

Article

Socioeconomic Inequalities in Social Protection Among People with Disabilities in Ecuador: A Cross-Sectional Study

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Abstract

In 2007, Ecuador ratified the United Nations Convention on the Rights of People with Disabilities and introduced a national social programme to improve access and quality of life for people with disabilities. This study assessed disability prevalence and socioeconomic inequalities in three social protection outcomes: household visits, benefits received during visits, and official disability accreditation. A cross-sectional study analysed data from the 2014 national population-based survey, which showed a 3.84% disability prevalence. Overall, 37% of respondents reported at least one household visit among them, 77% received a benefit and 60% had official accreditation. Marked socioeconomic disparities expressed in absolute differences were observed. Visits were less frequent among individuals without formal education (AD: −30.41; 95% CI: −37.15, −14.09) and those in the poorest households (AD: −17.74; 95% CI: −23.01, −12.48). Participants with primary education were less likely to receive benefits (AD: −19.51; 95% CI: −32.83, −6.19), while Afro-Ecuadorian (AD: 20.07; 95% CI: 4.20, 35.95) and Indigenous individuals (AD: 19.61; 95% CI: 6.99, 32.24) were more likely to receive them. Conversely, those with basic education (AD: 21.38; 95% CI: 13.53, 29.23) were more often accredited than those with higher education. Although the programme has reached many individuals, access remains unequal.

Keywords: people with disabilities; inequalities; Ecuador; social protection



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1. Introduction

More than 1.3 billion people (16% of the world’s population) have a disability [1]. People with disabilities are at increased risk of developing several diseases such as depression, asthma, diabetes, stroke, obesity, and poor oral health. Likewise, they may die up to 20 years earlier than people without disabilities [1,2]. These health inequities are often not due to the disability itself, but to the structural challenges that people with disabilities face. For example, people with disabilities are disproportionately exposed to stigma, discrimination, poverty, limited education, unemployment and restricted access to healthcare services, all of which contribute to a vicious cycle of social injustice [3–5].

Although the prevalence of disability across the region of the Americas differs, the average prevalence in 2021 was estimated to be between 14% and 19%; likewise, the World

Bank reported that nearly 52 million households in the region have at least one family member with some form of disability [6,7]. Ecuador, like other countries in the Americas, has a high degree of variation in disability prevalence, ranging from 2% to 13% [6,8]. Several provinces in the Andean region of the country, mainly in urban areas (Bolívar, Chimborazo, and Cañar), have reported a higher proportion of people with disabilities than the national average. The most recent available report highlighted that people with disabilities face significantly lower levels of educational and employment opportunities, along with higher levels of poverty [9,10], a situation that has been further exacerbated by the COVID-19 pandemic [11].

In 2007, Ecuador signed the United Nations (UN) Convention on the Rights of Persons with Disabilities, and in 2008, a revised national Constitution included 21 relevant articles to guarantee their rights in several social areas [12]. Following this mandate, Ecuador strengthened its national health and social programmes to address disability in a comprehensive manner in 2009 through the “Manuela Espejo Mission”. This programme established a comprehensive national strategy by deploying medical teams to conduct home visits once or twice each month throughout the country. The initiative aims to provide healthcare services, distribute assistive technology devices (e.g., hearing aids, communication tools, wheelchairs, and glasses) and supply medications, while also identifying additional individuals with disabilities within communities, particularly in rural areas [13]. Later, in 2012, the government approved a comprehensive Disability Law granting benefits in several social areas, prioritising medical care, rehabilitation and economic support [14].

In terms of funding, the government invested more than \$100 million between 2007 and 2017 into the “Manuela Espejo Mission” programme [15]. This programme, which initially received technical support from the Cuban government, was integrated as a routine programme into the Ministry of Social Welfare (MSW) and the Ministry of Public Health (MoPH). As a result, people with disabilities identified during the household visits were registered to have access to health programmes and socioeconomic benefits such as the Joaquín Gallegos Lara Bonus (Bono Joaquín Gallegos Lara in Spanish), which provides funds to caregivers in cases of severe disability of any family member and directly to people with disabilities if they live in extreme poverty.

However, despite these significant interventions, little is known about the social and health impacts of such programmes on people with disabilities. This study, therefore, sought to (i) determine the prevalence of disabilities and social protection among people with disabilities and (ii) assess the social inequalities in social protection among people with disabilities in Ecuador.

2. Materials and Methods

2.1. Data Sources and Population

We analysed secondary data from the latest National Living Standards Measurement Survey, conducted in 2014 by the National Institute of Statistics and Census (Instituto Nacional de Estadísticas y Censos—INEC in Spanish) [16]. This survey gathers sociodemographic and socioeconomic details including age, gender, residence, education, healthcare use, insurance status, household income, and disability type status (classified as physical, cognitive, hearing, visual, and psychosocial) based on the national MoPH classification of disabilities [17]. Out of 106,694 survey participants, 4101 individuals responded affirmatively to the question “Do you have any disabilities?” and were identified in this study as people with disabilities.

2.2. Variables

This study was guided by the social determinants of health framework, drawing on the distinction between structural and intermediary determinants proposed by the World Health Organization Commission on Social Determinants of Health [18]. Within this framework, socioeconomic position (SEP) is understood as a structural determinant that shapes individuals' material conditions and their interactions with social and institutional systems. Indicators such as wealth, education, place of residence, and ethnicity reflect underlying social stratification processes that influence access to resources, including disability-related social protection. Access to social protection was conceptualised not merely as an administrative outcome but as a socially patterned process shaped by material constraints (e.g., poverty and geographic isolation) and institutional dynamics (e.g., discrimination, information asymmetries, and bureaucratic complexity) [19]. Both frameworks underpinned the selection of the study variables and the interpretation of the results. The selection of variables was further guided by the availability of data in the survey.

2.3. Exposure Variables

The study assessed the following socioeconomic variables: (i) ethnicity (self-reported as Mestizo, Indigenous, White, Afro-Ecuadorian, or Mulato), (ii) education level (post-graduate, secondary, primary, basic, or none) and (iii) household wealth index (based on 15 households' assets and divided into five quintiles from richest to poorest) [18]. These variables were selected due to their relevance as social stratifiers, access to resources, and survey availability.

2.4. Social Protection Outcomes

Three social protection outcomes were measured: (i) household visits, which was determined by asking participants, "Did the Manuela Espejo Mission visit you during the last 12 months?"; (ii) the receipt of benefits, which was assessed using the following question, "Have you received any benefit (medical care, medicines, assets, household goods, clothing, legal advice, and access to education or employment) during the visits from the Manuela Espejo Mission?", and respondents answering "yes" were considered beneficiaries; (iii) official accreditation was captured with the question, "Do you have a disability card issued by the government?" This card is provided by the MoPH following a comprehensive assessment and a person should receive a certificate if they have at least a 30% disability rating according to the technical manual on disabilities issued by the MoPH [17]. Obtaining this card officially recognises a person with disabilities and allows them access to the social benefits provided for in the disability law [14].

2.5. Data Analysis

Descriptive statistics were estimated as frequencies and percentages for the entire population. The analyses for household visits and official accreditation were conducted on the entire sample ($n = 4101$). However, the analysis of benefits received during visits was restricted to people with disabilities who reported having received a household visit ($n = 1652$). To estimate absolute differences (ADs) as the measure of association, we used a generalised linear model (GLM) with a Gaussian family and an identity link function, incorporating analytic weights and estimating 95% confidence intervals for inferential purposes. First the association between the socioeconomic variables and outcomes were assessed in the crude model. Then, gender, age, disability type (physical, cognitive, hearing, visual, psychosocial, or multiple), place of residence and health insurance were used as covariates in the adjusted model according to the conceptual frameworks. Missing data was assessed for all variables. Given that missing values were below 2% for the wealth

index and education variables, complete-case analyses were performed. All analyses were conducted using Stata 15.1.

3. Results

The proportion of people with disabilities in the survey was 3.84%. Table 1 shows the main sociodemographic characteristics of the sample. Physical disability accounted for the highest proportion at 42%. Of this group, 54% were male and approximately 32% were aged over 65 years. Two thirds (66%) of respondents lived in urban areas, and 76% identified themselves as Mestizo, followed by Indigenous (8%). Most participants had little education: 24% were illiterate, while 39% finished only primary school. Around 32% belonged to the lowest 20–40% income group, and 65% lacked health insurance. Of the entire sample, 37% ($n = 1652$) indicated that their household had received a visit from the national social protection programme. Of all the people with disabilities who reported a household visit, 77% ($n = 1283$) received a benefit during that visit. Most benefits distributed were household goods, including kitchen and bedroom items (73%), while medical supplies and healthcare accounted for 11%. Nearly two thirds (60%) of the interviewees had received an official certification.

Table 1. Socioeconomic characteristics and prevalence of social protection outcomes among people with disabilities in 2014.

Variables	Frequency (n)	Percentage (%)	Household Visits (n/%)	Benefits on Visits (n/%)	Official Accreditation (n/%)
Total population surveyed: 106,694	4101	3.84	1652/37.22	1283/77.26	2453/59.81
Type of disability					
Physical	1726	42.10	23.79	27.91	21.82
Cognition	694	16.93	42.26	34.15	43.31
Visual	520	12.69	10.16	12.11	11.02
Hearing	546	13.33	8.15	9.38	10.81
Multiple	456	11.14	12.69	14.79	8.99
Psychosocial	156	3.82	2.97	1.65	4.05
Sex (gender)					
Men	2222	54.20	52.58	55.56	56.31
Women	1878	45.80	47.42	44.44	43.69
Age groups (years)					
>65	1292	31.51	28.52	30.53	21.21
40–64	1284	31.32	28.61	28.59	36.12
20–39	788	19.24	20.54	18.36	22.39
10–19	485	11.83	16.20	18.89	14.55
0–9	250	6.11	6.12	3.63	5.74
Residence					
Urban	2695	65.72	60.44	70.70	67.13
Rural	1405	34.28	39.56	29.30	32.87
Ethnicity					
Mestizo	3099	75.58	76.20	74.10	76.43
Indigenous	311	7.59	7.64	4.73	6.73
Mulato, other	394	9.62	9.15	12.17	10.05
White	189	4.62	4.21	6.80	4.27
Afro	106	2.60	2.79	2.20	2.52

Table 1. Cont.

Variables	Frequency (n)	Percentage (%)	Household Visits (n/%)	Benefits on Visits (n/%)	Official Accreditation (n/%)
Education					
Postgraduate (highest)	275	6.86	2.67	1.37	7.78
Secondary	704	17.54	12.94	14.21	17.15
Primary	1567	39.00	37.87	42.95	36.20
Basic	521	12.98	15.51	15.07	14.16
None (lowest)	948	23.62	31.01	26.40	24.71
Household wealth index					
Q1 (richest)	932	23.13	15.27	21.92	23.18
Q2	899	22.31	21.92	20.22	22.07
Q3	893	22.16	24.57	24.10	22.98
Q4	697	17.31	22.32	19.07	17.74
Q5 (poorest)	608	15.08	15.93	14.70	14.02
Health insurance					
Insured	1436	35.03	28.87	29.55	37.42
Uninsured	2664	64.97	71.13	70.45	62.58

Table 2 presents the crude and adjusted associations between the socioeconomic variables and the social protection outcomes. The crude model shows important and statistically significant inequalities among the less-educated and low-income groups regarding household visits, and among those with low education and a white ethnic background concerning social benefits. There were also moderate inequalities among individuals with low education and all ethnic and income groups, but these were non-statistically significant. In the adjusted model, for household visits, all education, ethnic and wealth quintile groups received statistically significantly fewer visits than the reference groups—those with tertiary education, with a white ethnic background and who were the richest respectively. Those with only primary education (AD: -19.51 ; 95% CI: $-32.83, -6.19$) reported statistically significantly fewer benefits than those with higher education, whereas Afro-Ecuadorian (AD: 20.07 ; 95% CI: $4.20, 35.95$) and Indigenous individuals (AD: 19.61 ; 95% CI: $6.99, 32.24$) and those in quintile Q2 (AD: 11.56 ; 95% CI: $4.60, 18.52$) obtained significantly greater benefits compared to the reference group. Finally, related to the accreditation, those with basic education (AD: 21.38 ; 95% CI: $13.53, 29.23$) had substantially more significant chances of getting official accreditation than the postgraduate group. Regarding ethnicity, though not statistically significant, Mulato (AD: -4.89 ; 95% CI: $-13.18, 4.60$) and Mestizo (AD: -2.83 ; 95% CI: $-9.84, 4.17$) individuals had less chance of getting accreditation. The poorest group was slightly more likely to be accredited than the richest group but this was not statistically significant (AD: 1.20 ; 95% CI: $-4.64, 7.04$).

Table 2. Absolutes differences and their 95% confidence intervals (CI) in outcomes by socioeconomic groups in people with disabilities 2014.

		Model 1 (Crude)					Model 2 (Adjusted)						
		Household Visits		Benefits on Visits		Official Accreditation		Household Visits		Benefits on Visits		Official Accreditation	
Variables	Difference	95% CI	Difference	95% CI	Difference	95% CI	Difference	95% CI	Difference	95% CI	Difference	95% CI	
Education													
Postgraduate	Reference		Reference		Reference		Reference		Reference		Reference		
Secondary	−13.02	−19.63; −6.41	−14.42	−28.46; −0.37	9.35	2.55; 16.15	−10.74	−17.39; −4.09	−16.06	−30.05; −2.06 *	6.61	−0.05; 13.28 *	
Primary	−21.74	−27.82; −15.67	−15.30	−28.53; −2.08	12.34	6.09; 18.59	−20.21	−26.53; −13.89	−19.51	−32.83; −6.19	2.50	−3.83; 8.84 *	
Basic	−30.13	−37.05; −23.20	−11.29	−25.13; 2.54 *	2.55	−4.56; 9.67 *	−16.50	−24.33; −8.68	−16.25	−30.86; −1.64 *	21.38	13.53; 29.23	
None	−34.54	−40.90; −28.18	−8.34	−21.67; 4.97 *	5.23	−1.31; 11.78 *	−30.41	−37.15; −23.67	−14.09	−27.59; −0.58 *	3.45	−10.21; 3.31 *	
Ethnicity													
White	Reference		Reference		Reference		Reference		Reference		Reference		
Afro	−6.10	−17.59; 5.37 *	20.33	4.38; 36.27	−2.61	−14.24; 9.01 *	−5.22	−16.53; 6.07	20.07	4.20; 35.95	−0.92	−12.26; 10.41 *	
Mulato	−1.43	−9.81; 6.94 *	7.01	−5.15; 19.18 *	−7.16	−15.64; 1.32 *	−0.07	−8.34; 8.19	6.71	−5.39; 18.82 *	−4.89	−13.18; 4.60 *	
Mestizo	−3.56	−10.66; 3.52 *	15.81	5.47; 26.16	−5.12	−12.31; 2.06 *	−3.85	−10.84; −3.13	16.71	6.41; 27.01	−2.83	−9.84; 4.17 *	
Indigenous	−3.52	−12.25; 5.21 *	24.51	11.97; 37.05	2.31	−6.53; 11.15 *	3.95	−4.80; 12.72	19.61	6.99; 32.24	1.98	−6.80; 10.77 *	
Wealth													
Q1 (richest)	Reference		Reference		Reference		Reference		Reference		Reference		
Q2	−12.02	−16.40; −7.65	12.75	5.78; 19.72	0.70	−3.69; 5.27 *	−10.07	−14.45; −5.69	11.56	4.60; 18.52	−0.28	−4.69; 4.12 *	
Q3	−16.73	−21.13; −12.35	11.30	4.49; 18.11	−2.08	−6.57; 2.40 *	−12.48	−17.01; −7.96	8.50	1.62; 15.39	−2.86	−7.42; 1.69 *	
Q4	−23.48	−28.17; −18.80	14.44	7.50; 21.39	−1.36	−6.16; 3.43 *	−17.74	−23.01; −12.48	7.70	0.16; 15.23	−2.95	−8.25; 2.35 *	
Q5 (poorest)	−14.77	−19.65; −9.89	12.74	5.26; 20.23	4.36	−0.64; 9.36 *	−7.74	−13.54; −1.94	3.74	4.75; 12.24 *	1.20	−4.64; 7.04 *	

* Non-statistically significant.

4. Discussion

This study found ongoing socioeconomic inequalities in social protection for people with disabilities in Ecuador. Whereas lower-income and less-educated individuals had fewer household visits, higher benefits were observed among Afro-Ecuadorian and Indigenous groups. In addition, individuals with primary or secondary schooling were more likely to receive disability accreditation.

Based on the 2010 data, this study found a lower proportion of persons with disabilities in Ecuador compared to other countries in the region like Panama (10.2%), Mexico (6.58%) and Brazil (29.1%). These differences likely reflect regional variations in data collection, definitions or demographics [20]. The study's reported prevalence may underestimate the actual figures, as projections from Ecuador's 2022 census suggest rates closer to 7% [21,22]. However, publicly available data from the MoPH from 2023 reported a prevalence of 2.6% of persons with disabilities in Ecuador.

The findings showed that most individuals with disabilities were adults aged 40–65 years, with physical disabilities representing the most prevalent type. This indicates that a notable share of the working-age or economically active population has been affected. These circumstances may stem from disabilities acquired in childhood, chronic diseases or from exposure to traffic accidents, which have become a significant and increasing public health issue in the country and the region [23]. A 2019 study found that, over the past decade, traffic accidents accounted for the highest disability-adjusted life years among young adults in Ecuador [24].

Despite significant government investment in disability programmes, certain socially disadvantaged people with disabilities received fewer household visits or benefits, including healthcare. A systematic review in Latin America and the Caribbean region found similar persistent health inequity in access to general care for this group [25]. Many studies about people with disabilities have evidenced how various social and economic factors limit access to healthcare services [26–28]. In this study, we observed that Afro-Ecuadorians and Indigenous respondents reported more access to benefits during visits, which is a positive outcome related to the programme, because usually these groups experience greater disparities in access to healthcare services [29]. The observed disparities by ethnicity require careful interpretation. Ethnicity should not be understood as a causal factor, but rather as a marker of historically rooted structural inequalities that shape individuals' interactions with state institutions. Differential access to disability-related social protection may reflect accumulated disadvantages, including discrimination, geographic marginalisation, less access to information, and reduced administrative support. At the same time, alternative mechanisms must be considered. Some programmes may explicitly target specific ethnic groups, which may influence patterns of enrolment and take-up. In addition, selection effects may operate if documentation status, disability certification, awareness of entitlements or prior engagement with public services differ systematically across groups. These intersecting structural and institutional processes likely contribute to the observed gaps and underscore the importance of interpreting ethnic inequalities within a broader socio-political context.

At the same time, even if official accreditation rates are high, many people with disabilities remain unaccredited. Obtaining accreditation is typically a detailed process involving several appointments and consultations with medical specialists to gather clinical reports, which can be challenging to access in specialty hospitals. Individuals with limited access to education or living in rural areas may face greater challenges during this process, which can result in a lower likelihood of obtaining official accreditation, thus restricting their entitlement to social benefits.

Beyond conventional public health explanations, our findings can also be interpreted through critical disability studies scholarly work. Sheldrick's work challenges biomedical and individualised understandings of disability, arguing that disability is produced and regulated through social, political, and institutional practices that define certain bodies as deficient or burdensome [30]. From this perspective, inequalities in household visits, benefit receipt, and accreditation are not simply gaps in service delivery but reflections of how state systems classify, prioritise, and manage populations with disabilities. Similarly, Evans' scholarly work highlights how disability intersects with poverty, race, and citizenship in ways that structure differential inclusion within welfare regimes [31]. Our results, particularly the patterned disparities by education and wealth, are consistent with this view, suggesting that access to social protection is mediated by broader power relations and institutional gatekeeping rather than disability status alone.

In addition, situating these findings within a Global North–South framework further illuminates their significance [32]. Much of the disability policy literature is grounded in welfare-state contexts of the Global North, where social protection infrastructures are comparatively consolidated. In contrast, in middle-income countries such as Ecuador, disability policy operates within historically unequal social structures, high levels of informality and resource constraints that may intensify bureaucratic barriers. Structural disadvantages, shaped by colonial legacies, ethnic stratification and persistent poverty, can therefore compound disability-related exclusion. Understanding social protection gaps in Ecuador requires the recognition of how disability intersects with broader North–South inequalities in state capacity, redistribution and institutional accountability [33]. This perspective underscores the fact that expanding coverage alone is insufficient; equity depends on transforming the structural conditions that differentially position citizens with disabilities within systems of care and entitlement [34].

Methodological Considerations

This study presents both strengths and limitations to be considered. First, the survey enabled identification of the disability situation following a broad state intervention involving numerous households nationwide. This study is, to the best of our knowledge, the first to analyse socioeconomic inequalities among people with disabilities. Second, responses to the question “Do you or do you not have a disability?” were self-reported, which could lead to a misclassification on the one hand and underestimation of the true accreditation rate on the other. Third, we did not validate self-reported disability status against the national government's disability registry. This may have introduced measurement bias and influenced the estimated magnitude of disparities in either direction, particularly due to underreporting or misclassification. Finally, recall bias may have influenced participants' responses regarding visits and benefits during the interview process.

Finally, although the data are dated, the findings remain relevant, as no new policies on disability have been implemented in the country since the study was conducted.

5. Conclusions

Although Ecuador's disability-related social protection programme achieved substantial coverage, important socioeconomic inequalities persist. Lower educational attainment and lower household wealth were consistently associated with fewer household visits, while accreditation and benefit receipt also varied by social position. These findings indicate that access to social protection remains socially patterned rather than universally equitable.

Policy responses should directly address the barriers identified. First, outreach strategies should prioritise individuals with less education and those in poorer households, where household visits were least frequent. Second, accreditation procedures should be

simplified and decentralised to reduce administrative burdens, particularly for people with limited schooling or those living in rural areas. Third, routine equity monitoring, disaggregated by education, wealth, and ethnicity, should be integrated into programme evaluation to identify gaps in real time.

Strengthening disability policy in Ecuador requires moving beyond overall coverage towards proportionate universalism, to ensure that those facing the greatest structural disadvantage receive intensified support. Future research should examine implementation barriers and assess whether recent programme changes have reduced these inequalities.

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Informed Consent Statement: Not applicable.

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Disability Language/Terminology Positionality Statement: This manuscript was prepared in accordance with the Journal Guidelines for the Use of Disability Language. The term people with disabilities is used consistently throughout the manuscript to emphasise person-first language and to align with terminology commonly used in public health research and international policy frameworks, including the United Nations Convention on the Rights of Persons with Disabilities.

Abbreviations

The following abbreviations are used in this manuscript:

MoPH	Ministry of Public Health
MSW	Ministry of Social Welfare
INEC	Instituto Nacional de Estadísticas y Censos
UN	United Nations

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