective, this requires an intersectional and participatory approach from needs assessment and design of response to peacebuilding, reconciliation and reintegration. To address the "inequalities in the social organization of care before, during and after crises and conflicts", it is necessary to engage women in mediation, peace negotiations, governance, processes, security sector reform, disarmament, demobilization and reintegration.

Source: UN Women. 2025. *Addressing Care in Times of Conflict and Crisis: Guidance Note*. pp. 16, 20, 29, 44.

1.2. THE CASE FOR TRANSFORMING THE ORGANIZATION OF CARE AND SUPPORT AT THE INTERSECTION OF GENDER AND DISABILITY

A high demand for care and support services for persons with disabilities, combined with inadequate formal care and support systems, places a significant share of unpaid care and support work on families, particularly women. The evolving care economy challenges the status quo of inadequate support for persons with disabilities and stark gender inequalities in the provision of unpaid work.[43]

1.2.1. Unpaid care and support: cumulative impact on caregivers in older age

According to the Disability Inclusion Status report 2025, women of older age, including women who spend time providing care and support for persons with disabilities, report experiencing low-income security, including no pensions or savings, compounded by limited social protection, which leaves them economically vulnerable.[44]

1.2.2. Women with disabilities wage gap

Women with disabilities earn 5 to 6 per cent less than men with disabilities.[45] Interventions that address disability inclusion may not entirely reduce the wage gap unless they also address gender-specific barriers.

1.2.3. Young persons with disabilities, unemployment and access to services

Young persons with disabilities are more likely than those without disabilities to be out of education, training and employment. Pre- and post-transition to adult services, they report unmet needs in knowledge, information and support with housing, benefits and finances, further education, employment and a range of other domains. This makes it less likely that, as adults, they will have access to key services, including healthcare and social protection benefits.[46]

1.2.4. Gender-based violence and women and girls with disabilities

Women and girls with disabilities are at a higher risk of violence than others, and experience specific manifestations of violence – for example, neglect, abandonment, removal or threats to remove assistive devices, water or food, and forced or coerced sterilization and contraception without free and informed consent. This violence is many times by State and non-State institutions, within the family or the community. At the same time, adequate and accessible support services and justice or related information are not available to them.[47] Women and girls with disabilities are often excluded from sexual and reproductive healthcare,[48] and are less likely than other women (77.6 and 46 per cent, respectively) to meet their family planning.[49]

1.2.5. Need for data and evidence

There is a need to improve evidence to support gender-responsive and disability-inclusive rights-based care and support systems across the life course, and to address persistent data gaps. Strengthening production, quality and use of gender and disability data, including by integrating disability questions in time-use surveys or other related household or labour force surveys, and time use, need and adequacy of care and support questions in disability inclusion surveys to capture disability-related data, is foundational to advancing gender-responsive and disability-inclusive care systems. This requires distinguishing care work and demand for support services, including by and for persons with disabilities in line with Article 31 of the CRPD, and standardizing methodologies.

Partnerships and international cooperation remain key to developing capacities and resourcing the production and use of data in this area. This requires States, non-State actors and organizations of persons with disabilities (OPDs) to work together.

1.2.6. Invisibility of caregivers with disabilities in policy and data

Persons with disabilities are not passive recipients of care and support. They also provide care and support to family members and others, including as paid care and support workers – such as nurses, personal assistants, community support workers and other professionals – whose contributions and labour rights often remain insufficiently recognized in policy and data systems, contributing to gaps in support measures such as respite services, income support and labour protections. Recognizing and supporting care and support by persons with disabilities is essential to developing inclusive care systems.

1.3. COMPREHENSIVE CARE AND SUPPORT SYSTEMS: A TRANSFORMATIVE APPROACH

Care and support systems fundamentally include: "legal and policy frameworks, services, financing, social and physical infrastructure, programmes, standards and training, governance and administration, and social norms"; a "comprehensive care and support system" involves these components working together in an integrated and intentional way to establish a new social organization of care that helps, supports "and cares for people and the environment."[50] Transforming care and support systems – and advancing comprehensive care and support systems – requires a "paradigm shift" away from models that treat care and support as private responsibilities and "towards a society that prioritizes the sustainability of life and care for the planet", guarantees the human rights of people who receive or provide care, and promotes co-responsibility for care provision – with the State as a primary duty bearer.[51] The State is responsible as a regulator, articulator and provider of care and support.

BOX 5

The 6Rs framework

As noted in the UN System Policy Guidance on Transforming Care Systems,[52] the 6R framework[53] (Recognize, Reduce, Redistribute, Reward, Represent, Resource)[54] can be used to identify the objectives and impact of care-related interventions. The framework is a human rights-based, transformative approach to public policy, grounded in gender equality and social justice, that has evolved over the years to encompass both unpaid and paid care work and the resourcing of care systems.[55]
It is important, as a developmental good, to build care systems that incorporate the 6Rs: ***Recognizes*** care work (unpaid and paid) as well as the rights and the contributions of those providing and receiving care and support across their life course; ***Reduces*** the time and energy required for indirect care work (e.g. cooking, laundry) by increasing access to time-/energy-saving technologies and infrastructure; ***Redistributes*** time, cost and responsibility for unpaid care work among the State, the private sector, communities, families/households and between genders; ***Rewards*** paid care workers by ensuring decent work, social protection, and equal rights and opportunities; ***Represents*** caregivers (paid and unpaid) as well as the people who receive care in decision-making and social dialogue; and ***Resources*** care systems over the long term through sustainable investments in the resources and social and physical infrastructure needed.[56]

Gender- and disability-transformative care and support policies and programmes may include those that focus mainly on: (a) care and support workers, like training and psychosocial support for them; (b) persons with disabilities like personal assistance and independent living programmes; and (c) care and support providers and recipients, like respite care, cash-for-care, peer support, care centres and care leave programmes. Some of these may intersect.[57]

Persons with disabilities may require care and support for daily living activities, communication and decision-making. Specific examples are supported decision-making and self-advocacy, sign-language or Deafblind interpretation, assistive technology, assistance with mobility, self-care, household management and participation in the community, adapted housing and accessible transport, and family support measures for caregivers – such as flexible working hours and carers leave for parents, family and other unpaid providers of care and support, and respite care.[58]

Robust and integrated care and support systems can contribute to the prevention of and quick response to gender-based violence (GBV), including by training those providing care and support to identify GBV against people who require support, and by providing information to women with disabilities on the topic, how to activate response routes and prevent revictimization in the process. Under robust care and support systems, governments have prevention and response routes to GBV, and government officials are trained on how address GBV against women with disabilities. Similarly, care and support systems can contribute to removing the barriers to access SRHR.

1.3.1. Gender- and disability-inclusive policy measures to operationalize the 6Rs

Specific measures to operationalize the 6Rs across care and support systems and ensure they are gender- and disability-inclusive include:

- **Recognize** the rights of those providing and receiving care and support through legal and policy frameworks that ensure access to care and support for persons with disabilities across the life course, and that recognize unpaid carers, including full-time unpaid carers, and the value of their work. ; strengthen gender- and disability-disaggregated data systems.
- **Reduce** the time and intensity of certain indirect care and support tasks by investing in technologies and equipment, including assistive technology (e.g. wheelchairs, screen readers, text-to-voice, wheelchairs, protheses) that enhance the independence of persons with disabilities and reduce the workload for caregivers, including when persons with disabilities themselves are caregivers; accessible infrastructure like tactile paving, Braille signage, auditory signals at traffic lights, visual announcements in transit, ramps, accessible websites, clear signage, and quiet rooms; and ensuring that such infrastructure and technologies are free or affordable for low-income groups.
- **Redistribute** care work through community-based services; flexible work arrangements and carers' leave programmes; inclusive education; social protection benefits for caregivers; training and support for family caregivers; tele-education and telemedicine; disability cash transfers; personal assistance; case-management systems; respite care; early identification and intervention; childcare and psychosocial support; social norms change campaigns that address intersectionality.
- **Reward** paid care and support workers through formalization; training and certification; and decent work and social protection.
- **Represent** caregivers (paid and unpaid) and care recipients through community-based participatory systems; peer support networks; and policies and processes that provide for the direct representation of specific groups and persons like older persons, migrant workers, youth and their organizations – including OPDs, unions and caregivers' organizations
- **Resource** care and support systems through long-term, sustainable public financing; gender- and disability-responsive budgeting; direct public resources towards universal social protection, care services and high-quality public infrastructure that are gender-, disability- and age-responsive; fiscal incentives and subsidies for care-related goods and services, and innovative public and private investments in areas of care and support including services, technology and training.

2. GENDER EQUALITY AND THE RIGHTS OF THE CHILDREN WITH DISABILITIES

2.1. CHILDREN WITH DISABILITIES

An estimated 1.3 billion people, or 16 per cent of the global population, experience significant disability.[59] Nearly 240 million of them are children.[60] Children with disabilities include children who were born with a genetic condition that affects their physical, mental or social development; those who acquired or sustained a serious injury, nutritional deficiency or infection that contributed to long-term functional difficulties; or those exposed to environmental toxins that resulted in developmental delays. Children with disabilities also include those who developed anxiety or depression because of life conditions and events that trigger significant physical and psychological strain.

Children with disabilities are rights holders entitled to individualized, community-based support that enables their development, participation and future autonomy on equal basis with others.[61] Recognizing the evolving capacities of the child, particularly in early childhood, care, if no longer required, should progressively shift to support. Gender norms and structurally insufficient, rights-based support systems for children with disabilities and contribute to the gendered gap in care and support.

2.1.1. Mothers as primary caregivers of children with disabilities

A notable gendered pattern can be seen in the care of children with disabilities. In some contexts, mothers are often expected to assume primary care and support. Some women choose part-time jobs, quit or reject higher responsibility jobs. In many cases, women caring for children with disabilities face discrimination in the workplace and reduced access to opportunities, often driven by social norms and structural barriers rather than individual choice.

Other female relatives, in particular grandmothers, are also likely to be involved. Studies on the care economy in Lebanon and Oman also indicate that mothers are the primary caregivers for children with disabilities and, to balance paid work and unpaid care responsibilities, they often rely on older women (grandmothers) to share these disproportionate responsibilities.[62]Primary caregivers organize access to services and support for children with disabilities, with the invisible and unrecognized work undertaken mainly by mothers.[63]

2.2. SOCIAL NORMS, STIGMA AND DISCRIMINATION: CHILDREN WITH DISABILITIES AND THEIR FAMILIES

2.2.1. Impact on mothers

The gendered division of care and support for children with disabilities is linked to stereotypical gender roles and ideals of motherhood, reinforced by prevailing charity and medicalized attitudes towards disability. In some contexts, caring for children with disabilities at an early age may be assumed as a form of self-sacrifice from 'perfect' mothers; in others, impairments may be considered a personal tragedy that is best managed privately.[64]

Mothers may encounter shame and blame for bearing a child with a disability. Such attitudes can be extreme when mothers are blamed for "causing" impairments because of presumed failings to observe lifestyle recommendations during pregnancy or when they choose to have the child despite the risk of congenital complications detected during pregnancy.[65] Many mothers and children with disabilities are often abandoned by their partners/fathers, either when the impairment is identified or as the long-term implications of the care and support needs become apparent.[66]

2.2.2. Stigma towards children with disabilities

In some cases, children with disabilities are seen as a curse and punishment for their parents, especially mothers who end up being pressured to abandon their children. Cases of medical professionals encouraging parents to institutionalize their children with disabilities, including after birth, have also been reported,[67] as well as institutionalization at very early childhood stages. While precise figures are difficult to obtain, children with disabilities are placed in institutional care. The result is that even informal support from extended families or community members is often not provided to those caring for and supporting children with disabilities. Parents or other caregivers often must struggle alone or may resort to placing children in institutional care.[68]

2.3. THE CASE FOR TRANSFORMING THE ORGANIZATION OF CARE AND SUPPORT FOR CHILDREN WITH DISABILITIES

Mothers of children with disabilities are exposed to economic consequences, such as time poverty, which also affects the upbringing of children with disabilities when finances are not sufficient to support them. Worldwide, women and particularly mothers, are expected to or may reduce, stop paid work or reject certain jobs to provide unpaid care and support for children with disabilities. In early childhood, mothers may be unable to secure, timely early therapeutic diagnosis, respite care and inclusive education opportunities because costs are too high.

In Europe, 85 per cent of families of children with autism reported that their incomes have been negatively affected, with 42 per cent of primary caregivers leaving their jobs and 32 per cent scaling back professional commitments.[69] The income to cover costs associated with care and support for children with disabilities are often insufficient, especially when employment opportunities are limited.

In some countries, the extra costs surpass the national average income,[70] which is clearly impossible for most families to meet. In the Philippines, families with children with disabilities were found to be systematically disadvantaged in accessing basic services compared with other families, with their children needing expenditures 40 to 80 per cent higher than other children. As a result, poverty rates were 50 per cent higher in households with children with disabilities,[71] with only 27.8 per cent of persons with severe disabilities worldwide receiving a disability benefit.[72]

The cumulative effects of stigma and isolation, and disproportionate care and support work, pose a physical and emotional toll on those that provide care and support particularly mothers, in the long run.Many primary caregivers experience high and sustained levels of anxiety, depression, fatigue, guilt, denial and fear, while lacking access to adequate mental health support. This is compounded by a sense of being left alone to navigate complex and fragmented care and support systems.[73] Without understanding these dynamics, care and support policies and programmes risk overlooking the hidden barriers that shape who provide care and support, how these are delivered and whose needs remain unmet.

2.4. RECOGNITION AND VALUATION OF CARE FOR CHILDREN WITH DISABILITIES

Such realities are inadequately captured in official data. Limited availability of gender- and disability-disaggregated data on care patterns and the experiences of persons with disabilities across their lives impedes evidence-based care policy formulation and the design of tailored social protection, decent work opportunities and rights-based disability-inclusive care support services.

Slow changes and investment in the recognition and valuation of care and support for children with disabilities have been observed globally, with significant data gaps and instances in which nuances are subsumed within various categories by traditional data-collection methodologies. The International Classification of Activities for Time-Use (ICATUS 2016) serves as an important input for monitoring progress made towards the achievement of the Sustainable Development Goals and targets, including Target 5.4 to 'recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate' and the related indicator 5.4.1 on the proportion of time spent on unpaid care and domestic work, by sex, age and location. However, the structure of ICATUS 2016 does not distinguish between caring for children with disabilities and caring for other children, because all children require care and supervision.[74]

While recognizing that ICATUS 2016 is not a disability-specific framework, meaningful insights into the lives of children with disabilities can be missed. There is an opportunity to capture children with disabilities specifically. For instance, this could be done using ICATUS codes on unpaid care and support for children and for dependent persons, layered with more granular codes. Such codes could relate to measuring service and infrastructure gaps for children with disabilities collected through other relevant questions in the background questionnaire of the time-use survey, while working in collaboration with OPDs. Without this evidence, care and support work remain undervalued, underresourced and disproportionately shouldered by women, including women with disabilities, therefore perpetuating cycles of inequality. This also may impact children with disabilities attaining and maintaining maximum independence, and full inclusion and participation in all aspects of life on an equal basis with other children.

2.5. INVESTMENT IN SUPPORTING FAMILIES AND CAREGIVERS

In line with the CRPD and CRC Conventions, it is important that States provide mechanisms that support the identification, rehabilitation – typically time-bound, health- or function-oriented – and habilitation[75] aimed at enhancing skills or capacities of children with disabilities within comprehensive care and support systems, including individualized support, grounded in the principles of human dignity and 'leaving no one behind.'

Investing in supporting families and those that provide care and support improves equitable social and economic growth,[76] and ensures the right of the child to a family. Support can be provided within a framework of gender-responsive, disability-inclusive and transformative care and support systems. Establishing legal and policy frameworks that provide early childhood support, education, health services, employment opportunities and social protection is crucial.

3. A SNAPSHOT OF GOOD PRACTICES AND KEY LESSONS

A gender-responsive, disability-inclusive and transformative care and support system must be grounded in the rights and needs of both the people who provide and receive care and support. This requires legal and policy frameworks that ensure access to adequate, quality, affordable and accessible care and support across the life course – such as early childhood support, education, health services, decent work and social protection – including for unpaid and paid care and support workers.

Targeted and adequately resourced measures are needed to address the specific barriers persons with disabilities face, recognize their roles and ensure the fulfilment of their rights. Upholding the right of persons with disabilities to independent living, autonomy, community inclusion, person-centred support must be at the heart of any measure.

This section highlights promising practices to inform gender-responsive, disability-inclusive care and support policies and programmes at the national level, including measures that strengthen support for families and unpaid care and support workers.

3.1. STRENGTHENING CARE LEGAL AND POLICY FRAMEWORKS

To be effective and human-rights compliant, national care and support systems must be developed, implemented and monitored in close and meaningful consultation with persons with disabilities, including children with disabilities and their families and caregivers.[77]

3.1.1. The Australian National Carer Strategy 2024–2034 and Australia's National Disability Insurance Scheme (NDIS)

The National Carer Strategy 2024–2034 recognizes and values the essential role caregivers play in Australian society and addresses significant challenges they face[78] to maintain their well-being, participate fully in social and economic life, and continue in their caring roles over the long term. The Strategy acknowledges that women often undertake care and support work and many caregivers also live with disability, and places emphasis on inclusion by committing to meet the needs of caregivers from diverse backgrounds. Their experiences are gathered through national consultation shaping policy. Through a 10-year national agenda and an initial 2024–2027 Action Plan, the Strategy expands services such as the Carer Gateway, increasing access to counselling, skills training, peer support and educational assistance, with the overarching goal of improving carers' quality of life and strengthening Australia's care system. This is complemented by Australia's National Disability Insurance Scheme (NDIS), which introduces individualized funding and greater choice and control for persons with disabilities over their support arrangements.

3.1.2. Romania’s Law 448/2006: Advancing care work, disability rights and family support

Romania’s legislative framework and care services recognize some of the values of unpaid care work and contribute to redistributing care work responsibilities for mothers of children with disabilities, care receivers and women with disabilities who are primarily in need of support. The Romanian State is responsible for ensuring that rights are statutorily guaranteed. Benefits and services are adequate and collectively financed as part of universal, solidarity-based[79] Law No. 448/2006 on the Protection and Promotion of the Rights of Persons with Disabilities, acknowledges caregiving as essential work, particularly the unpaid care provided by families of children with disabilities. However, it does not appear to explicitly recognize unpaid care as “essential work”. The law outlines measures for accessibility, non-discrimination and social support for persons with disabilities.[80] The rights and services guaranteed under Law no. 448/2006 are instrumental in addressing care work needs for families and care receivers, and time poverty among primary caregivers, particularly mothers. According to Article 1, paragraph (2), the rights of this normative act cover Romanian citizens, citizens of other States or stateless persons, according to the law, who have domicile or residence in Romania. Key benefits include financial relief to support the purchase of assistive devices and technologies, with caregivers able to access up to financial support , facilitating the child’s rehabilitation and autonomy as part of reasonable accommodations provided by the State. In addition, the State of Romania through different schemes offer free medical care and outpatient treatment, including free accommodation and meals for the child’s companion in residential care facilities, upon the recommendation of the family doctor or specialist doctor, provided by the National Single Social Health Insurance Fund.[81]

3.1.3. The Majulah Package in Singapore reflects sustainability and resilience

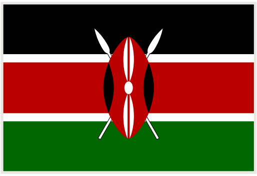
Singapore’s Majulah Package demonstrates how integrating disability and care into national social protection systems can enhance disability rights and contribute to reduce long-term reliance on family care, improve the income security of caregivers and ensure continuity of care for persons with disabilities. The Majulah Package, introduced by the Government of Singapore in 2024, is a national social protection initiative designed to strengthen retirement adequacy and healthcare for older Singaporean workers. The Package was estimated to cost USD SGD 8.2 billion (USD 6.4 billion) over its lifetime, with the Government of Singapore setting aside SGD 7.5 billion (USD 5.9 billion) in a new Fund to fund lifetime costs.[82] Persons with disabilities who qualify for ComCare Short-to-Medium Term Assistance,[83] caregivers residing with those they care for, and who are medically certified to have permanent moderate to severe disabilities, qualify for ESB of SGD 400/year (USD 314/year), even if they earn less than SGD 500/month (USD 393/month).[84] By allocating dedicated public financing for lifetime care needs, and including persons with disabilities and their caregivers in this scheme, the model demonstrates how targeted public financing can enhance access to benefits and support, strengthen financial security, and ensure that gender-responsive and disability-inclusive care systems are both sustainable and economically resilient.

3.1.4. Germany's social protection approach to supporting family caregivers and flexible work

In Germany, legal and policy frameworks ensure that caregivers can enjoy flexible work arrangements. The Family Caregiver Leave Act enables employees to take time off or reduce their paid work hours to care for close relatives, safeguarding their right to provide care without compromising their employment. Long-term care insurance contributes to pension entitlements for unpaid care and support workers, providing financial security for those who reduce or leave full-time employment. Under Social Code SGB VIII, early childhood policies ensure inclusive daycare, complemented by a child allowance (Kindergeld) and parental allowance (Elterngeld), helping caregivers balance paid work and unpaid care work. Additional benefits, such as child support advance payments (Unterhaltsvorschuss) and tax relief for single parents, support low-income families and primary caregivers, especially single mothers, strengthening their financial stability and well-being.[85]

3.2. DATA FOR INCLUSIVE CARE AND SUPPORT

3.2.1. Kenya's support needs assessment for persons with disabilities and their primary caregivers



To enhance disability inclusion, the Ministry of Labour and Social Protection, State Department for Social Protection and Senior Citizen Affairs in Kenya conducted the Support Needs Assessment for Persons with Disabilities and their Primary Caregivers in March 2022. The Assessment aimed to collect accurate disaggregated data for persons with disabilities on met and unmet need for support and the needs of caregivers who are members of the family. The findings established that during the assessment period more than three-quarters of primary caregivers were not engaged in any income-earning economic activity. Ninety-two per cent of caregivers indicated that they require financial support to provide care and support to persons with disabilities, 67 per cent also require support to access healthcare and 48 per cent to access assistive devices.[86] Such data, which go beyond what is captured in the Kenya Time-Use Survey 2021, are essential for generating deeper insights for strengthening care and support interventions.

3.2.2. Egypt's access to services through integrated service cards

To support access to health, rehabilitation and social protection programmes, in 2023, Egypt's Ministry of Social Solidarity launched the "Hanwaslak" Campaign to issue integrated service cards for persons with disabilities who did not have them. As of June 2023, more than 1.1 million cards had been issued, reaching approximately 40 per cent of persons with disabilities nationwide.[87] This initiative also supported women with disabilities' equitable access to services, particularly by allocating about EGP 3.2 billion Egyptian pounds (USD 25.4 million) annually, reaching 435,000 women with disabilities.[88]

3.3. UNITED NATIONS JOINT PROGRAMME ON UNPAID CARE, DISABILITY AND GENDER-TRANSFORMATIVE APPROACHES

In 2024, UN Women, in collaboration with the United Nations Development Programme (UNDP), International Labour Organization (ILO), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA), launched the United Nations Joint Programme on Unpaid Care, Disability and Gender-Transformative Approaches.[89] Funded by the Global Disability Fund (GDF), the joint programme is being implemented in Colombia, Kenya, Mozambique, Panama and the United Republic of Tanzania.

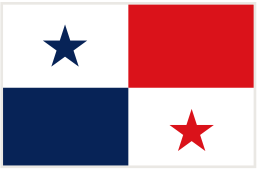
It adopts an intersectional approach to care and support system reforms, aiming to understand and dismantle the multiple barriers faced by persons with disabilities in achieving economic justice and accessing necessary care and support services. It also aims to address women's time poverty, the unequal distribution of care and support; and to ensure that persons with disabilities have access to the support services they need to exercise their right to live independently and to fully participate in society and their communities. In doing so, the programme emphasizes the importance of recognizing the interdependence between the provision and the requirement of care and support.

3.3.1. Colombia: Local care and support systems[90]

Colombia is implementing in the City of Villavicencio a policy pilot intended to develop, test, influence and refine the provision of disability-inclusive and gender-transformative local care and support systems. This pilot seeks to recognize the work of the care- and support-providers, and the rights of persons with disabilities to autonomy, independent living, and full participation by identifying and implementing care and support services delivery in the city. By integrating gender considerations and disability inclusion into local care and support systems, the pilot also aims to address the unequal distribution of care work.

The pilot has a component to contribute to representation by supporting the training of women providing care and support so they can participate and engage in the policy dialogue for the expansion, consolidation and investment in the city's care and support system. This pilot will serve as a model for the development of other local care and support systems across the country. Additionally, it will provide valuable insights for larger national or other local projects in the context of care and support systems to develop and deliver related services.

3.3.2. Panama: comprehensive care system, decent jobs and training[91]



Panama's National Care System, created in 2024 by Law 431,[92] sets out a legal framework to guarantee the right to care and promote the well-being and autonomy of care and support for those who provide and receive care. The law promotes measures to formalize and value paid care work and advance the redistribution of unpaid care work, including by supporting the economic participation of women, training and certifying caregivers and generating alternatives to unpaid care work. To respond to the high demand for care and support workers for persons with disabilities, and in line with the National Care System, UN Women is supporting the training of 100 women caregivers in Juan Díaz, David, and La Chorrera using a curriculum with a disability-inclusive approach.[93]

3.3.3. Tanzania: Mapping care and support services at the local level

In April 2025, Tanzania initiated a qualitative assessment of care and support services at the local level. The assessment aims to: (a) explore the needs, experiences, and implications for persons with disabilities and unpaid caregivers in Pwani and Northern Unguja, Zanzibar; and (b) ensure that care and support systems in Mainland Tanzania and Zanzibar reflect actual needs, bridge policy-practice gaps, and uphold the dignity and rights of persons with disabilities and their caregivers.

While still in draft form, the assessment, led by the Prime Minister's Office, is a multisectoral project whereby several ministries, other relevant government agencies, women groups, selected OPDs, civil society organizations, research institutions, community members, women caregivers (including those with disabilities), people with disabilities who receive care and support, and academic institutions are working closely work together.

BUILDING BLOCKS AND RECOMMENDATIONS FOR STRENGTHENING GENDER-RESPONSIVE AND DISABILITY-INCLUSIVE CARE SYSTEMS

Recognizing and addressing the care and support needs of persons with disabilities, as right holders both as caregivers and care recipients, is essential for building a more inclusive future. Developing gender-responsive, disability-inclusive comprehensive care systems offers multiple opportunities to improve well-being and fairness. This requires measures that structurally advance the right to independent living, autonomy, community inclusion, person-centred support and reduce reliance on institutional or family-based substitute care by ensuring individualized, community-based support, choice and control by persons with disabilities.

To realize this vision, States should adopt the following fundamental building blocks.

STRENGTHENING THE STATE'S ROLE IN UNIVERSAL AND INCLUSIVE CARE AND SUPPORT SYSTEMS

The role of the State in determining benefits, ensuring the availability and provision of quality care and support services and acting as a key funding entity in the labour market for care and support workers cannot be overlooked. States need to ensure care and support systems are sustainable and benefit everyone (in opposition to small-scale projects). States must take actions to make care and support systems sustainable and ensure that people in rural areas equally benefit from the care and support offer. The State has a role as articulator of public and private care and support; regulator to ensure universal access and its quality in line with International human rights frameworks; and provider of care and support services, issuing policy frameworks to secure financial resources for its provision.

States have the responsibility to ensure that rights are legally guaranteed and that benefits and services are available, accessible, affordable, of quality, adequate and collectively financed as part of a universal, solidarity-based system. This need is shown by States taking responsibility and creating regulatory frameworks that make care and support systems rights-based, fair and inclusive for everyone.

ENHANCING PRODUCTION, QUALITY AND USE OF CARE-RELATED GENDER AND DISABILITY DATA

Strengthening the production, quality and use of gender and disability data, including disaggregated by gender and disability among other factors, is foundational to advancing gender-responsive and disability-inclusive care systems and ensuring that no one is left behind. This requires standardized methodologies to distinguish between the supply of care (time and labour spent on paid/unpaid care work) and the need for care (demand, coverage and unmet need for care and support services), including by and for persons with disabilities at the intersection of gender and disability. This includes strengthening national statistical systems, integrating gender and disability markers across administrative and sectoral data, and enhancing analytical capacity to translate data into policy action.

Article 31 of the CRPD establishes data collection as a binding obligation to monitor the implementation of rights and identify structural barriers. Data systems must capture not only care provision, but also the realization of rights by persons with disabilities who receive support, while capturing autonomy, choice and independent living outcomes of rights holders. This requires a multidimensional data framework that explicitly incorporates provision of care (paid and unpaid), receipt of support (coverage, unmet need, accessibility, quality and affordability), and the time and administrative burden associated with managing support arrangements, including by persons with disabilities themselves. Time-use data and administrative data (e.g. social protection coverage, access to personal assistance, waiting lists, institutionalization rates, reasonable accommodation requests and complaints mechanisms) will contribute to this.

INVESTING IN DISABILITY-INCLUSIVE CARE AND SUPPORT INFRASTRUCTURE, SERVICES AND SOCIAL PROTECTION, INCLUDING THROUGH FINANCING AND RESOURCING

It is important for States to strengthen the accessibility, availability, affordability and quality of care and support services for persons with disabilities, in line with the CRPD. Persistent gaps remain across the care continuum, including physical and communication barriers, limited availability of disability-inclusive services, high out-of-pocket costs and fragmented service-delivery. Many care services continue to rely on institutional or medicalized models that limit autonomy and independent living. At the same time, community-based and personalized support, such as personal assistance, remains underdeveloped or unavailable. These challenges disproportionately affect women and girls with disabilities and those living in poverty, rural areas or humanitarian settings. Addressing these gaps requires sustained investment in accessible, community-based and person-centred care and support services, enforcement of accessibility standards, provision of reasonable accommodation, expansion of a disability-inclusive care and support workforce, and the meaningful engagement of persons with disabilities and their organizations in the design, monitoring and evaluation of services.

It is important to expand care infrastructure, services and social protection to ensure equitable access for persons with disabilities and their families through:

- **Free early identification and intervention:** For families and caregivers, early identification fosters a better understanding and capacity to respond to the child's needs. Early intervention can play an important role in preventing institutionalization and keeping families together. In the Republic of Moldova, the National Plan for the Development of Early Intervention Services 2023–2027 underpins the roll out of regional early intervention diagnosis centres, which are expected to cover nearly the entire country by 2027, free of charge. Children referred to Early Intervention Centres are assessed by an interdisciplinary team of specialists, including doctors (typically pediatricians and neurologists), physiotherapists, occupational therapists, speech therapists, psychologists, social workers and other relevant professionals. The team develops an Individual Early Intervention and Rehabilitation Plan for the child and family, which is discussed and agreed upon with the parents and delivered through regular sessions at the Centre.[94]
- **Social protection policy measures:** Care (and support) is the fourth pillar of social protection systems. This broader vision of care contributes to understanding care systems

that besides cash transfers, prioritizes the provision of care and support services with the aim of achieving a deeper social transformation towards gender equality and the rights of persons with disabilities.[95] A key building block is investing in comprehensive social protection systems that address disability-related additional costs of caregiving or those incurred by people who receive care and support, through financial allowances. Integrated and comprehensive approaches combining cash benefits with services respond more effectively to the needs of children with disabilities and their caregivers. In Sweden, for example, families of children with disabilities can benefit from additional cost allowances, housing allowances and home adaptations, as well as pension points to protect caregivers with reduced working hours. Other options include care allowances that allow caregivers or recipients to hire a personal assistant to support care work and home-based early therapeutic stimulation.[96]

- **Respite care:** Respite care provides short-term relief for primary caregivers and should be provided based on the needs of both those who provide and receive care. Respite care can be seen as an essential component of comprehensive support, complementing psychosocial support programmes for caregivers. Respite care is complementary to – rather than a replacement for – rights-based support in alignment with independent living standards, and includes continuous, individualized, community-based support that respect the will and preferences of persons with disabilities and avoid reinforcing reliance on family-based care as the primary support model.
- **Assistive technology:** Old-age pensions rarely factor in additional disability-related costs that make ageing with a disability more expensive, such as higher needs for healthcare, assistive technology, or care and support among older adults with disabilities.[97] Assistive technology investments are a crucial part of care infrastructure services because they enhance independence, safety and quality of life for persons with disabilities, especially children, women and girls, adolescents and the elderly.
- **Case management:** In some high-income countries, such as Australia and the United States, case managers help persons with disabilities develop their own support plans.[98] As a result, they coordinate care and support at the individual level and advocate for persons with disabilities when provided services do not meet their needs. Case managers act as intermediaries between persons with disabilities, caregivers, healthcare professionals and official government programmes. Given the difficulties in transitioning to or remaining in independent living, case management has been adopted as part of deinstitutionalization efforts in some high-income countries.[99] Successful case-management systems depend on robust disability-management information systems that allow case managers to access and store information regarding each client. In some cases, such as in Rwanda, these information systems are connected to survey data and data on available services, facilitating public policy planning and case-by-case management.[100] Given the short- and medium-term effects of case management, these interventions may need to be complemented with other care policies to achieve a sustained long-term impact.[101]

PROMOTING DECENT WORK AND CERTIFICATION OF CARE AND SUPPORT WORKERS

Promoting decent work for care and support workers is central to a rights-based approach to care and support and to the realization of the rights of persons with disabilities. Building a skilled, adequately trained and diverse care and support workforce – while ensuring fair wages, safe working conditions, social protection and access to additional training and certification – is essential to valuing care work and to the sustainable and equitable distribution of providing care and support.

Quality support training and certification for a support workforce that ensures the meaningful choice and control by persons with disabilities over their support arrangements – including personal assistance, sign language interpretation, supported decision-making and community-based support. Integral to this is adequate labour regulation that addresses challenges that differ significantly from those of traditional institutional care roles.This is particularly important for workers supporting persons with disabilities, including children with disabilities, whose right to quality, appropriate and person-centred support depends on a well-trained and protected workforce.

A promising practice in response to growing demand for care is the example from Panama, mentioned above, to strengthen care workforce capacity. Led by UNDP, the initiative aims to strengthen care workforce capacity while improving the geo-referencing of supply and demand for care and support services. Such approaches contribute to professionalizing care work, improving service quality, and advancing disability-responsive and rights-based care systems that respect both the rights of care workers and those they care for.

ENHANCING LEAVE AND FLEXIBLE WORK ARRANGEMENTS FOR CARERS

Adopting and implementing workplace policies and practices, such as flexible working arrangements and carers' leave and policies including for persons with disabilities are important tools for balancing paid and unpaid work responsibilities. In Estonia, parents of a child with a disability may take one day of paid leave per month. France provides flexible working arrangements and leaves for parents of children with disabilities or serious illness, who are entitled to "temporary care leave" (congé de présence parentale), which allows them to take up to 310 days of leave (spread over a three-year period) to care for their child. France offers the Allocation Journalière de Présence Parentale, a daily allowance compensating parents, which can be taken on a full-time or part-time basis, providing flexibility to accommodate the child's care needs.[102]

STRENGTHENING COMMUNITY-BASED CARE AND SUPPORT

Strengthening accessible and local care initiatives, including care system managed by local government, helps address demand for care and support services. Some countries have created structures to facilitate interoperability among multiple programmes.[103] For example, in Colombia, the City of ***Bogotá's Manzanas de Cuidado***—a care system managed by government of Bogota—offer a local, community-based, participatory system that supports caregivers, primarily women, through services like training, respite care and community laundries.[104] The approach to inclusive participatory design involves local communities in identifying needs and tailoring services to match local realities.

FACILITATING PEER-TO-PEER SUPPORT NETWORKS

The importance of peer-to-peer support is recognized globally, primarily because it provides more accessible support than through formal structures. Connecting with other families of persons with disabilities, including children with disabilities, is a powerful community-based tool for sharing experiences, information, emotional support and practical advice. For example, in Uzbekistan, a training module on the prevention of gender-based violence and the provision of disability-inclusive services to GBV survivors targets service-providers and addresses issues such as social model of disability, violence against women and girls with disabilities, making GBV services accessible and inclusive for women with disabilities, identifying and reaching out to women with disabilities, multidisciplinary support involving the social, legal and medical services, peer support and the participation of women with disabilities.[105]

STRENGTHENING THE REPRESENTATION AND MEANINGFUL PARTICIPATION OF THOSE WHO PROVIDE AND RECEIVE CARE AND THEIR ORGANIZATIONS

Ensuring the representation and meaningful participation of persons with disabilities is a core human rights obligation and a prerequisite for inclusive and effective policymaking. In line with the CRPD, persons with disabilities, including women and girls with disabilities and caregivers of children with disabilities, and their representative organizations must be actively involved in the design, implementation, monitoring and evaluation of laws, policies and programmes that affect their lives. Meaningful participation goes beyond consultation to include access to information, reasonable accommodation, and the removal of physical, institutional and attitudinal barriers that limit engagement. Strengthening the role of OPDs in the design and implementation of comprehensive care and support systems helps ensure that policies reflect lived experiences, address diverse and intersecting needs, and contribute to more accountable, responsive and inclusive governance.

TRANSFORMING SOCIAL NORMS ON GENDER-RESPONSIVE AND DISABILITY-INCLUSIVE CARE

Targeted social behaviour change campaigns that address societal expectations and cultural norms around caregiving for and by persons with disabilities are essential in helping to break gendered stereotypes associated with care and fostering shared responsibility in caregiving. By working with non-State actors and OPDs, including organizations of women with disabilities, such interventions also help address disability stigma and build peer-to-peer initiatives that support mothers and women with disabilities, and recognize persons with disabilities as rights holders.

CONCLUSION

Governments around the world have progressively demonstrated goodwill towards gender equality, disability rights and inclusive development as part of the SDG's 'leave no one behind' principle. Yet, for millions of persons with disabilities, and for the women and girls who disproportionately shoulder the responsibility of care and support, these commitments remain far from realized. The unequal and often invisible disproportionate responsibility of unpaid care and support for persons with disabilities, particularly children with disabilities, combined with the lack of adequate public care and support services, continues to reinforce gender inequality, limit access to education and employment, and undermine the full participation and autonomy of persons with disabilities.

It is imperative that States act with urgency to ensure the meaningful participation of persons with disabilities, especially women and girls with disabilities and caregivers of children with disabilities, in the design, implementation and monitoring of care and support policies and services. Their lived experience is essential to shaping care and support systems that are gender-transformative, rights-based and responsive to the diversity of disability-related needs across the life course.

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19. Language on "care and support" (including care and support systems and services) is reflected in recent United Nations resolutions and reports, including the General Assembly resolution on the International Day of Care and Support (A/RES/77/317); the Human Rights Council resolution on the human rights dimension of care and support (A/HRC/58/43); the Human Rights Council report on good practices of support systems enabling community inclusion of persons with disabilities (A/HRC/55/34); and the Economic and Social Council resolution on promoting care and support systems for social development (E/CN.5/2024/L.5).
20. UN HRC. *2016. Report of the Special Rapporteur on the rights of persons with disabilities. Note by the Secretariat*. A/HRC/34/58: para 13, as cited in UN Women. 2025. *Addressing Care in Times of Conflict and Crisis: Guidance Note*. Glossary: "SUPPORT: A concept established under the Convention on the Rights of Persons with Disabilities. Support is the act of providing help or assistance to someone who requires it to carry out daily activities and participate in society. Being a recipient of support and offering support to others are roles we all share, regardless of impairment, age, or social status.106 Support workers and support givers provide assistance to persons with disabilities in their daily life, not to simply meet recipients' basic needs but also to enable their participation in society with dignity and autonomy.'
21. OHCHR 2023 A/HRC/52/52, para 22.
22. UN HRC. 2022. *Transformation of services for persons with disabilities. Report of the Special Rapporteur on the rights of persons with disabilities, Gerard Quinn*, A/HRC/52/32, para 29.
23. Ibid., para 31.
24. OHCHR 2023, para 24, citing: Gröninger et al. v. Germany (CRPD/C/D/2/2010), paras. 6.3 and 7; and H.M. v. Sweden (CRPD/C/7/D/3/2011), paras. 8.7 and 8.9. For example, in a recent case, the Committee underscored that failure to provide

support services to families of persons with disabilities was discrimination by association, which violated the rights of persons with disabilities to family life, to live independently and to an adequate standard of living.42 [42 See *Bellini et al. v. Italy* (CRPD/C/27/D/51/2018)]. Support-related obligations are addressed in the Committee's general comments.43 [General comment No. 1 (2014), paras. 15–16; General comment No. 5 (2017), paras. 13, 15, 88 and 91; and General comment No. 8 (2022), paras. 19, 69–70, 73 and 77]. Likewise, in its concluding observations, the Committee has called upon States parties to ensure that persons with disabilities have access to the support that they need in various domains.44 [See, for example, CRPD/C/IDN/CO/1, CRPD/C/CHN/CO/2-3 and CRPD/C/NZL/CO/2-3.]

25. OHCHR 2023, para 18. [Cites: CRC/C/GRC/CO/4-6, paras. 30–31 and 33; CRC/C/CYP/CO/5-6, paras. 26–28 and 30; and CRC/C/MDG/CO/5-6, paras. 27–28 and 30.]

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27. Including the Independent Expert on the enjoyment of all human rights by older persons, the Special Rapporteur on extreme poverty and human rights, the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context, the Special Rapporteur on the rights of persons with disabilities, and the Working Group on discrimination against women and girls, which have also addressed support and care in their work.

28. These include: United Nations General Assembly Resolutions A/RES/77/317 to observe an annual International Day of Care and Support on 29 October and A/RES/80/152 on Contribution of the care economy to sustainable development; Human Rights Council Resolutions A/HRC/RES/28/4 on the right of persons with disabilities to live independently and be included in the community on an equal basis with others; A/HRC/RES/40/14 on empowering children with disabilities for the enjoyment of their human rights, including through inclusive education; A/HRC/RES/43/13 on mental health and human rights; and A/HRC/RES/47/15 on preventing and responding to all forms of violence against women and girls with disabilities; A/HRC/RES/54/6 on Centrality of care and support from a human rights perspective; Economic and Social Council resolution E/RES/2024/4 on Promoting care and support systems for social development; International Labour Conference ILC.112/Resolution V, on care work and the care economy; and The World Health Assembly resolution WHA78.16 on Accelerating action on the global health and care workforce by 2030. In March 2025, OHCHR presented a report on the human rights dimension of care and support to the Human Rights Council, analysing international human rights and labour standards relevant to care and support. For more information, refer to "Annex B evolution of care conceptual and normative frameworks" in United Nations. 2024. Transforming care systems in the context of the Sustainable Development Goals and Our Common Agenda. UN System Policy Paper.

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37. Cameroon, Chile, Costa Rica, India, Laos, Nicaragua, Pakistan, Peru, the Philippines and Tajikistan. The exceptions are Afghanistan, Georgia, Mexico and Sri Lanka.

38. World Bank 2025. [Note: The results from Cameroon and Pakistan should be interpreted with caution, given that the surveys do not employ population weights and the sample size is lower than 500 observations. Source: Afghanistan, Model Disability Survey (2019); Cameroon, Model Disability Survey (2016); Chile, Disability National Survey (2015); Costa Rica, Disability National Survey (2018); Georgia, Model Disability Survey (2021); India, Laos, and Tajikistan, Brief Model Disability Survey (2018); Mexico, National Survey on the Perception of Disability (2010); Nicaragua, National Household Disability Survey (2003); Pakistan, Model Disability Survey (2015); Peru,

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39. IDA 2025a. "Figure1.5. Unmet needs for care and support among older adults with disabilities," p. 33.
40. World Bank 2025, p. 16.
41. Ibid.
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