REPUBLIC OF KENYA

MINISTRY OF LABOUR AND SOCIAL PROTECTION

STATE DEPARTMENT FOR SOCIAL PROTECTION AND SENIOR CITIZEN AFFAIRS

INVESTING IN DISABILITY INCLUSIVE AND GENDER-RESPONSIVE CARE AND SUPPORT SYSTEMS ACROSS THE LIFE CYCLE IN KENYA

SHORT TO MEDIUM TERM COSTS

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OCTOBER 2025

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ABBREVIATIONS AND ACRONYMNS

ASD	Autism Spectrum Disorder
CBC	Competency Based Curriculum
CBK	Central Bank of Kenya
CBM	Christian Blind Mission
CHP	Community Health Promoters
CRPD	Convention on the Rights of Persons with Disabilities
DSD	Directorate of Social Development
DTSK	Differently Talented Society of Kenya
EARC	Educational Resource Assessment Centers
FGD	Focus Group Discussions
KAIH	Kenya Association of the Intellectually Handicapped
KBA	Kenya Bankers Association
KHIS	Kenya Health Information System
KIHBS	Kenya Integrated Household and Budget Survey
KII	Key Informant Interviews
KILEA	Kenya Integrated Literacy and Education Assessment
KISE	Kenya Institute of Special Education
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KPHC	Kenya Population and Housing Census
KRA	Kenya Revenue Authority
LSA	Learner Support Assistants
MCH	Mother and Child Health
NCPWD	National Council for Persons with Disabilities
NGAO	National Government Administration Officers
NTSA	National Transport and Safety Authority
OHCHR	Office of the High Commissioner Human Right
OPD	Organizations of Persons with Disabilities
PSV	Passenger Service Vehicles
PwSD-CT	Persons with Severe Disability Cash Transfer
SACCO	Saving and Credit Cooperatives
SHIF	Social Health Insurance Fund
SRC	Salaries and Renumeration Commission
VRC	Vocational Rehabilitation Centres

FOREWORD

Kenya is committed to ensuring that none of its residents succumb to poverty. The 2010 Kenyan constitution asserts the right to wellbeing by guaranteeing that all Kenyans are afforded social, economic, and cultural rights, including social protection. The operationalization of these rights is realized through policies, programmes, interventions, and legislative measures, aimed at protecting all persons in Kenya against poverty, inequality, vulnerability, exclusion, risks, contingencies, and shocks throughout their lives. Some of these measures include the Inua Jamii National Safety Net Programme which provides financial assistance through bi-monthly cash stipends to the country's most vulnerable populations, including older persons, persons with severe disabilities, and orphans and vulnerable children. In addition, the government implements the Hunger Safety Net Programme that provides regular, unconditional cash payments to chronically poor households in arid and semi-arid lands to reduce food insecurity and poverty.

The central theme of all these social protection programmes is the inclusion of marginalized and vulnerable populations including people with disabilities who are often overlooked. The 2019 Kenya Population and Housing Census revealed that about one in 10 Kenyans experiences some difficulty and require support. This is more so for children with disabilities whose disability related support needs compound their need for care. This support primarily comes from close household members, the majority of whom are women and girls. As such, disability inclusion is not just a policy priority but a fundamental social justice issue that demands a delicate balancing between upholding the right to quality care and support for persons with disabilities, and the rights of women who disproportionately provide caregiving, limiting their opportunities and workplace participation.

To ensure the social protection and meaningful inclusion of persons with disabilities without disproportionately burdening women and girls, this study developed a costed road map for disability inclusive and gender-responsive community care and support. The study also explores solutions to the systemic gaps and barriers within policy frameworks, identifying and costing the key asks and demands of persons with disabilities including children with disabilities and their caregivers. Emanating from this exercise are costed scenarios that not only expand the coverage of disability inclusion initiatives, but also reimagine disability-related caregiving, transforming it into a shared social responsibility, rather than a burden for women and girls. The costed scenarios are instrumental for disability inclusion in Kenya. I urge relevant ministries, counties, departments and agencies to take advantage of these self-justifying programmes as they draw up their budgets.

Finally, I would like to acknowledge all the national agencies, county governments, development partners, civil society organizations, national and grassroots organizations focused on persons with disabilities, that participated and contributed to this study and continue to support disability inclusion across Kenya.

Dr. Alfred N. Mutua, E.G.H.
Cabinet Secretary
Ministry of Labour and Social Protection

ACKNOWLEDGEMENT

The costed policy scenarios in this study have been developed through an inclusive, participatory and consultative process with all relevant stakeholders in the disability inclusion sub-sector.

We acknowledge with gratitude the contributions and sustained commitment of various government ministries, counties, departments and agencies, development partners, organizations of persons with disabilities, and all partners/stakeholders whose direct or indirect contribution made the development of these scenarios possible.

In particular, the costed scenario development process benefited greatly from the dedicated leadership of the Ministry of Labour and Social Protection (MoL&SP), and the coordination by the State Department of Social Protection and Senior Citizens Affairs. There was significant participation and input by the Directorate of Social Development, the Directorate of Social Assistance (DSA), the Directorate of Children Services (DCS), and the ministries of Education, Health, and the National Treasury. We are particularly grateful to the Directorate of Children Services for ensuring that the asks and demands of children with disabilities were heard and captured by the report.

Further, we acknowledge other actors, including the National Council for Persons with Disabilities (NCPWD), the Kenya National Bureau of Statistics (KNBS), the Kenya Institute of Special Education (KISE), the Social Health Insurance Fund (SHIF), the Office of the Controller of Budget (OCOB), the Kenya National Human Rights Commission (KNHCR) and national and grassroots organizations focused on persons with disabilities (OPDs).

We appreciate the financial and technical support from the United Nations Children's Fund (UNICEF), which created an enabling environment for this study to be conducted in a timely and meaningful way, as well as strategic partners which supported the data collection exercise across the country, such as the Christian Blind Mission (CBM), Sense International (SI), the Kenya Association of the Intellectually Handicapped (KAIH) and the Differently Talented Society of Kenya (DTSK). We also appreciate the participation of the following UN Agencies for their active participation, the ILO, the UNDP and the UN Women.

Special gratitude goes to the technical team from the from the Kenyan government which ensured the smooth development of this report. The team includes Richard Bosire, Rose Bukania, Tina Mungatana and Shem Sandro from the Directorate of Social Development; Hudson Imbayi and Clare Samoka from the Directorate of Children Services; Sarah Ayecho, Susan Wekesa and Ivy Ndinya from the National Council for Persons with Disabilities; Renice Mbunde from the Kenya National Bureau of Statistics; Rebecca Butalanyi from the Office of the Deputy President; and Stanley Hari from the National Council for Children Services. I acknowledge the pivotal role played by development partners in providing both financial and technical support. In this regard we recognize the unwavering support from Dr. Ana Gabriela Guerrero Serdan, Alex Cote, Charles Knox, Susan Momanyi, Nahashon Njuguna and Patrick Chege from the United Nations Children Fund. Special thanks go to the consultant, Mdoe Idi Jackson, for the technical assistance that he provided during the study process.

Finally, I extend my deepest gratitude to the respondents including persons with disabilities and their caregivers whose participation was indispensable to the development of the costed policy scenarios.

Joseph M. Motari CBS.
Principal Secretary
State Department for Social Protection and Senior Citizen Affairs

STATEMENTS FROM PARTNERS

STATEMENT FROM THE UNITED NATIONS GLOBAL DISABILITY FUND (GDF)

The United Nations Global Disability Fund (GDF), hosted by UNDP's Multi-Partner Trust Fund Office, provided funding and technical inputs for the development of *Investing in Disability Inclusive and Gender-Responsive Care and Support Systems across the life cycle in Kenya: Short to Medium Term Costs.* Established to serve as the UN's pooled financing mechanism dedicated to advancing disability inclusion globally, the GDF supports Member States, UN entities, and organizations of persons with disabilities to translate international commitments into national systems and results. The Fund has been pleased to accompany and support the Government of Kenya over the past several years in strengthening disability-inclusive policies and institutional capacities.

We commend the Ministry of Labour and Social Protection, the State Department for Social Protection, and the National Council for Persons with Disabilities for their leadership in developing this evidence-based roadmap. The participatory process that informed this study demonstrates how effective policy design centers the voices and lived experiences of persons with disabilities and their caregivers.

We are confident this work will further strengthen the Government's institutional capacity to design, cost, and finance inclusive policies and systems, ensuring durable, scalable impacts for persons with disabilities and their caregivers.

This collaboration is consistent with the GDF's 2025–2030 Strategy, particularly its focus on inclusive essential services, gender-responsive care and support, and community resilience.

It reflects our practice of supporting nationally led, evidence-based policy design and financing.

Through its pooled financing and the Inclusion Catalyst Hub, the GDF will continue to work with the Government of Kenya and partners to advance inclusive social protection, support implementation of relevant legislation and policies, and strengthen accountable, adequately resourced care and support systems for persons with disabilities and their caregivers. We look forward to seeing these findings inform budget planning, program design, and implementation at both national and county levels, transforming this roadmap into tangible improvements in the lives of persons with disabilities across Kenya.

Dr. Ola Abualghaib
Director, Secretariat of the United Nations Global Disability Fund

Global Disability Fund

STATEMENT FROM UNICEF

The recently passed Persons with Disabilities Act (2025) sets out a clear vision of, and responsibilities for, nurturing a society where persons with disabilities participate on an equal basis with other members of society through provision of robust community care and support systems. This is in line with Article 43 and Article 54 of the Kenyan Constitution which guarantee fundamental economic and social rights for all, and specific rights for persons with disabilities respectively. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa also advances the equal participation of persons with disabilities in society, in line with the UN Convention on right Rights of Persons with Disabilities (UNCRPD), which provides a coherent body of obligations related to the inclusion of persons with disabilities.

In fulfilling its obligations under international commitments and implementing the newly passed Persons with Disabilities Act (2025), Kenya's Ministry of Labour and Social Protection has undertaken an assessment to determine the cost of providing community-based care and support for persons with disabilities. This costing exercise is a crucial first step toward aligning with relevant laws and conventions, and in realizing the rights of persons with disabilities. The results are presented in the report, *'Investing in Disability Inclusive and Gender-Responsive Care Systems across the Life Cycle in Kenya',* which outlines the estimated costs of ensuring inclusive and adequate community-based care.

By having a clearer understanding of the requirements and costs of implementing effective community-based care and support systems, the report enables the Government of Kenya to now make the necessary policy decisions so that more persons with disabilities can receive the integrated support they require to realise their rights to full and equal participation in economic and social life. This is especially true for children with disabilities considering that early intervention through adequate human support opens the door to life-changing opportunities like education and employment opportunities. The outcomes of this study will also enable more effective coordination and integration of targeted interventions aimed at improving the lives of children with disabilities, ensuring that their distinct needs are systematically and comprehensively addressed. Lastly, implementation of the report's findings will help to address the disproportionate caregiving burden that is borne by women and girls, thereby giving them more freedom to pursue economic opportunities more freely.

UNICEF commends the State Department for Social Protection and in particular the Directorate of Social Development and the National Council for Persons with Disabilities for their exemplary leadership and commitment in identifying the priorities and requirements of persons with disabilities and their caregivers across Kenya. This has paved the way for advancing disability rights and transforming critical insights into costed programmes, now positioned for potential integration within the national budget framework.

UNICEF and other UN agencies (UN Women, ILO and UNDP) commend the inclusive, participatory process led by the Ministry of Labour and Social Protection, which engaged a wide range of stakeholders to ensure the voices of persons with disabilities were reflected in the findings. This collaborative approach is closely aligned with UNICEF's Disability Inclusion Policy, which prioritises ensuring that children with disabilities are fully included, protected, and able to participate in all aspects of life. By centring on the needs and voices of children with disabilities, this initiative also supports UNICEF's commitment to advancing their rights and fostering truly inclusive development.

UNICEF is pleased to have participated in this joint initiative and provided financial support, together with the Global Disability Fund, to advance the UN Disability Inclusion Agenda in Kenya and ensure children with disabilities receive the attention and support they need to thrive.

Dr. Shaheen Nilofer
Country Representative, UNICEF Kenya

unicef
for every child

STATEMENT FROM CHRISTIAN BLIND MISSION (CBM) KENYA

Christian Blind Mission (CBM) is an international development and humanitarian organization dedicated to improving the quality of life of persons with disabilities in the world's poorest countries. CBM addresses disability as a cause and consequence of poverty, and works in partnerships to create an inclusive society for all. Founded in 1908, CBM began its operations in Kenya in the early 1970s, and currently supports life-changing interventions in the areas of community-based inclusive development (livelihoods, inclusive education, and disability-inclusive social protection); inclusive humanitarian action (response, recovery, and resilience); and inclusive health (physical rehabilitation and assistive technology, inclusive eye health, and ear and hearing care). CBM engages with Kenyan government ministries, the Council of Governors and the National Council for Persons with Disabilities, as a keyway to scale coverage and reach people.

In support of this study, CBM provided both financial and technical assistance, including coordination of data collection and active participation in consultative processes. CBM views disability-inclusive social protection as a comprehensive and rights-based approach to risk management—one that integrates formal and informal mechanisms to protect persons with disabilities from poverty, exclusion, and shocks. This approach acknowledges that some individuals require more targeted support, emphasizing the importance of understanding intersectional challenges. CBM remains committed to promoting inclusive systems that uphold the rights of persons with disabilities and affirms that disability inclusion is not an act of charity, but a matter of human rights and social justice. It is our hope that this study provides an opportunity for likeminded partners to commit to the meaningful support of persons with disabilities in Kenya without disproportionately burdening women and girls.

David Munyendo
CBM Kenya, Country Director

cbm
christian blind mission

STATEMENT FROM THE KENYA ASSOCIATION OF THE INTELLECTUALLY HANDICAPPED (KAIH)

The Kenya Association of the Intellectually Handicapped (KAIH) is proud to be part of this landmark initiative, which prioritizes the voices and lived realities of persons with disabilities and their families. For decades, families members, especially women and girls, have shouldered the critical but often invisible responsibility of supporting persons with disabilities, often at great personal and economic cost. This costed roadmap is not only a policy tool but a symbol of long-overdue recognition that caregiving must be reframed, seeing it as a shared societal responsibility rather than a private, unsupported obligation. This initiative demonstrates Kenya's commitment to inclusive social protection and progressive realization of the rights, which are enshrined in the Kenyan Constitution and the Convention on the Rights of Persons with Disabilities.

KAIH celebrates the inclusive and consultative process that brought these costed scenarios to life. We believe that transforming caregiving into a community-based, gender-responsive support system is a key step toward equity and social justice. By integrating the needs and demands of persons with intellectual disabilities and their caregivers into budgeted national and county planning, this initiative sets the foundation for meaningful, systemic change. We call on all duty-bearers, government, civil society, development partners, and communities, to act on these findings and work collectively toward a Kenya where no caregiver is left behind and every person with a disability is supported to live a full and dignified life.

Fatma Wangare
Secretary General, Kenya Association of the Intellectually Handicapped (KAIH)

EXECUTIVE SUMMARY

Background: Kenya is party to the Convention on the Rights of Persons with Disabilities and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa. These instruments progressively provide for the autonomy and independency of persons with disabilities in an environment of inclusive care and support. To fulfil this mandate the country is in the process of developing disability-inclusive and gender-responsive community care and support systems.

Objectives: As part of this process the Ministry of Labour and Social Protection through the State Department for Social Protection sought to (i) review existing systems of care and support in Kenya; (ii) clarify the demand and supply issues in relation to care and support systems in Kenya; (iii) develop costed policy scenarios for disability inclusive and gender responsive community support systems; and (iv) resolve the tension between the need for care and support, and gender inequalities in its provision.

Methodology: The study objectives were achieved through a secondary review of existing systems of care and support, and primary data collection to clarify the key asks by persons with disabilities and their caregivers. The secondary data review included a detailed document review of policies and normative frameworks that govern the provision of care and support to persons with disabilities using the Office of the High Commissioner Human Rights assessment tool. Moreover, the primary data collection work included focus group discussions and key informant interviews.

Findings: Using the secondary review and analysis of primary data the study established the following:

Review of existing systems of care and support in Kenya: The evaluation of Kenya's existing systems of care and support readiness to implement disability inclusive and gender responsive care and support systems using the Office of the High Commissioner Human Rights scorecard revealed that policies exist and are transformative to a limited extent when it comes to awareness raising campaigns (71.9 per cent), inclusive early childhood care and development (65.5 per cent), assistive technologies (61.4 per cent), measurement frameworks (56.7 per cent), housing (52.3 per cent) and cash transfer (50 per cent). This is driven by social policies such as awareness activities conducted by the National Council for Persons with Disabilities, free primary education, affordable housing programming, the Kenya Integrated Household and Budget Survey (KIHBS) surveys and the disability-specific cash transfer programme.

The analysis further revealed that policies exist and are transformative to a limited extent in transport (34.8 per cent), concessions and discounts (34.4 per cent) and human support (28 per cent). This situation is more pronounced by two indicators, legal capacity (14.28 per cent) and deinstitutionalization (13.3 per cent) where policies do not exist. The underlying issue is that the government is not the main service provider for road transport services, and fails to enforce existing compliance standards among the passenger service vehicles making transport challenging for persons with disabilities. Moreover, a lack of comprehensive policies mean that Kenya is going without frameworks to guide benefits such as concessions and discounts, human support, legal capacity and deinstitutionalization.

Clarifying the demand and supply issues to care and support systems in Kenya across the lifecycle. Analysis of secondary and primary data revealed that there is significant demand and supply gaps in Kenya's care and support systems. Persons with disabilities and their caregivers lack affordable, flexible and accessible public and point-to-point transport; live in public and private housing that is not universally accessible; are not eligible for appropriate assistive devices due to exclusion from social security coverage, face poor last mile distribution, and lack services from qualified prescription-writing personnel; face inadequate and costly disability assessment that does not categorize persons with disabilities according to their functional limitations and support needs; face less supportive inclusive education that requires institutionalization and segregation of learners with disabilities; receive inadequate human support, particularly where women and girls are concerned; are supported through

cash transfers that do not promote independence and autonomy; lack legal capacity; do not receive enough concessions and discounts to cover disability related costs; and live in communities where adequate awareness about their challenges is absent. Their main needs are affordable and accessible public point-to-point transport; accessible housing, and well prescribed and distributed assistive technologies; standardized disability assessment services linked to social protection; expanded and individualized cash transfers; formalized and gender-balanced caregiving systems; and inclusive education options such as home-based learning. They also call for stronger enforcement of accessibility laws, expanded concessions and discounts, improved measurement of unpaid care work, and regular awareness campaigns to reduce stigma and promote disability rights.

Recommendations: developing costed policy scenarios for disability inclusive and gender responsive community support systems. To meet these key asks and demands, especially around disability-inclusive and gender-responsive care and support, this study costed:

- An expanded and individualized disability allowance targeted to 500,000 beneficiaries within 5 years with the full annual cost of KES 12 billion realized from the fifth year onward;
- A caregiver allowance to recognize the efforts of 130,000 caregivers of persons with severe disabilities and high support needs within the next 3 years with a full annual cost of KES3.12 billion from year three onwards;
- Formalized provision of human support through public and private co-operation through 5,800 "circles of care and support" within 5 years, with a full annual cost of KES 928 million form the sixth year;
- Provision of respite through transformation of the existing vocational and rehabilitation centres into resource, respite and rehabilitation centres, and their expansion from the current 12 to 47 centres over a 5-year period with an annual running cost of KES 597 million from the fifth year onwards;
- Provision of accessible transport to 36,209 learners with disabilities throughout the academic calendar at a cost of KES 2.22 billion, and 91,669 persons with disabilities seeking medical services at a cost of KES 110 million per year; providing 50 per cent discount on economy seats to 2,293 eligible travelers with disabilities at a cost of KES20.6 million per year; and
- Provision of assistive devices through Social Health and Insurance Fund (Taifa Care) at an insurance cost of KES700 million per year.

Overall, the proposed disability inclusion strategy will expand coverage and guarantee participation of persons with disabilities in the community by nearing doubling the disability inclusion costs from KES10.42 billion in year 1 to KES19.74 in year. This implies an increase of disability inclusion costs from 0.06 per cent of the GDP to 0.11 per cent, which will align Kenya's spending with commitments made at the 2025 Global Disability Summit commitments. This expansion will also position Kenya at the bottom of the good performing countries such as Egypt, Zambia and South Africa.

Further recommendations: resolving the tension between the need for care and support, and gender inequalities in care provision. Care and support provided to persons with disabilities can be a source of unpaid care work that is disproportionately borne by women and girls. In Kenya, 77.6 per cent of this care is provided by female members of the household and is unrecognized. Through costed policy scenarios, this study seeks to significantly reduce this burden by expanding disability allowance, introducing a caregiver allowance, recognizing disability costs through concessions and discounts; increasing formal care provided through day and residence care and support services in resource, respite and rehabilitation centres; formalizing of care arrangements through the circles of care and support and expanding access to appropriate assistive devices through the Social Health and Insurance Fund.

Dr. Lynett Ochuma,
Ag. Secretary for Social Development.

1

BACKGROUND

1.1 Study Context

Globally, the Convention on the Rights of Persons with Disabilities (CRPD) places a strong emphasis on the independence, autonomy and inclusion of persons with disabilities. The CRPD explicitly identifies the rights of individuals with disabilities and the fact they are entitled to make their own decisions and participate fully in society on an equal basis with others. Article 19 of the CRPD guarantee persons with disabilities have the right to live independently and be included in the community, choosing their place of residence and where and with whom they live on an equal basis. In addition to obligations to create accessible, non-discriminatory and inclusive environments and services, the CRPD clearly recognizes the obligation of governments to provide a wide range of care and support services. Article 16 and 23 say governments must provide support to parents and families of children with disabilities to prevent neglect, abuse and family separation, and these children grow up in family setting. Article 19 focuses on the needed support services that would allow autonomy and the choice to live in the community, while Article 21 focused on mobility Article 28 stipulates the role of social protection to address disability-related costs and access to needed devices and services. The CRPD also says signatories such as Kenya must ensure that persons with disabilities have access to the support they require to realize their rights to independence and autonomy. Disability support includes the provision of information in different formats, enabling persons with disabilities to make decisions on the provision of accessible transport, education, healthcare and jobs.

Regionally, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa lists the care and support activities that should be undertaken by the governments. The protocol mandates African nations take policy, legislative, administrative, institutional and budgetary steps to respect, promote and fulfill rights and dignity of persons with disabilities. Specifically, the countries are required to ensure high standards of care and support for persons with disabilities by guaranteeing non-discrimination (Article 5 & 6); legal capacity (Article 7); access to assistive devices for full realization of the right to life (Article 8); autonomy and independence (Article 9 & 26); protection from abuse (Article 10, 11, 12 & 28); supported decision making (Article 13, 22 & 23); community support (Article 14 & 25); environment free of barriers (Article 15); inclusive education (Article 16 & 29); accessible and inclusive health services (Article 17); habilitation and rehabilitation services (Article 18); economic empowerment (Article 19); social support (Article 20); political decision making (Article 21); access to information (Article 24 & 32); and gender equality (Article 27). As such the protocol holds African nations to the same high standards established by the CRPD.

Though the CRPD progressively provides for the autonomy and independency of persons with disabilities, at least 150 million persons around the world, with higher support needs, do not receive any publicly-funded disability support required for basic participation in their communities. Persons in Africa with disabilities go without support as the result of social stigmas, cultural barriers and limited resources.

As a result, persons with disabilities are isolated in institutions or households, where they don't enjoy the rights they are entitled to. While some progress has been made in Kenya regarding provision of care and support to persons with disabilities key challenges remain regarding education, healthcare, employment, transport, stigma free environment and gender equity. According to the 2015/2016 Kenya Integrated Household and Budget Survey (KIHBS), households with persons with disabilities are 1.34 times more likely to be living below the national poverty line (47 per cent) than those without a member with a disability (35 per cent). In addition, the 2022 Kenya National Bureau of Statistics (KNBS) reveals that 23.2 per cent of persons with disabilities have never attended school, 19 per cent cannot access primary healthcare clinics, 80 per cent are unemployed and 26.3 per cent cannot access public transportation.

Though the CRPD does not explicitly address the issue of unpaid care work, its provisions have implications for those who provide care and support to persons with disabilities. Moreover, provision of care and support for persons with disabilities has been a source unpaid care work in the labour market with women and girls bearing a larger burden than men. This has been the case in Kenya where 77.6 per cent of primary caregivers aged 18 and above are women. Due to this burden, 97.4 per cent of these women caregivers are unemployed. The disproportionate burden of care work on women and girls ofsupport inadequacies in Kenya. Because the work women and girls undertake isn't properly recognized by the community, persons with disabilities receive less care than would otherwise be provided in other settings. In addressing care and support systems for the persons with disability, gender inequality should be addressed too. For example, when care and support systems are designed, gender sensitivity should inform these systems, ensuring care workers are recognized and compensated for their work.

1.2 Objectives of the study

Because of the challenges in the provision of care and support to persons with disabilities in Kenya, and the prevailing gender imbalance in the provision of that care, the Ministry of Labour and Social Protection through the State Department for Social Protection has sought to:

- Review existing systems of care and support systems in Kenya;
- Clarify the demand and supply issues in relation to care and support systems in Kenya;
- Develop costed policy scenarios for disability inclusive and gender responsive community support systems; and
- Resolve the tension between the need for care and support and gender inequalities in its provision

1.3 Methodology

The study employs both the quantitative and qualitative designs to achieve the study objectives. Quantitative design was used to establish the prevalence of the various diversities of disabilities in Kenya and identify trends in budgetary allocations to various pillars of care and support and estimate the costs of the identified policies. Qualitative design was used to identify the needs and demands of persons of with disabilities and their caregivers. In addition, it was used to describe the policy options to meet the key asks and demands of persons with disabilities, caregivers and organizations representing persons with disabilities. Importantly, quantitative design was used to explain how the identified policies would resolve the tradeoff between the need for care and support by persons with disabilities, and inequalities in its provision.

Both primary and secondary data were analyzed in costing the policy scenarios. The secondary data included a detailed document review of policies and normative frameworks that govern the provision of care and support to persons with disabilities. Specifically, the review focused on policies such as the Updated Integrated National Transport Policy (2024), the National Building Code (2024), Rehabilitative Services and Assistive Technology Strategy 2022-2026 (2022), the Kenya Integrated Early Childhood Development Policy Framework (2017), Salaries and Renumeration Commission (SRC) circulars, the Kenya Social Protection Policy 2022 and the Draft Persons with Disabilities National policy (2024). Key legislations reviewed included the Persons with Disabilities Act, No. 14 of 2003, Affordable Housing

Act (2024), the Basic Education Act (2013), the Social Assistance Act No. 24 of (2013), the Mental Health (Amendment) Act (2022), and the 2010 Kenyan Constitution. Other secondary data sources reviewed included important statistical bulletins such as Kenya National Bureau of Statistics (KNBS) 2019 Kenya Population and Housing Census, various budgets, Kenya National Bureau of Statistics 2019 Kenya Population and Housing Census Analytical Report on Disability volume XV, the Kenya Institute of Special Education's national survey on children with disabilities and special needs in education, the 2022 Kenya Demographic and Health Survey, the Kenya National Bureau of Statistics support needs assessment survey (2022) and expenditure reports by key stakeholders such as Sense International Kenya (SIK), the Differently Talented Society of Kenya (DTSK), the Kenya Association of the Intellectually Handicapped, among others.

The primary data collected for this study included focus group discussions (FGDs) and key informant interviews (KIIs). These included persons with disabilities, their caregivers, grassroots organizations, and key strategic partners such as the SIK, KAIH, DTSK, Christian Blind Mission (CBM), and the National Council for Persons with Disabilities (NCPWD). A total of eight FGDs were conducted with grassroot organization and caregivers of persons with disabilities from counties including Machakos, Kisumu, Kwale and Garissa. Each FGD with the grassroot organizations comprised of 10 respondents. In total, 40 grassroot organizations representing different types of people with disabilities were surveyed. Similarly, each of the FGDs with the caregivers comprised 10 respondents representing different types of persons with disability. All the FGDs were mixed in terms of gender and age.

2

REVIEW OF EXISTING SYSTEMS OF CARE AND SUPPORT IN KENYA

2.1 The Office of the High Commissioner Human Rights (OHCHR) assessment tool

The review of the readiness of the existing systems of care and support to implement disability inclusive- and gender-responsive care and support systems were conducted using the OHCHR tool. The OHCHR tool assesses government readiness to implement care and support systems that are aligned with the CRPD across 11 indicators (pillars of care and support) including government awareness-raising campaigns, inclusive early childhood care and development, assistive technologies, measurement frameworks, housing, cash transfers, transport, concessions and discounts, paid human support, legal capacity and deinstitutionalization.

The indicators are sub-divided into measurable sub-indicators under four themes including accessibility and reach of the policy, budgeting and administration, regulation and monitoring, and design and impact. Each sub-indicator is graded on a three-point scale. If a sub-indicator is achieved, it is assigned a score of one 1, if it is partially achieved it is assigned a score of 0.5, and if it is unattained, it is assigned a score of 0. To obtain the percentage score of an indicator, scores across the sub-indicators are aggregated and taken as a proportion of the total number of the sub-indicators. In addition, a value judgement on the transformativeness of the indicator is obtained using a six-point Likert scale ranging from 0-5 as detailed in Table 1.

Table 1: Degree to which policies are transformative

Percentage score	Overall score	Degree to which policies are transformative for care
0%	0	Policies do not exist
1-20%	1	Policies exist but are not transformative
21-40%	2	Policies exist and are transformative to a very limited extent
41-60%	3	Policies exist and are transformative to a limited extent
61-80%	4	Policies exist and are transformative to a moderate extent
81-100%	5	Policies exist and are transformative to a great extent

The OHCHR tool assessment provided an opportunity of establishing the baseline against which the policies would be developed. Further, the assessment identified the gaps that could easily be filled if some policy scenarios were adjusted.

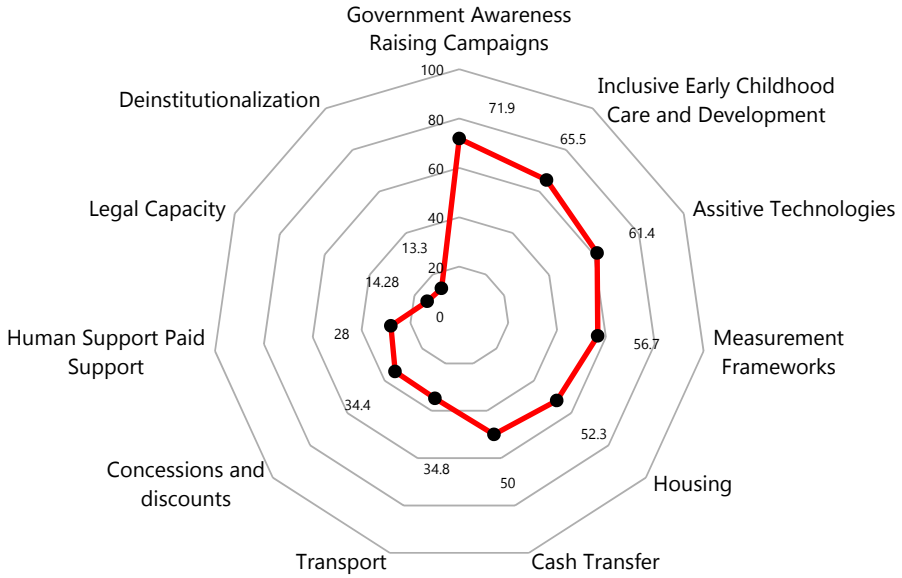
2.2 The review findings

Following the application of the tool, the assessment revealed that Kenya has achieved at least 50 per cent of the indicators in six pillars of care and support. These are government awareness raising campaigns (71.9 per cent), inclusive early childhood care and development (65.5 per cent), assistive technologies (61.4 per cent), measurement frameworks (56.7 per cent), housing (52.3 per cent) and cash transfer (50 per cent) (see Figure 1). This work has been driven by social policies such as awareness activities by the NCPWD, free primary education, affordable housing programme, the Kenya Integrated Household and Budget Survey (KIHBS) surveys and disability specific cash transfer programmes.

However, the assessment revealed that Kenya has not made much progress in five indicators which include transport (34.8 per cent), concessions and discounts (34.4 per cent), paid human support (28 per cent), legal capacity (14.28 per cent) and deinstitutionalization (13.3) (see Figure 3). The key challenges is that the government is not the main service provider for road transport services, and fails to enforce existing compliance standards among the passenger service vehicles making transport inaccessible to persons with disabilities. In addition, there are no comprehensive policies to guide indicators such as concessions and discounts, human support, legal capacity and deinstitutionalization. This has led to the exclusion of persons with disabilities with regard participation in their communities, through substitute decision making in the courts, isolation of persons with disabilities in institutions, and unpaid care work that burdens women and girls.

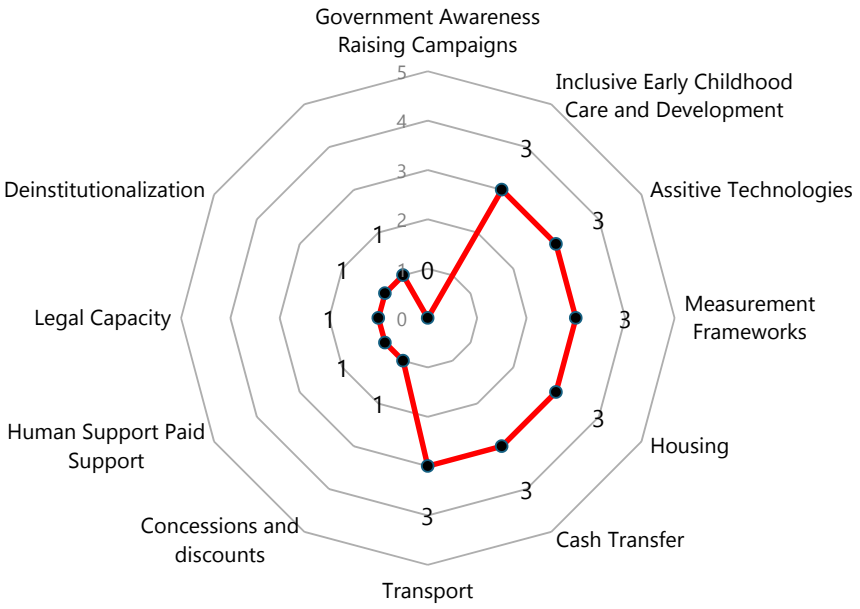
On premise of this performance, a validation workshop collectively considered Kenya's policies in government awareness-raising campaigns, inclusive early childhood care and development, assistive technologies, measurement frameworks, housing and cash transfer programmes scored a 3 on the transformative scale. However, the validation workshop only gave Kenya a 2 regarding policies related to transport, concessions and discounts, paid human support, legal capacity and deinstitutionalization. Overall, Kenya's policies averaged a 2, which implies they are transformative to a very limited extent.[1]

Figure 1: Care and support pillar percentage scores



1 See secondary data analysis detailed report for the scores on each pillar.

Figure 2: Pillar's degree of transformativeness



3

THE KEY ASKS/DEMANDS BY PERSONS WITH DISABILITIES AND CAREGIVERS ACROSS THE LIFE CYCLE

3.1 0-4 years (Pregnancy, Birth and the 1st 1,500 days)

The issues and key asks that arose from both the secondary review and the primary data collection for children with disabilities and their caregivers are as follows:

3.1.1 Early identification and Intervention

1. There is an existing level of screening for risk factors during pregnancy majorly through prenatal visits. Majority of the respondents observed that they adhered to all the visits and had healthy pregnancies. However, there is a lack of rigor in addressing complications that are identified during the prenatal visits. A mother from Garissa observed that appropriate action was not taken when the screening revealed that the fetus had a nuchal cord.[2] As a result, the child was later diagnosed with cerebral palsy.

2. There are deficits in handling the delivery process in Kwale and Machakos counties, where children are at increased the risk of cerebral palsy. The majority of mothers complained that they had prolonged labour. The worst case was in Kwale where a mother complained that she laboured for five days. According to the mothers, the main challenge is the shortage of qualified midwives in delivery rooms. Most observed that they were attended to by students because the sole midwife was attending to other serious cases. According to Diani Cerebral Palsy Caregivers Support Group, they have a membership of over 400 members mostly handling children and children of school-going-age with cerebral palsy arising from complications experienced during delivery.

3. The acute shortage of personnel in delivery rooms has led to misdiagnosis that has resulted in disability. A point in case in Garissa County shows that a newborn was misdiagnosed with convulsions and treated. The inappropriate treatment led to complications that resulted into cerebral palsy.

4. There is a limited level of multi-sensory screening among newborns. This has delayed early identification and detection of disabilities. In counties such as Kwale and Garissa where partners such as Sense International have invested in multi-sensory screening, there are low levels of awareness on the existence of such services, resulting to low utilization.

5. There is no locally customized checklist to confirm intellectual disabilities and autism among children. According to DTSK and KAIH, there is a lack of clinical guidelines for diagnosis of autism in the early years. Most children with autism and intellectual disabilities were diagnosed in the past five years. However, with time and early schooling through playgroups some parents are noticing autistic tendencies as early as two years. The

2 The condition of the umbilical cord being wrapped around a fetus's neck.

late detection of intellectual disabilities is denying children a chance to get support that is specific to their needs.

3.1.2 Disability assessment and registration

6. There are mixed findings on the cost of conducting disability assessments in the surveyed counties. Some children with disabilities paid as high as KES1,000 (Garissa), KES500 (Kisumu and Kwale) while some were not charged. The National Council for Persons with Disabilities confirmed that there is no common position on fees for disability assessment across the country. However, the assumption in the surveyed counties is that it is free. In Kwale, a medic and an occupational therapist confirmed that the assessment is free. However, due to lack of supplies such as stationery they are forced to charge around four persons with disabilities to provide services to around 50 persons with disabilities.
7. The registration process is now digital and captures the category of disability. However, it fails to further categorize the children with disabilities according to their functional limitations and support needs for purposes of planning.
8. The registration process lacks a referral pathway of referring children with disabilities to community-based support organizations and other support agencies in the country. It abruptly ends with a certificate which most caregivers and children with disabilities found to be of limited use.

3.1.3 Proposed policies (Key asks)

1. Supporting healthcare facilities to provide adequate mother and child services, especially in Garissa, Kwale and Machakos counties, by hiring qualified midwives and nurses.
2. Investing in multi-sensory screening for newborns and children of school going age in all level 3-6 hospitals and providing mobile multi-sensory screening devices for level 1-2 hospital and health personnel such as community health promoters.
3. Training last mile health promotion personnel such as community health promoters to conduct multi-sensory screening.
4. Raising awareness on existing support services such as the multi-sensory screening in Garissa and Kwale.
5. Developing customized clinical, home-based and school-based manuals for identifying children who might be at risk of intellectual disability and autism. This would involve customization of diagnosis manuals such as M-CHAT-R Screening Questionnaire, First Concern to Action Tool Kit, ASQ screening tests, among others. In addition, the exercise would involve a review of the Mother and Child Health (MCH) Handbook to incorporate the clinical, home-based and school-based manuals for assessing developmental and intellectual disabilities, including autism.
6. Improving disability assessment and registration to introduce interoperability between: Kenya Health Information System (KHIS) disability assessment module and the National Council for Persons with Disability Management Information System as well as National Council for Persons with Disability Management Information and Partner Management Information systems. To seamlessly, assess, register and refer children and persons with disability for care and support.
7. Reviewing disability registration to detail the functional limitations and support needs of children/persons with disabilities.
8. Conducting a census of partner organizations for referrals and provision of support and care services to children with disabilities

Key Ask: To mitigate incidences of disability in newborns in the first 1,500 days Invest in maternal health care and the provision of quality and comprehensive delivery services.

3.2 4-14 (children of school going age and early adolescence)

The issues that arose from both the secondary review and the primary data collection for children of school going age and their caregivers are as follows:

3.2.1 Inclusive education

1. Children with disability are facing challenges enrolling for school. They may either not enroll at all, enroll late or enroll too early.

   - Caregivers of children with high support needs did not see the need to enroll their children with disabilities to school out of the perception that they are incapable of learning. In Machakos, a mother expressed concerns regarding the practicality of providing an education for her child with cerebral palsy and high significant support requirements. Pointing to the child, she remarked, "Even you, do you think this one can go to school? Don't you think you will be disturbing her?"

   - This is also replicated in Kwale where caregivers are decrying rejection of their children with disabilities by both public and private schools due to their high support needs. The Diani Cerebral Palsy Caregivers Support Group has even established a school to take care of children with cerebral palsy in Kwale County.

   - In contrast, the case of children with autism presents a unique scenario. According to DTSK, these children are enrolled in educational institutions at an earlier age as a means of addressing their functional limitations. The caregivers hope that integrating these children with other children will facilitate the resolution of issues such as repetitive behaviors, lack of eye contact, and interest in other children.

   - Unlike children with autism, children with intellectual disabilities are enrolled way late in school. According, to KAIH some children with intellectual disabilities enroll for school as late as 10 and 14 years. The key challenge is that majority of them fail to meet or meet developmental goals way late in their life.

2. Children with disabilities encounter transportation difficulties on enrollment in school.

   - First, schools close to children with disabilities have limited capacity to handle children with disabilities such as cerebral palsy, epilepsy, autism and intellectual disabilities. Caregivers in Kwale remarked that nearby schools rejected their children for lack of personnel to provide for the support needs of their children. This creates a transport cost when the child is accepted by a school far from their home. However, nearby schools were open to enrolling children if the caregivers provided a personal assistant to support the child in their routine activities such as personal hygiene.

   - Second, when the caregivers are referred to Educational Resource Assessment Centers (EARCs) for placement in special schools, their children are enrolled in special schools far away from home creating the need for costly daily transport to and from school.

   - In Kisumu, children with physical disabilities are delayed from joining school due to mobility limitations. According to caregivers some children with physical disabilities enroll in school as late as age 10 due to lack of assistive devices to aid in their movement. The caregivers felt that their children could not cope in school due to mobility limitations and had to wait until they got the necessary transport devices, thereby delaying their enrolment.

   - Third caregivers of children are incurring extra transportation costs. A caregiver in Kwale complained that she must pay for both the personal assistant and her child with cerebral palsy to use the school bus.

3. In integrated schools, there is little learner support for children with disabilities.

   - According to Sense International, most schools lack the assistive devices to stimulate learning through all the functional senses. For instance, integrated public schools will provide for learners with blindness using braille. However, the schools will fail to support learners with high support needs such as those with complex disabilities. At present there are no

public schools with communication boards for children with complex disabilities and children with deaf blindness.

- Personal assistants for children with disabilities are not allowed to sit in classrooms. For learners with developmental challenges in personal hygiene and feeding, personal assistants are required. Caregivers in Kwale observed that schools in their region would enroll learners with complex disabilities when they are accompanied by personal assistants. However, despite the help of personal assistants being required in classroom setting, the personal assistants are not allowed in class. They must wait for break time to provide for the child's hygiene and feeding needs.
- Not all children with disabilities are provided learner-support assistants (LSAs). In supporting children with disabilities in integrated schools, LSAs are required to help children with disabilities learn through assistive devices or help them catch with the other learners without disability. However, this is not the case in most integrated settings. Caregivers observed that their children could read but could not write due to lack of appropriate learning materials in integrated schools. This was more so the case for learners with cerebral palsy.
- Examination administration in integrated schools is not supportive of learners with disabilities. According to Kisumu OPDs, learners with writing limitations are excluded in examinations. This view was also shared by DTSK and KAIH, which said that examinations for children with autism ignore non-written formats such as visual tests, oral tests, open book tests, non-timed tests, paired learning among others which would work for learners with autism and intellectual disabilities.

4. There are no alternative forms of education for children with disabilities who cannot make it to schools due to high-support needs. Children who cannot make it to schools due to the high-support needs can still access home-based education through learner support assistants and technology-based learning. However, this is not happening in most counties for the following reasons:
   - There are no learner-support assistants that are attached to children who cannot make it to school due to high support needs;
   - The education system especially Competency Based Curricullum (CBC) is school intensive due to its emphasis on formative exams that can only be done in schools.
   - Most households with children with disabilities and high support needs cannot afford to create learning spaces at home to provide for home-based learning;
   - Caregivers have divided attention due to other children who need support; and
   - Most caregivers do not know how to use resources customized for their child's learning such as tablets loaded with content for children with cerebral palsy.
5. Children with disabilities leave school without the prerequisite certificates. Learners in integrated settings and with writing limitations are excluded by the national exams. For this reason, they do not attempt national exams despite graduating from one grade to the next. The failure to sit for the written national exams means that the learner with disabilities and writing limitations leave primary school without a certificate showing that they attended school. This was confirmed by:
   - DTSK for learners with autism;
   - KAIH for learners with intellectual disabilities; and
   - Caregivers of children with cerebral palsy.
6. Children with disabilities and high support needs are forced to take vocational education that is stage rather than aged-based. The EARCs are mandated to conduct assessment for educational placement in Kenya. When learners are confirmed to be with disabilities they are automatically recommended for vocational training where they sit for Kenya Integrated Literacy and Education Assessment (KILEA) exams. After KILEA, the learners end up taking vocational training that is stage rather than age based. This has two key challenges:
   - The automatic placement for vocational education denies the learner a chance to

select their preferred career path had adequate support been provided; and

- The vocational education offered in most stage-based learning settings is on low value traditional careers such as beadwork, tailoring, knitting, leather work, plumbing among others. High value non-traditional vocational education such as data entry for children with autism, music among others is ignored.

7. Early childhood education and development school hours are not concomitant with work hours. Schooling can be a critical source of respite to caregivers. However, this is not attainable in the early years of schooling because schooling hours do not match work hours.

3.2.2 Proposed policies (4-14 years)

1. Capacity building caregivers to expose them to forms of schooling available for children with disabilities.
2. Creating awareness on the role and place of learner support assistants in integrated schools
3. Providing learner support assistants to children with disabilities in integrated schools.
4. Supporting early diagnosis of autism and intellectual disabilities for timely enrollment and customized education
5. Establishing early education centers for learners with autism and intellectual disabilities before they are enrolled in integrated schools.
6. Training and hiring personal assistants for children with disabilities in integrated educational settings
7. Providing alternative forms of schooling such as homebased schooling and vocational rehabilitation centers (VRC) for children with high support needs.
8. Mainstreaming alternative forms of formative assessment for children with disabilities in integrated schools and alternative forms of schooling.
9. Providing assistive devices to children with physical disabilities at an early age to avoid delaying enrollment
10. Recognizing prior learning for learners with disabilities who left school without certification through paired learning in a recognized national vocational centre.
11. Administering a relevant placement exam that reveals the career preferences of children with disabilities.

Key Ask: To provide learners with disabilities with appropriate education and their caregivers with respite, reform basic education.

3.3 14-18 years (Transitioning to work)

The issues that arose from both the secondary review and the primary data collection for young adults with disabilities and their caregivers are as follows:

3.3.1 Livelihood support

Persons with disabilities and their care givers lack placement support. Persons with disabilities who manage to acquire skills whether vocational or academic require support to secure placements and internships. However, this is happening at a limited scale leaving many qualified persons with disabilities without livelihood opportunities. Those with academic skills are missing out due to the following reasons:

1. Nationally the 5 per cent employment quota provided in Article 54(2) of the constitution has not been realized. The National Council for Persons with Disabilities, is assisting public agencies to progressively attain this requirement. At present, the key achievement is that this constitutional requirement is now a performance contracting obligation for public agencies. This, however, does not guarantee opportunities in the private sector. For instance, organizations of persons with disabilities in Garissa were concerned about the large number of non-governmental organizations operating in the county were not hiring persons with disabilities. In Kwale, a participant with visual disability has not secured a job despite graduating

from a leading university in the country.

2. Though the NCPWD is assisting persons with disabilities apply for jobs through their online job portal, few employers are aware of its existence especially those in the private sector. Further, it is not mandatory for all job opportunities to be advertised through the portal for accessibility by persons with disabilities. Those who wish to enter entrepreneurship are also missing out. Most of the caregivers and persons with disabilities with vocational skills and high support needs expressed interest in entrepreneurship opportunities. However, majority are not able to meet these aspirations for the following reasons:

3. The NCPWD tools of trade programme has limited reach due to funding gaps. According to the NCPWD, inadequate funding is adversely affecting provision of tools of trade for persons with disabilities who express interest.

4. The NCPWD tools of trade programme takes too long to procure and provide tools to persons with disabilities. Participants in Kisumu reported that the application process for these tools is both arduous and protracted. The application form must be filled by various national government administration officers (NGAOs), including the assistant chief, assistant county commissioners (formerly district officers), and deputy county commissioners (formerly district commissioners). The respondent's expressed dissatisfaction with the lengthy time required to complete the form, which often results in substantial financial outlays, amounting to approximately KES2,000. Those who had accessed tools from this programme had a waiting period of up to five years.

5. Most beneficiaries of the tools of trade lose them to caregivers or sell them. According to OPDs in Machakos, families of individuals with disabilities who receive the tools often sell them to meet their daily expenses. The respondents expressed their concern, stating, "If you provide a person with disabilities with a welding machine valued at KES150,000 and their households urgently require KES50,000, they may sell the machine, leaving the person with disabilities with nothing. Therefore, it is crucial for the NCPWD to monitor the recipients of these tools to prevent them from losing them."

6. There is a mismatch between the tools that persons with disability request and what they get from the NCPWD. Respondents from Garissa were surprised when an individual with disabilities who had applied for a welding machine was instead issued a sewing machine. The respondent expressed their dismay, stating, "I applied for a welding machine, but I was given a sewing machine that I could not utilize. Consequently, I had to sell it."

7. Most persons with disabilities do not access microfinance programmes. Due to legal capacity constraints (see section on legal capacity) persons with disabilities do not access credit from financial institutions which can hurt their ability to establish an enterprise.

Key Ask: To ease the entry of youths with disabilities into the labour market, accelerate provision of tailored tools matched to their investment priorities.

3.3.2 Legal capacity

Person with disabilities lack access to legal capacity to enter contracts and perform legal action due to several reasons. The primary data collection revealed that persons with disabilities do not access legal capacity due to the following reasons:

1. Persons with intellectual disabilities require support to get national identity cards which may not be forthcoming to most of them. According to KAIH, they support persons with intellectual disabilities apply for civil registration documents such as national identity cards and voters registration. However, only few get this privilege. In Kisumu OPDs decried the high transport costs that are hindering those with transport limitations from seeking civil registration.

2. Despite having government issued national identity cards, persons with disabilities are experiencing challenges opening bank accounts or gaining aspects of banking services such as mobile banking.

- For persons with intellectual disabilities, some banks outrightly refuse to open bank accounts for them. According, to KAIH, its takes advocacy efforts to have commercial banks open accounts for persons with intellectual disabilities. To have the accounts opened, for some cohort of persons with intellectual disabilities, KAIH had to train bankers to understand persons with intellectual disabilities. Further KAIH had to assume responsibility of training the persons with intellectual disabilities on safeguarding their bank accounts and ATM pin numbers.

- The experiences of individuals with intellectual disabilities are similar in those with autism spectrum disorder (ASD). For instance, according to DTSK, one of the caregivers traveled approximately 200 kilometres from Nairobi to a friendly branch to open a bank account for their child. For those who have successfully opened bank accounts, the DTSK has had to train the caregivers on how to navigate the intricacies arising of banking. One strategy involves the caregivers assuring the banks that they will co-manage the account with the young adult with autism. Alternative strategies have included creating a database of friendly banks and branches that understand challenges faced by persons with autism.

- The experience of individuals with physical disabilities in opening and operating bank accounts is distinct. Persons with physical disabilities are denied the right to open bank accounts or are denied access to some products such as mobile banking. In Kisumu, one participant reported being denied access to convenient banking services, including mobile banking, at their local branch. To resolve this issue, they descalate their complaint to the bank's headquarters in Nairobi, which ultimately allowed them to access mobile banking services. Another participant reported that a friend with hearing loss was denied the right to open a bank account and advised to operate one opened by a caregiver. The experiences are similar to those of persons with physical disabilities in Garissa. One participant was forced to switch banks to access mobile banking. The initial branch was worried that their functional limitation would expose them to fraud.

3. Despite having the requisite registration documents, persons with disabilities experience constraints in registering for mobile money. Mobile money services are critical for facilitating payments and financial inclusion. However, participants expressed concerns that they are denied access to these vital services. The majority of them reported that they are using mobile money services on lines registered by caregivers or close relatives. The primary challenge lies in the fact that mobile money agents are not permitted to register individuals with disabilities for mobile money services. This restriction stems from concerns that individuals with disabilities may be more susceptible to fraudulent activities due to their functional limitations.

3.3.3 Proposed policies (14-18 years)

1. Incorporating the private sector in the implementation of the 5 per cent hiring quota for persons with disabilities.
2. Mandating advertisement of jobs in formats accessible by persons with disabilities.
3. Reforming the tools for trade programme to ensure timeliness, increase coverage and monitor beneficiaries.
4. Providing placement services through human resource agencies.
5. Developing a financial inclusion policy for persons with disabilities in collaboration with key stakeholders such as the Central Bank of Kenya (CBK), Kenya Bankers Association (KBA), NCPWD, OPDs and mobile money service providers.
6. Developing a customized disability sensitization module for banking sector and mobile telephony employees.
7. Developing customized financial literacy modules for the various diversities of disability
8. Lobbying the CBK and the KBA to develop a financial inclusion package for the diversities of persons with disabilities with clear account opening forms formats for persons with disabilities and clear mobile money and mobile banking guidelines for the various diversities of disabilities.

Key Ask: To guarantee the financial inclusion of all persons with disabilities, there is an urgent need for banks to respect the legal capacity of persons with disabilities by establishing industry wide standard operating procedures.

3.4 Pillars cutting across the lifecycle

The issues that arose from both the secondary review and the primary data collection for all persons with disabilities irrespective of age and their caregivers are as follows:

3.4.1 Human support

Analysis of primary data and secondary data reviewed revealed that care work for persons with disabilities is disproportionately borne by women and is unrecognized. Over 99 per cent of the caregivers who attended the caregivers FGDs were female. The car givers reported that the care work is unrecognized and is neither shared with other family members and the society. The caregivers had the following asks:

1. Detachment training so that they can respect the independence of persons with disabilities, develop healthy boundaries to avoid over attachment, handle transition of persons with disabilities across the life cycle and have some selfcare for themselves. When inquiring about their capacity to separate themselves from individuals with disabilities, caregivers from Machokos expressed astonishment, remarking, "How can I allow this individual to be left alone? How can I entrust others with them? Can you not perceive their vulnerability?" Similarly, caregivers from Kwale shared similar concerns, stating, "I cannot envision a scenario where I leave my child unattended! Even my relatives are hesitant to handle them. Their father is disinterested and resides at a distance. If circumstances were dire and I were compelled to leave them, I would only entrust them to a fellow caregiver who has experienced what I have." One caregiver, compelled by illness to separate from their child, expressed their difficulty in relinquishing control when they remarked, "I experienced a worsening of my condition each time I recalled my child's solitude. Fortunately, my hospitalization was brief. There is an urgent need for us to acquire the knowledge and skills to let go."

2. Vocational and rehabilitation centres to provide them with respite. A key concern among caregivers was where to get trustworthy respite services. After being trained how to let go, the caregivers felt that they should be provided trustworthy centers where they can access respite services. One caregiver from Kisumu expressed their need for trustworthy respite centres when they remarked, "Before entrusting my child to another caregiver, I must place my trust in them. It is challenging to discern who to trust in this society. If our husbands have divorced us due to our children's disabilities, who else can we rely on? We require reliable facilities such as Nyabondo where we can confidently seek respite services."

3. Affordable respite services. When asked on their willingness to pay for respite care the results were mixed. Some caregivers felt that they could afford while others felt that they were not able to pay. In Kwale, a caregiver expressed their inability to pay for respite, stating, "If paying for therapy services is already a financial strain for us, what about respite care? Undoubtedly, I would prioritize therapy over my immediate need for self-care." In Garissa one caregiver expressed willingness to pay, stating, "irrespective of the amount, personally, I am willing to pay everything for the comfort of my child. I am willing to pay any amount from KES50 to KES500. I feel I can comfortably afford this."

4. Strong integration of disability services in education. Caregivers acknowledged that schooling can be an adequate source of respite services. However, schools are ill equipped and resourced to handle the various diversities of disability. Caregivers were of the view that having nearby schools equipped to accommodate their children during learning hours would provide them the much-needed rest.

5. Motivate men to join women in providing care and support services for persons with disabilities. Caregivers were concerned that only a pocket of men were interested in supporting females provide care. Some were of the view that financial support to caregivers would attract men into caregiving,

remarking, "if we get a similar cash transfer specifically for caregivers, just like we have for those with severe disabilities some men would join us in the caregiving." However, fellow caregivers were quick to remind them that the men would simply pick the transfer and abandon the care roles, stating, "this would not work. My husband came back when they learnt that I got a tablet for my child from Sense International. He was also agitated when he learnt that I receive Inua Jamii funds for my child. It became a domestic dispute that had to be resolved by the extended family. The only alternative is to use law enforcement to ensure that men in formal jobs who have abandoned us and our children are forced to pay! Unfortunately, men in informal setting would go scotch free!"

3.4.2 Proposed policies (Human support)

1. Providing detachment training to caregivers of persons with disabilities.
2. Providing respite centers with affordable residence and day services, paid professionals and support activities such as individualized learning.
3. Co-opting educational solutions in vocational and rehabilitation centers for children with high support needs that may not be addressed in a school setting.
4. Co-programming care within education. Equipping schools with requisite personnel and resources such as learner support assistants to accommodate learners with high support needs.
5. Enforcing the law on child support to ensure that females receive support from their male counterparts.
6. Recognizing informal care arrangements such as KAIH's parental support groups.
7. Establishing a caregiver's cash transfer

Key Ask: To recognize and redistribute disability related care work, organize persons with disabilities and their caregivers.

3.4.3 Accessible housing and transport

There are mixed findings on accessibility of housing and transport by persons with disabilities. Primary data and secondary sources reveal that there are regional disparities in the accessibility of housing and transport by persons with disabilities. The key issues include inaccessibility to old buildings, public service vehicles, inaccessible hygiene facilities, lack of discounts and concessions for persons with disabilities on publicly owned means of transport. The major asks by caregivers, OPDs and secondary sources on transport and housing include:

1. Provision of paratransit services to school and hospital for children with disabilities. The majority of the caregivers were concerned that with age and weight transporting their children to school or hospital was becoming cumbersome. A caregiver from Garissa expressed her inability to transport her child to school due to his increasing weight and hydrocephalus.[3] She stated, "My child has hydrocephalus, and he has become so heavy that I am unable to lift him on my own. The mobility device we previously used has become inadequate. As he ages, I am concerned about how I will manage to transport him to school and other events." Similarly, caregivers from Kwale expressed the burden of the regular transport costs to hospital for therapy sessions. One caregiver stated, "I occasionally contact the occupational therapist and request that he provides me with fare to the hospital. Each visit costs KES200. The frequency and regularity of these therapy visits are simply unaffordable for me. I genuinely require an alternative transportation solution. I am uncertain about the consequences when my child enrolls in school." Similar challenges were experienced by respondents in Kisumu who felt that inaccessible transport was hindering civic registration and participation of persons with disabilities.
2. Provision of accessible hygiene facilities in Garissa County public buildings and integrated schools. The OPDs from Garissa expressed dismay that public buildings and integrated schools did not have universally accessible toilets. An OPD leader remarked, "We have a big problem with our county government. How come their buildings are inaccessible for persons living with disabilities?

3 A condition where a child's head becomes abnormally large.

How come they lack universally accessible toilets. Imagine, even out integrated school lacks a universal toilet. This is unfair to us."

3. Offering services to existing transport and housing service providers to assist them adapt vehicles and housing to the needs of persons with disabilities. Secondary sources acknowledge that developments done before enforcement of universal access are still inaccessible to persons with disabilities and efforts should be made to make them compliant.

4. Supporting and publicizing practical and working innovations for passenger service vehicles (PSVs) and housing to be universally accessible. Road transport passenger services is dominated by the private sector. The sector is poorly organized and hardly complies with transport standards.[4] Consequently, the sector is hardly providing transport services to persons with disabilities with high support needs.

5. Increasing enforcement of existing legal and policy requirements for universal accessibility of transport services irrespective of the ownership status by coordinating with vehicle inspections agencies such as National Transport and Safety Authority (NTSA) and Customs at the ports of entry. There are existing legal requirements on universality of transport and housing. The Persons with Disabilities Act (2003) provides for the access and mobility rights of persons with disabilities to transport in Kenya through sections 21 and 23. Section 23(1) requires operators of PSVs to adapt it to suit persons with disabilities in such manner as may be specified by the NCPWD. County government transport acts such as the Nairobi City County Transport Act (2020) provides for community care and support by specifying the accessibility requirements and sitting capacity of persons with disabilities in various PSVs in Section 31(1) and Section 31(2). The act mandates PSVs with a capacity of 18 to 35 passengers to have two designated seats and those with over 35 passengers to have one three designated seats close to the alighting door for passengers with physical disability or special needs. In addition, the Draft Persons with Disabilities National Policy (2024) seeks to have a transport system that is inclusive and accessible to persons with disabilities by enforcing legislation, supporting innovative designs of modes of transport for use by persons with disabilities among others. However, enforcement of these requirements is weak.

6. Providing concessions and discounts to persons with disabilities who use public means of transport such as the Nairobi Commuter Buses, The Nairobi Commuter Rail and the *Madaraka* express. An informal inquiry with publicly owned means of transport such as *Madaraka* express showed that there are no existing discounts for adults living with disabilities. The inquiry revealed that children with disabilities would be covered under discounts enjoyed by all children under Madaraka express.

3.4.4 Proposed policies (Transport and Housing)

1. Buddy system. Using classmates of children with disabilities to accompany them to nearby schools
2. Providing mobility devices such as power wheelchairs, crutches, canes among others to children with disabilities to aid their mobility.
3. Escort services. Hiring aides to accompany children with disabilities and moderate support needs to nearby schools as a way of providing respite to caregivers.
4. Individualized transport plans for children with disabilities and high support needs. Which involves supporting public integrated schools with transport solutions for children with high support needs.
5. Pursuing alternatives options rather than transporting children with severe disabilities and high support needs to school such as homebased or VRC based schooling.
6. Creating awareness among private transport service providers on practical and working innovations for making transport universally accessible. A key step would be provision of docking spaces for mobility devices largely used in Kenya.
7. Training passenger service vehicles personnel on transport related care and support for persons with disabilities. Enlisting PSV personnel in the provision of care and support within the transport

4 Updated Integrated National Transport Policy (2024). Ministry of Roads and Transport. https://transport.go.ke/sites/default/files/INTP%20REVIEWED%20MARCH%202024%20SESA.pdf

industry would unlock mobility for majority of persons with disabilities. Since PSVs are organized in saving and credit cooperatives (SACCOs), it follows to advocate for the transport rights of persons with disabilities through the SACCOs.

8. Advocacy on the need for concessions and discounts for persons with disabilities who use *Madaraka* express. Being a public entity, the Kenya Railways can be used as a champion in providing concessions and discounts for persons with disabilities within the transport industry. The corporation provides a platform that can set standards for universal accessibility of transport services in the country.
9. Creating working collaborations between the NCPWD, NTSA and Customs to ensure compliance of imported and assembled vehicles with the inclusivity standards spelt out in the Persons with Disabilities Act, No. 14 of 2003.

Key Ask: To unlock the participation of persons with disabilities in community activities, enforce accessibility standards.

3.4.5 Disability assessment

Underscoring the provision of care and support for persons with disabilities is a functional governance system that brings together the government agencies and care and support partners. Such governance system would synergize and inform government agencies and partners on the need and status of provision of care to persons with disabilities.

1. The major ask arising from this is integration and monitoring of activities from disability assessment to referral for care and support. At present services to persons with disability occur in silos. Disability assessment is a function of the health system, registration is a function of the NCPWD and referral for services, and to partners for care and support, combines a range of actors. There is need for utilization of existing last mile networks as community health promoters in the assessment and provision of care and support; interoperability of management information systems for monitoring, referral and case management; synergizing efforts among partners; and creation of a cohesive whole unit for the provision of care and support.

3.4.6 Proposed policies (disability assessment)

1. Reforming and extending disability assessment and registration.

   - At present, disability assessment and registration end with the person with disabilities receiving a certificate that communicates their diversity of disability, ethnicity, age, sex and residency. This fails to communicate the support needs and functional limitations of the person with disability which limits planning. There is need to extend the assessment and registration process so that it captures adequate data for planning purposes and referral for support and care.
   - The fact that disability assessment is a function of health service providers means that challenges attending to health care also attend to disability assessment. Respondents from vast counties such as Garissa complained how the long distance between remote and Garissa general hospital is hindering disability assessment. Therefore, minimizing the role of medical facilities while uplifting the role of last mile networks such as community health promoters (CHPs) would simplify this process.

In addition to the failure to communicate support needs, the regular proof of life requirement for persons with permanent disability is cumbersome and disruptive to key services. A teacher from Garissa complained that their personal guide goes for about three to four months without pay as he renews his request to prove life to the teacher's service commission which he considers unfair. This could be resolved made easier if the civil registration systems were integrated with other registries to capture births and deaths of persons with disabilities.

Key Ask: To promote disability inclusion, extend disability assessment to capture functional limitations and the level of support needs.

4

PROPOSED COSTED POLICY SCENARIOS

Based on the key asks and demands by persons with disabilities and their caregivers, the study could have costed issues cutting across all the 11 pillars of care and support. However, the scope of the costing was limited to pillars at the heart of care and support such as accessible transport, human support, cash transfers, assistive devices, concessions and discounts as well as disability assessment. This section, therefore, presents costed scenarios of attaining these six pillars.

4.1 Providing accessible transport services

Transportation difficulties to and from daily activities of life can limit the independence of persons with disabilities especially those with high support needs. The need for specialized transport, increases financial costs to households which in turn leads to isolation of persons with disabilities and high support need and an increase of the dependency on their caregivers. Addressing transport needs is, therefore, an avenue of addressing unpaid care work. Primary data revealed that households with children with disabilities and high support needs are unable to regularly take their children to school or to hospital for occupational therapy sessions. It is the considered view of these, households, that paratransit services would unlock the participation of their children in school, treatment and other social activities.

Secondary data revealed that the existing road transport services are hardly providing transport services to persons with disabilities and high support needs. Further, there is weak enforcement of accessibility requirements by the Persons with Disabilities Act (2003). Given the need and the prevailing circumstances, a paratransit solution would be ideal in meeting the transport needs of persons with disabilities and their caregivers. Persons with disabilities and caregivers require transport services accessible by wheelchair users with trained drivers, which guarantee safety through door-to-door services. As a starting point, the paratransit services could focus on essential activities such as schooling (or vocational and rehabilitation centers), commute and medical appointments.

A key avenue for introducing paratransit services is Taifa Care (Formerly Social Health Insurance Fund where the new "high" contributions are used by the state to guarantee independent living for persons with disabilities as a human right. The critical advantage of socially provided paratransit services is that Taifa Care, being a national social insurance scheme, will guarantee a national roll out of paratransit services. Just like the hospital model where service providers are reimbursed for services rendered, paratransit service providers would be compensated for transport services rendered to qualifying persons with disabilities and qualifying transport services.

To provide the paratransit services the following will be required, a change in the law to mandate the government provide paratransit services, a qualifying criterion for both persons with disabilities and nature of transport service; an identification strategy for both the service providers and persons with disabilities; a monitoring mechanism to ensure safety; and a claim procedure for service providers. This study attempts to cost the process of developing this infrastructure and insuring the services.

A review of literature shows that the costs will include the actual insurance cost of the paratransit services; a one-off expense of establishing the eligibility criteria; a one-off cost of mooting co-operation with ride hailing service providers; concessions to investors who invest in persons with disabilities paratransit services; a one-off cost of mainstreaming ride eligibility determination in the service providers platforms; and a one-off expense of establishing an invoicing and settlement procedures for service rendered. The actual insurance cost will encompass estimation of the cost of insuring an average number of trips per year. The one-off expense of establishing the eligibility criteria will involve facilitating a decision by the relevant department at the NCPWD and partners such as the Directorate of Social Development and the Ministry of Education. The one-off expense of mooting co-operation with service providers will involve accreditation of service providers by Taifa Care and NCPWD. The concessions to investors who invest in persons with disabilities paratransit services will involve tax exemption of motor vehicles and other infrastructure used for persons with disabilities paratransit services such as wheelchair-accessible vehicles and identification technology. The one-off cost of mainstreaming ride eligibility determination in the service providers platforms will involve programming ride eligibility criteria in the service providers platforms. The one-off expense of establishing an invoicing and settlement procedures for service rendered will involve automating the invoicing and settlement process for transparency and accountability. Table 5 details these costs. The table reveals that persons with disabilities paratransit services focusing on assisting children with disabilities access schooling, routine health services such as occupational therapy, access medical care if ill and attend communal activities such as sports and religious worships would cost KES5.482 billion in the first year with a recurring annual cost of KES5.82 billion every year.

Table 2: Costs associated with the provision of persons with disabilities paratransit services

Cost category	Specific costs	Assumptions in computing the costs	Total Costs (KES)
The insurance costs	Transport to and from school	KNBS analytical report on disability[5] shows that there are 174,955 children of school going age with disabilities 129,694 are already in school leaving out 45,261 due to severe and moderate disabilities. If 80% (36,209) of these children can access some form of schooling when reasonable transport is provided and considering that they can attend 90% of the 170[6] school days in 2025 school calendar (153 days) we have 306 rides per child per year. Assuming an average distance of 6km to the nearest integrated school charged at KES200 per ride and considering the 306 rides for all the 36,209 pupils we get the total cost.	2,215,990,800

5 Kenya National Bureau of Statistics (2022). 2019 Kenya Population and Housing Census. Analytical Report on Disability volume XV. https://www.knbs.or.ke/wp-content/uploads/2024/05/2019-Kenya-Population-and-Housing-Census-Analytical-Report-on-Disability-Vol.XV_.pdf

6 Ministry of Education (2024). 2025 Academic term dates

Cost category	Specific costs	Assumptions in computing the costs	Total Costs (KES)
	Transport to and from routine care	According to KISE 5.9%[7] of learners in special units, special schools and integrated schools need occupational therapy. This translates to 2,668 learners out of 45,261 learners with severe and moderate disabilities. If the learners received OP at school for 36[8] weeks in a year, they are left with 16 uncovered weeks. Assuming that the occupational therapy is provided 2 times per week we have 4 rides to and from hospital every week costing KES800. Assuming a cost of KES200 per ride.	34,150,400
	Transport to and from healthcare facilities	If 10%[9] of the population with disability (91,669 persons) falls ill and needs 6 rides to and from hospital at a cost of KES200 per ride.	110,002,800
	Transport to and from work (commute)	Provided for through concessions such as tax exemptions	0
	To and from select social activities e.g. sports, church, mosque etc	Assuming the 113,511 persons with disabilities out of the labour force[10] and the 36,209 children with severe disabilities are supported to attend one event (sport or religious event every weekend (2 rides)) for 52 weeks in a year at a cost of KES200 per ride	3,114,176,000
Establishing eligibility	Facilitating task force sittings	Staff under government payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
Mooting co-operation with service providers	Establishing a cooperation standard using a task force	Staff under government payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
	Establishing an MOU through legal services	Legal fees for drafting agreements. Handled by respective legal departments in government agencies	0

7 Kenya Institute of Special Education (2018). National survey on children with disabilities and special needs in education. https://kise.ac.ke/system/files/2022-01/National%20survey%20on%20children%20with%20disabilities%20and%20special%20needs%20in%20education%202018-min.pdf

8 Based on 2025 school Calendar

9 According to between 5-15% of the population is likely to be sick at any one point. SZILAGYI, P. G., BLUMKIN, A., TREANOR, J. J., GALLI-VAN, S., ALBERTIN, C., LOFTHUS, G. K., … SHAY, D. K. (2016). Incidence and viral aetiologies of acute respiratory illnesses (ARIs) in the United States: a population-based study. Epidemiology and Infection, 144(10), 2077–2086. doi:10.1017/S0950268816000315. https://www.cambridge.org/core/journals/epidemiology-and-infection/article/incidence-and-viral-aetiologies-of-acute-respiratory-illnesses-aris-in-the-united-states-a-populationbased-study/0647B1D7BD12C0613C5F30D056819E34

10 Ibid 21

Cost category	Specific costs	Assumptions in computing the costs	Total Costs (KES)
	Signing of MOU with service providers. Accreditation of service providers by Taifa care and NCPWD	A public event to raise awareness and publicity on the new services available to persons with disabilities	1,000,000
Concessions on paratransit infrastructure	Forgone import duty	Implicit cost	0
	Foregone excise duty	Implicit cost	0
Mainstreaming eligibility criteria on service provider platforms	Integrating ride requests by persons with disabilities on service providers platforms with NCPWD eligibility determination mechanism	Facilitating service providers and NCPWD ICT team program and integrate the eligibility criteria. DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
	Integrating approved rides-route and persons-feedback mechanism with service providers platform		
	Mainstreaming riders identity with NCPWD platforms to address fraud		
Invoicing and accounting	Integrating service providers invoicing processes in Taifa Care invoicing platforms	Facilitating service providers and Taifa care ICT team program and integrate the eligibility criteria. DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
	Integrating Taifa cares settlement process with service providers platforms		
Total Cost			**5,482,320,000**

4.2 Human support

4.2.1 Organizing caregivers and persons with disabilities for care and support

At present disability assessment and registration are voluntary. As such actual numbers of persons with disabilities and their caregivers reported through the assessment and registration process only captures those who prefer to self-report. This issue further ails the data collected using mainstream measurement frameworks such the Kenya Population and Housing Census (KPHC). The data collected using this framework relies on the Washington Group Short Set of Disability Questions to gather information on persons with disabilities which again requires households to volunteer information on the number of members who have difficulties. As such, it is difficult to ascertain the number of persons and caregivers who require care and support in the country.

To address this deficit innovations by OPDs can be used to organize persons with disabilities and their caregivers at the grassroot level where self-reporting is complemented by societies surveillance to address issues such as stigma, infanticide and ableism. The social reporting would augment efforts to reach out to all persons with disabilities and their caregivers.

One such initiative is the creation of Circles of Support by the KAIH. The KAIH, has been organizing persons with intellectual disabilities and their caregivers across into these support groups. The groups mainly consist of 30 to 40 people with some stretching the membership to 70 persons. The circles \ are governed by a constitution that creates formal structures to facilitate membership and regular meetings. The frequency of the meetings varies depending on the locality. Some circles meet monthly, others weekly, and a few as often as twice a week. These support groups serve as platforms for further mobilization of persons with intellectual disabilities in their localities and information dissemination. The information ranges from discussions about disabilities, community engagement to referrals for medical support. Importantly, the circles helps KAIH in raising awareness on intellectual disabilities and advocacy. National representatives from the headquarters are often invited to the support group meetings to educate the members on identifying disabilities within their communities and the types of support KAIH provides. These sessions frequently occur in places of worship and social halls such as churches, mosques and community amenities, further integrating the initiative into the social and administrative fabric of the country. As a result, the circles are recognized by religious bodies, last mile health networks such as CHPs and the NGAOs. As of 2024, KAIH had successfully mobilized caregivers and guardians of persons with intellectual disabilities across 15 counties into a robust network of 135 parent support groups representing a movement of over 4,000 members spread across 500 households for persons with intellectual disabilities. A notable development withing this network is development of informal arrangements for paid care and support especially in the urban areas where caregivers must work to eke a living. A chairperson of one of the support groups in Nairobi said that they had organized themselves to provide care and support to their children with disabilities on a rotational basis across their households. One caregiver is left with a manageable number of children with intellectual disabilities in a day then another picks up the following day as each caregiver takes their turn. At the end of the end of the day, the free caregivers compensate the caregiver who oversaw the children. According to KAIH, most rotational arrangements are compensating the in-charge caregiver at a rate of KES50 per child per day. Other, informal arrangements include caregivers leaving their children with trusted members of the society such as shopkeepers, hairdressers and vegetable vendors. With adequate trust, these trusted members are helping persons with intellectual disabilities move around their neighbourhood. For instance, the chairperson explained how trusted shopkeepers are helping persons with intellectual disabilities visit their nearby relatives as they head to source stock in those neighborhoods. They drop the person with intellectual disability before picking their wares and pick them up once done with shopping to go back home.

Given the successes of the circles of support in organizing persons with intellectual disabilities, their caregivers and the society for provision of care and support, this study costs the scaling of circles of support across all diversities of disability and the life cycle. Key costs in establishing the circle of support in new areas include cost of entry, cost of organizing caregivers and persons with disabilities

and sustainability cost. The cost of entry varies from one region to another. It may involve costs such as identifying stakeholders such NGAO, religious units and grass root OPDs to help mobilize persons with disabilities for an inception meeting with KAIH. It may further involve a response to caregivers of persons with intellectual disabilities who have reached to KAIH following word of mouth from the existing networks. The organization costs involve KAIH meeting the persons with disabilities and their caregivers and taking them through the circle model. The training focuses on existing innovations that current caregivers and persons with disabilities support groups are using to meet their support needs and how they could be customized for the new settings. The sustainability costs include training coordinators of the new groups so that they further facilitate discussions at the community level and capacity build caregivers for care and support.

Table 2 details the costs and assumptions of extending this network to all diversities of disability within all counties in Kenya. As a starting point, Table 2 uses the self-reported disability figures reported during the KPHC 2019. Using the support needs assessment survey findings, Table 2 assumes that each person with disabilities has two primary caregivers (the household head and their spouse) who require organization. As such, the approximate number of caregivers is the number of persons with disabilities multiplied by two. Table 2 further assumes that both persons with disabilities and the caregivers would require organization. Therefore, the total number of persons organized in a column is the sum of persons with disabilities and their caregivers. The KAIH estimates that the entry cost for every group is about KES50,000 this yields the entry costs per each county column. The organizing costs per each person are estimated at KES2,500 based on KAIH's experience. This figure is used to arrive at organizing costs column. According to KAIH, the sustainability cost involves training of support group coordinators at a cost of KES40,000 per coordinator per month. If each coordinator receives 12 months of training every year, the sustainability costs are as detailed in the sustainability column in Table 2. The total costs of creating and running the support groups is obtained by aggregating the entry, organizing and sustainability costs as shown in Table 2.

Table 3: Costs associated with organizing persons with disabilities into support groups

County	Number of persons with disabilities	Approximate number of caregivers	Total number of persons to be organized	Total number of support groups	Entry Costs	Organizing Costs	Sustainability costs	Total Costs
Mombasa	14,226	28452	42,678	1066.95	53,347,500	106,695,000	512,136,000	672,178,500
Kwale	12,130	24260	36,390	909.75	45,487,500	90,975,000	436,680,000	573,142,500
Kilifi	20,044	40088	60,132	1503.3	75,165,000	150,330,000	721,584,000	947,079,000
Tana River	4,032	8064	12,096	302.4	15,120,000	30,240,000	145,152,000	190,512,000
Lamu	2,402	4804	7,206	180.15	9,007,500	18,015,000	86,472,000	113,494,500
Taita Taveta	8,301	16602	24,903	622.575	31,128,750	62,257,500	298,836,000	392,222,250
Garissa	5,187	10374	15,561	389.025	19,451,250	38,902,500	186,732,000	245,085,750
Wajir	3,731	7462	11,193	279.825	13,991,250	27,982,500	134,316,000	176,289,750
Mandera	6,190	12380	18,570	464.25	23,212,500	46,425,000	222,840,000	292,477,500
Marsabit	3,098	6196	9,294	232.35	11,617,500	23,235,000	111,528,000	146,380,500
Isiolo	2,694	5388	8,082	202.05	10,102,500	20,205,000	96,984,000	127,291,500
Meru	49,738	99476	149,214	3730.35	186,517,500	373,035,000	1,790,568,000	2,350,120,500
Tharaka-Nithi	13,014	26028	39,042	976.05	48,802,500	97,605,000	468,504,000	614,911,500
Embu	23,787	47574	71,361	1784.025	89,201,250	178,402,500	856,332,000	1,123,935,750
Kitui	26,991	53982	80,973	2024.325	101,216,250	202,432,500	971,676,000	1,275,324,750
Machakos	31,670	63340	95,010	2375.25	118,762,500	237,525,000	1,140,120,000	1,496,407,500

County	Number of persons with disabilities	Approximate number of caregivers	Total number of persons to be organized	Total number of support groups	Entry Costs	Organizing Costs	Sustainability costs	Total Costs
Makueni	36,292	72584	108,876	2721.9	136,095,000	272,190,000	1,306,512,000	1,714,797,000
Nyandarua	16,212	32424	48,636	1215.9	60,795,000	121,590,000	583,632,000	766,017,000
Nyeri	21,860	43720	65,580	1639.5	81,975,000	163,950,000	786,960,000	1,032,885,000
Kirinyaga	18,859	37718	56,577	1414.425	70,721,250	141,442,500	678,924,000	891,087,750
Murang'a	35,112	70224	105,336	2633.4	131,670,000	263,340,000	1,264,032,000	1,659,042,000
Kiambu	44,481	88962	133,443	3336.075	166,803,750	333,607,500	1,601,316,000	2,101,727,250
Turkana	7,900	15800	23,700	592.5	29,625,000	59,250,000	284,400,000	373,275,000
West Pokot	5,217	10434	15,651	391.275	19,563,750	39,127,500	187,812,000	246,503,250
Samburu	3,370	6740	10,110	252.75	12,637,500	25,275,000	121,320,000	159,232,500
Trans Nzoia	17,478	34956	52,434	1310.85	65,542,500	131,085,000	629,208,000	825,835,500
Uasin Gishu	15,057	30114	45,171	1129.275	56,463,750	112,927,500	542,052,000	711,443,250
Elgeyo Marakwet	4,856	9712	14,568	364.2	18,210,000	36,420,000	174,816,000	229,446,000
Nandi	14,221	28442	42,663	1066.575	53,328,750	106,657,500	511,956,000	671,942,250
Baringo	8,656	17312	25,968	649.2	32,460,000	64,920,000	311,616,000	408,996,000
Laikipia	8,344	16688	25,032	625.8	31,290,000	62,580,000	300,384,000	394,254,000
Nakuru	33,899	67798	101,697	2542.425	127,121,250	254,242,500	1,220,364,000	1,601,727,750
Narok	9,029	18058	27,087	677.175	33,858,750	67,717,500	325,044,000	426,620,250
Kajiado	10,379	20758	31,137	778.425	38,921,250	77,842,500	373,644,000	490,407,750
Kericho	8,554	17108	25,662	641.55	32,077,500	64,155,000	307,944,000	404,176,500
Bomet	9,109	18218	27,327	683.175	34,158,750	68,317,500	327,924,000	430,400,250
Kakamega	47,778	95556	143,334	3583.35	179,167,500	358,335,000	1,720,008,000	2,257,510,500
Vihiga	19,973	39946	59,919	1497.975	74,898,750	149,797,500	719,028,000	943,724,250
Bungoma	29,170	58340	87,510	2187.75	109,387,500	218,775,000	1,050,120,000	1,378,282,500
Busia	20,478	40956	61,434	1535.85	76,792,500	153,585,000	737,208,000	967,585,500
Siaya	35,439	70878	106,317	2657.925	132,896,250	265,792,500	1,275,804,000	1,674,492,750
Kisumu	39,868	79736	119,604	2990.1	149,505,000	299,010,000	1,435,248,000	1,883,763,000
Homa Bay	42,137	84274	126,411	3160.275	158,013,750	316,027,500	1,516,932,000	1,990,973,250
Migori	29,265	58530	87,795	2194.875	109,743,750	219,487,500	1,053,540,000	1,382,771,250
Kisii	36,308	72616	108,924	2723.1	136,155,000	272,310,000	1,307,088,000	1,715,553,000
Nyamira	17,536	35072	52,608	1315.2	65,760,000	131,520,000	631,296,000	828,576,000
Nairobi City	42,620	85240	127,860	3196.5	159,825,000	319,650,000	1,534,320,000	2,013,795,000
National	916,692	1,833,384	2,750,076	68,752	3,437,595,000	6,875,190,000	33,000,912,000	43,313,697,000

Arising from this analysis and assumptions are the national requirements for organizing all diversity of disability into circles of support. Since Table 2 uses the self-reported figures from the 2019 KPHC, there are at least 2,750,076 persons with disabilities and their primary caregivers to be organized into circles in about 68,752 support groups. The entry costs are estimated at KES3.44 billion. This is low compared to organizing costs (KES6.88 billion) and sustainability costs (KES33 billion). In total, the country requires KES43.3 billion to organize persons with disabilities into support groups for disability-sensitive and gender-inclusive care and support.

4.2.2 Detachment training for caregivers

During the primary data collection phase, one of the critical requests from the caregivers was detachment training. The caregivers expressed concerns about their lack of trust in individuals to care for their children with disabilities. In addition, they expressed concerns that their attachment to their children may be hindering their independence and autonomy. Many caregivers struggled to comprehend how their children could manage in the event of their separation.

One strength of organizing persons with disabilities and their caregivers into support circles is that the groups provide a platform for detachment training and mainstreaming informal care arrangements within a trusted circle. As such, the organizing and sustainability costs involved in creating the circle would meet this urgent need by caregivers.

4.2.3 Provision of key care and support services in vocational and rehabilitation centres

At present, the circle constructed by KAIH largely depends on informal arrangements to provide care and support such as paid rotational caregiving. However, due to the high disability costs and limited expertise of the caregivers in rotational arrangements, some persons with disabilities may miss getting the right quality and quantity of care and support that they need. To overcome this weakness of informal care arrangements this study costs establishment of government run VRCs for key care and support services, including them day and residence care and support services.

For sustainability, each VRC would require adequate demand for its services. If 40 circle groups (1,600 persons with disabilities and caregivers) are required to have each VRC running, then 1,719 VRCs are required nationally. At present the government runs 12 VRCs across the country with the mandate of providing vocational training and rehabilitation for persons with disabilities. To achieve the role of a center for the 40 circles the mandate would need to be expanded to provision of a range of services to persons with disabilities and their caregivers. The VRC mandate can be expanded so that they serve as one-stop centres where persons with disabilities and their caregivers receive a range of services.

Where the government meets the privately organized circles, the VRCs should provide respite services (both day and residential) across the country, behavioral health services, vocational training and placements, adult day and residential services as well as advocacy and awareness services. As such, the VRC should have different arms focusing on these broad themes. Each arm of the VRC would require personnel at the grassroot level and supervision at the national level by both the NCPWD and the Directorate of Social Development (DSD).

To run the vocational training and rehabilitation arm, the DSD has been operating 12 VRCs at a cost of KES152,425,201.[11] This translates to KES12,702,100 per VRC for the single function. Assuming similar requirements, it would cost KES63,510,500 to run a VRC with all its functions. Aggregating this for the 1,719 VRCs required nationally, integrated VRCs for supporting persons with disabilities and their caregivers would cost KES109.17 billion annually to run.

4.2.4 Extending coverage of personal guides to the formal private sector

The government provides public officers with disabilities personal guides. Through the 2019 SRC circular[12] the government provides personal guides for public officer with hearing disabilities, visual/vision disabilities and wheelchair users. The personal guides are renumerated at a rate of KES20,000 per month. However, this human support is not extended to workers with disabilities in the private sector or the informal economy. Given the lack f information on the numbers of persons with disabilities in the informal economy this study costs the extension of human support services to the formal private sector. The KNBS estimates that the formal private sector

11 Open Budget Kenya, (2024). https://openbudget.or.ke/project/1185000600_Vocational_rehabilitation/2024/

12 Salaries and Renumeration Commission (2019). Remuneration for a Personal Guide for Public Officers Living with Disability Ref No. SRC_TS_NCPWD_3_18_(80). https://ncpwd.go.ke/download/guide-allowance-src-circular-2019-pdf/?ind=607fadbf052ba&filename=GUIDE-ALLOWANCE-SRC-CIRCULAR-2019.pdf&wpdmdl=573&refresh=675233377bb531733440311

employs 68.4 per cent of the wage employees in Kenya.[13] The KNBS further estimates that 155,727 persons with disabilities are in wage employment[14] using the proportions shared between the public and the private sector, 106,518 (0.684*155,727) persons with disabilities are in the private sector. If all of them do not have personal guides the private sector requires KES2.1 billion per month to provide persons with disabilities personal guides. This translates to KES25.6 billion per year.

4.3 Cash Transfer

Provision of care and support would require cooperation between the public sector (government) and the private sector (OPDs). The OPDs could organize persons with disabilities and their caregivers while the government provides services that the private sector cannot. One such service is the provision of social assistance to persons with disabilities. The government has a role of ensuring that persons with disabilities and their caregivers do not fall into destitution. At present, the government achieves this role using the Inua Jamii cash transfers programme. The PwSD-CT is targeted towards protecting persons with severe disabilities from sinking into destitution by supporting their households. Specifically, the PwSD-CT seeks to protect persons with severe disabilities by enhancing the capacities of the caregivers through regular and predictable cash transfers. The idea is that the cash transfer mitigates the effects of the disability on the household by enhancing the caregiver's capacity. As a result, the PwSD-CT aims to accomplish three objectives simultaneously. Under the first objective, the cash transfer seeks to provide basic income support for impoverished households through elevated care and support requirements. Under the second objective, the PwSD-CT seeks to provide basic income security for individuals with disabilities who are unable to engage in employment. Lastly, the cash transfers provide a disability allowance for individuals with disabilities to cover their disability-related expenses. However, the fact the programme targets households rather than individuals means the transfers are ineffective in providing individuals with severe disabilities a basic income or covering their disability-related costs, as they lack direct control. On the other hand, its design fails to acknowledge the caregivers. At present, therefore, neither caregivers nor persons with severe disabilities are not specifically targeted by the PwSD-CT. There is a need, therefore, to redesign the cash transfer so that they specifically targets persons with severe disabilities or their caregivers. Some of the options involve retaining the PwSD-CT as it is but acknowledging it goes to the household rather than a person with severe disabilities or introducing a caregiver cash transfer and making PwSD-CT individual specific.

Other shortcomings that were associated with the cash transfer during the primary data collection included its limited coverage. Many eligible households reported frustration at being surveyed and listed as potential beneficiaries, only to never receive the cash transfer despite the prolonged wait. Benefiting households, further complained that the cash transfer was inadequate in meeting the disability costs. To some it was not adequate to cover transport costs to and from occupational therapy sessions in a month.

To address these shortcomings, this study costed the extra effort required to cover all qualifying households and attempts to cost an adequate amount to cover the disability costs incurred by households. Semi-structured interviews with the DSD revealed that the PwSD-CT originally covered 47,000 households. However, as of November, payroll the coverage had increased to 62,315 households leaving 100,000 qualifying households. Therefore, if the PwSD-CT were up-scaled to cover the qualifying households an extra KES200,000,000 would be required per month translating to an extra KES2.4 billion per year. There is limited information on disability costs incurred by households in Kenya.[15] Therefore, it is difficult to estimate a cash transfer amount that can adequately cover disability costs at the household level. Results from comparator countries such as South Africa show that disability costs required for persons with

13 Kenya National Bureau of Statistics (2024). Economic Survey 2024. https://www.knbs.or.ke/wp-content/uploads/2024/05/2024-Economic-Survey.pdf
14 Kenya National Bureau of Statistics (2022). 2019 Kenya Population and Housing Census. Analytical Report on Disability volume XV. https://www.knbs.or.ke/wp-content/uploads/2024/05/2019-Kenya-Population-and-Housing-Census-Analytical-Report-on-Disability-Vol.XV_.pdf
15 Directorate of Social Development (2024). Semi-structured Interviews with the Directorate of Social Development

disabilities to participate fully in societal activities are at least three times more than the incomes of people living on the poverty line.[16] This aligns with primary data concerns raised by participants. An OPD representative expressed concern that their members incur double costs for daily living as compared to persons without disabilities. Therefore, in estimating the average cash transfer required to make the PwSD-CT adequate for disability-related costs to be at least 2.5 times (the average between the double costs from primary data and triple costs from literature) above the national poverty line. Data from the 2021 Kenya Continuous Household Survey shows that a household is overall poor if the total monthly expenditures per person in the household are less than or equal to KES3,947 in rural Kenya and KES7,193 in urban Kenya.[17] There is paucity of data on the distribution of PwSD-CT beneficiaries between rural and urban areas. As such, in calculating an adequate amount of PwSD-CT that can cover disability costs, the urban poverty line is used as an upper limit. Using the 2.5 factor, a household with a person with disabilities requires KES17,982.5 (2.5*7,193) per adult to meet disability costs. The disability costs of KES17,982.5 cannot be purely covered by cash transfers. There are other programmes in Kenya that support persons with disabilities cover disability-related costs such as tax exemptions, provision of personal guides at work, workplace adjustments provisions and provision of assistive technologies for those of working age, scholarships and bursaries for school-going children with disabilities, the Social Health Insurance Fund (SHIF) for those who contribute, provision of sunscreen and cancer screening for persons with albinism, among others. The question then translates to what proportion of disability-related costs the Kenyan government might be willing to cover through cash transfers. International practice shows that the leading investors in social protection in Sub-Saharan Africa, South Africa, are spending 0.301 per cent of their GDP on two disability related cash transfers as of 2024.[18] These transfers include the care dependency grant, that provides income support to caregivers earning less than R249 600 (KES31,200[19]) (single) and R499 200 (KES62,400) (married) a year to help them care for children who are mentally or physically disabled, and disability grant that takes care of adults with disabilities who cannot work due to a mental or physical disability.[20] In comparison, PwSD-CT is currently 0.02 per cent of the GDP in Kenya.[21] Were Kenya to progressively work towards reaching the top of disability related cash transfers in Africa by increasing the expenditures related to disability cash transfers by two-and-a-half fold, to a sixth of what South Africa is achieving, 0.05 per cent of the GDP, KES7.554 billion per year would be dedicated to disability costs through cash transfers using 2023 GDP figures. If this is to cover 162,315 persons with disabilities and 10 per cent of the caregivers of children with disabilities (174,955[22]), a total of 179,810 beneficiaries would be covered by this amount. Assuming equal distribution of benefits between caregivers and persons with disabilities, the caregiver allowance and persons with severe disabilities cash transfer would be KES3,501 per month for each beneficiary. This would translate to 19.5 per cent of the disability costs for households that just receive the persons with severe disabilities cash transfer and 38.9 per cent for households that receive both transfers.

16 Daniel M, Alex C, Jill H, Lena M, Vlad Grigorus, Ludovico C, Zachary M, and Monica P., (2022). Estimating the Extra Costs for Disability for Social Protection Programs. ILO, UNICEF, International Disability Alliance (IDA) and UN Partnership on the Rights of Persons with Disabilities. https://www.social-protection.org/gimi/Media.action;jsessionid=18kEZReYuR4YKCTxe8HBuwRDNw-Xqbz-SFjXBjt6pnNaAh9lTS-fk!1206897467?id=18879

17 Kenya National Bureau of Statistics (2021). The Kenya Poverty Report. Based on the 2021 Kenya Continuous Household Survey. https://www.knbs.or.ke/wp-content/uploads/2023/09/The-Kenya-Poverty-Report-2021.pdf

18 Republic of South Africa (2025). 2025 Budget Review. https://www.treasury.gov.za/documents/National%20Budget/2025/review/FullBR.pdf

19 Assuming 1Rand=KES8

20 Stephen K, Lorriane, W, Diloá B., & Anh T,. (2020). Social Protection and Disability in South Africa. https://www.developmentpathways.co.uk/wp-content/uploads/2018/07/Social-protection-and-disability-in-South-Africa-July-2018.pdf

21 Kenya Country Report: Social Protection and Inclusion of Persons with Disabilities (2020).

22 Kenya National Bureau of Statistics (2022). 2019 Kenya Population and Housing Census. Analytical Report on Disability volume XV. https://www.knbs.or.ke/wp-content/uploads/2024/05/2019-Kenya-Population-and-Housing-Census-Analytical-Report-on-Disability-Vol.XV_.pdf

4.4 Assistive devices

Assistive devices are important in promoting the independence and autonomy of persons with disabilities. Results from the secondary review and the primary data analysis reveal that the social security infrastructure does not cover all assistive devices. Persons with disabilities complain that insurance companies and Taifa care claim that their conditions are congenital and, therefore, not insurable. Second, the analysis revealed that the distribution of assistive devices is not reaching persons with disabilities in the last mile. This has left persons with disabilities in underserved and marginalized areas without access to critical assistive devices. The results further revealed that assistive devices such as wheelchairs are distributed as part corporate social responsibility leading to unprescribed devices for persons with disabilities. At present the NCPWD has a programme that supports persons with disabilities access assistive devices. All a person with disabilities needs is to complete an assistive devices application form that can be found in NCPWD county offices or at the NCPWD website;[23] get a professional recommendation for the assistive device from an expert such as a physiotherapist for physical devices, an audiologist for hearing devices, or an ophthalmologist for visual devices. Then people need to attach copies of documents including NCPWD registration certificates, national ID cards, assessment reports, parent's or guardian's national ID for persons with disabilities who are under 18 years, pro-forma invoice if the device is not from a prequalified supplier, and then submit the completed form to the NCPWD county office for processing. The NCPWD processes the request and should the applicant qualify, they provide the assistive device. Though this process appears smooth, it is tedious and takes a long time. Participants in the FGDs and validation workshops claimed that persons with disability can wait for up to an year before the assistive device is provided. Further, the programme does not handle repairs of existing devices, frustrating those who need them. The fact that this process starts at the county headquarters also alienates persons with disabilities who live long distances away from the headquarters, and adds extra costs in the acquisition of assistive devices.

To solve the exclusion of the marginalized persons with disabilities and hasten the procurement of assistive devices, this study costs the provision of assistive devices through Taifa care as a platform for catering for both the marginalized and those in the centre. In costing the assistive devices, the costs are not estimated using the actual quantities of the devices because the types of devices vary based on the diversities of disability. Further, due to technological improvements the types of assistive devices and their prices change, compounding the challenges of having an estimate based on the quantities. The exercise become even more difficult when possible economies of scale from voluminous government purchases are considered. As an alternative, this study uses analysis of NCPWD expenditures by various agencies and funds to arrive at an approximate figure.

Under the assistive devices assembling programme the Kenya Institute of Special Education (KISE) had requested for KES250,000,000[24] in the financial year 2024/2025. However, the budget item was cancelled after the rationalization that followed the finance bill protests. The NCPWD has a fund for providing assistive devices to persons with disabilities through service providers. The NCPWD allocates funds to service providers for the fabrication and distribution of these devices to beneficiaries after a comprehensive assessment of their suitability. Service providers must submit applications for the funds and maintain proper records of their usage before requesting additional funds. In the financial year 2019/2020 the NCPWD spent KES40,000,000 through this fund to provide assistive devices. Other sources of funds for assistive devices include the National Fund for the Disabled of Kenya. In the financial year 2019/2020 the fund spent KES60,000,000 on assistive devices and tools of trade on persons with disabilities.

Aggregating these expenditures by different entities and funds yields a total expenditure of KES350,000,000. Since these expenditures are based on requests received by the funds, the aggregate is short of unrevealed demand by those who are unaware of the existing support systems. Assuming that an equal number of persons with disabilities is unaware of the existing structures to provide them with assistive

23 https://ncpwd.go.ke/download/assistive-devices-and-technologies/
24 Open Budget Kenya, (2024). https://openbudget.or.ke/project/1066105500_Assembly_of_Assistive_Devices_KISE/2024/

devices, Kenya would require KES700,000,000 (KES350,000,000*2) to provide assistive devices. To make assistive devices available to all persons with disabilities in Kenya, irrespective of their distance from the center, *Taifa* Care can cover the costs at annual fee of KES700,000,000. Given the national reach of the *Taifa* care, all persons with disabilities in the country would be covered for assistive devices.

4.5 Concession and discounts

Concessions and discounts are one of the avenues of providing for disability costs. Data from secondary and primary analysis shows that there is a lack of concessions and discounts to persons with disabilities who use public means of transport such as the Nairobi Commuter Buses, The Nairobi Commuter Rail and the *Madaraka* Express. Further, the amount of income that is tax exempt is limited relative to disability costs. The situation is compounded by inadequacies withing disability assessment. The assessment process does not capture the functional limitations and supports needs of persons with disabilities. In addition, the assessment does not segregate persons with disabilities based on support needs. This limits decisions on the extent to which discounts and concessions can be provided to persons with disabilities.

To address these shortcomings, this study costs provision of discounts to persons with disabilities using *Madaraka* Express and extent to which tax exemption could be extended to cover disability costs. An economy ticket to and from Mombasa costs KES1,500. This compares to KES4,500 for a first-class ticket and KES12,000 for a premium ticket[25 26]. Primary data shows that majority of persons with disabilities incur double costs during transport due to their support assistants or assistive devices. This implies that when disability transport costs are factored a person with disabilities will pay KES3,000 for the economy ticket, KES9,000 for a first-class ticket and KES24,000 for a premium ticket. To cover these disability costs in using *Madaraka* Express, both the person with disabilities and their personal assistants should get a 50 per cent discount on the fares for all the fare classes. This, however, does not cover disability costs that come with functional limitations. Some persons with disabilities are not able to work at all but require services. Factoring this in the discount, persons with disabilities who are not economically engaged, and their personal assistants can get an extra 25 per cent discount to cover these costs. Therefore, persons with disabilities who require personal assistants but are economically engaged and their personal assistants should pay KES750 for economy tickets, KES2,250 for a first-class ticket and KES6,000 for a premium ticket. On the other hand, those persons with disabilities who are not economically engaged, and their personal assistants should pay KES375 for an economy ticket, KES1,125 for a first-class ticket and KES3,000 for a premium ticket.

It is not easy to estimate the number of trips that persons with disabilities make on the *Madaraka* Express. The passenger volumes are not disaggregated by disability. However, passenger volumes and disability prevalence rates can help estimate passenger volumes by persons with disabilities. On average the SGR has been transporting 197,682 passengers per month in 2024. If 2.2[27] percent of these passengers are with disabilities, the SGR has approximately been transporting 4,349 persons with disabilities per month. If 11.3[28] percent of these passengers have severe disabilities, then 491 passengers per month have high support needs. Therefore, 491 persons with disabilities per month would get a discount of 75 per cent on the SGR while 3,858 would get a 50 per cent discount. Assuming

25 Kenya Railways (2024). Madaraka Express Passenger Services. Train Fare adjustment effective 1st January 2024. https://krc.co.ke/wp-content/uploads/2023/12/SGR-NEW-RATES.pdf

26 Kenya Railways (2024). Madaraka Express Passenger Services. https://metickets.krc.co.ke/MADARAKA-EXPRESS-SCHEDUL_E-FARE-REVISION.pdf

27 Kenya National Bureau of Statistics (2022). 2019 Kenya Population and Housing Census. Analytical Report on Disability volume XV. https://www.knbs.or.ke/wp-content/uploads/2024/05/2019-Kenya-Population-and-Housing-Census-Analytical-Report-on-Disability-Vol.XV_.pdf

28 Severity rates based on KNBS analytical report on disability (ibid 20)

an economy ticket for those with less support needs (3,858) and a first-class ticket for those with high support needs, the *Madaraka* Express would incur a cost of KES3,445,875 (750*3858+491*1,125) on average per month to cover the discounts. On a yearly basis the *Madaraka* Express would incur a cost of KES41,350,500 to cover these discounts.

With respect to expanding tax exemption beyond an income of KES150,000, there are 134,510[29] persons with disabilities employed outside the household. If 12.35 percent[30] of these persons earn KES150,000 and above, then 16,612 persons with disabilities require exemptions past KES150,000. Assuming an average income of KES250,000 for these persons, the Kenya Revenue Authority (KRA) will forgo taxes on KES100,000 should the entire income be tax exempt. Assuming that the income taxes are 30 percent of the income. The KRA would forgo KES30,000 per each person with disabilities. This would translate to KES498,360,000 per month translating to KES5,980,320,000 per year (KES5.9 billion).

4.6 Disability assessment

Disability assessment is a key step in establishing the number of persons who require care and support. At present disability assessment is a two-step process divided between the health system and the NCPWD. The health system ascertains disability while the NCPWD registers persons for support. The registration process is voluntary and must be initiated by the person with disability. Courtesy of the assessment being provided by County governments there are mixed findings on the cost of conducting disability assessment in the surveyed counties. Some children with disabilities paid as high as KES1,000 (Garissa), KES500 (Kisumu and Kwale) while some were not charged. The NCPWD has digitized the registration process, where persons with disabilities can use E-citizen or go to the NCPWD County offices for help with registration. At present, the registration process captures the category of disability but fails to further categorize persons with disabilities according to their functional limitations and support needs for purposes of planning. In addition, to these challenges three key issues limit the assessment and registration process. First the assessment and the registration process are not interlinked. As a result, a person can be assessed but fail to register without the NCPWD and partners noticing. Second, the registration process lacks a referral pathway of referring persons with disabilities to community-based support organizations and other support agencies in the country. It abruptly ends with a certificate which most caregivers and persons with disabilities found to be of limited use. Third, despite assessment certifying that a person with disability has permanent disability, persons with disabilities are required to regularly prove their life every five years. This interferes with provision of key support services. At Garissa, one teacher with disability complained that their personal guide had not been paid for three months because they were in the process of proving their life.

To address these challenges with disability assessment this study proposes a revamped disability assessment process and costs a disability assessment process that integrates assessment and registration; integrate civil registration systems with NCPWD systems; details and categorizes persons with disability with respect to their functional limitations and support needs; and refers registered persons with disabilities to the care and support infrastructure in the country.

The proposed integrated assessment process begins with introducing interoperability between the Kenya Health Information System (KHIS) disability assessment module and the NCPWD management information System as well as NCPWD's management information and partner management information systems (see Figure 1). The interoperability of the KHIS and NCPWD's management information system alerts NCPWD and partners when a person seeks disability assessment services. This alert allows NCPWD and partners to monitor the assessment and registration process from the onset. The process is online and provides various stakeholders opportunity to complete their sections.

29 Ibid 20

30 Kenya National Bureau of Statistics (2024). Statistical Abstract. https://www.knbs.or.ke/wp-content/uploads/2024/12/2024-Statistical-Abstract1.pdf (proportion of Kenyans earning KES100,000 and above in 2024 was 12.35%)

In the first stage (Stage I), last mile health service providers such as CHPs, level 1 health facilities and assessment institutions in other sectors such as EARCs access the first part (section A) of the integrated information management system to fill in details and refer cases of suspected disability for assessment at a gazetted facility where the medical service providers access the second section (Section B) of online assessment form (Stage II) and confirm disability or not. When disability is not confirmed the case is closed by medical personnel and the person pays for the assessment.

When disability is confirmed, the case enters stage III where the third, fourth and fifth (C, D, E & F) section of the form is completed for settling of disability assessment fees, identification of functional limitations and enumeration of support needs, processing of the disability certificates that communicate and categorize persons with disability with respect to functional limitations and support needs, and refer cases to partners within the circles of support for care and support services in the fourth stage. Should there be grievances, the NCPWD should refer the case back to the third step for re-evaluation.

To avoid disruptions in the provision of care and support with the regular proof of life for persons with permanent disability, the NCPWD's register of the categorized persons with disabilities should be integrated with the civil registry module on deaths. This will help alert the NCPWD when there need to clean the register and avoid the need for regular proof of life for persons with permanent disability.

This study, therefore, costs the process of introducing interoperability between the Kenya Health Information System (KHIS) disability assessment module and the NCPWD management information System as well as NCPWD's management information and partner management information systems; settling of disability assessment costs by NCPWD; the process of training last mile personnel (CHPs) for disability assessment, the issue of categorized disability certificates and cards; introducing interoperability between civil registry module on deaths with NCPWD's disability register; and a census of partner organizations for referrals and provision of support and care services to persons with disabilities. The costed processes are shown in Table 3. Cumulatively, the revamping of disability assessment would cost KES3.46 billion.

Figure 3: Proposed revamped disability assessment process

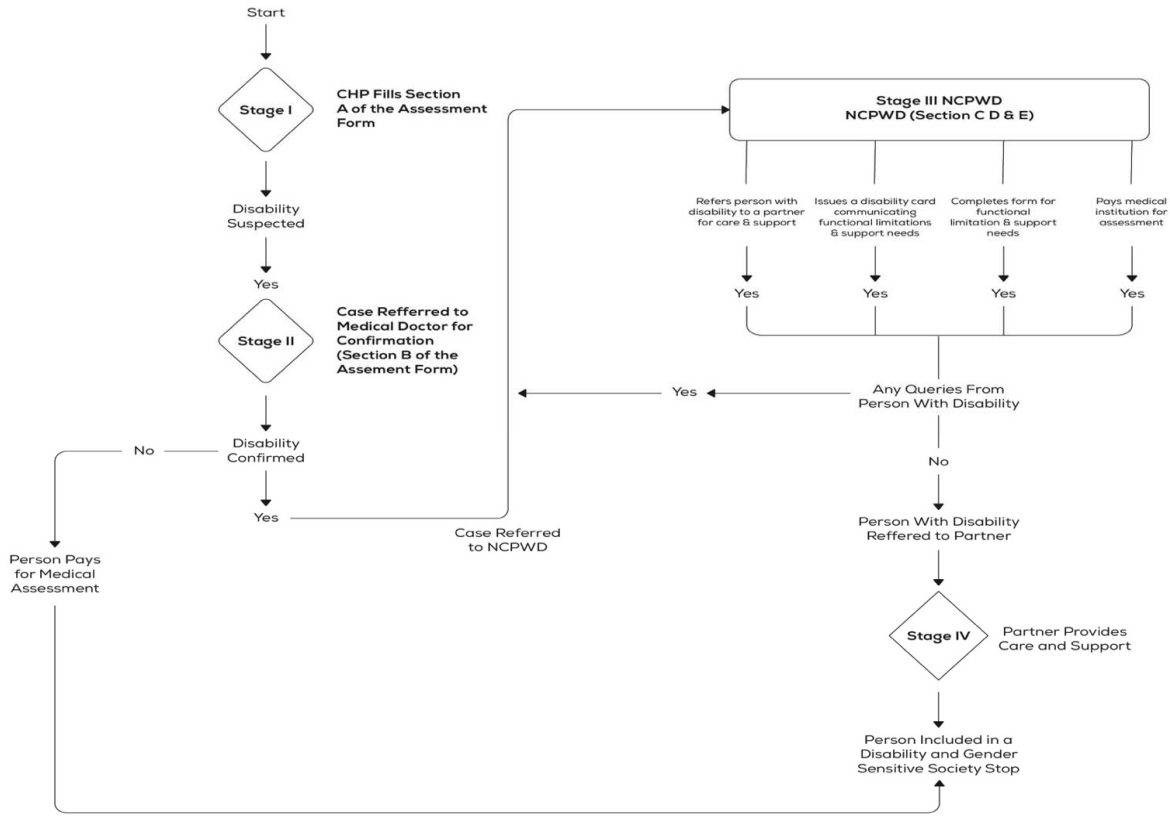


Table 4: Costs associated with the revamped disability assessment process

Item	Specific Costs	Assumptions	Total Costs
Introducing interoperability between the KHIS disability assessment module and the NCPWD management information as well System as NCPWD's management information and partner management information systems	Introducing interoperability between the KHIS disability assessment module and the NCPWD management information System	Workshop to moot collaboration between health facilities and the NCPWD. Staff are under government payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
		Workshop to facilitate Ministry of Health ICT team and NCPWD ICT team program and integrate the modules. Staff are under government payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
	Introducing interoperability between NCPWD's management information system and partner's information systems	Workshop to moot collaboration between NCPWD and partners on disability assessment. Staff are under government and partners payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
		Workshop to facilitate NCPWD ICT team and partner's ICT team program and integrate the modules. Staff are under government and partners payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000
Settling disability assessment costs by NCPWD	Assessment fees	NCPWD settles all the assessment fees for all confirmed cases of disability as a concession to persons with disability. The fee ranges from KES500 to KES1,000 across the country. Using a fee of KES1000 and 100,000[31] new registrations in a year. The total cost of assessment per year comes to KES100,000,000.	100,000,000

31 According to Development Initiative the NCPWD seeks to register 100,000 persons with disability every year. https://devinit.org/resources/disability-data-kenya-2022-comprehensive-inventory/#:~:text=Each%20year%20the%20NCPWD%20aims,does%20not%20complete%20enough%20assessments.

Item	Specific Costs	Assumptions	Total Costs
Using Community Health Promoters to provide last mile disability assessment	Training Community health promoters for disability assessment	If all the 104,000[32] community health promoters are trained at a cost of KES4,000[33] per day for two days to regularly mobilize suspected cases disability in their jurisdiction for assessment a total of KES832,000,000 would be required for the training.	832,000,000
	Compensating Community Health Promoters for disability assessment services	Community health promoters are already jointly compensated by National and County Governments, only additional compensation is required for the additional role. Assuming that each Community Health Promoter is compensated additional KES2,000[34] for disability assessment every month for a given target of assessments. A total of KES2,496,000,000 would be required.	2,496,000,000
Issuing categorized disability cards/ certificates	Categorization costs	Costs of a multistakeholder workshop to set the categorization criteria. If 100 participants participate in a 3-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day. Personnel cost of identifying functional limitations and support needs of previously and new registration of persons with disability are zero because staff are under NCPWD payroll.	4,650,000
	Recommending discounts based on categorized certificates	Workshop to align and recommend discounts and concessions based on the categorization of persons with disabilities. If 100 participants participate in a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	7,750,000
Introducing interoperability between civil registry module on deaths with NCPWD's disability register	ICT workshop	Workshop to facilitate NCPWD's ICT team and civil registry ICT team program and integrate the modules. Staff are under government payroll. However, DSA required for a workshop, assuming a workshop with 20 participants for a 5-day workshop at an average DSA of KES15000 and conference facilities costing KES50,000 a day	1,750,000

32 Ministry of Health (2024). Community health services frequently asked questions. MOH, Nairobi. https://www.health.go.ke/sites/default/files/2023-10/Community%20health%20services%20frequently%20asked%20questions.pdf

33 Figure obtained from Sense Internationals past CHPs training sessions

34 An estimate of a reasonable allowance for the additional role

Item	Specific Costs	Assumptions	Total Costs
A census of partner organizations	Updating of OPD register	Awareness campaign through OPD federations to identify active partners who can be involved in providing care and support through circles of care. Assuming a sustained 6-month campaign with monthly campaign workshops across the eight regions in Kenya with 100 OPDs in a day's workshop with an average DSA of KES15,000 at conference facilities costing KES50,000 per day.	9,300,000
Total			**3,458,450,000**

5

THE WORKING SCENARIO

The scenario proposed by persons with disabilities and their caregivers expresses the scope of the needs without specific consideration of the availability of resources in Kenya. However, the fiscal space in Kenya, as in most developing countries, there are limits to the fiscal space that can be secured for disability inclusion in the short- to medium-term. With rising debt obligations, sluggish revenue mobilization, rising competing demands for social spending and unfavourable external shocks, policy makers in Kenya are consistently navigating a delicate balance between service provision and a tight fiscal environment. This chapter, therefore, seeks to align the key asks and demands from persons with disabilities and their caregivers with the economic reality in the country through reasonable rationalization.

5.1 The need for rationalization

The proposed scenario requires resources dedicated to disability inclusion in Kenya to rise nearly 28-fold which is unrealistic within the current fiscal context. Table 5 shows that the aspirations of persons with disabilities and their caregivers would annually cost KES 203.4 billion. This is equivalent to 1.10 per cent of the GDP and 4.95 per cent of government expenditure. In contrast in the financial 2023/2024, the government spent KES7.2 billion representing only 0.04 per cent of the GDP and 0.19 per cent of the government expenditures (see Table 6). Meeting the aspirations of persons with disabilities and their caregivers would require an expansion of resources by 28 times. This may not be feasible under the prevailing fiscal space.

The largest disability inclusion expenditure item carries the potential risk of undermining the UNCRPD. The statistics presented in Table 5 show that the largest expenditure item under disability inclusion is human support which costs 0.97 per cent of the GDP. This represents 87.4 per cent of the proposed disability inclusion costs. A disaggregation of the costs under this item in Table 7 reveals that the huge cost arises from the need to provide key care and support services through 1,719 VRCs across the country. Though the VRCs are intended to provide respite services, behavioral health services, vocational training and placements, adult day and residential services as well as advocacy and awareness services, there are risks that these roles could be misunderstood during implementation leading to institutionalization and other outcomes which go against the tenets of the UNCRPD. To preserve the spirit of the demands of persons with disabilities and their caregivers while mitigating against the potential abuse of the VRCs this ticket item calls for a rethink.

The proposed scenario emphasizes government direct provision of services over more flexible mechanisms such as cash transfers. Table 5 shows that the prioritized items are human support (0.97 per cent of the GDP), provision of transport services through a public means (0.04 per cent of the GDP). While these may provide relevant ambitions, building service delivery models and accompanying infrastructure is likely to take time in a county such as Kenya. Such models are relatively new in Kenya and will require learning and adjustment over time and may also rely on actions within broader sectors (such as health and education) where there are broader gaps in service delivery. Given these issues, many low- and middle-income countries have prioritized disability cash transfers as a rapid way to support people with disabilities to cover extra costs, in a way that allows flexibility and choice. This working scenario, therefore, puts greater emphasis on expanding cash transfers, while continuing to develop enhanced service delivery models in parallel.

Less progressive expenditure items have been prioritized over near universal mechanisms such as cash transfers. Table 5 further shows that allocations to regressive care and support pillars such as concessions and discounts (0.03 per cent of the GDP) are comparable to cash transfers (0.04 per cent of the GDP) and exceed those of assistive technologies (0.004 per cent). This means that most of the resources dedicated to disability inclusion would only benefit a few persons with disabilities who are privileged to access services that are granted discounts and concessions. To make the utilization of the resources more equitable, therefore, there is need to rationalize and reprioritize the asks by persons with disabilities and their caregivers.

Neither the current spending nor the proposed scenario meets Kenya's realistic spending on disability inclusion. Table 6 shows that Kenya is spending 0.04 per cent of her GDP on disability inclusion while Table 5 shows that persons with disabilities and their caregivers would wish the country to spend 1.11 per cent of the GDP. However, neither of these levels of expenditures align with the country's lower middle-income status and her commitments during the 2025 Global Disability Summit. During the 2025 Global Disability Summit Kenya committed to strengthen the capacity of Ministries, Departments, Counties and Agencies (MDCAs) on disability responsive budgeting by 2028. Comparative analysis shows that lower-middle-income countries that have put in place a basic package of support for persons with disabilities tend to spend at least 0.1 per cent of GDP, as in Thailand and Zambia which spend 0.14 per cent of GDP. Other countries, such as Namibia, spend towards 0.5 per cent of GDP. To remain aligned with her peers and avoid falling behind, a reasonable target would be for Kenya to progressively expand her allocation from 0.04 per cent to around 0.2 per cent of GDP over the next five years. This represents a more moderate fivefold increase, which can be achieved within the medium term, and would demonstrate Kenya's commitment to disability inclusion as spelt out in the global, regional and national frameworks such as the UNCRPD and the Persons with Disabilities Act 2025.

Table 5: The annual cost of providing the proposed scenario

Pillar	Total cost	% of 2025 GDP	% of 2025 government expenditure
Transport	5,482,320,000	0.03%	0.13%
Human support	178,052,567,216	0.97%	4.33%
Cash transfer	7,554,000,000	0.04%	0.18%
Assistive devices	700,000,000	0.00%	0.02%
Concessions and discounts	5,980,320,000	0.03%	0.15%
Disability assessment	3,458,450,000	0.02%	0.08%
Total cost	**203,443,648,016**	**1.10%**	**4.89%**

Table 6: Current spending on disability inclusion

Sector	Total expenditure	% of 2025 GDP	% of 2025 government expenditure
Cash transfer	1,200,000,000	0.01%	0.03%
Assistive devices	855,000,000	0.01%	0.02%
Education	1,153,659,631	0.01%	0.03%
Livelihoods	395,000,000	0.00%	0.01%
Access to government procurement	3,552,000,000	0.02%	0.09%
Total	**7,155,659,631**	**0.04%**	**0.19%**

Table 7: Costs breakdown under the human support pillar

Activities	Cost	% of GDP	% of government expenditure
Organizing persons with disabilities and their caregivers into circles of care and support	43,313,697,000	0.24%	1.05%
Detachment training (Covered in the circles of care and support)	0	0.00%	0.00%
Provision of key care and support services in vocational and rehabilitation centres	109,174,550,216	0.60%	2.65%
Extending coverage of personal guides to the formal private sector	25,564,320,000	0.14%	0.62%
Total	**178,052,567,216**	**0.97%**	**4.33%**

5.2 Rationalized scenarios

This section presents the modified scenarios that would enable the government to progressively increase expenditures on disability inclusion from the current 0.04 per cent to 0.2 per cent of the GDP. Based on flexibility and equity of the interventions, the rationalized scenarios prioritized in the following order: cash transfer, resource respite and rehabilitation centres (VRCs), circles of care and support, assistive devices, and concessions and discounts.

5.2.1 Cash transfer

The proposed scenario sought to redesign the PwSD-CT to increase its coverage, cover disability costs, increase independence and autonomy of persons with disabilities, and recognize caregivers. In addition to achieving these demands, the working scenario recognizes the flexibility of cash transfers over direct provision of services and, therefore, capitalizes on its expansion. However, unlike the proposed scenario that expands the PwSD-CT to 100,000 persons with disabilities, some changes are made to the working scenario, notably:

- A focus is put on expanding coverage. The current coverage of the PwSD-CT is very low by international standards reflecting the poverty-targeted nature of the scheme, and gaps in the disability assessment process. The working scenario assumes that that the benefit would be made available to all persons assessed as having severe disabilities, without use of means testing. The benefit would also be paid to the individual (rather than the household) to provide greater choice and control to the person with disabilities. Evidence on the scale of this target population is limited, but – based on experience from other countries such as Eswatini and Zambia – it is assumed that the cash transfer would reach 0.9 per cent of the population within the next five years.
- The working scenario prioritizes expansion over coverage of disability costs and retains the transfer value at KES2,000 per month. While the limits in benefit adequacy are well known, the gaps are less significant when compared to international standards. Therefore, coverage extension is prioritized.

To avoid straining the resource basket the working scenario proposes staggering of the expansion over the next five years. Since the PwSD-CT currently covers 62,315 persons. To expand it to 500,000 beneficiaries over the next five years an additional 437,685 beneficiaries are required. Should these additional beneficiaries be added equally every year, 87,537 persons will be added each succeeding year for the next five years. Table 8 summarizes the budgetary allocations that would be required to meet this staggered expansion.

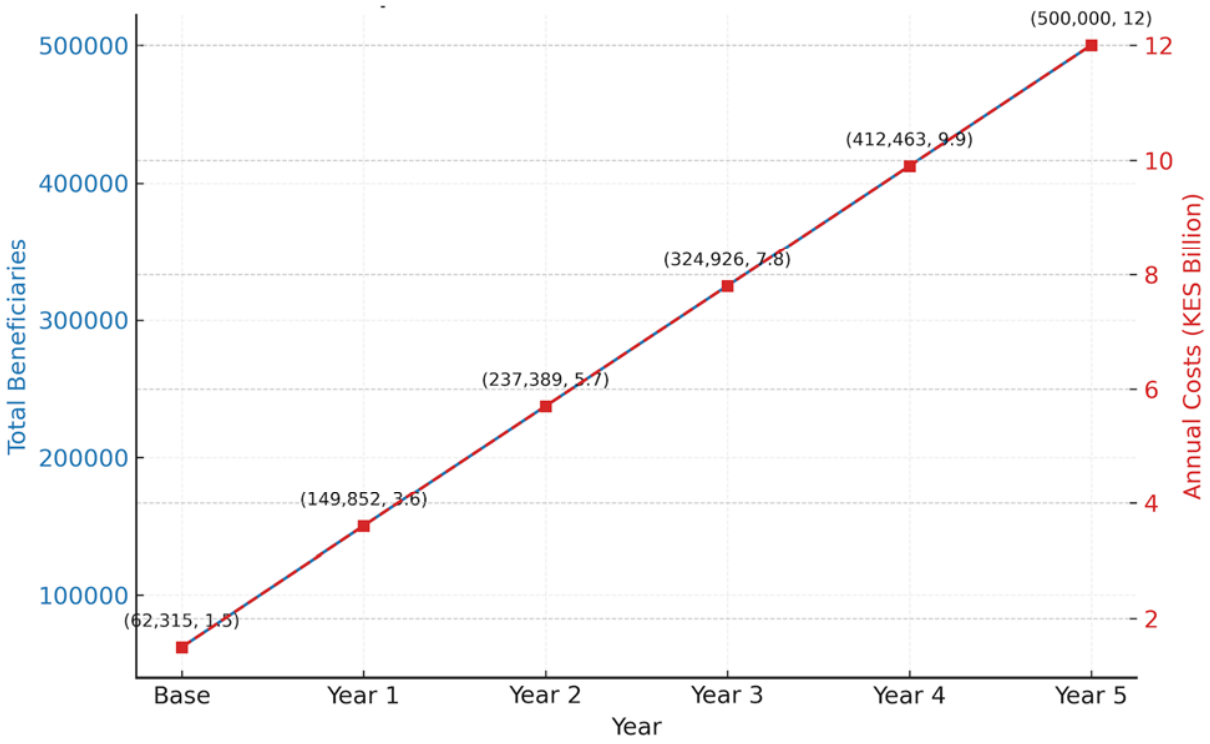
Table 8 shows the staggered pathway of expanding the coverage of the PwSD-CT from the current

coverage of 62,315 beneficiaries to the target of 500,000 beneficiaries in five years. From a planning perspective, the annual programme outlay increases from KES1.5 billion in the base year to KES12 billion in year five. This is equivalent to an eight-fold increase in the programme outlays. In addition, Figure 4 shows that the scale up has a dual-axis trend which demonstrates a trade-off between coverage expansion and budgetary capacity.

Table 8: Staggered costs of expanding the coverage of PwSD-CT to 500,000 beneficiaries in five years

	Additional beneficiaries	Total beneficiaries	Annual Costs KES billion	As % of govt expenditure in 2024	As a % of 2024 GDP
Base year	-	62,315	1.5	0.04	0.01
Year 1	87,537	149,852	3.6	0.09	0.02
Year 2	87,537	237,389	5.7	0.14	0.03
Year 3	87,537	324,926	7.8	0.19	0.04
Year 4	87,537	412,463	9.9	0.24	0.05
Year 5	87,537	500,000	12	0.29	0.07

Figure 4: The trend in the annual costs and beneficiaries of a scaled up PwSD-CT



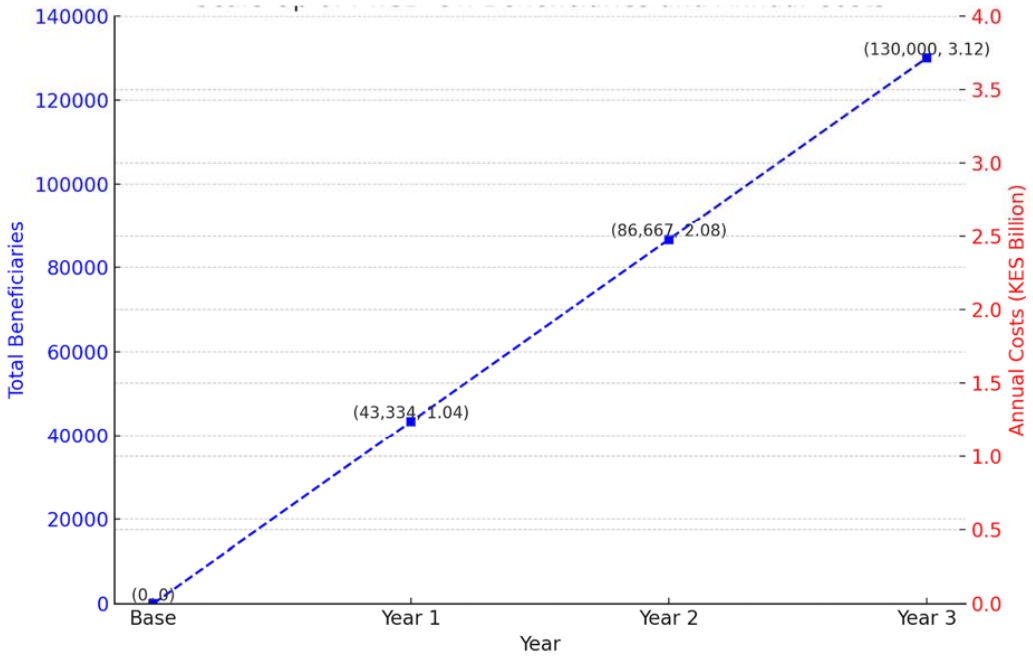
To recognize caregivers and enhance independence and autonomy persons with disabilities, the working scenario proposes establishment of a caregiver allowance that is separate from the individualized PwSD-CT. Experience from comparator countries like Vietnam, shows that 25 per cent of disability allowance recipients with severe disabilities also have high levels of support needs. In Kenya, a caregiver disability allowance pilot revealed that out of 96 people who receive the PwSD-CT, 18 (19 per cent) were identified for the top up cash transfer to support caregiving. Allowing for population growth and considering experience from comparator countries, it is reasonable to approximate that at around 26 per cent of the 500,000 recipients of the PwSD-CT will have severe disabilities and high support needs. Therefore, the number of recipients of the proposed caregiver allowance is estimated at 130,000. The formulation and implementation of this transfer could as well be staggered within three years, implying 43, 333 additional beneficiaries every year. To sustainability the transfer amount is still limited at KES2,000 per month per each caregiver. Table 9 summarizes the formulation and implementation of the caregiver allowance given these assumptions.

Table 9 shows the progressive introduction and scale of the caregiver allowance within three years. The beneficiaries steadily rise from 43,334 in year one to 130,000 in year three. Financially, the outlays for this transfer rise from KES1.04 billion in year oe to KES3.12 billion in year three. This expenditure line is entirely new. In addition, Figure 5 shows that the introduction and scale up has an upward dual-axis trend which demonstrates a trade-off between coverage expansion and budgetary capacity. The transfer is good for disability inclusion but a cost for fiscal capacity.

Table 9: The costs of formulating and operationalizing a caregiver allowance in Kenya

	Additional beneficiaries	Total beneficiaries	Annual costs (KES billion)	As a % of 2023/2024 Gov't expenditure	As a % of 2024 GDP
Base year	-	0	0	0.00	0.00
Year 1	43,334	43,334	1.04	0.03	0.006
Year 2	43,333	86,667	2.08	0.05	0.011
Year 3	43,333	130,000	3.12	0.08	0.017

Figure 5: Trend in the introduction and scaling up of a caregiver allowance



5.2.2 Circle of care and support

In the proposed scenario persons with disabilities and their caregivers aspired to be organized in care circles to overcome data challenges through self-reporting and community surveillance, scale up rotational care arrangements across the country, reduce disability related unpaid care work, rope in trusted members of the society in the care network, and integrate persons with disabilities into social and administrative processes. The idea was to organize all persons with disabilities irrespective of their diversity and stage in the lifecycle with care circles. Arising from this was a cost to establish about 68,752 support groups at a cost of KES43.3 billion.

The experience of the civil society, however, shows that the number of persons with disabilities likely to be covered by care circles was likely overestimated in the proposed scenario. In addition, the set up and and maintanance costs are incurred on a rolling basis rather than as a lumpsum. Therefore, the proposed scenario is overestimating the actual needs and capacity. To reflect the existing context, the working scenario assumes that only the 103,242[35] persons with severe disabilities would be willing to be organized. In addition, instead of allocating each person with a disability two primary caregivers, each person is allocated a single caregiver. This yields a total of 206,484 persons with disabilities and their caregivers. With an average membership of 35 people, 5,800 care circles would be required in the country. To align within the fiscal constraints the organization of these circles is phased over a five-year period. Further, the monthly sustainability cost for each circle is translated into a quarterly expenditure to reflect the quarterly trainings and implementation cycles adopted by KAIH. The logistics of entering a new area and organizing a new circle is time intensive. So, in the year a circle is established, coordinators are only trained for one quarter. At present there are 200 existing circles meaning that around 7,000 persons with severe disabilities and their caregivers have already been organized. This leaves 199,484 persons with disabilities and their caregivers who should be organized in approximately 5,700 circles within five years. The implication is that per year, approximately 1,140 circles should be organized. Table 10 and Figure 3 summarize the costs associated with setting up and sustaining these circles over the five years.

Table 10 and Figure 6 show that with the scaling of the number of circles of care and support from the current 200 to 5,800 in five years, the total costs of set up, organization and sustainability rise from a modest KES32 million to KES928 million. The set up and organizing costs are relatively stable at KES57 million and KES99.8 million annually. Therefore, much of the rapid increase in total cost is as a result of sustainability costs.

It is notable that these sustainability costs are not mere overheads but involve creation of 1,140 new jobs every year for a total of 5,800 jobs for in five years. These jobs help caregivers of persons with severe disabilities receive respite through rotational arrangements, reduce disability-related unpaid care work, include trusted members of the society into care networks, and integrate persons with disabilities into social and administrative processes. While the rapid expansion from KES32 million to KES928 million may appear substantial, the social and economic dividends of job creation, gender equity in care, and wellbeing for people with disabilities are enormous.

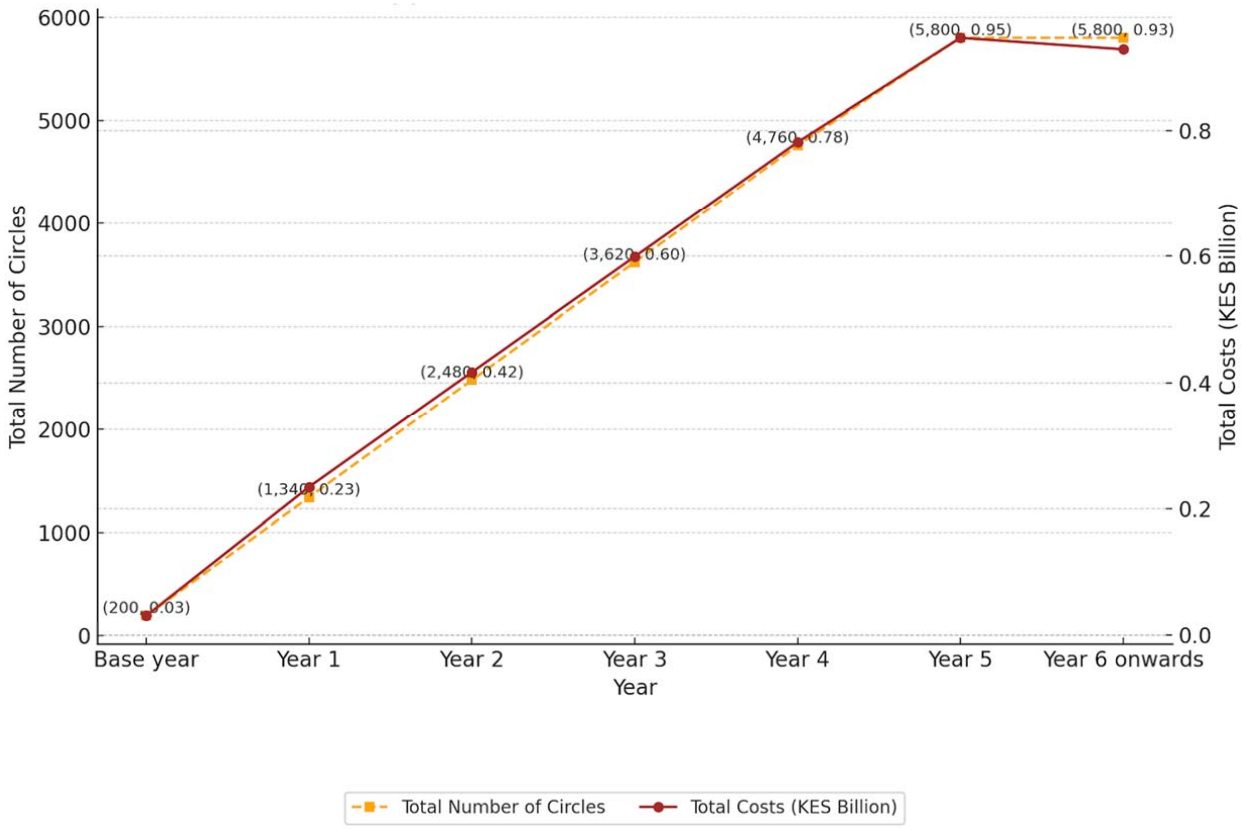
35 Kenya National Bureau of Statistics (2022). 2019 Kenya Population and Housing Census. Analytical Report on Disability volume XV. https://www.knbs.or.ke/wp-content/uploads/2024/05/2019-Kenya-Population-and-Housing-Census-Analytical-Report-on-Disability-Vol.XV_.pdf

Table 10: Staggered costs of establishing, organizing and sustaining circles of care and support

			One off cost		Recurring costs			
	Additional circles	**Total number of circles**	**Entry costs**	**Organizing costs**	**Sustainability costs**	**Total**	**As a % of government expenditure**	**As a % of GDP**
Base year	0	200	0	0	32,000,000	32,000,000	0.0008	0.0002
Year 1	1,140	1,340	57,000,000	99,750,000	77,600,000	234,350,000	0.0057	0.0013
Year 2	1,140	2,480	57,000,000	99,750,000	260,000,000	416,750,000	0.0101	0.0023
Year 3	1,140	3,620	57,000,000	99,750,000	442,400,000	599,150,000	0.0146	0.0033
Year 4	1,140	4,760	57,000,000	99,750,000	624,800,000	781,550,000	0.0190	0.0043
Year 5	1,040	5,800	52,000,000	91,000,000	803,200,000	946,200,000	0.0230	0.0052
Year 6 onwards	0	5,800	0	0	928,000,000	928,000,000	0.0226	0.0051

Notes: Entry costs are KES50,000 per each circle
Organizing costs are 2,500 per person to be organized
Sustainability costs are KES40,000 per circle per quarter
Circles are only sustained for 1 quarter in the year they are introduced

Figure 6: The trend in mooting and sustaining circles of care and support



5.2.3 Resource, respite and rehabilitation centers (VRCs)

In the proposed scenario persons with disabilities, and their caregivers, sought to have care circles interact with government agencies through VRCs, offering respite services (both day and residential) across the country, behavioral health services, vocational training and placements, adult day and residential services, as well as advocacy and awareness services. Each VRC was envisaged to serve 40 care circles, leading to demand for 1,719 VRCs across the country at an exorbitant cost of KES109.17 billion per annum.

Though well-meant this demand has high likelihood of being misunderstood. This would have negative consequences of undermining requirements in legal frameworks such as the UNCRPD. Further, it overemphasizes government direct involvement in the provision of disability inclusion services over more flexible mechanisms such as cash transfers. As such, this item is rationalized through divestments into flexible arrangements such as an expanded cash transfer and minimized roles.

This role minimization maintains the spirit of the initial proposal by reducing the number of VRCs demanded from 1,719 to 47, representing one centre per county. To acknowledge the divestment to other flexible service provision alternatives, the roles of the centers are limited to resource, respite and rehabilitation functions to individuals within the catchment area. The resource function should serve the entire county and could potentially serve other regions if the centre possesses specialized skills or knowledge that could benefit these regions. In discharging their mandate, the centres would provide training and practical experience in inclusive vocational training, respite care, and rehabilitation, and serve as demonstration labs for assistive technology and home adaptation.

To run the vocational training and rehabilitation arms, the DSD has been operating 12 VRCs at a cost of KES152,425,201.[36] This translates to KES12,702,100 per VRC for a single function. Assuming that the new functions lead to negligible strengthening and capacity building costs, the costs of running each VRC will remain constant at KES12,702,100 per annum. If the additional 35 VRCs are phased over a 5-year period, seven VRCs would be added each year. Table 11 shows the costs of scaling up the resource, respite and rehabilitation centres across the country over a 5-year period. The VRCs would increase to 47 with corresponding increase in annual running costs from KES152 million to KES597 million in year five. This is fourfold the current costs. To meet these costs, the VRCs could be co-financed by both national and county budgets or be contracted out to high-performing NGOs/OPDs, subject to strict accreditation and licensing requirements.

5.2.4 Providing accessible transport services

In the proposed scenario, persons with disabilities had asked for publicly provided paratransit services to cover transport to and from school for children with disabilities, routine care, health facilities, work, and social activities. The cost of providing these paratransit services was translating to KES7.7 billion in a year. As much as this cost is relevant in its scope, it is a strain on the budget. To reflect the different kinds of transport arrangement at the local level, considering possible public private partnership, and possible absorption of transport costs by the expanded cash transfers, the

Table 11: Phased costs of scaling up VRCs to all counties in Kenya

	Additional VRCs	Total Number of VRCs	Total costs per annum (KES)	As a % of Gov't expenditure 2023/2024	As a % of 2024 GDP
Base year	0	12	152,425,200	0.0037	0.001
Year 1	7	19	241,339,900	0.0059	0.001
Year 2	7	26	330,254,600	0.0080	0.002
Year 3	7	33	419,169,300	0.0102	0.002
Year 4	7	40	508,084,000	0.0124	0.003
Year 5	7	47	596,998,700	0.0145	0.003

36 Open Budget Kenya, (2024). https://openbudget.or.ke/project/1185000600_Vocational_rehabilitation/2024/

scope of provision is reduced to providing transport to-and-from school, routine care and health care. To reduce the need for extra administrative costs, the transport transfers could be distributed through the capitation mechanism at the Ministry of Education and the Social Health Insurance Fund, under the Ministry of Health.

Table 12 provides the annual estimates of providing accessible transport to children with disabilities for schooling, and routine care and persons with disabilities for health services. The table reveals that persons with disabilities paratransit services, focusing on assisting children with disabilities access schooling, routine health services such as occupational therapy, and access to medical care, would cost KES2.36 billion every year. The bulk of the cost (93.9 per cent) is related to providing accessible transport to school-going children with disabilities. Therefore, it is a vital investment of ensuring inclusivity in the present and the future. As much as it may be costly now, it is an instrument of lowering future inclusivity costs, and should be prioritized within the fiscal arrangements.

Table 12: Costs associated with the provision of paratransit services for persons with disabilities

Cost category	Specific costs	Assumptions in computing the costs	Total Costs (KES)
The insurance costs	Transport to and from school	KNBS analytical report on disability[37] shows that there are 174,955 children of school going age with disabilities 129,694 are already in school leaving out 45,261 due to severe and moderate disabilities. If 80% (36,209) of these children can access some form of schooling when reasonable transport is provided and considering that they can attend 90% of the 170[38] school days in 2025 school calendar (153 days) we have 306 rides per child per year. Assuming an average distance of 6km to the nearest integrated school charged at KES200 per ride and considering the 306 rides for all the 36,209 pupils we get the total cost.	2,215,990,800
	Transport to and from routine care	According to KISE 5.9%[39] of learners in special units, special schools and integrated schools need occupational therapy. This translates to 2,668 learners out of 45,261 learners with severe and moderate disabilities. If the learners received OP at school for 36[40] weeks in a year, they are left with 16 uncovered weeks. Assuming that the occupational therapy is provided 2 times per week we have 4 rides to and from hospital every week costing KES800. Assuming a cost of KES200 per ride.	34,150,400
	Transport to and from healthcare facilities	If 10%[41] of the population with disability (91,669 persons) falls ill and needs 6 rides to and from hospital at a cost of KES200 per ride.	110,002,800
Total Cost			**2,360,144,000**

37 Kenya National Bureau of Statistics (2022). 2019 Kenya Population and Housing Census. Analytical Report on Disability volume XV. https://www.knbs.or.ke/wp-content/uploads/2024/05/2019-Kenya-Population-and-Housing-Census-Analytical-Report-on-Disability-Vol.XV_.pdf

38 Ministry of Education (2024). 2025 Academic term dates

39 Kenya Institute of Special Education (2018). National survey on children with disabilities and special needs in education. https://kise.ac.ke/system/files/2022-01/National%20survey%20on%20children%20with%20disabilities%20and%20special%20needs%20in%20education%202018-min.pdf

40 Based on 2025 school Calendar

41 According to between 5-15% of the population is likely to be sick at any one point. SZILAGYI, P. G., BLUMKIN, A., TREANOR, J. J., GALLIVAN, S., ALBERTIN, C., LOFTHUS, G. K., … SHAY, D. K. (2016). Incidence and viral aetiologies of acute respiratory illnesses (ARIs) in the United States: a population-based study. Epidemiology and Infection, 144(10), 2077–2086. doi:10.1017/S0950268816000315. https://www.cambridge.org/core/journals/epidemiology-and-infection/article/incidence-and-viral-aetiologies-of-acute-respiratory-illnesses-aris-in-the-united-states-a-populationbased-study/0647B1D7BD12C0613C5F30D056819E34

5.2.5 Concessions and discounts

In the proposed scenario persons with disabilities and their caregivers has asked for the expansion of concessions and discounts as a means of covering disability costs. As such, they requested for discounts when using public means of transport such as the Nairobi Commuter Buses, the Nairobi Commuter Rail and the Madaraka express. Further, they requested that the amount of income that is tax exempt be expanded since it is limited relative to disability costs.

Following these demands, the proposed scenario provided for discounts amounting to KES41,350,500 on the Madaraka express for 2.2 per cent of its passenger volume, representing the proportion of population with disabilities. However, the 2.2 per cent of the passenger volume overestimates the scope of the discount since not all persons with disabilities have a disability certificate. Indeed, the support needs assessment shows that only 52.7 per cent of persons with disabilities have a disability card.[42] Therefore, out of the 197,682 Madaraka express passengers 2,293 (0.527*0.022*197682) are eligible for discounts.

The proposed scenario had provided discounts for all the passenger classes. However, to fit within the tight fiscal space, the rationalized scenario limits these discounts to the economy class but retains the discount at 50 per cent to reflect the double costing of transport costs. An economy ticket to and from Mombasa costs KES1,500. This means that each passenger with disability will receive a discount of KES750, which is equivalent to KES1,719,750 discount per month and KES20,637,000 per year for the 2,293 passengers.

With respect to expanding tax exemption beyond an income of KES150,000, it is noteworthy that this exemption is highly regressive since it covers persons with disabilities who are already employed, and are part of the middle class. Compared with persons with disabilities, who are solely dependent on the PwSD-CT, persons receiving tax exemption may be indirectly receiving a transfer of KES37,383[43] for an income of KES150,000 per month. This is close to 19 times the cash transfer. Therefore, it is inequitable to expand the tax exemption beyond the current KES150,000, which reduces the revenues that would have been foregone by the KRA in the proposed scenario, by KES5.9 billion per year.

5.2.6 Assistive devices

The proposed scenario recommended that the social security infrastructure (Social Health Insurance Fund (SHIF)) in the country cover the provision assistive devices to include the marginalized persons with disabilities, and hasten the procurement of assistive devices. By consolidating the expenditures by the various disability inclusion agencies, the proposed scenario proposed coverage of all assistive devices under SHIF with an annual premium KES700 million. This was informed by doubling of expenditures and requests by KISE (KES250 million), NCPWD (KES40 million), and the National Fund for the Disabled of Kenya (KES60 million). Doubling the expenditure was done on the assumption that there is an equal number, just like the beneficiaries, who are unaware of the existing structures to provide them with assistive devices. This is supported by a World Health Organization (WHO) survey that estimated that there is significant potential to expand the provision of AT in Kenya, well beyond the current 8,000 beneficiaries. As much as there is a lack of certainty that doubling these costs may meet all the needs, it is a reasonable approach in scaling expenditures in the medium term. So, the working scenario proposes a scaling of AT expenditures to KES700 million per annum within the first year for the next five years. To avoid logistical expenses, the working scenario recommends retaining the distribution of AT under the existing channels.

5.3 Summary of the working scenario

Table 13 and Figure 7 show the phased costs of implementing the working scenario in the medium term. The costs nearly double from KES10.42 billion in year one to KES19.74 in year five largely driven by cash transfers. By year five, cash transfers (PwSD-CT and caregiver allowance) form the bulk (76.5 per cent) of the disability inclusion costs, underscoring

42 Ministry of Labour and Social Protection Republic of Kenya (2022). Support Needs Assessment Report for Persons with Disabilities and their Primary Caregivers, Nairobi: Ministry of Labour and Social Protection

43 Income tax on KES150,000 monthly salary computed using the existing tax rates

the scenario's emphasis on flexible disability inclusion pathways other than service-based interventions. As a percentage of the GDP, the cost of the working scenario gradually increases from 0.06 per cent to 0.11 per cent, aligning with commitments made at the 2025 Global Disability Summit and positioning Kenya at the bottom of the good performing countries such as Egypt, Zambia and South Africa. In reference to the current spending (0.04 per cent of the GDP), the working scenario is nearly triple the base spending. This is modest considering the expansion in coverage and attainment of disability inclusion obligations spelt out in the UNCRPD and the just accented Persons with Disabilities Act (2025). In addition, the tripling of expenditures is associated with transport costs to and from school and healthcare which guarantee unlocking human capital potential for persons with disabilities. These long-term social and economic dividends far outweigh the tripled investments, making the working scenarios proposals a priority for the government.

Table 13: Cost of the working scenario

Pillar	Items	Year 1	Year 2	Year 3	Year 4	Year 5
Cash transfer	PwSD-CT	3.60	5.7	7.8	9.9	12
	Caregiver Allowance	1.04	2.08	3.12	3.12	3.12
Human support	Circle of care and support	0.2344	0.4168	0.5992	0.5992	0.9462
	VRCs	0.241	0.330	0.419	0.508	0.597
Transport	Accessible transport to school and health facilities	2.36	2.36	2.36	2.36	2.36
Assistive devices	Assistive devices	0.70	0.70	0.70	0.70	0.70
Concessions and discount	Discounts on Madaraka express	0.0206	0.0206	0.0206	0.0206	0.0206
Total cost (KES billion)		**8.20**	**11.61**	**15.02**	**17.21**	**19.74**
Cost as a % of government expenditure		**0.20**	**0.28**	**0.37**	**0.42**	**0.48**
Cost as a % of GDP		**0.04**	**0.06**	**0.08**	**0.09**	**0.11**

Figure 7: The cost of the working scenario

6

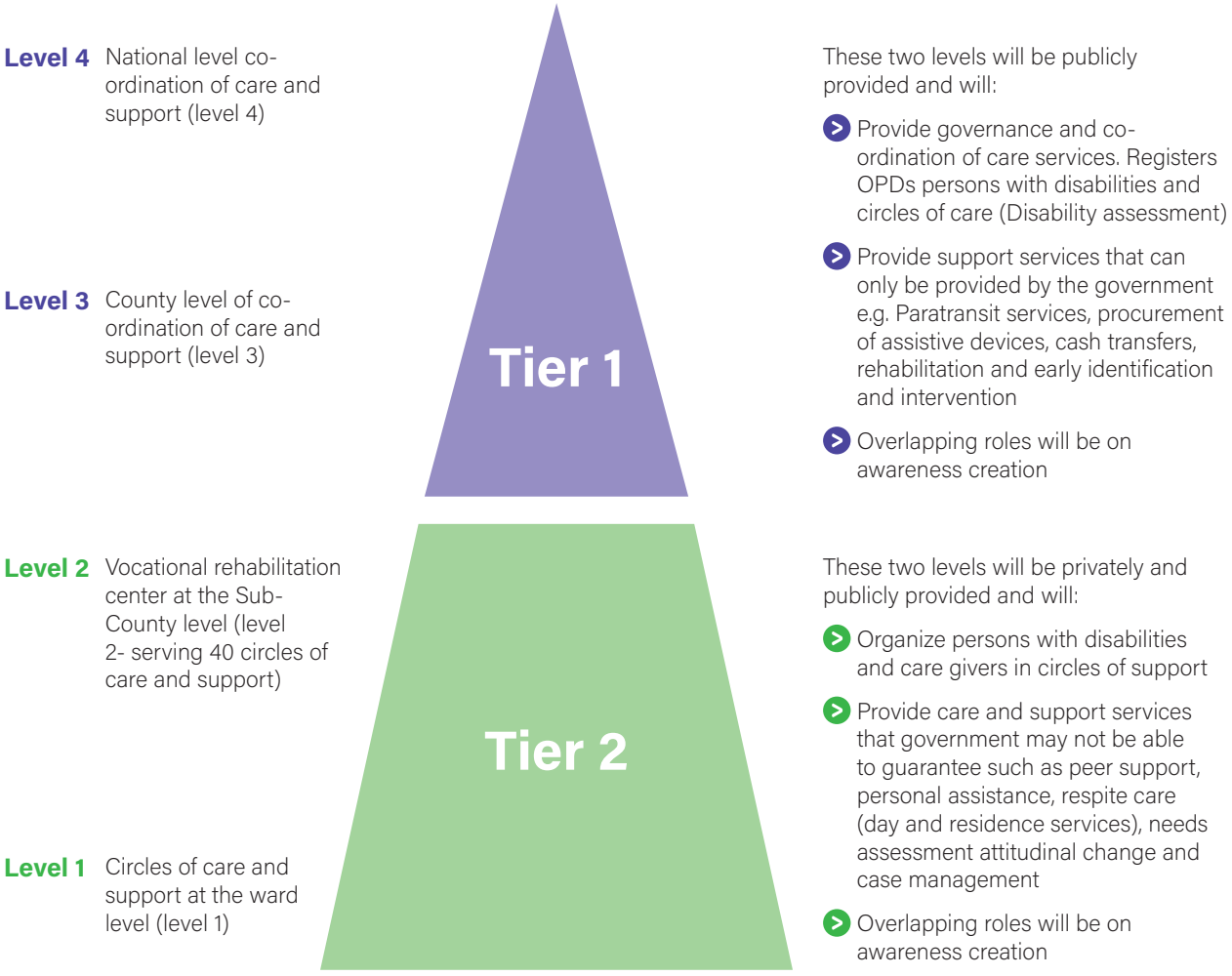
RECOMMENDATIONS: RESOLVING THE TENSION BETWEEN THE NEED FOR CARE AND SUPPORT AND GENDER INEQUALITIES IN ITS PROVISION

The costed policy scenarios point to collaboration between the government and OPDs in the provision of care and support to persons with disabilities in a two tier but symbiotic process. In the first tier, the private sector helps organize persons with disabilities and care givers in support circles, provide care and support services that government may not be able to guarantee such as peer support, personal assistance, respite care (day and residence services), needs assessment attitudinal change, and case management and conduct overlapping roles such on awareness creation. In the second tier the government provides services such governance and co-ordination of care services through registration OPDs, persons with disabilities and care circles of care; provides support services that can only be provided by the government such as paratransit services, procurement of assistive devices, cash transfers, rehabilitation and early identification and intervention; and conducts overlapping roles such as awareness raising.

To follow the administrative structure in the country, Tier 1 services can be organized at both the ward and sub-county levels. At the ward level (Level 1) \ care circles would be organized by the OPDs while at the sub-county level (Level 2) vocational rehabilitation centres would serve the care circles. In the second tier (Tier 2) government services can be organized at the national and county levels. At the county level (Level 3) government-provided services such as disability assessment, co-ordination and governance of care and support, rehabilitation, and early identification and intervention would be provided. Disability assessment, rehabilitation and early identification, and intervention would largely be at this level, since health is a devolved function. At the national level (Level 4), government provided services such as national governance and co-ordination of care and support, paratransit services, procurement of assistive devices and cash transfers, would be provided by the line ministries.

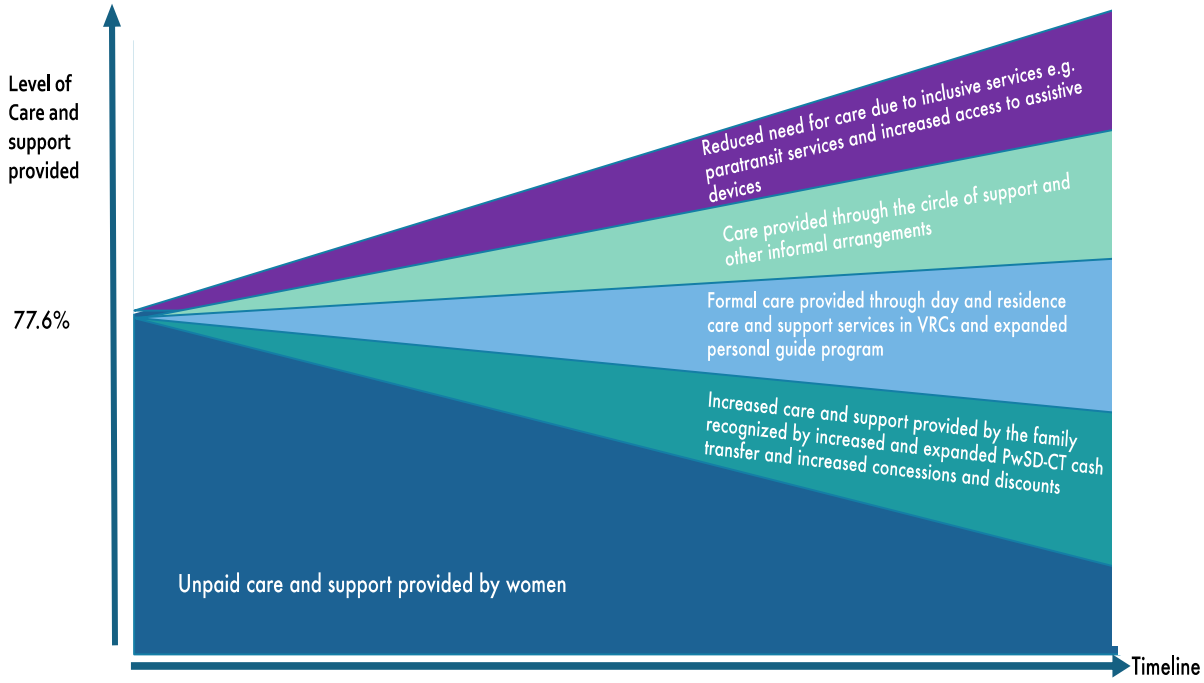
These levels and tiers are as detailed in Figure 8:

Figure 8: Proposed organization of care and support in Kenya



These four levels of care and support would help reduce the need for unpaid care and support for persons with disabilities, especially by women and girls. In the long-term, and with adequate implementation of the costed scenarios, persons with disabilities would be receiving care and support from the society as a whole, rather than from women household members. This redistribution and recognition of care work for persons with disabilities would help resolve the tension between their need for care and existing gender inequalities in its provision. Overall, with the implementation of the costed scenarios, it is expected that the burden of caring for persons with disabilities borne by women would be reduced from the current 77.6 percent to a more equitable share as shown in Figure 9.

Figure 9: Resolution of the tension between the need for care and support and gender inequalities in its provision



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