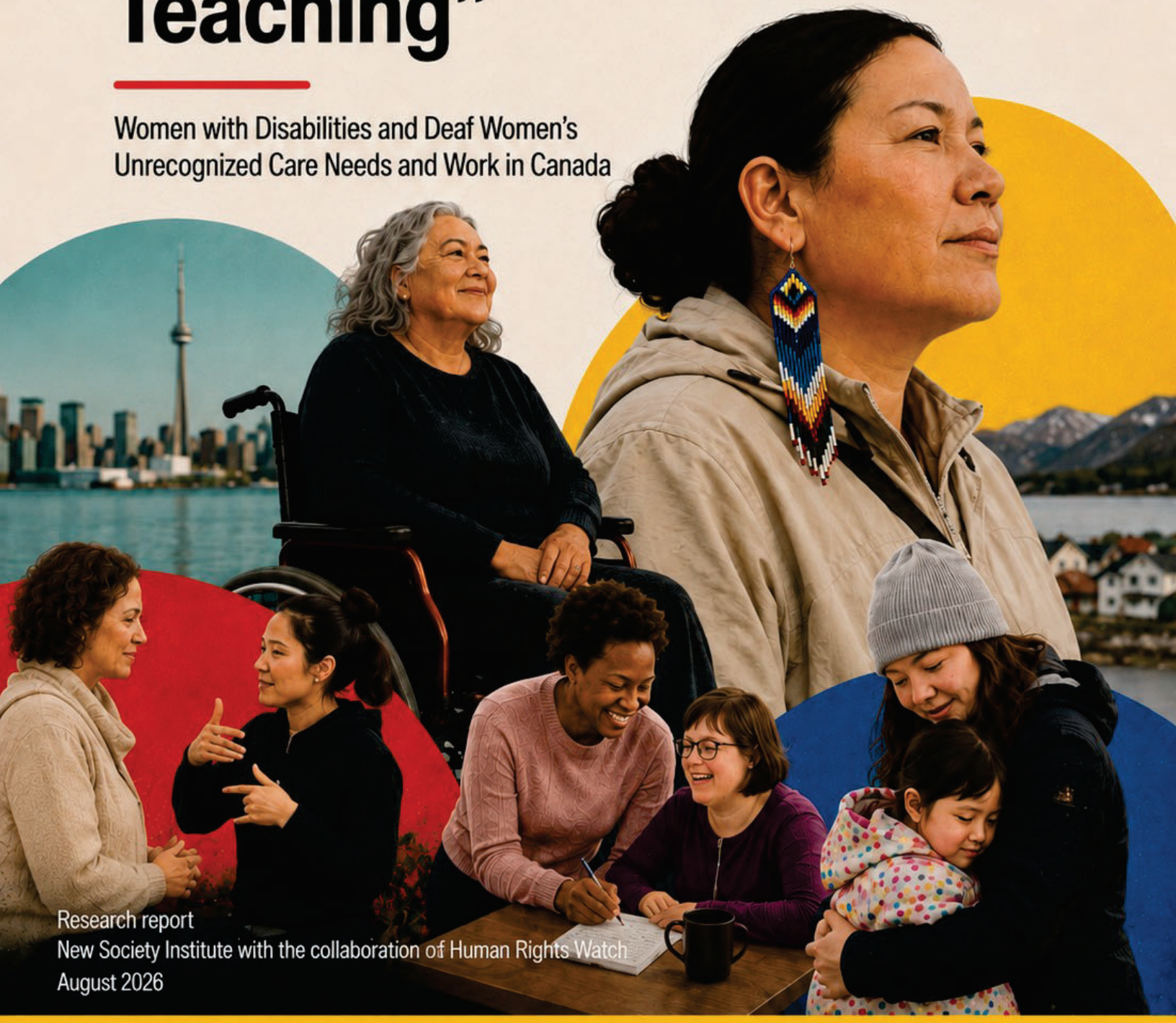
“We Are Always Leading, Supporting, Teaching”

Women with Disabilities and Deaf Women’s Unrecognized Care Needs and Work in Canada



Research report
New Society Institute with the collaboration of Human Rights Watch
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Use of generative artificial intelligence. ChatGPT (OpenAI) was used in developing Appendix B to assist in synthesizing the research findings and human rights and normative analysis into indicators and measures within the framework designed by the NSI research team. All methodological choices, substantive judgments, and final content were determined and reviewed by the research team. AI was not used to analyze the focus group data or draft the report's background, findings, or human rights standards sections. The cover artwork was also AI-generated; it is illustrative and does not depict research participants.

Executive Summary

This report by the New Society Institute and Human Rights Watch examines the experiences of women with disabilities and Deaf women within Canada's care economy—not only as people who receive care and support, but as mothers, family caregivers, peer supporters, community members and paid care workers who also provide it. Drawing principally on eight focus groups involving 49 participants, supplemented by interviews, research and a scan of relevant laws and policies, the study asks how public policy shapes these intersecting experiences of receiving care, providing care and exercising self-care.

The findings reveal recurring barriers that reach well beyond access to individual services. Participants described restrictive eligibility requirements, burdensome processes for proving disability and obtaining support, fragmented information and services, shortages of home and community care, inaccessible transportation, under-resourced and sometimes stigmatizing services, and repeated demands to self-advocate simply to secure needed support. Poverty and inadequate housing further undermined women's capacity for self-care. At the same time, the substantial paid and unpaid care work undertaken by women with disabilities—including family caregiving, parenting and peer and community support—was frequently unrecognized and unsupported. Women also described exclusion from the policy and program decisions that shape their lives.

The report argues that these experiences cannot be understood as the consequences of a single failing program or service. They are shaped through a dispersed, cross-sectoral and inter-jurisdictional ***Care Economy Policy Regime*** encompassing laws, programs, funding arrangements, eligibility rules and administrative systems across health and home care, disability supports, income security, housing, employment, transportation and other policy fields. International human rights standards – including equality and non-discrimination, health, social security, independent living, family life, decent work and participation—provide a normative foundation for assessing that regime.

To support that assessment, the report proposes a framework organized around six regulatory functions: defining care and support; establishing access; regulating service design and delivery; regulating paid and unpaid care work; establishing the material and social conditions for self-care and caregiving; and governing care-economy policies and programs. These functions are linked to human-rights-based indicators and provision-level measures that can be applied across laws and policies.

The report does not propose a comprehensive blueprint for redesigning Canada's care economy. Rather, it calls for governments to ***make the existing regime visible, assess it systematically, identify gaps and contradictions, and undertake sustained reform with women with disabilities, Deaf women and others who provide and receive care centrally involved in that work.***

Introduction

This report presents research by the New Society Institute and Human Rights Watch on the experiences of women with disabilities and Deaf women in Canada's care economy—as people who receive care and support, provide paid and unpaid care and support to others, and undertake the work of caring for themselves.

"Care" and "support" are acts that enable people to enjoy their human rights. They are essential to the realization of human rights and to the functioning of families, communities, and societies. These forms of labour and support are diverse: they include a parent caring for a child, a teacher supporting a student, a nurse providing health care, a direct support professional assisting someone with daily activities and community participation, family and peer support, and the many activities through which people maintain their own health and well-being. Everyone requires care at different points across the life course to meet diverse and changing physical, psychological, cognitive, mental health, and developmental needs.

Yet care and support are also organized through social, economic, and institutional arrangements. Much of this work is unpaid or poorly compensated, and women perform a disproportionate share of both paid and unpaid care work. These gendered patterns, together with the social importance and economic undervaluing of care, have contributed to the development of the concept of the *care economy* – the wider field of activities, relationships, labour, institutions, and resources involved in providing and receiving care and support.

The care economy is not simply a collection of private relationships or individual acts of care. Governments and public authorities play a central role in structuring it. Through legislation, public programs, funding arrangements, eligibility requirements, administrative rules, service systems, labour regulation, income and disability supports, housing policy, and other forms of public policy, they shape who can obtain care and support, how it is provided, how care work is valued and supported, and the material conditions within which people care for themselves and others. This report refers to these interconnected governing arrangements as the *care economy policy regime*.

Understanding this policy regime requires looking beyond policies formally labelled as "care" policies. The conditions under which care is received, provided, and exercised may be shaped by decisions made across health, disability, income security, employment, housing, transportation, family support, and other policy fields, often across different levels of government. The concept of a policy regime provides a way of bringing these dispersed arrangements into view and examining how they operate together.

The Government of Canada has taken steps toward recognizing the care economy as an explicit field of public policy. In 2023, it published *Canada's Care Economy: Proposed Conceptual Framework*, outlining paid and unpaid dimensions of care. In Budget 2024, the federal government committed to consultations on a national caregiving strategy and to convening a Care Economy Sectoral Table, which was subsequently established in 2025.

These developments create an important opportunity to consider whose experiences, needs, and contributions are recognized as governments increasingly turn their attention to the organization and sustainability of care.

Women with disabilities and Deaf women occupy an important and insufficiently examined position within this policy landscape. They may require care and support themselves while also providing substantial paid and unpaid care to children, family members, peers, and communities. Disability, gender, race, Indigeneity, income, geography, migration status, and other circumstances can also shape how people encounter the institutions and policies through which care and support are organized.

To better understand these experiences, New Society Institute and Human Rights Watch undertook qualitative research with women with disabilities and Deaf women and with paid and unpaid care providers. This research was supplemented by interviews with civil society representatives and academics, a review of relevant research and government data, and a scan of laws and policies affecting the care economy in Canada.

The study has two related purposes.

- First, it seeks to better understand the lived experience of women with disabilities and Deaf women within the care economy, including their experiences of receiving, providing, and undertaking care and support.

- Second, it seeks to develop a framework for critically assessing the Care Economy Policy Regime: the laws, policies, programs, and institutional arrangements through which public authorities structure those experiences. By bringing qualitative evidence into dialogue with policy-regime analysis and international human rights standards, the research develops a framework for examining whether particular policy arrangements address or reproduce disadvantage and discrimination, and for identifying where further policy analysis and reform may be required.

Organization of the Report

The report proceeds in seven main sections.

- Section I introduces the key concepts and broader Canadian context, including the concepts of care and support, the care economy, and the Care Economy Policy Regime.
- Section II describes the research framework and methodology.
- Section III presents the findings from the qualitative research.
- Section IV considers the policy implications of those findings and identifies the principal regulatory functions of the Care Economy Policy Regime.
- Section V examines the international human rights law and standards that provide the normative foundations for assessing that regime.

- Section VI brings these elements together in a proposed framework of dimensions, indicators, and measures for assessing the Care Economy Policy Regime in Canada.
- Section VII identifies strategic directions for further assessment and reform.

There are two Appendices to the study:

- Appendix A presents the policy scan of selected laws, policies, and institutional arrangements relevant to regulating the care economy. This is not an exhaustive list of sources but is intended to illustrate the complexity of the care economy policy regime, its cross-cutting and intersectoral nature.
- Appendix B presents a proposed Care Economy Policy Regime Assessment Framework, based on the research. It links six proposed dimensions of the regime to human-rights-based indicators and provision-level measures, and explaining the lived-experience and normative foundations for each.

At its core, the study asks how the experiences of women with disabilities and Deaf women can deepen understanding of the care economy as a field of public policy, and how the laws and policies that structure that economy can be assessed systematically from the standpoint of inclusion and human rights. In doing so, it seeks both to make visible experiences that have received insufficient attention in care-economy policy debates and to provide an analytical framework for examining the policy arrangements through which care and support are organized in Canada.

I. Women with Disabilities and the Care Economy: Key Concepts and Human Rights Issues in the Canadian Context

Care and support are essential to the exercise of human rights and to the functioning of families, communities, and societies. Yet the ways in which care and support are understood, organized, financed, and delivered can also reproduce inequalities and create barriers to the enjoyment of rights. These tensions are particularly significant for women with disabilities, who may require care and support at different points in their lives while also providing substantial paid and unpaid care to others. A human rights approach requires moving beyond a binary conception of "caregivers" and "care recipients," recognizing people as rights-holders who may both give and receive care and support.

This section establishes the key concepts and human rights framework used throughout the report and situates the experiences of women with disabilities within the gendered organization of Canada's care economy.

A. Key Concepts

1. The Right to Care

Although the right to care has yet to be codified in international human rights treaties, several treaty bodies have referred to the right to care.[1] The Inter-American Court of Human Rights issued in 2025 an advisory opinion (OC-31/25) affirming that all people have a right to care, including the right to receive care, to give care, and to exercise self-care.[2] In 2022, the Economic Commission for Latin America and the Caribbean member states, which includes Canada, adopted the Buenos Aires Commitment,[3] committing to adopt regulatory frameworks to ensure the right to care through comprehensive care policies and systems. Most notably, the International Labour Organization adopted in 2024 the Resolution Concerning Decent Work and the Care Economy "embracing the 5R Framework for Decent Care Work (recognition, reduction and redistribution of unpaid care and reward and representation of care workers)."[4]

2. Disability

In considering the right to care from a disability perspective, it is essential to start with the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This international treaty recognizes disability as "an evolving concept [resulting] from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others."

These impairments include “long-term physical, mental, intellectual or sensory impairments.” A health impairment which is initially conceived of as illness can develop into an impairment in the context of disability because of its duration or its chronicity.[5]

Not all people with disabilities identify with this definition and there are different, unique cultural understandings of disability across Canada. For example, for most Deaf Canadians the capital “D” indicates a distinct identity, meeting the criteria for cultural identity, with unique language, norms or behavior, traditions, and values. Deaf Canadians’ first languages are American Sign Language (ASL) or Langue des signes québécoise (LSQ). In addition, for Inuit people there is no direct Inuktitut word for “disability,” and this term does not align with traditional understandings of how people contribute to society and in their community.[6]

3. Care and Support

This report adopts the United Nations High Commissioner for Human Rights’ definition of “care and support” as “acts of caring for oneself and of assisting others to carry out daily activities, maintain wellbeing and participate in society with dignity and autonomy.”[7]

Importantly, “care” and “support” are not identical or interchangeable concepts. All people, not just people with disabilities, require “care” across the course of their lives to meet diverse physical, psychological, cognitive, mental health, and developmental needs. However, “care” is not a neutral term regarding disability.[8] Traditional care policies have typically focused on caregivers and depicted recipients of care, including people with disabilities, as societal burdens and passive dependents without decision-making powers. This approach leads to their “loss of autonomy, economic disempowerment, and segregation and isolation … in institutions or in family homes.”[9]

Alternatively, the CRPD marks a shift from a “care” paradigm to one with support systems for independent living in the community.[10] “Support” refers to assistance, including personal assistance, to enable people with disabilities to carry out daily living activities and actively participate in their communities. Regardless of its form, supports must respect individual autonomy and dignity. “Support systems” refer to a network of people, products, and services, both formal and informal, that provide such assistance.[11]

4. Care and Support Work

The International Labour Organization (ILO) describes care work as “activities and relations that pursue sustainability and quality of life; nurture human capabilities; foster agency, autonomy and dignity; develop the opportunities and resilience of those who provide and receive care; address the diverse needs of individuals across different life stages; and meet the physical, psychological, cognitive, mental health and developmental needs for care

and support of people including children, adolescents, youth, adults, older persons, persons with disabilities and all caregivers."[12] The ILO's principles for regulating care work include that "[p]rovision of, access to and receipt of care should be based on the principles of non-discrimination, solidarity, sustainability, equity, universality, and social co-responsibility."[13] Notably, the ILO's definition excludes self-care (for example, personal hygiene or leisure).[14]

This report understands care and support work as a wide range of labour that people provide themselves and each other, which enables people to enjoy their human rights. Care work can be paid or unpaid and encompasses both direct (such as supporting someone with daily activities, including hygiene, getting out of bed, and dressing), as well as indirect care activities (like cooking, cleaning, and arranging appointments).[15]

5. Care Economy

The care economy encompasses both direct and indirect care activities and can be defined "the sum of all forms of care work," both paid and unpaid.[16] The ILO's Resolution Concerning Decent Work and the Care Economy states:

> The care economy comprises care work, both paid and unpaid, and direct and indirect care, its provision within and outside the household, as well as the people who provide and receive care and the employers and institutions that offer care. Care work consists of, among others, activities and relations that pursue sustainability and quality of life; nurture human capabilities; foster agency, autonomy and dignity; develop the opportunities and resilience of those who provide and receive care; address the diverse needs of individuals across different life stages; and meet the physical, psychological, cognitive, mental health and developmental needs for care and support of people including children, adolescents, youth, adults, older persons, persons with disabilities and all caregivers.[17]

6. Care Economy Policy Regime

For purposes of this study, the *care economy policy regime* refers to the governing arrangements through which public authorities shape the conditions under which care and support are received, provided, and exercised. It includes the laws, policies, programs, fiscal arrangements, administrative rules, implementation mechanisms, institutional structures, and documented practices that together structure the care economy.

The concept draws on policy-regime research, which examines the governing arrangements through which complex policy problems are addressed across

multiple policy systems and institutions. Policy regimes may span several policy "subsystems" and levels of government rather than being contained within a single statute, ministry, or program. This is particularly relevant to the care economy in Canada, where care and support are shaped through intersecting systems of health and home care, disability supports, social protection, housing, transportation, employment, family support, and other areas of public policy.

In this study, *policy* is understood broadly, drawing on classic formulations, as the authoritative choices – and non-choices – through which legislatures and governments allocate values and resources in society, including decisions about who receives what benefits and supports, under what conditions, and through what institutional arrangements.[18] This understanding encompasses law as one of the principal means through which authoritative policy choices are established and enforced, while also recognizing that important policy effects arise through programs, administrative rules, funding arrangements, and government decisions not necessarily expressed in legislation.

The *care economy* and the *care economy policy regime* are therefore related but distinct concepts. The care economy refers to the wider field of activities, relationships, labour, institutions, and resources involved in providing and receiving care and support. The care economy policy regime refers to the governing arrangements through which public authorities structure that field.

B. Lack of Access to Needed Care and Support

According to a Canadian Human Rights Commission survey, 38 percent of people with disabilities across Canada reported not getting the care they need to live independently, such as help with bathing, cooking, cleaning, or shopping.[19] This, in turn, has a domino effect, impacting the ability of women with disabilities to live more independent lives, including the capacity to fulfill their roles as caregivers themselves.

Lack of community-based home care and support results in institutionalizing people with disabilities in residential and health care facilities. Entitlement for home care hours under regulation often does not translate into the availability or access to actual home care hours in practice. In 2018 report produced by Statistics Canada, one third of adults receive home care identified themselves as unmet home care needs with the most frequent barrier to receiving care being the unavailability of services.[20] Even where there is no service hour maximums set in regulation, such as in Ontario,[21] there are shortages in the actual receipt[22] and quality[23] of services. Recent provincial investments into home care,[24] including plans to increase reimbursement for family caregivers,[25] fails to address larger system issues and the unavailability of home care staffing. Across Canada, provincial and territorial

governments invest more in institution-based health care than in home and community care (See Table I).

Table I: Per Capita Provincial and Territorial Government Health Expenditure, 2023[26]		
Province/Territory	**Home and Community Care[27]**	**Institutional Care (Other than Hospitals)[28]**
Alberta	285.26	526.43
British Columbia	568.78	799.98
Manitoba	305.00	820.52
New Brunswick	292.46	658.66
Newfoundland and Labrador	746.94	994.62
Northwest Territories	167.42	2,292.68
Nova Scotia	443.31	1,046.32
Nunavut	200.17	2,071.13
Ontario	353.16	629.11
Prince Edward Island	476.28	886.61
Quebec	360.02	1,164.58
Saskatchewan	334.32	711.20
Yukon	374.09	1,981.62

C. Women's Disproportionate Participation in the Global Care Economy

Care work, including support for people with disabilities, is essential for people's enjoyment of human rights and for the functioning of everyday life of families, communities, and societies at large. However, this work is not well valued within dominant wage-based economic systems and these forms of socially necessary and rights-essential labour receive little or no remuneration.

Such labour, performed largely by women, is viewed—inaccurately—as both unskilled and an extension of women's perceived "natural" caregiving abilities, which contributes to caregivers' low status and pay.[29] Care work has been treated as "unproductive" labour that has no financial value because it is not commodity-producing and often happens outside the economic market, in the privacy of the home.[30]

Globally, women disproportionately perform paid care work—for example, as domestic workers, educators, and healthcare workers—where they often face low pay, poor working conditions, violence and harassment, and limited social protections.[31]

Despite accounting for billions of hours each year, women's work remains underpaid and unpaid. As a result of gendered social and cultural norms, women disproportionately shoulder unpaid care work, such as caring for children, cooking, and cleaning. This results in foregone wages, lost opportunities, and negative physical and mental health impacts.[32]

The devaluation of care work has impacts that very across different social strata, with racialized and immigrant women especially impacted.[33] As care economy researcher Ito Peng observes, the "outsourcing of household/familial care responsibilities," that women with higher incomes can afford to do, has created further divides among women along socioeconomic, racial, ethnic, and citizenship lines.[34]

Unpaid care work underpins our communities, countries, and global systems, yet national measures of progress, like Gross Domestic Product (GDP), omit and thereby render this labour invisible.[35] If it were assigned a monetary value, the International Labour Organization (ILO) estimates that women's unpaid work exceeds 40 percent of GDP in some countries.[36] In response, women's rights activists, particularly feminist economists, developed the concept of the "care economy" to analyze and address the inequalities that stem from or are exacerbated by the invisibility of care work, its economic devaluation, and its deeply gendered structure.[37]

In 2018, the ILO put forward five key policy objectives for a "high road to care work" known as the 5Rs approach: recognize, reduce, and redistribute unpaid care work; ensure adequate reward for paid care work; and "promote the representation of unpaid carers, care workers and care recipients in social dialogue" (emphasis added).[38] These objectives are guiding both advocates' and governments' approaches to action and reform of the care economy.[39]

However, these objectives overwhelmingly focus on the needs of care workers as opposed to those of people who need care and support and emphasize a binary understanding of care relationships. This binary approach risks treating caregivers as people who do not need care and support, and in turn casts people receiving care and support (in this case, people with disabilities) as passive recipients who do not themselves also provide care. Thus, it ultimately creates additional barriers for women with disabilities who are both givers and recipients of care and support.[40]

D. Care and Support Work and Disability in Canada

Federal government data shows that care work and disability are deeply gendered experiences in Canada, with women doing the bulk of paid and unpaid care work, and women disproportionately experiencing disability. Further, women with disabilities are not exempt from the gendered expectations and impacts of care work.

1. Paid Care Work

An analysis of the 2016 census showed that almost one in five employed people in Canada at that time was a paid care worker, working in a variety of sectors including "care for children, seniors and people with disabilities, as well as health care and education."[41] According to this analysis, in 2016, women accounted for three-quarters of all paid care workers.[42] The gender disparity was even stronger among jobs supporting people with disabilities.[43]

Care and support work in Canada is often precarious and poorly paid, particularly for racialized and migrant women. Government data shows that care workers are less likely to have a permanent job than non-care workers and more likely to simultaneously hold multiple jobs.[44] Women in care occupations in 2016 also had lower employment incomes than men in those same positions (C$59,300 vs. C$73,400) in 2015.[45] That year, Filipina and Latin American women, and women who were not permanent residents reported the lowest average employment incomes (respectively, C$45,700, C$40,700, and C$31,500).[46] These figures are approaching or are below the government's low-income cut-off for households larger than one person living in larger population centers, meaning they must spend a much greater share of their income to cover food, shelter, and clothing, and those supporting larger families face greater financial precarity.[47]

Findings from a 2023 survey of 351 paid care workers by the Canadian Centre for Caregiving Excellence underscored the toll of low wages and other labour rights issues. Eighty percent of paid care providers for people with disabilities reported considering changing careers.[48] The top reasons reported were not being paid a "high enough" salary (35 percent), poor work-life balance, burnout, or stress (35 percent), and lack of benefits (24 percent). More women than men said they are not being paid fairly (56 percent vs. 36 percent), and women were more likely to report poor work-life balance, burnout and stress as a reason they have considered changing careers (42 percent vs. 26 percent).[49]

A follow-up 2026 report by the Centre shows that the situation and concerns of both recipients of care and care providers is worsening. *Caring in Canada 2026* draws on the 2025 National Caregiving Survey of more than 2,600 caregivers and paid care providers across Canada. It portrays a care system under increasing strain, with the affordability crisis intensifying the financial, employment, and personal costs borne by Canada's more

than eight million caregivers. Nearly half (49%) of caregivers experience financial strain, one in five spend more than $12,000 annually out of pocket on care-related expenses, and more than 20% have stopped saving altogether.[50]

Care responsibilities also constrain labour-force participation: 59% of caregivers combine paid employment with caregiving, while 36% of those employed report reduced productivity and lost earnings. The effects extend to well-being, with 77% reporting negative impacts including stress, fatigue, and burnout.[51] The paid care workforce faces similarly serious pressures: 73% of care providers have considered leaving the sector, citing low compensation, inadequate staffing, and unsafe working conditions.[52] Despite the scale and social importance of care, a majority of both caregivers (61%) and care providers (54%) report feeling unsupported by government.[53] Overall, the findings point to a care economy that continues to rely heavily on the largely uncompensated financial, employment, and personal contributions of families and on an increasingly precarious paid care workforce.

Research by New Society Institute found similar issues for paid care workers from marginalized communities. That research points to additional disadvantages and impact of lack of accommodation, tokenism, workplace discrimination, and the toll for marginalized workers of their invisible labour in maintaining credibility and navigating non-inclusive environments:

> *Workers are expected to perform gratitude for inclusion while simultaneously self-advocating, educating coworkers, masking access needs, and overcompensating to counter stigmatizing assumptions about competence.*[54]

2. Unpaid Care Work

Significantly more women and girls over age 15 provide unpaid care work in Canada to children and adults with disabilities—52 percent, compared to 42 percent of men, according to federal government data.[55] There is less gender disparity overall among people who support adults with long-term physical or mental health conditions or disabilities than those caring for children.[56] However, significant gender disparities persist for specific age ranges spanning 25-64: for example, 31.5 percent of women ages 45-54 engage in unpaid care for adults compared to 21.1 percent of men the same age.[57]

Women are more likely than men to do ongoing and routine caregiving activities on a set schedule to support adults with long-term conditions or disabilities, according to a 2022 federal survey (See Table III).[58] According to 2018 federal data, meanwhile, women also make up a significantly larger portion of those who provide 20 or more hours of care per week (64 percent women vs. 36 percent men).[59]

TABLE III: Proportions of unpaid care activities for adults in the past 12 months, by gender, 2022[60]		
Type of care work for the adult care recipient	**Women (%)**	**Men (%)**
Emotional support	83	77
Meal prep, housecleaning, and laundry	62.7	56
Personal care	40	30
Scheduling and coordinating appointments	48	37

Women who do unpaid care work for children or adults are more likely than men to experience mental health consequences as a result, according to a 2022 federal survey. For example, 62 percent of women who provide care reported feeling tired, compared with 48 percent of men. In the same survey, women reported feeling tired, anxious, overwhelmed, and depressed because of caregiving responsibilities.[61]

Caregiving has opportunity costs as caregivers must forgo other pursuits to manage caregiving responsibilities. For example, caregivers' ability to maintain paid employment can be impacted: 16 percent of unpaid caregivers of children or adults in the survey said they had adjusted their work schedule to be more flexible, 7 percent reduced their weekly work hours, and 5 percent could not work.[62] These data do not reflect those unable to alter their workload because of financial constraints or fear of job loss.

According to a study that analyzed 2018 federal survey data, women are more likely than men to report caregiving impacts on their work productivity and job security, and women accounted for 60 percent of all employees who left or intended to leave the paid labour force that year because of caregiving.[63]

Additionally, studies show that caregivers may face significant out of pocket costs that contribute to financial strain.[64] According to 2018 federal data, financial support, government assistance, and tax credits were the most common types of support that caregivers with unmet needs said they would have liked to have received (68 percent).[65]

Marginalized caregivers (including Black, racialized, Indigenous, gender diverse, 2SLGBTQIA+, immigrant caregivers) as well as caregivers from linguistic minorities and caregivers with disabilities face unique barriers and challenges to caregiving, but there is a lack of comprehensive data on their intersectional experiences in Canada.[66] The aforementioned 2023 Canadian Centre for Caregiving Excellence survey found that racialized, Indigenous, and 2SLGBTQIA+ caregivers were more likely to experience negative impacts from caregiving.[67] For example, almost half of racialized caregivers experienced financial hardship due to caregiving, compared to one-third of non-racialized caregivers.[68]

3. Women with Disabilities and Care Work

In 2022, the government estimated that 27 percent of Canadians 15 and older had at least one disability, with women more likely than men to have a disability.[69]

Many women with disabilities are paid and unpaid care workers. The government's 2017 Canadian Survey on Disability revealed stark gendered differences among people with disabilities who do paid care work—roughly four times as many women with disabilities as men with disabilities were employed in health occupations (12 versus 3 percent).[70] Government data from 2015, meanwhile, shows similar overall gendered trends among people with disabilities in unpaid care work (See Table IV).[71]

Table IV: Participation rate and time spent on unpaid work activities, 2015				
	Men without disabilities	**Men with disabilities**	**Women without disabilities**	**Women with disabilities**
Rate of participation in unpaid work	78.7 %	82.0%	88.7%	89.3%
Average time spent (hours)	3.0	3.1	4.0	4.0

Analysis of government data from 2017-2018 indicates that having a disability is associated with increased unmet health needs.[72] People with disabilities are over four times more likely than people without disabilities to report an unmet health need.[73] Results of the 2022 federal survey on disability, meanwhile, found high incidences of unmet healthcare needs: 45.7 percent of people with disabilities reported unmet needs related to health care services.[74] Persons with disabilities who considered themselves housebound were more likely to experience unmet health care needs.[75]

4. Legacies of Colonialism on Care in Inuit Culture

Inuit women with disabilities who participated in the focus group in Iqaluit, Nunavut, underscored the importance of understanding care in relationship to their culture and the ongoing legacy of colonial harm in their communities.

They said "care" means "welcoming" and ensuring that no one is left behind, including by providing everyone food, shelter, and support.[76]

This type of "care" is deeply ingrained in Inuit culture. The Inuit value of Inuuqatigiitsiarniq, which means "respecting others, relationships, and caring for people," centers care in Inuit communities as something that "does not need to be prescribed or ordered. It is part of how communities naturally function."[77]

In this cultural context, care work is not gendered,[78] and everyone has a role to play in caregiving.[79] However, according to the Inuit women in the focus group, colonialism, including forced settlement, disrupted their way of life and upset their traditional gender balance in caregiving and connection to the land as a source of care. “They invade our land and make us useless for us,” one participant said. “Inuit is just a statistic to them.”[80]

The forced relocation and separation of Inuit people for tuberculosis treatment in the mid-20th century also created profound and lasting trauma, characterized by family separation, loss of culture, and a deep mistrust of the medical system. Given this context, Inuit focus group participants sometimes saw formal care contexts as part of ongoing colonial intrusions that risked further disrupting Inuit care relationships. Some described not wanting to participate in the colonial system and only seeking assistance in extreme need or emergency. “We are trying to just care for ourselves,” one woman said, noting the harms caused by non-Inuit “trying to say what is good for us.”[81]

A 2024 report by the Nunavummi Disabilities Makinnasuaqtiit Society, the only Inuit cross-disability organization in Nunavut, similarly warned:

> *Homecare or health services delivered by non-Nunavummiut (often on short-term contracts) may be seen as eroding the networks of care that keep communities strong.... Caregiving in Nunavut is not just about attending to immediate needs; it is about preserving the fabric of the community, maintaining cultural integrity, and ensuring that care remains a natural and respected part of daily life*.[82]

E. Governance and Funding of Care and Support Services in Canada

1. Home and community care services

Home and community care services are regulated and delivered at the provincial, territorial, and municipal level in Canada.[83]

The federal government provides funding for health and social services through transfer payments to provinces and territories. The Canada Social Transfer (CST) is largely intended to support education, childcare, and social assistance. Provinces and territories are not required to report on how CST funds are disbursed.[84] The Canada Health Transfer (CHT) provides funding for health care, and the Canada Health Act defines the health services each provincial and territorial health insurance program must include to qualify for federal funds.[85] The act only requires coverage for medically necessary hospital, physician, and certain surgical-dental services, not home and community care services or mental health care.[86]

However, the federal government has committed "directed funding" to support mental health and community care services in the provinces and territories.[87] The 2025 federal budget projected C$1.2 billion per year in transfers supporting home and community care and mental health and addictions services set to expire after 2026-27.[88]

The federal government bears the primary responsibility for delivering home care services to First Nations people on-reserve and Inuit in designated communities. Indigenous Services Canada reports C$417.03 million in program spending for home and long-term care in 2024-2025.[89] The federal government further committed the following funds over 10 years to address Indigenous health disparities in the 2023 budget:

- C$350 million, given the added costs of medical travel and delivering health care in the territories; and
- C$2 billion, given the unique challenges Indigenous peoples face regarding access to quality and culturally safe health services.[90]

However, ongoing jurisdictional disputes that occur for Indigenous peoples between provincial, territorial, and federal governments, have proven to be extremely detrimental to Indigenous people attempting to access healthcare and disability-related services.[91] Despite federal funding commitments to programs that seek to address the uncertainty in support for specific groups such as Indigenous children with disabilities,[92] the actual administration of support frequently falls short.[93] The patchwork of responsibility can result in Indigenous people not receiving the services they require and contributes to ongoing health disparities between Indigenous and non-Indigenous people in Canada.[94]

Budget 2019 provided C$8.5 million towards a First Nations and Inuit-led engagement on a new approach "to better support First Nations and Inuit individuals living with chronic illnesses and disabilities," which was conducted in 2021-2022.[95] As of May 2025, the federal government was still working with Indigenous communities and organizations to develop a Long-term and Continuing Care Framework.[96]

Budget 2025 also announced the government's intention to undertake "a comprehensive assessment of health care and health infrastructure needs in the North" to identify ways to reduce medical travel costs.[97]

The challenges for financing and delivering needed care and support services in northern communities are well-documented. In Nunavut, for example, the territorial government provides home care based on a "comprehensive assessment … to determine the level of care and services that are required."[98] An individual can refer themself to the program or "be referred by a health care professional or a family member."[99] For people with disabilities, home care in Nunavut is focused on helping "increase their level of functioning

or self-care so that they can function without the supports of home care services."[100] Home care is framed as something to be temporarily available to increase recovery rather than recognizing some people will always need it.

Although individual assessments are intended to identify and facilitate the provision of needed services, a territorial needs assessment concluded that the "provision of home and community care services is inconsistent across the territory" with "at least one community in which no home care is available due to the inability to recruit home care staff."[101] Thus, even when an individual has been identified as requiring specific support services, these services may not be forthcoming.

According to the territorial government, the unavailability of home and community support services is largely due to limited resources:

> Lack of capacity and resources to provide quality care is an ongoing challenge and affects Nunavut's Home and Community Care program … it faces significant staffing challenges related to nursing staff, as well as para-professional staff.[102]

The territorial government acknowledged that its lack of capacity and resources puts demands on families to fill the care and support gap, pointing out that "families play a significant role in the delivery of community care across the territory."[103] Yet this acknowledgment overlooks that many family caregivers are themselves people with disabilities who also need care and support.[104] In reality, the situation is more complex: women with disabilities, in particular, are often both caregivers and recipients of care. When adequate care and support are not available for them, they cannot fulfill the caregiving role on which the government relies.

2. Individual Disability Benefits and Transfers

The federal government offers tax credits, including the Disability Tax Credit, the Home Accessibility Tax Credit, and other deductions for persons with disabilities, their supporting family members, and caregivers, as well as a Registered Disability Savings Plan (RDSP) which includes government funded grants and bonds.[105]

It also provides several forms of direct financial support for people with disabilities, including:

- The federal Disability Tax Credit (DTC) provides some tax relief for people with disabilities and, in certain circumstances, family members who support them;

- The Canada Pension Plan disability benefit, a taxable benefit for eligible people who are unable to work because of a disability, amounting to C$1,198.66 per month on average in 2025;[106]
- The Child Disability Benefit, a tax-free benefit for families caring for a child with a disability, amounting to up to C$284.25 per month;[107] and
- The Canada Disability Benefit, introduced in June 2025, for people with disabilities between 18 and 64, with payments up to C$200 per month starting in July.[108]

Advocates have long raised concerns about the limitations of the DTC, which presents numerous barriers to access, including a complex, bureaucratic application process.[109] As a non-refundable tax credit tied to eligibility criteria and taxable income, it does not directly address the substantial out-of-pocket care costs, lost earnings, and longer-term financial insecurity experienced by people with disabilities and many caregivers.

Part of the DTC application must be completed by a medical professional, access to which is severely limited across Canada. In June 2024, the College of Family Physicians of Canada called on the federal government to "relieve medical practitioners of this obligation," noting that six million Canadians lack access to a regular family doctor, the application's administrative burden compromises access to care, while the financial cost of completing DTC forms is often passed on to patients.[110] Even though the government, and as well civil society organizations, offer free support to fill out the DTC application,[111] the complexity and administrative burden can lead individuals to seek support from costly private organizations.

For people with disabilities, the DTC is an essential access point to other federal programs, including the Registered Disability Savings Plan, the Child Disability Benefit, and the Canada Disability Benefit.[112] But the Canada Revenue Agency's Disability Advisory Committee notes, the DTC "remains underutilized," with only one quarter of eligible people with a disability submitting a completed DTC application.[113] Recent Statistics Canada analysis, meanwhile, found that over 60 percent of persons with "very severe" disabilities did not claim the DTC.[114]

In Budget 2025, the federal government recognized that applying for the DTC presents a barrier to access for some and committed to providing a one-time supplemental payment of $150 for each DTC certification or re-certification that gives rise to a CDB entitlement to be made available before the end of 2026-2027.[115] In a letter to Human Rights Watch, Minister of Jobs and Families Patty Hajdu, flagged steps the Canada Revenue Agency has taken to make the DTC application process easier for people with disabilities and medical practitioners, including launching a fully digital application process in 2023, having DTC Navigators within each CRA tax center to assist individuals and their representatives with complex DTC cases, and expanding the list of medical practitioners eligible to certify the application.[116]

Provinces and territories are also responsible for administering disability assistance and other social assistance programs, which are partially funded by the federal government through the Canada Social Transfer.[117] In most jurisdictions, eligibility for benefits is determined by a combination of the duration of disability and income-based means-testing.[118]

The punitive means-tested design of many disability benefits programs effectively discourage people with disabilities from participating in the labour market. Programs like the Ontario Disability Support Program impose strict income limits and deductions that can result in the loss of benefits for earning beyond a very low threshold.[119]

Research by NSI underscores that there are many barriers to accessing federal and provincial/territorial benefits – restrictive eligibility, lack of information, complexity of systems without help to navigate them. All of these barriers are compounded for diverse people with disabilities due to language and cultural barriers, as well as the lack of outreach and communication strategies that are trauma-informed and population-specific.[120]

Summary

There is a strong foundation for a rights-based approach to examining the place of women with disabilities in the care economy in Canada. The emerging recognition of the right to care – including the rights to receive care, provide care, and exercise self-care – finds a home in within international human rights standards, particularly the CRPD and the ILO's decent-work framework. Within this context, it is essential to emphasize the CRPD's shift away from models that cast people with disabilities as passive dependents toward support systems that enable autonomy, dignity, independent living, and participation in the community.

Despite this human rights framework, there is a deeply gendered structure to the care economy: women perform a disproportionate share of both paid and unpaid care work, while racialized, migrant, Indigenous, and other marginalized women experience intersecting inequalities. Canadian data demonstrate that women with disabilities occupy a particularly important and often overlooked position within this system – as providers of paid and unpaid care as well as people who may themselves require care and support. Canada's fragmented system of federal, provincial, territorial, and Indigenous jurisdictional arrangements for the funding and delivering of care, support, and disability benefits, determines whether people can obtain the supports necessary to enjoy and exercise their rights.

II. Research Framework

The research for this report was conducted by New Society Institute, a Canadian organization that focuses on the rights of systemically marginalized populations grounded in the experience of disability, in collaboration with Human Rights Watch, an international human rights non-governmental organization.

New Society Institute hosted eight focus groups from June through August 2024 with 49 participants from diverse communities, who were recruited through local community networks across Canada. The aim was to gather insight about their understandings of "care" and experiences of receiving and/or providing care and support. Thirty-six participants were women, including 3 trans women, who identified as having a disability and/or chronic health condition. Of these 36, 12 had work experience in paid care and support contexts, and most engaged in unpaid care work: as mothers (13), caring for family other than children (4), and volunteering in community and disability services (7).

A focus group approach was used to ensure participants' comfort, be inclusive of the access and support needs of different types of disabilities, and explore shared experiences, collective meanings, and a diversity of views. Participants supported each other in communicating and took time to share knowledge and support access to resources outside of the focus groups.

Five focus groups were held, including 36 women and 3 trans women with a range of disabilities. Two participants did not disclose a disability. Four of the focus groups were in person in English in Iqaluit, Nunavut; Saint John, New Brunswick; Toronto, Ontario; and Winnipeg, Manitoba. The focus group for participants in Montreal, Quebec, was in French and was hosted online at the request of participants. Following guidance on creating a culturally appropriate space for sharing in Iqaluit, that focus group was hosted as a beading workshop with an Indigenous Inuk artist.

Researchers gathered input over three additional online focus groups from unpaid caregivers and paid care providers—with and without disabilities—who work in disability support contexts, including personal support workers, direct support professionals, and group home and long-term care workers. These included 18 participants, including 2 women who had also joined the Toronto focus group. Researchers interviewed an additional participant separately who could not attend a paid care provider focus group.

The online focus groups used captioning and Sign Language interpretation as needed. Simultaneous French interpretation was provided as needed.

TABLE I: FOCUS GROUP DISABILITY REPRESENTATION

Type of Disability	Number of Occurrences[121]
Physical[122]	15
Intellectual/Cognitive[123]	17
Psychosocial[124]	7
Deaf women	8
Chronic health condition[125]	4
Unspecified	4

TABLE II: FOCUS GROUP GEOGRAPHIC REPRESENTATION

Participants from	Number
Ontario	14
Quebec	10
Manitoba	7
New Brunswick	7
Nunavut	7
Alberta	1
British Columbia	1
Nova Scotia	1
Yukon	1

The research has a few key gaps. Because of our city-based approach, researchers were unable to ensure substantial representation of people with disabilities living in rural or hard-to-access places. Researchers also could not ensure good representation of people with disabilities living in institutional settings, who may be restricted in being able to choose where and how they spend their time. People aged 65 and older play a substantial role in unpaid caregiving but were not well represented among our participants. Finally, while researchers recruited women and gender diverse people as focus group participants, recognizing that gendered expectations of care do not only impact women, no one self-identified as gender diverse. Thus, the research findings are restricted to women, including trans women.

Each focus group was semi-structured and approximately 1.5 hours long. Researchers informed participants of the focus groups' purpose and voluntary nature and how their accounts would be used. Participants were promised anonymity in publication. In keeping with its policy, Human Rights Watch provided no compensation to participants. In accordance with the Canadian Human Rights Commission's guidance on compensation for engagement, New Society Institute paid participants C$90 each.[126]

To supplement the focus groups, we reviewed publicly available government data and research on gender and disability in the care economy, including in particular research by disability justice advocates who critique and give nuance to understandings of care.

Human Rights Watch also interviewed 17 civil society representatives and academics working at the intersection of gender and disability.

Human Rights Watch sent letters to federal, provincial (Manitoba, New Brunswick, Ontario, Quebec), and territorial governments (Nunavut) in November 2025. The letters provided a summary of Human Rights Watch findings, included specific questions for the government, and offered to reflect the government's response in the report. At time of writing, written responses were received from Federal Minister of Jobs and Families Patty Hajdu and Manitoba's Deputy Minister of Families Michelle Dubik. No written response was received from the New Brunswick, Ontario, Quebec, or Nunavut governments.

III. Findings

> *What is care? What comes to mind is an act that responds to a need… And since it meets a need, it seems to me that sometimes we miss the point by forgetting the need, by forgetting the person receiving the care, by forgetting the constant dialogue that needs to take place between the caregiver or the institutions providing care and … the person [receiving care].*
> —Quebec woman with a visual disability, June 2024

The focus group research identified five main themes from the accounts of personal experience shared by women with disabilities and paid support professionals, many of whom were women with disabilities themselves. The main themes are:

- There are major barriers to accessing needed care and support.
- Concerns about the quality of care and support services.
- Care and support work by women with disabilities and Deaf are unrecognized and unsupported.
- Poverty and core housing needs undermine self-care.
- Women with disabilities are excluded from policy and program designs.

A. Barriers to Accessing Needed Care and Support

Access to care and support by women with disabilities and Deaf women was limited by the inadequate availability of these services, particularly in rural and Northern areas. Home care services, however, were largely unavailable across all regions studied. Other challenges also created barriers to accessing care and support where it was ostensibly available, including the time burden, as well as the physical and financial cost of access; difficulty obtaining a diagnosis when needed to access care and support or receive reimbursement for utilizing these services; informational barriers; and restrictions by service providers on those with perceived other, informal care and support options. Additionally, participants spoke about barriers stemming from social discrimination and exclusion.

These barriers make it far more difficult for women with disabilities and Deaf women to access paid care and support, and in doing so, increase the demands for their unpaid and paid care work.

Seven main barriers were identified:

- Restrictive eligibility requirements;
- Burdensome requirements to access care and support;

- Difficulties obtaining official recognition of disability;
- Lack of information and coordination support;
- Lack of supports (particularly in Northern and Inuit communities) and resorting to institutionalization;
- Inaccessible and costly transportation services; and
- Discriminatory treatment and exclusion.

1. Restrictive eligibility requirements

Some participants shared that service providers denied them access to needed support services because they had family who, in theory, could help them. A woman with disabilities in Quebec explained:

> It's a double-edged sword, because often in the services, when you know that the person has a close caregiver, they want to cut the services, they want to say, "yes ma'am, you could do that, couldn't you? For your mom?".... It's as if you gain from having a caregiver and after that, you lose a little bit.

A woman with disabilities in New Brunswick gave a specific example. "Assistance won't even help me because my son is helping me," she said. "I feel bad for him, here he is in his 30s, why should he be taking care of his parents? He should have his own life."

2. Burdensome requirements to access care and support

Across the focus groups, participants indicated that the time consuming and complex bureaucratic nature of the application process and arrangement of home care was itself a barrier to access which left women physically, psychologically, and financially exhausted.

Many participants noted the heavy toll of paperwork and regular medical assessments to "prove" disability-related needs to access government benefits. "There's just so many barriers all the time for people to get support," one woman with disabilities said, explaining that there are "copious amounts of forms, and then if you miss one box, you've got to start over, and the wait is 24 months." One Indigenous woman with disabilities recounted the years she has spent trying to access the Canada Pension Plan (CPP) disability benefit, a monthly payment for people who have contributed to the CPP while working but can no longer maintain employment because of a disability. "I've gone through specialists, my doctor, got all the information that [the CPP] needed, and they still denied [me] because it wasn't up to their standards," she said. "I went through a tribunal, they okayed it, now it's up to the CPP. If they don't OK it, [the application] goes back and could be another three years." This process has taken a toll on her well-being. She shared:

> I've been working since I was 9. For me not to work, it really bothers me. I'm going to swear, I … worked for this all my life, for them to turn around and say "no, you're not getting this" …. Is it because I'm Native? Because I'm not disabled enough? There are times [when] I sort of gave up, but thank goodness, my son won't let me give up.

Women with disabilities and Deaf women highlighted challenges accessing the Disability Tax Credit (DTC). Some said cost was an obstacle to assembling the necessary documents, including travel costs to collect needed documentation, and the high cost of paying a third-party to help navigate the application process.

3. Difficulties obtaining official recognition of disability

An official diagnosis or assessment is sometimes necessary to access care and support. Participants indicated that accessing a diagnosis can become a barrier to care and support as it's often burdensome to obtain a diagnosis. One woman explained:

> When it comes to services, you have to fit into the little box. But if you're not in the little box, you don't have access to such and such care or access to such and such material assistance…. The most important thing is that care and services should always be offered with the patient's needs in mind. Not with the aim of responding to a diagnosis and a little box you can tick on a form.

Participants further observed that getting diagnosed was a deeply gendered experience. Regarding physical health, gender influenced whether symptoms were taken seriously. Some women described how their illness or disability was sometimes minimized or completely disregarded. As one woman said, "It's like woman equals more hysterical so it's in the head." Some women said healthcare professionals accused them of "faking" their disease or disability to get attention or told them to simply push through their pain and discomfort. One woman recalled how her doctor dismissed her fatigue and other symptoms after a bout of COVID-19: "I had a doctor in internal medicine, who told me just to start doing sports again, to go back to work, that everything would be fine."

Women with myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), a chronic, multi-system disease, had unique challenges with having healthcare professionals recognize and validate their symptoms. One woman with ME described this obstacle:

> It takes years [to get an ME/CFS diagnosis], and it's important to get it in order to have access to services and financial assistance, but that's the issue: It's how, where and when to get a diagnosis. It can be very complicated.

The struggle of one woman with ME/CFS to get her local hospital to recognize her condition has been crushing. The hospital diagnosed her with bipolar disorder. She said the hospital thought she was "emotional" and gave her this diagnosis which does not align with her family doctor's assessment. She is now fighting to have BPD removed from her records. “I don’t even want to go to hospital anymore, I’d rather die at home,” she said.

Neurodivergence also has gendered dimensions. Neurodivergence often appears differently in women than in men, and women are often diagnosed later in life. However, adult assessments can cost thousands of dollars and be difficult to afford in Canada as government health plans rarely cover them.

Stigma and resistance to the medicalization of a diagnosis can also present barriers to seeking an assessment, which can have repercussions for the individual and their family in accessing care and support. One woman in the Iqaluit focus group explained how her child does not want to be assessed for Autism, but this means her child does not qualify for certain services and that she does not receive financial support for her care work since he came of age. While requiring a diagnosis may be reasonable to access support services, it is essential to design assessment systems with the input of those who the programs will benefit. Women with disabilities should have the opportunity to provide input into the design of care and support policies. Their input would help ensure that services are more likely to reach those who need them most.

One woman who identified as having Autism and ADHD shared her conflicted feelings about the diagnosis:

> *Whether I had a diagnosis or not, the need [for care and support] is there regardless…. I know people who have needs …who unfortunately don’t have the chance to have care adapted to their needs because they don’t have a particular diagnosis. I think people should still have services specific to their needs even if they don’t have a diagnosis.*

4. Lack of information and coordination support

Across the focus groups, participants reported difficulty accessing clear information on what care and support programs and services were available.

“I didn’t know who to turn to for help, they give this number and that number,” one Inuk woman with disabilities shared in the Iqaluit focus group. “The government doesn’t tell you anything. You have to do your homework,” said a woman with disabilities in Toronto. Research by NSI underscores that information barriers are compounded for diverse people

with disabilities due to language and cultural barriers, as well as the lack of outreach and communication strategies that are trauma-informed and population-specific.

Focus group participants' confusion about where to go was magnified by lack of coordination among health and social services. One woman with disabilities unpacked the problem: "The lack of coordination between the different players and different doctors and different organizations and so on … leads to a lot of difficulties, a lot of battles that take away a lot of energy. It's detrimental to the well-being of people with these needs."

Paid care workers also described the exasperation of navigating a "patchwork" system of care and support programs and not being able to connect clients with the supports they need. Figuring out what services are available "is difficult enough as it is," one disability support professional shared. Adding intersecting identities or marginalizations "complicates matters further and makes it even more difficult to understand what services exist and how to navigate them."

Although most focus group participants identified the lack of information as a significant problem, some women with disabilities in two focus groups reported encountering staff and advocates who connected them with resources. One trans woman, who had served in the military, shared how a veterans advocate connected her with financial supports and services she was entitled to but unaware of. Another woman recalled how an out-patient counselor ensured that her rehab program would be covered by provincial health insurance so she could afford to attend. "I really owe her a lot, it saved my life at the time," she said.

5. Lack of supports (particularly in Northern and Inuit communities) and resorting to institutionalization

Women with disabilities reported immense challenges they face because of the unavailability of needed health and home care.

For some, particularly for those in rural and Northern locations, the healthcare they needed was not available in their community. Some spoke about the difficult choices they must face when they are unable to get the support they need locally. They stressed the difficulty of having to choose between moving away to obtain care and thereby losing their community network or staying in their community and losing access to care. "If I wanted more care [advanced cancer care], I'd have to leave my little town and move," one woman in New Brunswick said. "But I'd lose the few friends and relationships I have left." Having access to the care she needs "would be life changing, maybe I'd start working again," she said.

Women in the Iqaluit focus group expressed similar challenges, noting that to access advanced health care of any kind, they would need to leave Nunavut and travel thousands

of kilometers to Ottawa or elsewhere at high personal cost, risking loss of culture and community. Family and community are essential caregivers in Inuit society. “Care is ingrained in our Inuit society, to never leave anyone behind,” one woman explained. Nevertheless, participants in the Iqaluit focus group recognized a need for formal home care services to ensure all care and support needs are met. One Inuk woman, for example explained that she needed help to shower and maintain personal hygiene, but her children were too embarrassed to help her and home care was not available. One Inuit woman mentioned that the lack of home care means that Inuit women with disabilities must learn to do things themselves or do without. People with intensive support needs, meanwhile, are left to wait for admittance to one of the territory’s three long-term care facilities or they are forced to leave the territory.

Participants in three focus groups particularly emphasized needing and not receiving home care. Home care can encompass a variety of support services that enable people to live independently at home, from assistance with daily activities like personal hygiene and eating to support with taking medications and administering health needs. According to a Quebec woman with disabilities, unavailable care and support creates a vicious cycle of deteriorating health and well-being and increased needs: “If there’s a lack of care, I need it even more, and I have even less.” Another woman with disabilities in Quebec explained that home care is essential, as “we’re not always able to leave our homes.” For her, losing access to a care worker who was able to visit her at home has meant losing a fundamental support: “I had a social worker who came to the house. Poor her, she fell ill for an indefinite period so I'm now a file on a desk [with] a social worker … a long way from home. I no longer have any help.” To access more care, she explained, she would need to leave her town, and risk losing “the few friends and relationships I have left” as well as the support of a doctor who “finally understood” her condition.

As noted in Section I, inadequate home care programming can also result in institutionalization being the only available option to obtain care. A community service navigator from Manitoba who provides support to people with disabilities confirmed this outcome:

> If I sustained a stroke right at this moment, I would have two options in this province. I either could live in a long-term care facility, where the goals of care are not at all appropriate for a 35-year-old to get back activities of daily living and independence. Or … I would be entitled to up to 55 hours a week of home care through our Manitoba health funding.… The idea that I would actually receive that care is not realistic whatsoever. I would be told by the government that I’m lucky to receive half of that. With a lot of the people with disabilities that I support, that’s a big crack that they are falling through.

6. Inaccessible and costly transportation services

Accessing transportation is a major barrier to obtaining needed care and support. Transportation services are costly and physically inaccessible but are needed to make applications, obtain assessments, get to workplaces (including care work), and apply for or arrange needed supports such as housing. Many women with disabilities described the difficulty of physically accessing needed care and support within their communities due to lack of accessible public transit and the difficulty or cost of travel. An Inuk woman in the Iqaluit focus group said even going to a food bank is difficult because of the lack of public transportation and expensive cost of cabs.

Sometimes the journey to access care or support is too physically taxing. A woman with disabilities in Quebec weighs the benefit of care and support with the journey's negative impacts:

> It's always a question of energy to know, in the end, is my appointment going to bring me more than it's going to take away? Every journey, every action often puts us in a state of post-exertional discomfort: is it really worth it? When I know that just the journey, sitting in the waiting room with the noises, sounds, smells, light … the journey to my home, in the end, won't I make my condition worse, that I'm just better off not seeking help?

A woman with disabilities in Toronto who is unhoused described the ordeal she faces travelling to provincial service offices to access care and support and as part of her housing search. Not only is the travel exhausting for her, but she also often does not return to the shelter where she lodges in time to eat. On those days, she just goes to sleep without eating. On the day of the focus group, she said her only meal would be the food served there.

Her search for housing is particularly onerous and time-consuming. But as one of almost 105,115[127] people on the city's waiting list for social housing, when an opportunity comes to view a potential home, she must move quickly.

By contrast, two participants in the Toronto focus group described how having access to a centralized care hub was extremely beneficial. "Last year, I finally found an amazing doctor, nutritionist, and therapist that's accessible. Everything's right in the same building," one said. "I'm getting a lot of care now."

7. Discriminatory treatment and exclusion

Discrimination and prejudice against people with disabilities are pervasive in care and support systems. Service providers may have preconceived ideas of what people with disabilities need and frequently deny them the agency to make decisions related to their needs and desires. Paid support workers, as well as women with disabilities themselves, stressed that they must routinely engage in advocacy to counter such ableism. One provider said: "I've had to advocate very strongly," noting it was particularly so when it comes to women with disabilities.

Paid care providers in two focus groups said some healthcare providers do not make medical procedures accessible or do not want to provide care because of bias or prejudice. One paid care provider said that some healthcare professionals outright deny care based on false understandings of disability. She recounted an example of a dentist refusing to manage a person with disabilities' pain. While accompanying a client to receive dental surgery, she asked how the dentist would support pain management:

> The dentist literally said, "Oh, well, they don't feel pain." And I was shocked. Like, is he kidding or joking? I could not believe it.... I was like, of course they do! What are you talking about? They are human beings, of course they feel pain!

One woman with visual disabilities from Saint John said on the day of the focus group, a city bus driver would not lower the ramp so she could safely board. Saint John's bus accessibility policy is targeted at people "with mobility impairment, who typically find it difficult to board the bus." "If they can put a ramp down for someone in a wheelchair, they can put it down for a blind person," she said

In addition, women with disabilities in two focus groups described being judged negatively and being denied services when they expressed particular care and support needs. An Indigenous woman in Toronto was frustrated that healthcare professionals questioned her preference to seek culturally appropriate care, saying: "[t]hey don't respect if you want to do the thing holistically. I have healthcare professionals say to me 'well, why are you coming to me if you want to see an Indigenous healer?'" Another woman said she lost access to home care when she refused to wear support stockings because of a health condition that makes the skin on her legs very fragile:

> The [provincial agency] stopped taking care of me at home because I didn't want to wear [support] stockings ... My legs are very, very fragile ... as soon as you took the stocking off, the skin would follow, and that would cause wounds ... I had an amputation on my left leg precisely because of things like that: because I had a sore that didn't heal, you know. Then they decided to cut it off, there was nothing more to be done, the infection kept coming back. I've got one [leg] left. Can you manage to save that one?

Her dermatologist also advised against wearing support stocking, but she still cannot access home support again. People have the right to decide what kind of treatment they want without losing access to the services they need.

B. Concerns about Quality of Care in Support Services

Women with disabilities and Deaf women who participated in the focus groups identified ways they experience care and support across a complex network of relationships. They emphasized that, ideally, there is an approach to support and care that recognizes human interdependence and connection. An overall theme was that care should encompass all needs, including food and shelter, physical and mental health, financial support, and support for daily living activities. In other words, "care" is an essential tool for rights fulfilment.

Yet, these ideals are far from the current systems of care. Focus group participants emphasized the critical need for increased resources in the care and support sector. They also stressed the need for action to address disability stigma and discrimination, particularly when layered with anti-Black, anti-Indigenous racism and anti-immigrant sentiments. Further, focus group participants also pointed to the need for more services "by and for" people with disabilities, with diverse representation, including culturally appropriate Indigenous care and support.

Some women with disabilities shared positive experiences with specific care workers who worked above and beyond to ensure their care and support needs were met. One woman said, "I'm feeling very well because I have a wonderful person working in my home this morning." However, the widely shared sentiment was that the labour of any excellent individual care workers was not enough to overcome larger, systemic barriers to care and support.

Four main concerns about the quality of care and support were identified:

- Under-resourcing of care and support.
- Stigmatizing language and framing of care.
- Having to constantly self-advocate and bear the consequences.
- Services not designed to foster autonomy and self-determination.

1. Under-resourcing of Care and Support

Paid care workers shared their frustration that the lack of funding and other necessary resources compromised the quality of care and support they were able to provide, while also increasing the risks of burnout and overwork for them.

Resources are lacking across the board, one provider explained:

> *We are lacking financial resources: We are never paid enough for the work that we do. We lack human resources: We have caseloads that are overflowing. There's a lack of building resources: I don't have enough group home options for clients that are in need. We lack IT resources. The resources we have are ridiculous. I have a phone that is so bad I don't even use it. I have a computer that won't connect when I'm in rural areas, and I work in rural areas. It makes no sense.*

She also attributes clients' long wait times to access care and support to inadequate resources. She gave an example of a client who needed help with a college's admissions process, but she only got the file 3.5 years later. Meanwhile, the school program in question only lasts two years.

Another care worker observed that the system is focused on provision of short-term care and support. She stressed that there is an assumption that "people are supposed to go into a service, use a service, and move out. But some people with ongoing issues can't do that and are going to be in the system for the rest of their lives." The "bean counting of every little function means that people do not receive the care they need that can reduce the need for more serious intervention later."

Women with disabilities in three focus groups described how service providers' practices limiting care and support compromised the quality of care and support they received. For some, support agencies could not allocate staff to support them for the number of hours they felt they needed each week. Even if the needed hours were secured, some women with disabilities perceived the support person as being in a rush and under time pressure. One woman with disabilities in the Montreal focus group described feeling like the care workers who came to her home to provide support did not have time to engage with her as a person: "[Their care] lacks humanity or listening. They have too much tunnel vision."

Having to interface between client needs and inadequate resources is a significant source of stress for paid care workers. One support worker observed that people often assume the difficult part of her job is the people she supports or the nature of support work itself. In reality, she found that the lack of ability to provide that support "definitely takes a toll on me in a negative way." She continued: "It is hard to do my job if all of those other things are

not contributing." Another paid caregiver likewise observed, "It can be one of the most disheartening things to tell people that there's practically nothing for them."

Support workers highlighted how the lack of program resources impacted not only what they could offer clients, but also the quality of care they could provide themselves, which contributed to burnout. Many wore "a variety of hats," having to cover multiple programs or areas of work to fill capacity gaps. One provider described the absence of support for care and support workers this way:

> We are all overworked, burnt out, with things constantly on our plate. You're kind of in the state of juggling things around every day and you adjust to the fact that this is your life now. Who supports the support worker? That's the question I'm thinking about all the time. You have to rely on yourself a lot.

One group home worker explained why good care and support work requires "having a full team behind you." She continued:

> Then you know that you do have a team to go [to] with your concerns, who's able to connect you with those proper resources … just having that team approach so it's not just one person chasing all these leads and trying to tie up loose ends. It's that team approach to best support both the care provider and the client.

2. Stigmatizing language and framing of care

Many participants pointed to how diagnoses, characterizations of the "needs," and disability stereotypes directly affected their personal self-perceptions and the quality of care and support. Women with disabilities in three focus groups expressed that navigating Canada's current care and support system was dehumanizing and that meaningful "care" was rare. According to one woman with disabilities, it is "like a cold system where everyone's a number. You forget about the human being in all this. And their rights too."

Women with disabilities emphasized the importance of an approach to care that recognizes human interdependence and connection. Participants in five focus groups believed a good care relationship is premised on "teamwork," mutual caring, and a focus on support. One participant explained that support means rather than "doing it for them, helping them do what they need to get done." For everyone's care needs to be met, there "has to be care everywhere."

Paid care workers who participated in the focus groups emphasized that care work should be "person-centered" and focused on respect for individual agency and dignity. Many paid care providers, especially those providing direct support, stressed the importance of

distinguishing between “care” and “support.” One provider explained that the term “care” is more associated with work to meet people’s basic needs, including regarding their daily living activities. “Support” considers how a person moves through life and what they need to be able to achieve their goals.

3. Having to constantly self-advocate, and bear the consequences

Women with disabilities in four focus groups similarly recognized that accessing care and support required considerable self-advocacy to get providers to overcome their initial perceptions and stereotypes. Several women in the Montreal focus group described their personal struggle for care and support services in terms of the “fight.” One woman described dealing with “all the research, all the requests, all the explanations” necessary to obtain care and support as “fighting battles.” “We have to fight again and again to get so many services,” another said. One woman was surprised by this additional burden: “I could never have imagined the extent to which I would have to fight to receive care.”

Several women with disabilities described the self-advocacy they have been forced to undertake to access care and support, not just for themselves but for others, as a form of unrecognized care work. One woman explained:

> In all the battles I’ve fought—my God, I’ve fought some—I’ve always said to myself that if I fight this battle, others will follow for whom it will be easier. Yes, it takes a lot of energy, it’ll knock me down for days or weeks for certain things.... I think it’s important, even if you’re ill, to always remember that the battles you fight will help other people too.

But self-advocacy, like other forms of care work, can come at a significant personal toll. “It’s really heavy, at times draining, to educate people when you go in for different services,” one woman explained. Another woman with disabilities remarked: “For people who have to constantly be activists for themselves, you know, we’re leaders, involved in many things, but at the same time, we’re not necessarily doing well all the time [ourselves].”

According to women with disabilities in three focus groups, self-advocacy can sometimes result in serious backlash, including the denial of further care and support. One woman who identified as a “survivor” of the mental health care system described the risk of standing up for oneself in mental healthcare settings: “If you go to a hospital, they prefer for you to be as passive to care as possible. As passive and non-decision-making. And if you do fight for your rights, you get that added to your label to make you even more unwelcome.”

4. Services not designed to foster autonomy and self-determination

Paid care providers observed that formal care and support systems are often not designed to respect the agency and decision-making capacity of people with disabilities and Deaf persons. They emphasized that care work should be "person-centered" and focused on respect for individual agency and dignity. Yet, as one paid care worker explained:

> Usually, people with disabilities don't get to choose what PSW [Personal Support Worker] comes, if that PSW is any good, or if they have a good relationship with their worker or not … and the person with a mental health disability is often overridden … often the power is taken out of their control.

Paid care workers also described trying to respect their clients' wishes when confronted with differing directions from family members and agencies. "You're kind of caught between two fires," one paid staff shared. "It gives me anxiety to think how to navigate through all that."

C. Care and Support Work by Women with Disabilities and Deaf Women Unrecognized and Unsupported

In addition to the care and support they receive through self-care, and from family members, friends, volunteers, peer support, and paid care, many women with disabilities and Deaf women recounted experiences of the care and support they provide. This included various roles and contexts – as unpaid family members, as mothers, as Indigenous women in communities still reeling from the legacies of colonialism, as paid workers, and as peers.

Five main sub-themes were identified concerning the paid and unpaid caregiving work women with disabilities undertake:

- Unsustainable demands of family caregiving work.
- Indigenous women with disabilities as carers experience cultural stigma and barriers.
- Mothers with disabilities and unsustainable care work.
- Necessity of recognizing informal peer support care work.
- Disability representation as essential to effective caregiving and barriers to the paid labour force.

1. Unsustainable demands of family caregiving work

Focus group participants shared their experiences doing significant unpaid care work for their families, particularly for older parents and children, as well as unpaid community care

work as peer supporters. Demand for this unpaid care work is exacerbated when government support is inadequate as described by the women who participated in the focus groups

Several women with disabilities said they were the only ones who could provide care and support for older parents when they became sick or acquired a disability. One woman with disabilities recounted how she took care of her mother when she got sick, recalling that she would “change her, wash her, feed her, soothe her when she had her episodes. It was me because no one else could, she trusted me.”

A woman with a visual disability explained the unique dynamic of the mutual, evolving caregiving between her and her mother. “She was my caregiver when I was already an adult, because of my visual limitations, which at first were not diagnosed,” she said. “I had difficulty functioning in life. I needed her.” When her mother developed motor limitations from severe osteoarthritis, she became her mother’s caregiver and supporter. Their caregiving was reciprocal, and “even to the end, while I was giving her a lot of different help, I could still say listen, what’s written there? because I can't see.”

Many participants recounted experiences of caregiving work. However, they are acting as caregivers within systems that define people with disabilities only as needing care and support and people without disabilities as care providers. Women with disabilities who provide care are therefore often perceived and treated as incapable of providing care, impacting their daily tasks and the lives of the people who rely on them, parents, children, and adults with needs for care and support. Because they are perceived this way, many expressed that the demands of the caring and support work they do go unrecognized and unsupported; and are therefore largely unsustainable.

2. Indigenous women with disabilities as carers experience cultural stigma and barriers

Indigenous women participants also underscored the importance of cultural representation in care and support. One Indigenous woman shared the impact she observed facilitating access to culturally appropriate care: “For me it’s a very powerful thing: the women and the kids I’ve connected with these cultural services … it gives them a sense of empowerment and connection to culture.”

However, because of cultural values and colonial trauma, many Inuit women undertook care work outside of formal, paid contexts. According to one woman, “We are not care providers for money. We are not materialistic at all. It is so ingrained in us to give what a person around you needs in that moment.” At the same time, Inuit women asserted that the government should be subsidizing people and supporting them.

Inuit women in Iqaluit also shared fears about facing repercussions for providing unlicensed care and support. Mothers and elders provide essential and quality care and support, based on their own lived experience and expertise, including related to mental health, amid a lack of accessible and culturally safe options. But they are reluctant to be identified, fearing the government will penalize them for delivering care and support without formal licensing.

3. Mothers with disabilities and unsustainable caring work

Women with disabilities with children highlighted how disability and societal ableism impacted them as caregivers as well as their children and created additional care work demands.

i. The threat of losing parental rights

Parents with disabilities experience unique challenges due to systemic ableism. Women with disabilities in three focus groups reported facing judgment about their capacity to parent and, in some cases, the threat of losing custody of their children.

One woman with an intellectual disability whose daughter has a disability said people ask "how can you be a good mom?" because of her disability:

> They're like, "well, you have a disability, you don't know what you're talking about." Excuse me? I know what I'm talking about. I understand. I have a disability, so I know what my daughter is going through, not you.

Another woman shared how disclosing that she, like her daughter, has Autism resulted in more exclusion and judgment at her daughter's school. "They used it against me," she said. "It very much affected how they treated me, how they worked with my daughter, and how they communicated with me." Her input was devalued: "Instead of realizing that I had lived experience, that I understood what she was struggling with." Now she homeschools her daughter, adding to the level of unpaid care work she does.

This experience has also increased her fear of revealing her disability in future. That she feels forced to hide her disability is problematic and risks harm. Autism masking—which is the act of hiding certain behaviors or traits to better conform to social expectations—can have serious health and well-being consequences for people with Autism, including increased risks of burnout, anxiety, depression, and suicidality.

For racialized and Indigenous women with disabilities, fear of judgment about their capacity to parent presented a barrier to seeking care and support. Some participants expressed concern that Child and Family Services would separate them from their children.

“I get scared to go to supports and open up,” one Indigenous woman shared. “I don’t know if they will call [Child and Family Services] on us. There’s that added stigma and pressure for me,” noting that it is worse because she is a single mother. She reported dealing with serious postpartum symptoms in addition to Complex-PTSD. When she has “an episode,” she needs support. She described her most recent “episode”: “The last one I had a couple weeks back, I couldn’t get off my couch, and I was scared to reach out.”

Instead, she relies on family and friends. “My parents help me, thank God,” she said, adding that she also has “a couple of close friends I can talk to.” She has a mutual support relationship with one friend where “we kind of help each other.” “I help her with some of her traumas. It’s a support system where you can open up about anything and everything.”

Her fears are not misplaced. Two other women recounted how disability and lack of support contributed to losing custody of their children. “My story is misjudged,” one woman said. “I can’t have [my daughter] because I have seizures.” Instead of providing the support she needed to care for her daughter, Child and Family Services removed her child from her care. “There have to be other parents out there with seizures [who retain custody],” she said.

Another woman who has multiple disabilities, including schizophrenia, recounted how Child and Family Services determined she and her partner would not be able to raise their daughter. She recalled: “They tested us, they made sure we could bathe her, and we couldn’t. What does this tell the child? This will have a lifelong effect on the child.” Now her sister-in-law is raising her daughter. The woman can see her daughter, but she mourns losing the chance to live as mother and daughter.

Paid care workers also observed critical gaps in available services to support women with disabilities to have and raise children. A disability program navigator recounted the challenges of finding additional funding when a woman with disabilities supported by community living disability services has a child. “There’s nothing for her child,” she said. “That’s a big gap because a lot of women might suddenly have someone else in tow.”

Instead of funding and support, women with disabilities face scrutiny from government services. “There tends to be a huge overstepping of boundaries,” a paid caregiver with a disability said. “As soon as I have a disability and I have a child, I have the government in my house, in my bank account, talking about my body.”

ii. Preparing children to face disability stigma

Women with disabilities in three focus groups whose children also have disabilities recounted the added care work demands of preparing their children to face stigma and discrimination.

One woman with disabilities whose children also have disabilities shared how she prepares her children to live in an ableist world:

> We are in a society that tries not to relate to … people with special needs. So, besides care, like making [my kids'] meals and trying to teach them to be independent, I try to teach them to accept themselves, and to know that there is nothing wrong with them…. I try to let them know that they can do whatever others are doing.

This added labour has repercussions. One woman with disabilities described how preparing her child to encounter similar ableist barriers in life that she faced was a form of "generational trauma." She explained: "If your children are experiencing barriers or things that you have experienced, it is very challenging to support and relive some of those things while also coping with … your own disability."

People raising and caring for boys with disabilities were also afraid of the consequences of their children being stereotyped, especially if they are racialized. One mother said one of her sons, who is Black and has Down syndrome, is "a social butterfly" who wants to express affection but does not always understand other people's boundaries. People respond negatively to some of his behaviors, whereas "nobody says anything" when a non-Black child does the same thing. Her other son, who is Black and has ADHD, sometimes "gets frustrated and when he gets bullied, he has to fight back and defend himself." She is trying to teach him other ways to cope because she knows "being physical" carries specific risks for Black boys and men.

A First Nations woman shared similar concerns for her grandson who "gets involved with the police, and it's always something I worry about because we don't have very good relations with police in our community." She added: "I'm glad that he doesn't fight back." Their concerns align with data that shows Black people, Indigenous people, and people with psychosocial disabilities are overrepresented in police-involved deaths in Canada.

Importantly, the burden of addressing disability stigma does not only apply to women with disabilities whose children have disabilities; it also extends to those whose children do not. One Deaf woman whose children are hearing had to teach them not to be ashamed she has a disability:

> I can use my voice, but some words I say wrong, some things I'm not able to hear, and so sometimes my kids are embarrassed if I use my voice in front of other people. So that can be a challenge. Just teaching them to not be embarrassed by having a Deaf mother.

iii. Navigating lack of disability inclusion at school

Governments' failure to provide and ensure adequate paid disability support in the context of education requires mothers to provide significant unpaid care work to fill this gap. Women with disabilities in three focus groups recounted significant challenges navigating the lack of disability accessibility and existence of stigma at their children's schools.

Some said they had difficulties in advocating for their children's access to the supports they need. "You have to work with the schools to make sure [the children] get all they need," one woman said. "I had to fight!" She had to write to government officials to get support for physical adaptations like ramps and direct assistance for her son to be included in class.

Some reported significant challenges supporting their children in the face of disability-related bullying. "My children have experienced [bullying] just due to who their parents are," one Deaf mother with hearing children recounted. "They come home crying. They're so emotional they can't even communicate." She said the school has not adequately communicated about the bullying. Instead, the school principal actively discouraged parental involvement in resolving the issues, claiming the need to encourage children to be independent and develop problem-solving skills. But the bullying continues. "I am afraid for them," she worried. "School isn't a safe space, and you are sending your kids there, and that is really hard."

Another mother with disabilities was not informed by the school about incidents of bullying against her daughter with disabilities. "My daughter loves school," she said. "For me to send her to school and her coming home crying and can't express herself, that hurts me as a parent. I need to be informed."

iv. Caregiver burnout among mothers

Women with disabilities in three focus groups reported needing resources to address caregiver burnout among mothers. "Mothers need a break," one Inuk woman emphasized, but she feels they have nowhere to go. One woman with disabilities spoke of caring for her daughter with high support needs: "If she's upset, she very much needs me to help regulate her body again, so I can't go away for the weekend or anything like that." For her, "caregiver burnout is the hardest." At the end of the day, "I am just done. My husband comes home from work and I'm pretty much like, okay, I'm going to go lie in bed until tomorrow…[I'm] just mentally and emotionally, physically drained."

Summarizing the challenge, another woman said: "Unless you have somebody who supports you and a system that really supports you, to encourage you, you can just get

frustrated. You're bone tired. You're confused … sometimes hopeless. You don't know what to do."

Even where respite services are available, some cited a lack of options that they could trust. One woman whose daughter is non-speaking shared why trust is a challenge:

> My daughter had a very negative experience at school where her bully was an adult in the building. I have a very hard time leaving her with people since that…. It's at the point that if she ever gave me any idea that something happened, the trust isn't there with anyone. Even for me to attend [the online focus group] right now, my mom is in the living room. I wouldn't leave the house, I would stay.

Participants also pointed to how burnout was not some immutable or inevitable outcome of being a mother with a disability. It was available and accessible support to them as mothers and as women with disabilities that made the difference. Women with disabilities in three focus groups described the amazing support they received for themselves as individuals and as parents. For most, this support came from family.

One woman with disabilities expressed gratitude for how her support worker has helped both her and her daughter. "The way that [he] cares for me, he'll call me, check in on me, help me with my daughter, and find resources for her. I love that." Her daughter "needs a lot of support," she said, "but I need a lot of support also."

4. Necessity of recognizing unpaid informal peer support care work

Women with disabilities in four focus groups reported doing a significant amount of unpaid care work in the form of peer support. Largely, their experience was that this peer support work is essential in helping to close the gap in women's unmet needs for care and support, but that this work goes unrecognized and unsupported.

Some reported undertaking disability support work to help people who became newly disabled or are learning to live with a new understanding of a disability. "I help them with the things I went through when I was disabled," one explained. Another woman explained how women with her diagnosis share resources, training, and support: "We're always there, even with illness, disability or whatever, we're always there with a desire to help, I have three people I follow regularly who can call me or whom I see once a week via Zoom."

Peer support was not limited to the disability and Deaf communities. Women with disabilities and Deaf women engaged in community care work in other contexts where they identified gaps in government services or challenges accessing needed support through their lived experience, including access to gender-affirming care for trans people and

support for people who are unhoused. One woman with disabilities who is unhoused explained: “I do care a lot for the homeless people, because I’m one of them. I talk to them and try to know their situation. Like how they become homeless…I try to help them get into programs, get wrap around services.”

5. Disability representation as essential to effective caregiving and barriers to the paid labour force

Women with disabilities and Deaf women underscored the importance of having people with lived experience working in the care and support sector to ensure that related programs are responsive to peoples’ needs and to reduce people with disabilities’ need for self-advocacy. One woman who worked as a peer supporter in a service by and for people with Autism explained:

> People in marginalized situations often find themselves having to retell their story. Repeating things they’re tired of explaining…. Whereas the people who come to our service don’t necessarily need to explain it because we’ve had training, and we have experiential knowledge.

Services “by and for” people with lived experience “take away the administrative burden” of having to inform and educate service providers about disability from a human rights perspective. As one woman with lived experience noted: “We wouldn’t have to have two full meetings just to explain what it means, you know Autism, neurodiversity, and all that.”

However, there is a concern that while women with disabilities and Deaf women are providing essential peer care and support services, they are sidelined away from the paid labour market. Deaf women, women with disabilities and gender diverse people with disabilities continue to face significant barriers to obtaining and maintaining employment as care and support workers. This is of increased concern for persons with a disability or Deaf people who have intersecting marginalized identities.

D. Poverty and Core Housing Need Undermining Self-Care

Many participants expressed frustration with the constant work of trying to care for themselves and the sustained burnout from doing so. They understood self-care as an essential need, just like receiving care and support or providing it to others, and one that underpinned the ability to maintain their physical and mental health, live in dignity, independently in community, and provide care for others. “If you can’t take care of yourself, you can’t take care of others,” one woman said. Self-care was not always a solo endeavor. A woman with a visual disability shared: “For me, self-care involves walking with someone and having them describe the environment.”

Poverty increased their care needs and undermined their capacity for self-care. “It’s a luxury to be alive,” one woman remarked. Another noted the challenge of finite time and energy: “You’re not in a situation where you have the time or energy or opportunity to take care of yourself because you’re always fighting just to survive, to feed yourself, to have a roof over your head.” Another woman described her self-care as “not very well, because with the battles, the emergencies, … housing is always a big problem.”

Participants in three focus groups described forgoing personal care because of financial constraints. “I cut my own hair; I don’t want to spend any money,” one woman shared. Because provincial disability supports are so inadequate, another woman said she saved money for everyday living expenses, including groceries, by cutting laundry.

Women with disabilities, especially mothers, spoke about limiting their food because of financial constraints. “What I’m getting now [in provincial disability support] is not enough just for basic needs like groceries,” one woman said, noting that this support did not reflect recent increases in cost of living. “Say you get your money, but first, you say let my child eat, but then you go with nothing to eat.”

“My rent takes over 80 percent of my income, and I still have to pay utilities,” another woman said. “It’s hard. You feed your child first. I’ve gone times where I’ll only eat a piece of toast.” She noted this context does not allow self-care, especially because she is afraid it may add to false perceptions that she is not taking care of her child. “Everything is invested in my son,” she added. “The one thing I do for myself is sleep.” The “mom guilt” she observed is both personal and societal. She said that feeling is “worse if we’re marginalized … because there’s already stigma.”

Women with disabilities in two focus groups associated the meeting of their housing needs with the ability to exercise self-care and independence. One participant explained that getting her own apartment was critical to removing herself from a public trustee: “I had to prove that I could get my independence.”

E. Exclusion From Policy and Program Design

Focus group participants expressed frustration with being excluded from program design and broader policymaking given the direct impact of these decisions on their lives, health and well-being and on their ability to care for themselves, their children. One woman with disabilities who works as a provincial service coordinator said:

> This is a patriarchal system, all of these policies, all of the funding that’s in place—I’m going to be frank—these were a bunch of white, upper-middle class, wealthy dudes that sat at a table and developed these policies. What

> do you think is the likelihood that there was even one female that was present during these huge decision-making opportunities, let alone a female with lived experience with a disability? Did we ever get to the point where the table was stacked with women with disabilities? I don't think so.

"What you need is someone who's been a part of the system on both sides, who has lived experiences and understands every shortcoming possible," a special education specialist and teacher recommended. "Everything seems very surface, there just needs to be a deeper dive," which she suggested should include consulting with the direct caregivers, their employers, the care recipients, and families.

One support staff person observed that even where opportunities exist for people with disabilities to provide critical insight on policies and programs, their time and expertise are rarely appropriately valued. He observed: "Governments or NGOs or companies reach out and ask for their guidance, which is already taxing on them as it is, and just expect information without any compensation."

Summary of Findings

The findings reveal a care economy in Canada that too often fails to provide women with disabilities and Deaf women with the care and support that should enable equality, autonomy and social participation. Across the focus groups, participants described barriers not simply to obtaining services, but to exercising basic choices about where and how they live, maintaining their health, raising their children, participating in their communities, earning a living, and providing care to others. These experiences implicate a broad range of human rights – including equality and non-discrimination, health, an adequate standard of living, independent living and community inclusion, autonomy and self-determination, family life, and participation in decisions affecting one's life. The findings do not suggest a single broken program or policy. They point instead to recurring structural problems in how care and support are defined, funded, accessed and governed.

A central problem is that having a need for care or support does not mean being able to obtain it. Participants described restrictive eligibility rules, repeated demands to prove disability, costly or inaccessible assessments, complex applications, inadequate information, fragmented programs, transportation barriers and long delays. In some cases, the presence of family support was itself used as a reason to reduce formal services – effectively transferring public responsibility for care onto relatives. Where services existed, people frequently had to expend substantial time, money and physical and emotional energy simply trying to reach them. Where they did not exist – particularly home and community supports – women faced much more consequential choices: go without support and risk deteriorating health and independence or leave family, community and culture to obtain care elsewhere. These pressures were particularly acute in Northern and

Inuit communities, where geography, chronic service shortages and jurisdictional arrangements intersect with the continuing effects of colonialism on community relationships of care.

This research also exposes an important distinction between access to care and the quality and nature of that care. Under-resourced services left workers with high caseloads, insufficient time and limited capacity to provide the support people needed; participants repeatedly emphasized that exceptional individual workers could not compensate for systemic shortages. At the same time, women described encounters shaped by ableist assumptions, stigmatizing language and predetermined ideas about what a person with a disability should need or should be allowed to choose. Some were required to constantly advocate, explain, and educate merely to obtain services. That advocacy itself consumed scarce energy and, in some settings, asserting one's rights could carry the risk of being labelled difficult or losing access to support. The resulting contradiction is stark: systems intended to provide care can require the people who need them most to undertake another form of unpaid labour simply to make those systems respond.

Perhaps the most significant finding is that prevailing approaches continue to divide people too neatly into "caregivers" and "care recipients." The lives described in this research do not fit that binary. Women with disabilities and Deaf women were mothers, daughters, partners, workers, peer supporters and community members who provided substantial paid and unpaid care while also having care and support needs of their own. Yet policies and services frequently treated disability as evidence of dependency rather than recognizing women with disabilities as caregivers and sources of expertise. Their family and peer support work often filled gaps left by formal systems while remaining unpaid, unrecognized or unsupported. Women with lived experience also described barriers to entering and remaining in paid care and support work – even though that same lived experience could make services more responsive, accessible and effective.

These contradictions were particularly severe for mothers with disabilities. Participants described being required to undertake additional care work because schools and other systems were inaccessible to their children, while some simultaneously faced suspicion about their own capacity to parent. For Indigenous, racialized, and other marginalized mothers, seeking assistance coincided with fear that asking for support would trigger scrutiny or child-welfare intervention. Some women described losing custody in circumstances where they believed support to parent could have made a decisive difference. The issue is therefore not only whether services are available, but whether systems respond to disability by providing the supports necessary to exercise rights or by restricting those rights because support is required.

Poverty and housing insecurity intensified nearly every other barrier identified. Women described disability benefits insufficient to meet basic living costs, rent consuming most of

their incomes, reducing food and other necessities, and having too little time, energy or money left for their own health and well-being. Self-care in these circumstances cannot meaningfully be reduced to individual resilience or personal responsibility. The findings show it to be materially dependent on access to adequate income, housing, transportation, health services and disability support. When these foundations are absent, the costs do not disappear; they are absorbed by women themselves, their families and informal networks in the form of poorer health, exhaustion, unpaid labour, and foregone opportunities.

Finally, participants repeatedly identified a deeper governance problem: the people most affected by care policies are too often absent from designing them. Women with disabilities described programs constructed around assumptions that did not reflect their lives. Consultation frequently occurred late, intermittently, or without recognizing lived experience as expertise worthy of compensation. This exclusion helps explain many structural findings of this research. Systems built around standardized categories, institutional silos and assumptions about dependency can fail to recognize the interdependence, cultural relationships, intersecting identities, and changing roles through which care is actually given and received.

Taken together, the findings point to something more consequential than a shortage of services. They reveal a mismatch between the lived realities of care and the policy architecture through which care is presently organized. That architecture can make support conditional on diagnosis rather than need; rely on unpaid family labour while failing to support those families; fund institutional responses while community support remains unavailable; provide services while limiting the recipient's control over them; and seek the expertise of women with disabilities without consistently giving them power in the decisions that shape their lives. The challenge, therefore, is not simply to add more care to the existing system. It is to examine the policy regime governing the care economy itself: what responsibilities it assigns to governments, families and individuals; who it recognizes as entitled to support; what needs it responds to; whose labour it values; how resources are allocated; how autonomy and choice are protected; and who participates in designing and governing the system. That is the point at which the barriers documented in this research become questions of policy design—and where human rights standards can provide concrete direction for reform.

IV. Policy Implications: The Care Economy Policy Regime

The findings in the preceding section point to barriers arising across very different areas of women's lives. Women with disabilities and Deaf women described difficulties obtaining needed care and support; restrictive eligibility requirements and burdensome application processes; inadequate and poorly coordinated services; poverty and housing insecurity that undermine self-care; lack of recognition and support for their paid and unpaid care work; and exclusion from decisions about policies and programs that directly affect them. These barriers are experienced personally, but they are not simply individual problems. Taken together, they point to a broader policy regime which shapes the conditions under which care and support are received, provided, and exercised.

The term *care economy* is used in this report to describe the wider field of activities, relationships, labour, institutions, and resources involved in providing, receiving, and organizing care and support. The *care economy policy regime* is a related but distinct concept. It refers to the dispersed collection of laws, policies, programs, fiscal arrangements, administrative rules, and governance structures through which governments shape these conditions.

Not every component of this regime is conventionally understood as a "care policy." Income-support programs, housing policies, transportation systems, labour regulation, disability benefits, and family-support programs may nevertheless determine whether a person can obtain needed care, provide care to someone else, or exercise self-care. The relevant analytical question is therefore not simply whether a law or policy is formally classified as part of the care economy, but whether it materially structures the conditions under which care and support take place.

A. Identifying the Principal Regulatory Functions of the Regime

Having analysed the barriers experienced by women with disabilities and Deaf women, the research considered the systemic factors shaping those barriers and the laws, policies, programs, and institutional arrangements through which those factors are produced, maintained, or addressed. Through an iterative comparison of the lived-experience findings with the law and policy landscape, six principal regulatory functions of this regime were identified.

These functions represent the principal ways in which law and policy structure the conditions under which care and support are received, provided, and exercised. They are not intended to define the care economy itself, but to provide an analytical framework for understanding the operation of the policy regime shaping the economy of care and support.

1. Defines the scope and nature of care and support

The first function of the regime is definitional. Laws, policies, programs, and policy frameworks establish what governments recognize as care and support, which activities and relationships fall within that understanding, and who is recognized as providing or receiving care.

These definitions matter because they establish the boundaries of policy attention and public responsibility. A regime organized around a binary distinction between "caregivers" and "care recipients," for example, may fail to recognize that the same person can occupy both roles. Similarly, policy frameworks may recognize formal or family caregiving while overlooking peer support, community-based care, culturally grounded forms of care, or self-care. The way care and support are defined therefore shapes the populations, relationships, activities, and needs that subsequent laws and programs address.

2. Establishes access to care and support services

A second regulatory function concerns who can obtain care and support, what they can access, and under what conditions. Law and policy establish eligibility criteria, assessment processes, diagnostic or documentation requirements, application procedures, service entitlements, geographic boundaries, and the conditions under which publicly funded care and support are available.

This function extends beyond formal eligibility. Information about services, assistance navigating fragmented systems, transportation to reach services or complete assessments, the availability of services within a person's community, and the relationship between formal and informal support can all determine whether nominally available care is accessible in practice. The Findings demonstrate that these regulatory arrangements can make the difference between receiving support at home, relying on family members to fill gaps, leaving one's community to obtain care, or entering an institutional setting.

3. Regulates the design and delivery of care and support services

Obtaining entry into a service does not determine the quality or nature of the support received. A third function of the regime is therefore to structure how care and support services are designed, funded, organized, and delivered.

Policies and program rules determine such matters as the amount and duration of support available, staffing and resource levels, continuity of services, whether support responds to changing or ongoing needs, the degree of choice a person has over providers and arrangements, and the extent to which services are individualized and culturally appropriate. These arrangements also structure power within care relationships: whether people receiving support can exercise choice and control, whether their preferences are

respected, and whether they can raise concerns or advocate for themselves without jeopardizing services. This function therefore concerns not merely the existence of services, but the way the system organizes the actual relationship between people receiving support, people providing it, and the institutions responsible for delivery.

4. Regulates paid and unpaid care and support work

A fourth function concerns the labour through which care and support are provided. Law and policy structure both paid and unpaid care and support work, although they do so through different mechanisms.

For paid workers, employment law, labour standards, compensation, benefits, staffing arrangements, public funding, employment equity measures, and the design of care programs shape working conditions and the capacity of workers to provide quality support. For unpaid caregivers, the regime operates through income supports, tax measures, caregiving leave, respite programs, disability and family supports, and assumptions embedded in service eligibility rules about the availability of family care.

This function is particularly important for the analysis in this report because women with disabilities and Deaf women cannot be situated neatly on one side of a caregiver/care-recipient divide. Many provide substantial unpaid family or peer support while also requiring support themselves; others work in the paid care and support sector. The regime therefore structures both their ability to perform care work sustainably and whether that work is recognized and supported.

5. Establishes material and social supports related to self-care and caregiving

Care and support do not occur independently of the broader material conditions of people's lives. A fifth regulatory function concerns the income, housing, disability, health, transportation, and other social supports that make self-care and caregiving possible.

The Findings demonstrate the connections directly. Inadequate disability income can require women to choose between food, housing, disability-related costs, and personal care. Inaccessible or unaffordable housing can undermine independent living and increase support needs. Transportation costs can make care inaccessible. Conversely, adequate income, accessible housing, assistive supports, and related benefits can provide the material basis from which people are able to maintain their own well-being and provide care to others.

These systems may sit administratively outside what governments designate as the care sector, but they nonetheless form part of the care economy policy regime relevant to care because they structure people's practical capacity to receive, provide, and exercise care.

6. Establishes governance of care-economy policies and programs

Finally, the regime establishes who makes decisions about care and support and how those decisions are made. Governance arrangements determine who participates in defining policy priorities, designing programs, allocating resources, administering services, monitoring implementation, and reviewing whether systems are achieving their objectives.

This includes formal government structures and intergovernmental arrangements, but also advisory bodies, consultation processes, program governance, data collection, and mechanisms through which people directly affected by care policies can influence decisions. The Findings demonstrate that women with disabilities and Deaf women frequently possess significant expertise derived from navigating care systems as recipients, caregivers, workers, parents, advocates, and peer supporters, while remaining underrepresented in the places where policies and programs are designed.

Governance is therefore not simply an administrative matter. It determines whose knowledge is treated as authoritative in defining problems and designing responses, and whether the people most affected by the regime have meaningful influence over its development.

B. Mapping the Laws and Policies that Constitute These Functions

The law and policy scan provided a second level of analysis. Having identified the principal regulatory functions, the research examined the types of law and policy provisions through which these functions are constituted and regulated in practice.

The scan demonstrates that no dimension corresponds neatly to a single statute, government department, or program. Instead, each function is produced through multiple instruments, often operating across several policy fields and levels of government. The following examples are illustrative rather than exhaustive.

Regulatory function	**Illustrative laws, policies, programs, and regulatory mechanisms identified through the scan**
1. Defines the scope and nature of care and support	Federal care-economy and caregiving policy frameworks, including Canada's proposed care-economy conceptual framework and emerging national caregiving policy processes; disability, home-care, continuing-care, and independent-living frameworks that define different forms of care and support and the populations to whom they apply.

Regulatory function	Illustrative laws, policies, programs, and regulatory mechanisms identified through the scan
2. Establishes access to care and support services	Provincial and territorial home-care programs and policy manuals; disability-support and developmental-services programs; eligibility and assessment rules; First Nations and Inuit Home and Community Care; Jordan's Principle; medical-travel and transportation programs; individualized-funding and independent-living programs.
3. Regulates the design and delivery of care and support services	Home- and community-care service frameworks; individualized-funding programs; BC's Choice in Supports for Independent Living; Ontario Health at Home and comparable provincial and territorial programs; residential-care, long-term-care and continuing-care policies; service standards and program guidelines governing intensity, duration and organization of support.
4. Regulates paid and unpaid care and support work	Employment Insurance benefits and caregiving leave; the federal Pay Equity Act and Employment Equity Act; provincial respite and family-support programs; policies governing support-worker funding and staffing; income and tax measures affecting unpaid caregivers; disability-employment supports and programs affecting participation of people with disabilities in paid care work.
5. Establishes material and social supports related to self-care and caregiving	The Disability Tax Credit, CPP Disability Benefit and Registered Disability Savings Plan; provincial and territorial disability and social-assistance programs; housing strategies, public and supportive housing, rental benefits and accessibility-modification programs; health benefits; transportation and medical-travel assistance; other disability-related benefits and supports.
6. Establishes governance of care-economy policies and programs	The federal Care Economy Sectoral Table and national caregiving-policy processes; federal-provincial and territorial fiscal and program arrangements; Indigenous policy and governance frameworks such as the Inuit Nunangat Policy and consultation mechanisms; advisory and consultation processes; mechanisms for program administration, monitoring and review.

The breadth of this mapping itself is significant. The policy review ranges from federal disability tax and income measures to provincial disability supports, housing programs, residential care and home-care systems, and transportation and medical-travel assistance across the provinces and territories. It demonstrates that the care economy is governed not

through a discrete body of "care law," but through the interaction of multiple policy systems.

Individual provisions may also perform more than one regulatory function. A home-care eligibility rule can determine access to services while simultaneously assuming that family members will provide unpaid care. An individualized funding policy can affect access, service design, personal choice, and employment conditions for support workers. A disability-income rule can affect self-care, housing security, employment, and a person's ability to provide care to others. The dimensions are therefore analytical lenses rather than mutually exclusive policy silos.

C. An Evolving, Cross-Sectoral and Inter-Jurisdictional Care Economy Policy Regime

The resulting picture is of an evolving, distributed, cross-sectoral and inter-jurisdictional care economy policy regime.

Home and community care is largely regulated and delivered provincially and territorially, while the federal government influences provision through fiscal transfers, taxation, disability benefits, labour and employment policy, and targeted funding. The federal government also has particular responsibilities in relation to First Nations people on reserve and Inuit in designated communities. At the same time, housing, income assistance, disability supports, transportation, health services, employment programs, and family supports operate through their own legislative and administrative systems.

Canada has also begun more explicitly to construct "the care economy" as a field of federal policy. The federal government's proposed conceptual framework, the establishment of a Care Economy Sectoral Table, and plans for a national caregiving strategy are evidence of this development. Yet these emerging initiatives sit alongside long-established systems whose mandates and administrative boundaries were not necessarily designed as parts of an integrated care regime.

There is consequently no single central institution responsible for regulating the care economy as a whole. Responsibility is distributed across levels of government, ministries, health authorities, agencies, and service systems. This makes integrated reform difficult to design and implement. It also creates political challenges: reform in one area may depend on changes to funding, eligibility, labour, housing, health, or social-protection arrangements controlled by another government or ministry.

The Findings show what this fragmentation can mean in people's lives. A woman may have to navigate one system to establish that she has a disability, another to receive income assistance, another to obtain home support, another to find accessible housing, and another to obtain transportation to health services. A failure in one system can increase pressures elsewhere. Inadequate public support shifts care onto families; inadequate income makes disability-related supports inaccessible; inaccessible housing can increase

support needs; and the absence of support for a caregiver with a disability can undermine both her well-being and the care available to another person.

The complexity of this regime should not become a rationale for accepting fragmentation as inevitable. But it does mean that the barriers documented in this report are unlikely to be addressed through a single new benefit, program, caregiving strategy, or funding commitment. These barriers call a more robust assessment of how numerous components within the regime operate individually and together.

D. Toward a Framework for Assessing the Regime

The distributed character of the care-economy regime presents an important methodological problem. If the conditions under which people receive, provide, and exercise care are structured through numerous provisions spread across multiple policy fields and jurisdictions, simply cataloguing programs cannot tell us whether the regime is becoming more inclusive or whether it is addressing the barriers documented in this research.

A framework is needed that assesses very different laws, policies, programs, guidelines, and administrative provisions using a common analytical structure. The six dimensions provide the descriptive architecture for such a framework. They identify the major regulatory functions performed by the regime: what it defines; how it establishes access; how it structures service design and delivery; how it regulates care work; how it establishes the material conditions surrounding care; and how it governs decision-making about care and support. They do not, however, tell us what an inclusive regime ought to look like. That requires a normative step.

The next section therefore turns to the human-rights standards relevant to care and support. Those standards, considered alongside the barriers identified through the lived-experience research, provide the basis for defining indicators of an inclusive and rights-respecting policy regime. For each regulatory function, the indicators ask what conditions would need to be in place to overcome the barriers identified in the Findings in a manner consistent with human rights. Measures can then translate those indicators into characteristics capable of being assessed in individual provisions of laws, policies, programs, guidelines, and documented administrative practices.

The framework thus links three levels of analysis: lived experience identifies the barriers; law and policy analysis identifies the regulatory structures producing or addressing them; and human-rights standards provide the normative basis for assessing those structures.

This approach does not attempt to eliminate the complexity of the care economy. Rather, it provides a means of analyzing that complexity systematically – and of asking whether the different components of the care economy policy regime are together creating conditions in which people can receive and provide care and support while maintaining dignity, autonomy, equality, and security.

V. Human Rights Standards: Normative Foundations for Assessing the Care Economy Policy Regime

The preceding section identified the principal functions of the care economy policy regime shaping care and support in Canada and highlighted its dispersed, cross-sectoral, and inter-jurisdictional character. The next step is normative: what standards should guide the design, interpretation, and assessment of that regime? The lived-experience findings identify the barriers that must be overcome, while international human rights law and standards provide the basis for determining the conditions that a more inclusive care and support system should meet.

Although a freestanding right to care has not yet been codified in international treaty law, an emerging body of international standards increasingly recognizes care as encompassing the rights to receive care, provide care, and exercise self-care. At the same time, Canada is already bound by well-established human rights obligations relevant to care and support, including equality and non-discrimination, health, an adequate standard of living, social security, independent living and community inclusion, family life, work, and participation in decisions affecting one's life. These standards are particularly important for women with disabilities and Deaf women, whose experiences reveal the ways in which barriers to care intersect with gender, disability, poverty, housing, employment, and other forms of structural inequality.

This section reviews those international human rights standards. It begins with the emerging recognition of a right to care and then examines the established rights and obligations most directly relevant to the six regulatory functions identified in the preceding section. Together, these standards provide the normative foundation for the indicators and measures developed in the proposed care economy assessment framework that follows.

A. Toward a Human Right to Care

At time of writing, the right to care is not codified in international human rights treaties or accepted as a matter of customary international law. The Inter-American Court of Human Rights—the first international court asked to address the question of the right to care—issued an advisory opinion (OC-31/25) in August 2025 affirming that all people have a right to care, including the right to receive care, to give care, and to exercise self-care.[128] The court highlighted the interdependence and indivisibility of the right to care with the rights to health and social security and recognized the right to support for people with disabilities as essential to the right to care.[129] Care and support for people with disabilities, the court affirms, must be provided based on "their recognition as rights holders and not only recipients of care," and as people "with autonomy and independence that can exercise

self-care."[130] Further, the court calls for special measures to ensure the rights of women with disabilities who undertake unpaid care work.[131]

Canada has not ratified the American Convention and is not bound by the court's guidance.[132] As an OAS member, however, Canada must comply with the human rights provisions of the OAS Charter, including the American Declaration of Rights and Duties of Man. In OC-31/25 the Inter-American Court of Human Rights indicated that "the American Declaration of the Rights and Duties of Man contains references that evidence an early understanding of care within the framework of the IAHRS as a human need and a social duty."[133] The Advisory Opinion analyses provisions from universal and regional instruments related to the right to care, including the International Covenant of Civil and Political Rights (ICPR), the International Covenant of Economic, Social and Cultural Rights (ICESCR), the Convention for the Elimination of all forms of Discrimination against Women (CEDAW), the Convention on the Rights of People with Disabilities (CRPD), and the Convention on the Rights of the Child (CRC). The Inter-American Court of Human Rights stated in the Advisory Opinion that "receiving care — or having the appropriate conditions to provide it— is essential for people to live a dignified life, exercise their freedom independently, and participate fully in society."[134]

With regards to the right to provide care, the Court states that it "consists of the right of provide care in decent conditions, both unpaid and paid. This right implies that caregivers, both within and outside the family, can carry out their work without discrimination and with full respect for their human rights, guaranteeing their physical, mental, emotional, spiritual and cultural well-being.[135] Whereas the right to self-care "implies the right of caregivers and care recipients to pursue their own well-being and attend to their physical, mental, emotional, spiritual and cultural needs. This aspect of the right recognizes the importance of individuals having the time, space and resources to care for themselves, exercise their independence and lead a dignified life.[136]

The UN Human Rights Committee has also recognized the concept of care by referring to "the importance of respecting, protecting and fulfilling the human rights of paid and unpaid caregivers and care and support recipients." It has also expressed concern "at the unequal distribution and organization of care and support work." It has also urged States to implement all necessary measures to recognize and redistribute care work among individuals, families, communities, the private sector, and States, while increasing investment in care and support policies and infrastructure to ensure universal access to affordable, quality services.[137]

In November 2022, the Economic Commission for Latin America and the Caribbean member states, which includes Canada, adopted the Buenos Aires Commitment, committing to adopt regulatory frameworks to ensure the right to care through comprehensive care policies and systems that consider gender, intersectionality, and

human rights.[138] It recognizes "care as a right to provide and receive care and to exercise self-care," the responsibility for which is shared by families, communities, businesses, and the State.[139]

In an annex to the Buenos Aires Commitment, Canada explained its position on the right to care:

> The Buenos Aires Commitment contains references to a 'right to care,' which has not yet been established as a matter of customary international law, is not provided for in treaty law, and does not have an agreed international meaning. That said, Canada looks forward to working with the UN Economic Commission for Latin America and the Caribbean, as well as fellow Member States, to continue promoting and protecting the human rights of all people.[140]

Regardless of a State's formalization of the right to care, States must abide by existing international law and standards related to care and support systems.[141] Canada is a State party to the relevant treaties: International Covenant on Economic, Social and Cultural Rights , the Convention on the Rights of Persons with Disabilities , and the Convention on the Elimination of All Forms of Discrimination against Women , Convention on the Rights of the Child, and Convention on the Rights of Persons with Disabilities.[142]

B. Human Rights Relevant to Care and Support

1. Right to Nondiscrimination

The Committee on the Rights of Persons with Disabilities (CRPD Committee) has interpreted the CRPD to require States parties to take targeted measures to address multiple and intersecting forms of discrimination "with respect to disaggregated data collection, consultation, policymaking, [and] the enforceability of non-discrimination policies." [143]

Its recommendation follows its finding that women with disabilities face multiple and intersecting forms of discrimination, particularly regarding, among others, economic opportunities, social interactions, and their ability to exercise control over their own lives, including in healthcare contexts, such as sexual and reproductive health services, and regarding where and with whom they wish to live. Sexual and reproductive health and rights includes the right to found a family.

The CRPD Committee subsequently observes that traditionally, laws and policies on disability have ignored women and girls with disabilities while those on women have

ignored disability. This pattern perpetuates the intersectional discrimination experienced by women and girls with disabilities. It recommended one State party "mainstream the rights of women and girls with disabilities into all gender legislation and strategies," and "mainstream a gender perspective into disability policies and programmes."[144] The CEDAW Committee likewise called for States parties to address specific structural inequalities faced by women with disabilities in accessing the labour market, health care, housing, economic empowerment programs, and family benefits, among others.[145]

2. States Parties' Obligation to Raise Awareness Regarding People with Disabilities

The CRPD requires States parties to adopt immediate and effective measures to:

(a) Raise awareness … and to foster respect for the rights and dignity of persons with disabilities;
(b) Combat stereotypes, prejudices and harmful practices relating to person with disabilities….;
(c) Promote awareness of the capabilities and contributions of persons with disabilities.[146]

Such measures include public awareness campaigns "[to] promote positive perceptions and greater social awareness towards persons with disabilities" and promoting "recognition of the skills, merits, and abilities of persons with disabilities, and of their contributions to the workplace and the labour market."[147] Raising awareness of the contributions of women with disabilities as unpaid care workers would align with this obligation.

3. Right to Health

Everyone is entitled to "the highest attainable standard of health conducive to living a life in dignity."[148] This right to health includes both physical and mental health, as well as the right to exert control over one's health and body, including sexual and reproductive health and freedom from non-consensual medical treatment.[149]

The Committee on Economic, Social and Cultural Rights (CESCR) has interpreted that Convention to require States parties to ensure health facilities, goods, and services are accessible, affordable, and of good quality for all, as well as culturally appropriate.[150] This includes basic preventive and "rehabilitative health services; appropriate treatment for diseases, illnesses, injuries, and disabilities, preferably at community level; essential drugs; and appropriate mental health treatment and care."[151]

The CRPD affirms the right to health specifically for people with disabilities and obligates States parties to provide them with health services designed to minimize and prevent the development of further disabilities.[152] Healthcare facilities and services must be "available, accessible, adaptable and acceptable for persons with disabilities in their communities" and include nurses, physiotherapists, psychiatrists, or psychologists in hospitals and at home."[153]

The CEDAW Committee recommended a few States parties ensure "a sufficient number of health-care facilities with adequately trained staff, in particular in rural and remote areas" for physical accessibility.[154] It also recommended to a couple States parties that they ensure affordability by providing access "free-of-charge" for those without sufficient means.[155]

The CEDAW Committee recommended States parties give special attention to the health needs and rights of women with disabilities.[156] It urged a couple of States parties to "train health professionals on human rights, dignity, autonomy and the needs of women with disabilities, and promulgate ethical standards for public and private health care." [157]

4. Right to an Adequate Standard of Living

The Universal Declaration of Human Rights (UDHR), which is widely accepted as reflecting customary international law, enshrines the right to an adequate standard of living, including adequate food, clothing, housing, and medical care; necessary social services; and the right to security "in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[158]

In Article 11(1), the ICESCR codifies the right to an adequate standard of living, including adequate food, clothing, and housing, and to the continuous improvement of living conditions.[159]

The CESCR has stressed that people with disabilities' right to an adequate standard of living[160] includes the availability of rights-respecting support services, assistive devices, and technologies.[161] The CRPD's interpretation of independent living in the community directs States parties to ensure "access to appropriate and affordable services, devices and other assistance for impairment-related requirements, especially for those persons with disabilities who live in poverty.[162] It then notes: "It is considered contrary to the Convention for persons with disabilities to pay for disability-related expenses by themselves."[163] To this end, the CRPD recommended one State party continue covering disability-related costs even after someone enters employment.[164]

5. Right to Social Security for People with Disabilities

People with disabilities' right to an adequate standard of living under the CRPD includes a specific provision guaranteeing their right to "social protection."[165] It requires States parties to ensure people with disabilities' equal access to appropriate and affordable services, devices, and other assistance; social protection, poverty reduction, particularly for women, girls, and older people with disabilities, and public housing programs; and retirement benefits and programs. States parties should also ensure people with disabilities and their families living in poverty have access to state assistance with disability-related expenses, including adequate training, counseling, financial assistance, and respite care.[166]

In interpreting the right to an adequate standard of living and social protection, the CRPD Committee underscored the importance of promoting the economic inclusion of people with disabilities by removing barriers to disability supports, including age cut-offs; reducing or eliminating re-assessment burdens; and not solely relying on medical reports when assessing their eligibility for social protection entitlements.[167]

The CRPD Committee has further directed States parties to take measures to address "gender-based inequalities in accessing support and social protection." Such measures should include those that support women with disabilities in entering or re-entering the open labour market and should ensure men and women have equal parental rights and responsibilities.[168]

The CRPD Committee has made recent recommendations to Canada specifically on the entitlement of persons with disabilities to social security that "support[s] an adequate standard of living and alleviate[s] poverty." This includes increasing the accessibility of entitlements and tax benefits by "streamlining procedures" and ensuring "that all laws and policies on social entitlements, tax exemptions, housing and poverty strategies across jurisdictions are disability-inclusive."[169]The CRPD Committee has also recommended that Canada should "[s]ignificantly invest in and implement at the federal, provincial and territorial levels," measures to address "systemic failures" related "to poverty alleviation, access to healthcare, accessible housing, prevention of homelessness, prevention of gender-based violence, and the provision of community-based mental health support, care services at home."[170]

6. Participation of People with Disabilities in Relevant Decisions

The CRPD Committee explicitly connected the realization of the right to an adequate standard of living and social protection to States parties' need to closely consult and actively involve people with disabilities in all decisions concerning them. It made clear that their participation is essential to address exclusion, inequality, and poverty among them and their families living in poverty. The Committee directs States parties to particularly engage with organizations of people with disabilities and persons with disabilities who are

unemployed, who do not have a fixed income, or who do not work because they would lose disability benefits; those in rural or remote areas; and Indigenous people, women, and older people. This consultation should occur in taking, reviewing, and monitoring actions to realize people with disabilities' right to adequate standard of living and social protection.[171]

In the 2025 concluding observations to Canada, the CRPD Committee recommended that the "[m]ainstream[ing] of gender and disability into all poverty and homelessness laws, policies, and strategies," must be done "in close consultation and active involvement of persons with disabilities, including women and girls with disabilities through their representative organisations."[172]

7. Right to Social Security

The right to social security is enshrined in the UDHR, ICESCR, and CEDAW.[173] It is key to securing other economic and social rights, particularly the right to an adequate standard of living.

International human rights law clearly describes "social security" as a set of entitlements that protect against income insecurity throughout a person's life. According to the CESCR, social security systems should encompass the nine "principal branches," listed in the following order: health care, sickness, older age, unemployment, employment injury, family and child support, maternity, disability, and survivors and orphans following the death of a breadwinner.[174] The CESCR further clarified that States parties should, to the maximum of their available resources, ensure social security support covers people working in the informal economy, non-nationals, and, in the context of disability, family members and other informal caregivers.[175]

States parties should make social security programs available, accessible, acceptable, and adaptable. This also requires providing benefits, whether in cash or in kind, that are adequate in both amount and duration.[176]

In its concluding observations to several States parties, the CEDAW Committee emphasized the importance of tackling the "feminization of poverty" by addressing discrimination in pensions and social security schemes, "taking into account interruptions in their employment due to child-rearing periods, their concentration in informal employment and their engagement in unpaid care and domestic work."[177]

8. Right to Live Independently and Be Included in the Community for People with Disabilities

The CRPD enshrines people with disabilities' right to live independently and be included in the community.[178] The CRPD Committee's interpretation of this right emphasizes that

support services should enable people with disabilities' full participation in all aspects of life, as tailored to the individual's needs and choices, thereby fostering autonomy and self-determination.[179] It also clarifies independent living "should also not be interpreted solely as the ability to carry out daily activities by oneself"; instead, it "should be regarded as the freedom to choose and control."[180]

Importantly, the right to live independently is rooted in the recognition that being part of a community and having relationships with others is a critical part of personal development.[181] Human Rights Watch believes this framing envisions a broader notion of caregiving, beyond the family unit, in which people with disabilities are equally entitled to engage.

To realize this right, States parties should develop a concrete action plan, including by taking steps to facilitate formal supports for independent living within the community and ensuring that informal support (for example, by families or friends) is not the only option.[182] The right to access support services is an economic, social, and cultural one that States parties must realize by taking steps to the maximum of their available resources. And as a core obligation, States parties should "use any available funding, including regional funding and funding for development cooperation, to develop inclusive and accessible independent living services."[183]

Individual support services are "a right rather than a form of medical, social or charity care."[184] Support services should be available, accessible, affordable, acceptable, and adaptable to people with disabilities. They should be "assessed … and tailored to the specific activities and actual barriers to inclusion in the community that persons with disabilities face."[185] Such support should extend beyond mere assistance; it should facilitate the person with disabilities' choice, control, and freedom over their lifespan.[186] States should also ensure personnel working in disability-related services are adequately trained on independent living in the community.[187]

A person with disabilities' right to choose where and with whom they live is not fulfilled if they lack options. Thus, they cannot enjoy this right in the following situations, among others:

> where informal support by the family is the only option, where support is unavailable outside of institutions, where housing is inaccessible or support is not provided in the community, and where support is provided only within specified forms of residence such as group homes or institutions.[188]

People with disabilities should be actively involved in leading and managing support services, per a core principle of disability rights.[189] This is important because they have first-hand knowledge that would make support services more responsive and tailored to the

needs of the disability communities they serve.[190] Such participatory governance ensures that policies and programs consider the realities of users, thereby increasing their effectiveness and relevance while fostering empowerment.[191]

9. Connection of the Right to Live Independently to the Right to Housing

The right to live independently and be included in the community is directly tied to the right to housing. Accessible housing for people with disabilities, whether they live alone or with their family, must be sufficiently availible within all areas of the community.[192] People with disabilities must also have access to public and subsidized housing programs in the community.[193] In its concluding observations to a few States parties, the CEDAW Committee underscored the importance of special measures to ensure women with disabilities have access to housing. Thus, it directed these States parties to provide rental allowance and prioritize allocating public housing to women with disabilities.[194]

10. Right to Peer Support

People with disabilities have a right to peer support. Article 24 of the CRPD (on education) requires States parties to enable people with disabilities to acquire skills for participation in education and community by "facilitating peer support and mentoring." Article 26 (on "Habilitation and rehabilitation"), meanwhile, obliges States parties to "take effective and appropriate measures, including through peer support" to enable disabled people's independence and inclusion.

The CRPD has clarified that peer support "should be self-directed, independent of institutions and medical professionals, and autonomously organized by persons with disabilities."[195] The CRPD has called on States parties to "invest in peer support, self-advocacy, circles of support and other support networks – including organizations of persons with disabilities, particularly those of survivors of institutionalization – and centres for independent living."[196]

11. Right to Family for People with Disabilities

People with disabilities have the right to found a family. Under the CRPD, States parties should ensure the rights and responsibilities of people with disabilities regarding children by providing them with appropriate assistance for their child-rearing responsibilities.[197] Support for exercising the right to family should include access to personal assistants, so the person with disabilities does not have to rely on informal supporters or caregivers.[198] States parties should also ensure children are never separated from their parents on the basis of disability, of either the child or one or both parents.[199]

12. Right to Work

Workers' rights are guaranteed by the UDHR, ICESCR, International Covenant on Civil and Political Rights (ICCPR), and core conventions of the International Labour Organization (ILO). The ICESCR specifies the rights of everyone to earn a living by work freely entered into, fair wages and equal remuneration for work of equal value without any distinction, a decent living for workers and their families, and safe and healthy working conditions.[200]

The CEDAW Committee urged States parties to ensure women care workers and domestic workers enjoy the same protections regarding remuneration and working conditions as workers in other sectors.[201] ILO Convention No. 189 on Decent Work for Domestic Workers affirms that domestic workers[202] are entitled to the same basic rights as other workers, including weekly days off, limits on working hours, minimum wage, overtime compensation, and social security.[203]

According to the CRPD Committee, for people with disabilities, "[f]unding for personal assistance must be provided on the basis of personalized criteria and take into account human rights standards for decent employment."[204]

C. Rights of Indigenous Peoples Relevant to Care and Support

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) provides an Indigenous-specific human rights framework relevant to the care economy and to several barriers identified in this research. Adopted by the UN General Assembly in 2007, UNDRIP is a declaration rather than a treaty and is therefore not subject to ratification. Canada endorsed the Declaration without qualification in 2016. In 2021, Parliament enacted the United Nations Declaration on the Rights of Indigenous Peoples Act, which affirms UNDRIP as a universal international human rights instrument with application in Canadian law and establishes a framework for its federal implementation.[205]

The Declaration is particularly relevant to the experiences described by Inuit and other Indigenous women with disabilities in this study, including colonial disruption of community relationships of care, lack of culturally safe and locally available services, circumstances in which people must leave family and culture to obtain care, and failures of formal systems to recognize or support culturally grounded forms of caregiving. UNDRIP recognizes Indigenous peoples' right to self-determination and their right to maintain and strengthen distinct political, legal, economic, social and cultural institutions. Its protections against forced assimilation and forced relocation also speak to the colonial histories described by participants. These standards support an approach to care and support policy that does not treat Indigenous social and cultural arrangements merely as informal substitutes for public services but recognizes Indigenous peoples as rights-

holders with authority in shaping the institutions and relationships through which care is organized.[206]

UNDRIP also speaks directly to the material and service conditions implicated in the findings. Article 17 protects Indigenous individuals' rights under applicable labour law and their right not to be subjected to discriminatory conditions of labour, employment or salary. Article 21 recognizes the right of Indigenous peoples, without discrimination, to improvement of their economic and social conditions, expressly including employment, housing, health and social security, and requires particular attention to Indigenous women and persons with disabilities. Article 22 similarly requires particular attention to Indigenous women and persons with disabilities and measures, in conjunction with Indigenous peoples, to protect Indigenous women and children from violence and discrimination. Article 24 protects traditional medicines and health practices, non-discriminatory access to social and health services, and the right to the highest attainable standard of health.[207]

UNDRIP further strengthens the governance standards relevant to the care economy. Article 18 recognizes the right of Indigenous peoples to participate in decision-making through representatives chosen in accordance with their own procedures and to maintain and develop their own decision-making institutions. Article 19 requires States to consult and cooperate in good faith with Indigenous peoples through their representative institutions to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them. Article 23 recognizes the right of Indigenous peoples to determine and develop priorities and strategies for development, to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions. In the federal sphere, the UN Declaration Act requires the Government of Canada, in consultation and cooperation with Indigenous peoples, to take all measures necessary to ensure federal laws are consistent with the Declaration and to implement an action plan to achieve its objectives.[208]

These standards do not themselves establish a freestanding Indigenous right to care. They do, however, add a critical collective and self-determination dimension to the rights framework applied in this report. In assessing the Care Economy Policy Regime, they support attention not only to whether services are culturally appropriate and non-discriminatory, but also to whether Indigenous peoples are able to maintain valued care relationships and institutions, determine priorities, participate meaningfully in policy and program design, and shape or administer the social, health and other programs through which care and support are provided.

D. Guidance on the Governance of Care and Support

Several of the CRPD and CEDAW Committees' concluding observations have provided guidance on what the governance of care and support entails. The CEDAW Committee made recommendations to several States parties, including to have a "comprehensive national care policy,"[209] have "transformative fiscal policies and strategies to meet the needs imposed by care work, to reduce the burden of unpaid care work on women," and facilitate "access to high-quality and affordable gender-responsive public services."[210] The CRPD Committee directed a couple States parties to harmonize all disability laws and policies with the human rights model of disability and focus on the barriers people with disabilities face and the support they need to enjoy their rights.

The CEDAW Committee recommended one State party develop robust data-collection programs related to care and support, including on the situation of women with disabilities' access to public life, employment, and health care, including sexual and reproductive health services, among others, and on the multiple and intersecting discrimination and gender-based violence they face.

In other instances, the CEDAW Committee specifically called for several States parties to generate data on and establish the monetization of unpaid care work as a baseline for its recognition and compensation.

Summary

Taken together, these standards establish a substantial human rights foundation for assessing the policy regime shaping care and support. They require more than the formal availability of services. They point toward care and support systems that are non-discriminatory, accessible, affordable, culturally appropriate, adequately resourced, and responsive to individual needs and choices; that support independent living, family life, social security, and decent work; and that recognize the participation and expertise of people directly affected by care and support policies.

The emerging recognition of a right to care adds an important integrative dimension to these existing obligations by bringing together the rights to receive care, provide care, and exercise self-care. For women with disabilities and Deaf women, this challenges policy frameworks that treat people as either caregivers or recipients of care and instead recognizes the interdependence of these roles. These normative standards provide the basis for the framework developed in the next section, which translates the rights and principles identified here into indicators and measures for assessing the multiple laws, policies, programs, and administrative provisions that constitute the care economy policy regime.

VI. Proposed Framework for Assessing the Care Economy Policy Regime in Canada

The findings of this research make clear that the barriers experienced by women with disabilities and Deaf women are not isolated failures at the margins of otherwise functioning systems. They arise repeatedly across access to care and support, the design and quality of services, paid and unpaid care work, income and housing, self-care, and participation in policy and program decisions. They are produced and reinforced through the interaction of laws, policies, programs, funding arrangements, eligibility rules, and administrative systems operating across sectors and jurisdictions.

The care economy is therefore not an abstraction. The conditions under which care and support are received, provided, and exercised are actively structured through decisions made by legislatures, governments and public authorities. Those decisions determine what forms of care and support are recognized; who is eligible for publicly funded services; how much support is available and where; how paid and unpaid care work is treated; whether people have adequate income and housing to care for themselves and others; and whose knowledge and experience shape policy. Taken together, these arrangements constitute a policy regime, even though that regime has no single statute, ministry, or institution responsible for it as a whole.

The dispersed character of the regime makes it especially important to bring it into view. Without a framework for examining its component parts together, systemic gaps can remain hidden within individual programs and jurisdictional boundaries. Responsibility can be displaced from one system to another; inadequate formal support can be absorbed as unpaid family or community care; and barriers produced by income, housing, transportation, health, disability, and employment systems can be treated as unrelated problems. The findings demonstrate the consequences of that fragmentation in the lives of women with disabilities and Deaf women. Without sustained efforts to identify and address these structural gaps, there is a serious risk that existing inequalities will become further embedded in the very systems increasingly being relied upon to respond to growing care needs.

The stakes are fundamental. Access to care and support affects people's ability to maintain their health and well-being, live in the community, exercise autonomy, sustain family and community relationships, participate in employment and public life, and provide care to others. The international human rights standards reviewed in the preceding section establish that these are not simply matters of efficient service delivery or social policy preference. They engage equality and non-discrimination, health, an adequate standard of living, social security, family life, independent living and community inclusion, decent work,

and participation in decisions affecting one's life. For women with disabilities and Deaf women, the capacity of the care and support regime to respect and realize these rights is consequently of profound importance.

A. From Regulatory Functions to an Assessment Framework

The preceding analysis identified six principal regulatory functions of the policy regime shaping care and support. These functions provide the descriptive architecture of the proposed framework. They identify what the regime does: it defines the scope of care and support; establishes access to services; regulates service design and delivery; regulates paid and unpaid care work; establishes material and social supports related to self-care and caregiving; and establishes how policies and programs are governed.

Description alone, however, is insufficient. Identifying the regime does not tell us whether it is inclusive, whether it is addressing the barriers documented in this research, or whether its provisions are consistent with human rights. The framework therefore adds a second, normative level of analysis.

For each dimension, indicators identify the conditions that would characterize an inclusive and rights-respecting regime. These indicators are grounded in two sources: the lived-experience barriers documented in the Findings and the international human rights standards reviewed in Section V. Measures provide a further level of operationalization by translating the indicators into characteristics that can be examined in individual provisions of laws, policies, programs, guidelines, and documented administrative practices.
In this way, the framework moves from: **lived-experience barriers → regulatory functions → human rights standards → indicators → provision-level measures.**

B. Proposed Care Economy Policy Regime Assessment Framework

Dimension / regulatory function	Indicators of an inclusive and rights-respecting regime
1. Defines the scope and nature of care and support	**1.1** Care and support are understood inclusively to encompass receiving care and support, providing care and support, and exercising self-care. **1.2** The regime recognizes that people may both provide and receive care and support and does not rely on a binary caregiver/care-recipient model. **1.3** Diverse family, peer,

	community, and culturally grounded forms of care and support are recognized.
2. Establishes access to care and support services	**2.1** Eligibility responds to actual care and support needs and circumstances rather than unnecessarily restrictive categories or diagnoses. **2.2** Processes for accessing care and support are accessible, proportionate, affordable, and timely. **2.3** People have accessible information, navigation, and coordination support. **2.4** Needed care and support are available in the home and community, including in rural, remote, Northern, and Indigenous communities. **2.5** Transportation and other access costs do not prevent access. **2.6** Access is non-discriminatory and does not depend on accepting unwanted treatment or relying on family or other informal support.
3. Regulates the design and delivery of care and support services	**3.1** Services are adequately resourced, timely, continuous, and responsive to changing and ongoing needs. **3.2** Care and support respect autonomy, dignity, choice, and self-determination. **3.3** Services are respectful, non-stigmatizing, culturally appropriate, and responsive to diverse identities and lived experience. **3.4** People can identify unmet needs, advocate for themselves, and challenge decisions without retaliation or loss of support.
4. Regulates paid and unpaid care and support work	**4.1** Unpaid family caregiving is recognized and adequately supported, including where caregivers themselves have disabilities. **4.2** Parents with disabilities receive the supports needed to exercise parenting and caregiving responsibilities without discrimination. **4.3** Informal peer and community care and support are recognized and supported. **4.4** Indigenous and Inuit forms of community caregiving are recognized in culturally appropriate

	ways. **4.5** Paid care and support work provides fair remuneration, social protection, and decent working conditions. **4.6** Women with disabilities and Deaf women have equitable access to paid care and support employment, and lived experience is recognized and valued as expertise.
5. Establishes material and social supports related to self-care and caregiving	**5.1** Income and social protection are adequate to meet basic needs and disability- and care-related costs. **5.2** People have access to adequate, affordable, and accessible housing that supports independent living, self-care, and caregiving. **5.3** The regime recognizes that self-care may itself require assistance and support.
6. Establishes governance of care-economy policies and programs	**6.1** People who receive and provide care and support meaningfully participate in policy and program design, implementation, monitoring, and review. **6.2** Participation is accessible, supported, and appropriately recognized and compensated. **6.3** Governance processes include diverse lived experience and provide mechanisms through which participation can influence decisions and accountability.

C. Applying the Framework to Laws and Policies

The distinction among dimensions, indicators, and measures is important. The dimensions are descriptive: they identify the principal functions of the policy regime. The indicators are normative: they describe what the performance of each function would look like in a regime capable of overcoming the barriers identified in this research consistently with human rights. The measures are operational: they identify what researchers should look for in law and policy provisions.

For example, Indicator 2.1 establishes that eligibility should respond to actual care and support needs and circumstances rather than unnecessarily restrictive diagnostic or

categorical requirements. Provision-level measures can then ask whether eligibility is based on individualized support needs rather than solely on a diagnosis; whether rules accommodate changing or episodic needs; and whether needed formal support can be reduced or denied because family or other informal caregivers are assumed to be available. In this way, an experience identified in the Findings—being denied support because a family member is presumed capable of providing it—can be traced to the provisions structuring eligibility and assessed against a common normative standard.

A single provision may be relevant to more than one dimension or indicator. This is not a defect in the framework but a reflection of the interconnected character of the regime. A home-care eligibility rule may affect access to services while also shifting care work onto family members. An individualized-funding provision may affect access, the design of support, personal choice and control, and the employment conditions of support workers. An income-support rule may affect self-care, housing security, labour-market participation, and the capacity to provide care to others.

The framework is therefore intended to make visible both gaps within individual policy systems and gaps between them. Applied across jurisdictions, it can also identify significant differences in the ways comparable needs are recognized and addressed and where jurisdictional fragmentation itself contributes to unequal access or outcomes.

D. Making the Regime Visible and Accountable

The purpose of the framework is not to collapse the complexity of the care economy into six policy silos or to suggest that a single score can capture whether a jurisdiction respects the rights of people who provide and receive care and support. Its purpose is to create a common analytical structure through which the numerous provisions that collectively shape people's experiences can be examined systematically.

That is particularly important because fragmentation can obscure accountability. A person encountering a barrier may experience it as a denial of home care, insufficient income, inaccessible transportation, lack of appropriate housing, an employment problem, or an inability to obtain respite. Viewed separately, each can appear to be a problem confined to a particular program. Viewed through the framework, they can be examined as interconnected elements of a regime governing whether people have the conditions required to receive care and support, provide it to others, and exercise self-care.

The framework also offers a basis for moving from diagnosis to sustained reform. It can help identify where laws and policies already reflect human rights standards, where significant gaps remain, where provisions in different policy systems work at cross-purposes, and where reform requires coordination across governments or sectors rather than adjustment to a single program.

The experiences documented in this report demonstrate the urgency of that task. A care economy already exists, and governments already structure it. The policy choice is not whether to create a care economy, but whether the policy regime shaping it will continue to reproduce barriers and transfer their costs onto women, families, workers, and marginalized communities, or whether it will be systematically assessed and transformed in accordance with the rights and realities of the people whose lives it governs.

For women with disabilities and Deaf women, this is not an abstract question of policy architecture. It concerns whether they can obtain the support they need without sacrificing autonomy, community, income, health, family relationships, or their own capacity to care for others. Bringing the regime into view, identifying its gaps, and establishing mechanisms for sustained assessment and reform are therefore essential steps toward ensuring that the human rights examined in this report are realized in practice rather than remaining commitments on paper.

VII. Strategic Directions for Reform

The findings of this report identify recurring barriers affecting women with disabilities and Deaf women as they receive care and support, provide paid and unpaid care, and undertake self-care. The law and policy analysis indicates that these barriers are not confined to individual programs or service systems. They are shaped through a dispersed regime of laws, policies, funding arrangements, eligibility rules, administrative practices, and institutional responsibilities spanning disability, health and home care, income security, housing, employment, transportation, family support, and related fields. The human rights standards reviewed in Section V provide a normative basis for assessing these arrangements and the conditions they should secure.

The directions set out below are not intended to be a comprehensive blueprint for redesigning Canada's care economy. The qualitative research undertaken for this report identifies significant and recurring barriers and, together with the law and policy review and human rights analysis, points to areas requiring sustained attention and reform. More detailed policy development will require systematic jurisdictional analysis, application and further testing of the assessment framework proposed in Section VI, as well as meaningful participation by the people who receive and provide care and support.

At the same time, maintaining the status quo is not a neutral option. The barriers documented in this research are shaped through existing policy arrangements. Leaving those arrangements fragmented and largely unexamined risks continuing to reproduce unmet needs, unpaid and unsupported care work, poverty, loss of autonomy, institutionalization, and exclusion from decision-making. The immediate task is therefore both to make the regime visible and assessable and to begin addressing the structural barriers that the research has already brought into view.

A. Make the Care Economy Policy Regime Visible and Assess It Systematically

Federal, provincial, territorial, and other public authorities responsible for care and support should recognize that the conditions under which care is received, provided, and exercised are shaped by an interconnected care economy policy regime rather than by a single care program or sector.

Governments should:

- **Undertake systematic reviews of the laws, policies, programs, guidelines, funding arrangements, and administrative practices that shape care and support**, using the six regulatory functions identified in this report as a common analytical framework.

- **Assess these provisions against lived-experience barriers and human rights standards**, including through the indicators and measures proposed in Section VI.
- **Identify gaps and contradictions within and between policy systems**, including circumstances in which inadequate provision in one system shifts costs, responsibilities, or risks onto another system, families, unpaid caregivers, or people requiring support.
- **Establish baseline information and repeat assessment over time** so that progress in addressing barriers can be monitored rather than inferred from the existence of individual programs or spending commitments.
- **Report publicly on identified gaps, priorities for reform, and progress in implementation**, including where effective reform requires coordination between ministries, sectors, or orders of government.

The framework proposed in this report should itself be treated as a starting point. Its indicators and measures should be tested and refined through further jurisdictional analysis and through engagement with people who receive and provide care and support.

B. Prioritize Action on Structural Barriers Identified in the Research

Systematic assessment should not delay action on barriers already clearly identified through the research. The findings point to several priority directions.

1. Broaden the recognition of care and support

Care-economy policies should move beyond a binary model in which people are classified as either caregivers or recipients of care. Women with disabilities and Deaf women may simultaneously provide substantial paid or unpaid care, require support themselves, and undertake forms of self-care essential to maintaining health, autonomy, and participation. Policy frameworks should therefore recognize receiving care and support, providing paid and unpaid care, and exercising self-care as interconnected dimensions of people's lives. They should also recognize family, peer, community, and culturally grounded forms of care rather than assume formal services or conventional family caregiving arrangements are sufficient.

2. Improve equitable access to home and community-based care and support

The findings identify:

- restrictive eligibility rules;
- burdensome application and reassessment processes;

- diagnostic gatekeeping;
- lack of information and navigation assistance for services;
- transportation barriers;
- geographic disparities; and
- inadequate availability of home and community services.

Governments should review the rules and administrative practices governing access to ensure that support: responds to actual needs and circumstances; that obtaining it does not impose disproportionate financial, administrative, or physical burdens; and that the presumed availability of family or informal support is not used as a substitute for necessary formal services. Particular attention is required to rural, remote, Northern, and Inuit communities where lack of locally available support can require people to choose between unmet needs and leaving family, culture, and community.

3. Make care and support person-directed and rights-respecting

Access alone is insufficient if services are inadequately resourced, stigmatizing, inflexible, or organized in ways that diminish autonomy and self-determination. Participants described rushed and fragmented services, limited choice over workers and arrangements, repeated requirements to self-advocate, and risks associated with challenging decisions. Care and support systems should be designed to respect dignity, autonomy, choice, cultural identity, and individual preferences; provide continuity where needs are ongoing; and enable people to raise concerns, challenge decisions, and advocate for their needs without retaliation or loss of support. Governments and service providers should address discriminatory and ableist practices structurally, including through standards, accountability mechanisms, workforce development, and appropriate training.

4. Recognize and support paid and unpaid care and support work

Women with disabilities and Deaf women who provide care should not disappear from policy because they are presumed only to be recipients of support. The findings document substantial family caregiving, parenting, peer and community support, and participation in paid care work, often undertaken while managing women's own disability-related needs. Policies should recognize and support unpaid family caregivers with disabilities; ensure parents with disabilities have access to the supports required to exercise their parenting responsibilities without discriminatory assumptions about their capacity; recognize the importance of peer and community support; and ensure that culturally grounded Indigenous and Inuit caregiving practices are respected.

Paid care and support workers should have decent working conditions, adequate compensation, social protection, manageable workloads, and safe workplaces. Women with disabilities and Deaf women should also have equitable opportunities to enter and

remain in paid care and support employment, with their lived experience recognized as expertise rather than confined to unpaid or precarious roles.

5. Address the material conditions necessary for self-care and caregiving

The ability to care for oneself or others depends upon material conditions that often sit administratively outside the formal care sector. Participants described inadequate income, high housing costs, food insecurity, transportation costs, and disability-related expenses as directly undermining their capacity for self-care and caregiving.

Governments should assess disability income, social protection, housing, transportation, and related programs for whether they provide the material conditions required to meet basic needs and disability- and care-related costs. Income and benefit systems should not leave people choosing between food, housing, personal care, disability supports, and the needs of family members. Accessible and affordable housing should likewise be recognized as integral to independent living, self-care, and sustainable caregiving.

6. Build meaningful participation into the governance of care and support

People directly affected by care and support policies should have meaningful roles in defining problems, designing responses, monitoring implementation, and evaluating outcomes. This includes people receiving support, unpaid caregivers, paid workers, parents with disabilities, peer supporters, and organizations representing diverse disability communities.

Participation should be accessible, adequately supported, and appropriately compensated. Particular effort is needed to include women with disabilities and Deaf women who experience intersecting marginalization, including Indigenous, Black, racialized, migrant, and low-income women. Engagement should be designed so that lived-experience input has an identifiable route into decisions rather than being limited to episodic consultation. This direction is consistent with the international standards reviewed in Section V by emphasizing close consultation and active involvement of people with disabilities in decisions affecting them.

7. Build the Institutional Capacity for Sustained and Coordinated Reform

The cross-sectoral and inter-jurisdictional character of the care and support regime means that reform cannot be achieved by a single ministry or through isolated program changes. Governments should establish sustained mechanisms for coordination across the systems that shape care and support, including disability services, health and home care, income security, housing, labour and employment, transportation, and family supports. This will require:

- **Federal government**: The federal government has an important leadership role, particularly through its spending and fiscal capacities. Federal disability and income programs, responsibilities toward First Nations and Inuit communities, and emerging work on the care economy and a national caregiving strategy are all key factors. Federal initiatives should explicitly include people with disabilities not only as recipients of care but as caregivers, workers, parents, peer supporters, and policy experts. National initiatives should also support greater consistency in rights protection while respecting provincial, territorial, and Indigenous jurisdiction and governance.

- **Provincial and territorial governments**: These jurisdictions, which regulate and deliver many of the services most directly affecting care and support, should review home and community care, disability services, income assistance, housing, transportation, and related programs through the same cross-system lens. Particular attention should be given to places where formal responsibility is fragmented between programs or where lack of publicly available support shifts responsibility onto unpaid caregivers.

- **Data and evidence Infrastructure**: Governments at all levels should also strengthen the data and evidence infrastructure needed for reform. Existing data should be supplemented by disaggregated information on unmet care and support needs, paid and unpaid caregiving, disability, gender, race, Indigeneity, geography, income, and other intersecting circumstances. Data collection should illuminate not only who receives services but also: who remains excluded, who fills gaps through unpaid work, and what effects policy arrangements have on autonomy, health, income, employment, and community participation.

- **Ongoing review and accountability**: Finally, governments should create mechanisms for ongoing review and accountability. Care needs, labour markets, demographic conditions, service models, and public programs change over time. Assessment of the regime should therefore be an ongoing process rather than a one-time policy exercise.

Conclusion

The research undertaken for this report does not provide a complete design for Canada's future care economy, nor should policy reform be developed without much broader participation and jurisdiction-specific analysis. It does, however, identify a necessary starting point.

A care economy already exists, and governments already shape it. Laws, policies, funding decisions, eligibility requirements, service models, labour arrangements, and social protection systems distribute care, resources, responsibilities, risks, and power every day. When these arrangements are examined only within their separate administrative silos, the cumulative effects documented in this report can get lost.

The immediate challenge is therefore to **bring the regime into view, assess it systematically, and create sustained processes for closing the gaps that the assessment reveals**. The proposed framework offers one means of beginning that work. Its value will ultimately lie not in the framework itself, but in whether it helps governments, communities, people who provide care, and people who receive support identify where existing arrangements fall short and build more coherent responses.

For women with disabilities and Deaf women, this work has particular urgency. The findings demonstrate that inadequacies in care and support do not affect a single domain of life. They can determine whether a person has adequate food and housing, whether she can remain in her community, maintain her health, exercise autonomy, parent her children, participate in paid employment, care for family and community members, or obtain support without surrendering dignity and control. The strategic direction is therefore clear: **care and support must be treated as a matter of sustained public responsibility, subjected to systematic rights-based scrutiny, and reformed in partnership with the people whose lives are most directly shaped by the regime at the centre of that work.**

Notes

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[14] It includes, however, "Provision of services for own final use" such as "household accounting and management, preparing and serving meals, cleaning, decorating and maintaining one's own dwelling, and also childcare, transporting and caring for dependents, including older persons and other household members." International Labour Organization. (2018). *Care Work and Care Jobs:*

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[140] Salazar-Xirinachs, J., M. et al. *Buenos Aires Commitment*. Economic Commission for Latin America and the Caribbean, (p. 18).

[141] Relevant provisions include: *International Covenant on Economic, Social and Cultural Rights* (arts. 3, 6–7 and 9–13).; *Convention on the Elimination of All Forms of Discrimination against Women* (preamble and arts. 1–2, 5, 11–14 and 16).; and *Convention on the Rights of the Child* (arts. 3, 7, 18–19, 23–25, 38 and 40).
[142] Government of Canada. (2024). Human rights treaties. https://www.canada.ca/en/canadian-heritage/services/canada-united-nations-system/treaties.html; United Nations Human Rights Treaty Bodies. *Treaty Body Database: Ratification Status for Canada*. https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=31&Lang=EN
[143] Committee on the Rights of Persons with Disabilities. (2016, November). *General comment No.3 on Article 6 – women and girls with disabilities*. CRPD/C/GC/3 (paras. 16 and 63).
[144] Committee on the Rights of Persons with Disabilities. (2024, 7 October). *Concluding observations on the combined second and third periodic reports of Mauritius*. CRPD/C/MUS/CO/2-3 (para 12(a)).
[145] Committee on the Rights of Persons with Disabilities. (2016, November). *General comment No.3 on Article 6 – women and girls with disabilities*. CRPD/C/GC/3 (paras. 2).
[146] *Convention on the Rights of Persons with Disabilities*, art. 8(1).
[147] *Convention on the Rights of Persons with Disabilities,* art. 8, part a.
[148] UN Committee on Economic, Social and Cultural Rights, "General Comment No. 14, The Right to the Highest Attainable Standard of Health," UN Doc. E/C.12/2000/4, August 11, 2000, para. 1; see also ICESCR Art. 12(1); Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979.
[149] UN Committee on Economic, Social and Cultural Rights, "General Comment No. 14, The Right to the Highest Attainable Standard of Health," UN Doc. E/C.12/2000/4, August 11, 2000, para. 8.
[150] UN Committee on Economic, Social and Cultural Rights. (2000, 11 August). *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. E/C.12/2000/4 (para 12).
[151] UN Committee on Economic, Social and Cultural Rights. (2000, 11 August). *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. E/C.12/2000/4 (para 17).
[152] *Convention on the Rights of Persons with Disabilities*, art. 25.
[153]Committee on the Rights of Persons with Disabilities. (2011, 27 October). *General Comment No. 5 (2017) on living independently and being included in the community*. CRPD/C/GC/5 (para 89).
[154] Committee on the Elimination of Discrimination against Women. (2022, 12 July). *Concluding observations on the tenth periodic report of Mongolia*. CEDAW/C/MNG/CO/10 (para 33 (b)).; Committee on the Elimination of Discrimination against Women. (2022, 1 March). *Concluding observations on the sixth periodic report of Uzbekistan*. CEDAW/C/UZB/CO/6 (para 34(c)).; Committee on the Elimination of Discrimination against Women. (2020, 8 January). *Seventh periodic report submitted by the Plurinational State of Bolivia under article 19 of the Convention*. CEDAW/C/BOL/7 (para 31(a).
[155] Committee on the Elimination of Discrimination against Women. (2021, 24 November). *Concluding observations on the tenth periodic report of Ecuador*. CEDAW/C/ECU/CO/10 (para 34(b)).; Committee on the Elimination of Discrimination against Women. (2021, 24 November). *Concluding observations on the tenth periodic report of Sweden*. CEDAW/C/SWE/CO/10 (para 36).
[156] Committee on the Elimination of Discrimination against Women. (1999). *General Recommendation No. 24: Article 12 of the Convention (Women and Health)* (para 25).
[157] Committee on the Elimination of Discrimination against Women. (2019, 2 December). *Tenth periodic report submitted by Portugal under article 18 of the Convention, due in 2019*. CEDAW/C/PRT/10 (para 41(c)). See also, Committee on the Elimination of Discrimination against Women. (2020, 8 January) *Seventh periodic report submitted by the Plurinational State of Bolivia under article 19 of the Convention, due in 2019*. CEDAW/C/BOL/7 (para 28(g)).
[158] Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810, art. 25(1).
[159] International Covenant on Economic, Social and Cultural Rights, art. 11

[160] In its General Comment No. 14, the CESCR identifies the state's obligation to "ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions." Committee on Economic, Social and Cultural Rights. (2000, 11 August). *General Comment No. 14* (para. 36).
[161] Committee on Economic, Social and Cultural Rights. (1994, 9 December). *General Comment No. 5: Persons with Disabilities*. E/1995/22 (para. 33).
[162] Committee on the Rights of Persons with Disabilities. (2011, 27 October). *General Comment No. 5 (2017) on living independently and being included in the community*. CRPD/C/GC/5 (para. 92).
[163] Committee on the Rights of Persons with Disabilities. (2011, 27 October). *General Comment No. 5 (2017) on living independently and being included in the community*. CRPD/C/GC/5 (para. 84 and para. 92).
[164] Committee on the Rights of Persons with Disabilities. (2024, 30 September). *Concluding observations on the combined second and third periodic reports of Belgium*. CRPD/C/BEL/CO/2-3 (para 59(a)).
[165] Convention on the Rights of Persons with Disabilities, art. 28.
[166] Convention on the Rights of Persons with Disabilities, art. 28.
[167] Committee on the Rights of Persons with Disabilities. (2024, 7 October). *Concluding observations on the combined second and third periodic reports of Mauritius*. CRPD/C/MUS/CO/2-3 (para 50). See also Committee on the Rights of Persons with Disabilities. (2024, 8 October). *Concluding observations on the combined second and third periodic reports of Denmark*. CRPD/C/DNK/CO/2-3 (paras. 56 and 74).
[168] Committee on the Rights of Persons with Disabilities. (2011, 27 October). *General Comment No. 5 (2017) on living independently and being included in the community*. CRPD/C/GC/5 (para. 74).
[169] Committee on the Rights of Persons with Disabilities. (2025, 15 April). *Concluding observations on the combined second and third periodic reports of Canada*. CRPD/C/CAN/CO/2-3 (paras 56 (b) and (c)).
[170] Committee on the Rights of Persons with Disabilities. (2025, 15 April). *Concluding observations on the combined second and third periodic reports of Canada*. CRPD/C/CAN/CO/2-3 (para 20(c)).
[171] Committee on the Rights of Persons with Disabilities. (2018. 9 November). *General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention*. CRPD/C/GC/7 (para. 87).
[172] Committee on the Rights of Persons with Disabilities. (2025, 15 April). *Concluding observations on the combined second and third periodic reports of Canada*. CRPD/C/CAN/CO/2-3 (paras 12 and 12(a)).
[173] Universal Declaration of Human Rights, art 22; International Covenant on Economic, Social and Cultural Rights, art 9; Convention on the Elimination of Discrimination against Women, arts. 11 and 14.
[174] Committee on Economic, Social and Cultural Rights. (2008, 4 February*). General Comment No. 19, The Right to Social Security, (Art. 9 of the Covenant)*. E/C.12/GC/19 (pages 4-7).
[175] Ibid., paras. 20, 33-34, and 37
[176] Human Rights Watch. (2023, 25 May). *Questions and Answers on the Right to Social Security*. https://www.hrw.org/news/2023/05/25/questions-and-answers-right-social-security
[177] Committee on the Elimination of Discrimination against Women. (2022, 1 March). *Concluding observations on the sixth periodic report of Uzbekistan*. CEDAW/C/UZB/CO/6 (para 36(b)); Committee on the Elimination of Discrimination against Women. (2021, 24 November). *Concluding observations on the tenth periodic report of Ecuador*. CEDAW/C/ECU/CO/10 (para 36(d)); Committee on the Elimination of Discrimination against Women. (2021, 29 November). Concluding observations on the fifth periodic report of Kyrgyzstan. CEDAW/C/KGZ/CO/5 (para. 38(b)); Committee on the Elimination of Discrimination against Women. (2022, 1 March). Concluding observations on the eighth periodic report of Panama. CEDAW/C/PAN/CO/8 (para 40(c)).

[178] *Convention on the Rights of Persons with Disabilities*, art. 19.
[179] Committee on the Rights of Persons with Disabilities. (2017, 27 October). *General Comment No. 5: on Article 19 – the right to live independently and be included in the community*. CRPD/C/GC/5 (paras. 4 and 16).
[180] Ibid., para 16.
[181] Ibid., paras. 8-9.
[182] Ibid., para. 38(c).
[183] Ibid., paras, 38(h), 39, and 41.
[184] Ibid., para. 28.
[185] Ibid., para. 63.
[186] Committee on the Rights of Persons with Disabilities. (2017, 27 October). *General Comment No. 5: on Article 19 – the right to live independently and be included in the community*. CRPD/C/GC/5 (paras. 2 and 8).
[187] Ibid., para. 65.
[188] Ibid., para 25.
[189] *Convention on the Rights of Persons with Disabilities*, art. 4(3). Examples of different types of organizations of people with disabilities that should be consulted are identified in: Committee on the Rights of Persons with Disabilities. (2018, 9 November). *General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention*. CRPD/C/GC/7 (para. 12).
[190] Committee on the Rights of Persons with Disabilities. (2016, 25 November). *General comment No.3 on Article 6 – women and girls with disabilities*. CRPD/C/GC/3 (paras. 1, 9, and 18).
[191] Ibid., paras. 18 and 33.
[192] Committee on the Rights of Persons with Disabilities. (2017, 27 October). *General Comment No. 5: on Article 19 – the right to live independently and be included in the community*. CRPD/C/GC/5 (paras. 34 and 59).
[193] Ibid. para. 92, see also para. 84.
[194] Committee on the Elimination of Discrimination against Women. (2019, 2 December). *Tenth periodic report submitted by Portugal under article 18 of the Convention, due in 2019*. CEDAW/C/PRT/10 (para 35 and 41(b)). See also: Committee on the Rights of Persons with Disabilities. (2024, 8 October). *Concluding observations on the combined second and third periodic reports of Denmark*. CRPD/C/DNK/CO/2-3 (para. 56); Committee on the Rights of Persons with Disabilities. (2024, 7 October). *Concluding observations on the combined second and third periodic reports of Mauritius*. CRPD/C/MUS/CO/2-3 (para. 32);
[195] Committee on the Rights of Persons with Disabilities. (2022, 9 September). *Guidelines on deinstitutionalization, including in emergencies*. CRPD/C/5 (para 73).
[196] Ibid., para 70.
[197] *Convention on the Rights of Persons with Disabilities*, art. 23(2).
[198] Committee on the Rights of Persons with Disabilities. (2024, 20 September). *Concluding observations on the combined second and third periodic reports of Belgium*. CRPD/C/BEL/CO/2-3 (para 47(c)).
[199] *Convention on the Rights of Persons with Disabilities*, art. 23(4).
[200] International Covenant on Economic, Social and Cultural Rights, art. 6 and 7.
[201] Committee on the Elimination of Discrimination against Women. (2021, 23 November). *Concluding observations on the fifth periodic report of South Africa*. CEDAW/C/ZAF/CO/5 (para 50(a-b)). See also, Committee on the Elimination of Discrimination against Women. (2020, 8 January). *Seventh periodic report submitted by the Plurinational State of Bolivia under article 19 of the Convention*. CEDAW/C/BOL/7 (para 26(f)).

[202] Domestic work is defined by the ILO as "work performed in or for a household or households" and encompassing personal and household care: International Labour Organization. *C189 - Domestic Workers Convention, 2011 (No. 189)*, art. 1(a).
[203] Ibid., art. 14.
[204] Committee on the Rights of Persons with Disabilities. (2011, 27 October). *General Comment No. 5 (2017) on living independently and being included in the community*. CRPD/C/GC/5 (para 16(d)(i)).
[205] United Nations General Assembly. (2007, 13 September). United Nations Declaration on the Rights of Indigenous Peoples, GA Res. 61/295. A/RES/61/295; Government of Canada. (2016, 10 May). Canada Becomes a Full Supporter of the United Nations Declaration on the Rights of Indigenous Peoples," https://www.canada.ca/en/indigenous-northern-affairs/news/2016/05/canada-becomes-a-full-supporter-of-the-united-nations-declaration-on-the-rights-of-indigenous-peoples.html ; United Nations Declaration on the Rights of Indigenous Peoples Act, S.C. 2021, c. 14, s. 4, https://laws-lois.justice.gc.ca/eng/acts/U-2.2/
[206] *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), arts. 3, 5, 8, 10 and 20.
[207] *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), arts. 17, 21, 22, and 24.
[208] Ibid., arts. 18, 19 and 23; *United Nations Declaration on the Rights of Indigenous Peoples Act*, S.C. 2021, c. 14, ss. 5-6.
[209] Committee on the Elimination of Discrimination against Women. (2020, 8 January). *Seventh periodic report submitted by the Plurinational State of Bolivia under article 19 of the Convention*. CEDAW/C/BOL/7 (para 26(d)).
[210] Concluding observations on the fifth periodic report of Kyrgyzstan. CEDAW/C/KGZ/CO/5 (para. 38). See also, Committee on the Elimination of Discrimination against Women. (2022, 1 March). *Concluding observations on the sixth periodic report of Uzbekistan*. CEDAW/C/UZB/CO/6 (para 36(a)); Committee on the Elimination of Discrimination against Women. (2020, 8 January). *Seventh periodic report submitted by the Plurinational State of Bolivia under article 19 of the Convention*. CEDAW/C/BOL/7 (para 26(d)); Committee on the Elimination of Discrimination against Women. (2021, 24 November). *Concluding observations on the tenth periodic report of Ecuador*. CEDAW/C/ECU/CO/10 (para 38(a)); Committee on the Elimination of Discrimination against Women. (2016, 25 July). Concluding observations on the seventh periodic report of Turkey. CEDAW/C/TUR/CO/7 (para 50); Committee on the Elimination of Discrimination against Women. (2022, 1 March). Concluding observations on the seventh periodic report of Gabon. CEDAW/C/GAB/CO/7 (para 29(a)).

Appendix A: Care Economy Law and Policy Review

This appendix lists the laws, policies, public programs, policy manuals, organizations, and other supports identified through a scan of laws and policies regulating different aspects of the care economy in Canada. The scan was conducted in parallel with the focus group research to help identify the instruments, systems, and institutional arrangements implicated in the barriers described by participants. It is an exhaustive listing of all the sources relevant to the care economy policy regime; however, the selection indicates its breadth and complexity.

The scan was organized initially by broad thematic areas, including disability, income support, housing, residential care, home and community care, supports for marginalized populations, transportation, and related services. Analysis of this policy landscape alongside the lived-experience findings helped identify the principal ways in which law and policy structure the conditions under which care and support are received, provided, and exercised. Through this iterative process, six regulatory functions of the care economy policy regime were identified, which form the dimensions of the data model developed in this report. The appendix therefore provides the underlying policy mapping from which the broader functional structure of the regime was distilled.

Federal laws, programs, and supports

Support area	Laws, programs, and supports identified
Disability	• Disability tax credit (DTC) • Registered disability savings plan (RDSP) • Canada Disability Savings Grant • Canda Pension Plan Disability Benefit • Child Disability Benefit • Caregiver Recognition Benefit (for veterans)

Support area	Laws, programs, and supports identified
Income	• Employment Insurance Benefits and Leave (Regular and Sickness Benefits) • Pay Equity Act • Employment Equity Acy • Employment Insurance Act • Employment Insurance Regulations • Canada Pension Plan • Canada Pension Plan Regulations • Old Age Security Act • Old Age Security Regulations • Canada Disability Benefit Act • Canada Disability Benefit Regulations • Canada Workers Benefit
Housing	• Home Accessibility Expenses (tax deduction/credit)
Marginalized identities	• Government Assistance for refugees • Guaranteed Income Supplement • Old Age Security Pension • On-Reserve Income Assistance Program • Non-Insured Health Benefits Program • First Nations and Inuit home and community care • Jordan's Principle
Miscellaneous	• Canadian Dental Care Plan

Provincial and territorial laws, programs, and supports

British Columbia

Support area	Laws, programs, and supports identified
Disability - Developmental/Intellectual	• Services to Adults with Developmental Disabilities (STADD) • Community Living BC • At Home Program
Income Support	• Disability Assistance • Endowment 150
Housing	• BC Rebate for Accessible Home Adaptations (BC RAHA) • BC Housing - Supportive Housing and Subsidized Housing • Rental Assistance Program (RAP)
Residential Care	• Independent Living BC (ILBC) • British Columbia's Residential Care Regulation (B.C. Reg. 96/2009)
Home care	• Choice in Supports for Independent Living • Home and Community Care • Better at Home
Miscellaneous	• BC Bus Pass Program • Crime Victim Assistance Program (CVAP)

Alberta

Support area	Laws, programs, and supports identified
Disability (incl. Deaf supports)	• Alberta Aids to Daily Living (AADL)
Disability - Developmental/Intellectual	• Persons with Developmental Disabilities (PDD) program • Complex Needs Initiative (Community Support Teams)
Income Support	• Assured Income for the Severely Handicapped (AISH) • Disability Related Employment Supports (DRES) • Alberta Seniors Benefit • Emergency Needs Allowance • Alberta's Income Support Program • Income and Employment Supports Policy Manual
Housing	• Residential Access Modification Program (RAMP) • Affordable Housing Programs • Shelters (for individuals escaping family violence or individuals experiencing homelessness)
Residential Care	• Community Access for People in Continuing Care • Supplementary Accommodation Benefit • Continuing Care
Marginalized populations (i.e., racialized, queer, older populations, etc.)	• Escaping Abuse Benefit • Alberta Adult Health Benefit • Domestic Abuse Response Team • Indigenous Wellness Core
Home care	• Home & Community Care

Saskatchewan

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Saskatchewan Aids to Independent Living
Disability - Developmental/Intellectual	• Cognitive Disability Strategy (CDS) Support • CDS Policy Manual
Income Support	• Saskatchewan Assured Income for Disability (SAID) • Saskatchewan Employment Incentive (SEI) • Saskatchewan Income Support (SIS) • Employment Assistance for Persons with Disabilities (EAPD)
Housing	• Home Repair Program – Adaptations for Independence • Saskatchewan Housing Benefit • Rental Housing for People with Low Incomes
Residential Care	• Personal Care Home Benefit
Marginalized populations (i.e., racialized, queer, older populations, etc.)	• Seniors' Drug Plan • Seniors Income Plan (SIP) • First Nations and Métis Health Services • Moms & Kids Health Saskatchewan
Home care	• Home Care Saskatchewan • Individualized Funding for Home Care
Miscellaneous	• Supplementary Health Benefits • Discounted Bus Passes for Income Assistance Clients • Emergency Assistance for Prescription Drugs

Manitoba

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Manitoba Supports for Persons with Disabilities • Manitoba Possible (variety of services) • Disability and Health Supports Unit • The Disability Support Act • The Caregiver Recognition Act, CCSM c C24
Disability - Developmental/Intellectual	• Community Living disAbility Services • Community Living disAbility Services Guiding Principles • The Adults Living With an Intellectual Disability Act, CCSM c A6.1
Income Support	• Employment and Income Assistance • Employment and Income Assistance for Persons with Disabilities • Employment and Income Assistance for Single Parents
Housing	• Social Housing Rental Program • Cooperative Housing • Rent Supplement • Sponsor Managed Social Housing • Urban Native Non-Profit Housing • Affordable Housing Rental Program • Canada-Manitoba Housing Benefit • Manitoba Rent Relief Fund • Community Living DisABILITY Services
Home Care	• Manitoba Home Care Program

Ontario

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• The Ontario Caregiver Organization
Disability - Developmental/Intellectual	• Developmental Services Ontario • Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008, S.O. 2008, c. 14
Income Support	• Ontario Disability Support Program (ODSP) • Ontario Disability Support Program Act, 1997, S.O. 1997, c. 25, Sched. B • Ontario Works
Housing	• Special Priority Policy (under the Housing Services Act, 2011) • Canada-Ontario Housing Benefit (COHB) (overlap with marginalized identities) • Ontario Priorities Housing Initiative (OPHI) (overlap with marginalized identities) • Canada-Ontario Community Housing Initiative (overlap with marginalized identities)
Marginalized populations (i.e., racialized, queer, older populations, etc.)	• Investing in Women's Futures (IWF)
Home care	• Ontario Health at Home • Connecting Care Act, 2019, S.O. 2019, c. 5, Sched. 1 • O. Reg. 187/22: HOME AND COMMUNITY CARE SERVICES

Quebec

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Information and suppose services for people with disabilities • Programme d'adaptation de véhicule pour les personnes handicapées (PAV) • Travel Expense Program • e-20.1 - Act to secure handicapped persons in the exercise of their rights with a view to achieving social, school and workplace integration
Disability - Developmental/Intellectual	• Services for persons with a physical or intellectual disability or an autism spectrum disorder (ASD)
Income Support	• Social Assistance and Social Solidarity Program • Basic Income Program • A-13.1.1 - Individual and Family Assistance Act
Housing	• Residential Adaptation Assistance Program • Shelter Allowance Program • Low-Rental Housing • AccèsLogis Québec • Rent Supplement
Residential Care	• Financial Contribution Program for Accommodated Adults
Marginalized populations (i.e., racialized, queer, older populations, etc.)	• s-4.2 - Act respecting health services and social services for the Inuit and Naskapi
Home care	• Home Support Services • Daily Living and Domestic assistance program • Bien Chez Soi • Financial Assistance Program for Domestic Help Services

New Brunswick

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Disability Support Program • Vision Loss Rehabilitation • Employment and Support Services Program (ESSP)
Income Support	• Social Assistance Program • Emergency Fuel Benefit • New Brunswick Low-Income Seniors' Benefit • 2011, c.154 - Family Income Security Act
Housing	• Affordable Rental Housing Program • Housing Assistance for Persons with Disabilities • Public Housing, Rent Supplement Program, and Portable Rent Supplement Program • New Brunswick-Canada Housing Benefit
Residential Care	• Healthy Aging and Long-Term Care Act CHAPTER 2018, c.8
Marginalized identities (i.e., racialized, queer, older populations, etc.)	• Access to Safe and Affordable Housing for Abused Women • Off-Reserve Aboriginal Home Ownership Program (ORAH)
Home care	• Home Support Services • Extra-Mural Program

Nova Scotia

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Disability Support Program • Flex Individualized Funding Program • Wheelchair Recycling Program
Disability - Developmental/Intellectual	• Community Outreach Assessment Support and Treatment Team (COAST) – Dual Diagnosis Program
Income Support	• Income Assistance • Fast Forward Program
Housing	• Canada-Nova Scotia Targeted Housing Benefit
Residential Care	• Alternative Family Support Program Policy
Marginalized identities (i.e., racialized, queer, older populations, etc.)	• Immigrant Services Association of Nova Scotia – Disability Support Services • Survivors of Gender-Based Violence Benefit
Home care	• Home Care and Community Care Services • Independent Living Support (ILS)

Prince Edward Island

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• AccessAbility Supports • Supports for Persons with Disabilities Act, RSPEI 1988, c S-9.2
Income Support	• Social Assistance Act, RSPEI 1988, c S-4.3 and Social Assistance Program
Housing	• Family Housing • Closing Cost Support Program
Residential Care	• PEI Association of Community Long Term Care
Marginalized identities (i.e., racialized, queer, older populations, etc.)	• Women & Gender Diverse People's Health Hub
Home care	• Home Care • Caring for Older Adults in the Community and at Home (COACH)

Newfoundland and Labrador

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Office of Employment Equity for Persons with Disabilities (OEEPD) • Newfoundland and Labrador Disability Benefit
Disability - Developmental/Intellectual	• Board and Lodging with Relatives Subsidy
Older Persons	• Special Assistance Program
Income Support	• Income Support Program • Newfoundland and Labrador Disability Benefit
Housing	• Rental Housing Program • Provincial Home Repair Program (PHRP) • Home Modification Program
Residential Care	• Provincial Co-operative Apartment Program • Provincial Alternate Family Care Program • Long Term Care Facilities NL
Home care	• Home Support Program • Shared Living Arrangements

Yukon

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Chronic Conditions Support Program (CCSP) • Chronic Disease and Disability Benefits
Income Support	• Low-income senior's income supplement • Yukon Supplementary Allowance • Yukon Social Assistance
Housing	• Rent-Geared-to-Income • Yukon Housing Corporation (YHC) Rent Assessment Policy • YHC Community Housing Asset Cap Policy • YHC Minimum Age of Eligibility Policy • YHC Seniors Age of Eligibility Policy • YHC Priority Policy (Only applicable to Whitehorse Clients) • YHC Victims of Violence Policy (only applicable to rural Yukon clients) • Canada-Yukon Housing Rental Benefit • Household Income Limits (HILs)
Residential Care	• Seniors and Elders Community Day Program
Marginalized identities (i.e., racialized, queer, older populations, etc.)	• Pioneer Utility Grant • Canada-Yukon Housing Benefit Gender-Based Violence Subsidy • Travel Assistance for Victims of Gender-based Violence
Home care	• Home Care
Miscellaneous	• Housing Disaster Recovery Fund • Yukon Disaster Financial Assistance Program • Medical Travel Program

Northwest Territories

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Income Assistance for Seniors and Persons with Disabilities
Income Support	• Income Assistance • NWT Senior Citizen Supplementary Benefit
Housing	• Canada-NWT Housing Benefit • Homelessness Assistance Funding • Mobility Modifications • Public Housing Program
Marginalized identities (i.e., racialized, queer, older populations, etc.)	• Senior Home Heating Subsidy • Stanton Indigenous Wellness Program
At-home care	• Home and Community Care
Miscellaneous	• Extended Health Benefits • Medical Travel Benefits • NWT Community Counselling Program • Disaster Assistance Policy • Disaster Assistance Funding Policy • Disaster Financial Assistance • Victims of Crime Emergency Fund

Nunavut

Support area	Laws, programs, and supports identified
Disability (incl. Deaf)	• Disabled Incidental Allowance
Income Support	• Income Assistance Program • Nunavut Child Benefit
Housing	• Senior Citizens and People with Disabilities Property Tax Relief Policy • Tenant to Owner Program • Canada-Nunavut Housing Benefit • Elder's Housing Program • Public Housing
At-home care	• Home & Community Care
Miscellaneous	• Extended Health Benefits

Appendix B: Towards a Care Economy Policy Regime Assessment Framework

This document provides an architecture of descriptive dimensions, normative inclusivity/accessibility/human-rights indicators, and measures for assessing the care economy policy regime in Canada from a human rights-respecting and inclusive normative vantage point. It explains why each indicator is included: the barriers it responds to as identified in the research for this study; the functions/dimensions of the care economy policy regime to which it relates; and the measures through which provisions of laws, policies, programs, guidelines, funding arrangements, and documented practices can be assessed.

The model presented here was built through an analytic sequence: from lived-experience evidence about barriers, to the conditions needed to overcome those barriers, to normative indicators, and finally to measures that can be applied to particular provisions of the sources of the care economy policy regime. The dimensions are descriptive: they identify what the care-economy policy regime regulates. The indicators are normative: they describe what a fully inclusive and rights-respecting version of that dimension looks like.

A. Overall Data Model of Dimensions, Indicators and Measures

The barriers, policy scan, and normative sources (in Section V) were analysed to design a data model for the purposes of guiding assessment of the care economy policy regime. The data model is presented below in schematic form. The following sections link the barriers to the descriptive functions of the care economy regime; followed by the normative sources for the indicators and measures for assessing those functions.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure	
1.0	**Defines the scope and nature of care and support**	**1.1**	**Care and support are defined inclusively to encompass receiving care and support, providing care and support, and self-care.**	1.1.1	The provision recognizes receiving care and support as part of the care economy.
				1.1.2	The provision recognizes both paid and unpaid provision of care and support.
				1.1.3	The provision recognizes self-care as an essential dimension of care.
				1.1.4	The provision recognizes both direct and indirect forms of care and support.
		1.2	**Care and support policy recognizes interdependence and does not assume a binary division between caregivers and care recipients.**	1.2.1	The provision recognizes that a person may both provide and receive care and support, including at the same time.
				1.2.2	The provision recognizes people with disabilities and Deaf people as potential providers of care and support as well as recipients.
				1.2.3	The provision avoids framing people who require care and support as passive, dependent, or incapable solely because they require assistance.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure	
		1.3	**Diverse family, peer, community, and culturally grounded forms of care and support are recognized.**	1.3.1	The provision recognizes family and other informal care and support relationships.
				1.3.2	The provision recognizes peer and community-based care and support.
				1.3.3	The provision recognizes culturally grounded forms and understandings of care and support, including Indigenous and Inuit approaches, as legitimate forms of care and support within the policy regime.
				1.3.4	The provision enables formal care and support to complement, rather than unnecessarily displace, valued family, peer, community, and cultural relationships.
2.0	**Establishes access to care and support services**	**2.1**	**Eligibility for care and support responds to a person's actual needs and circumstances rather than rigid categories or assumptions.**	2.1.1	The provision bases eligibility on the person's care and support needs and circumstances, and does not rely solely on a specified diagnosis or disability category.
				2.1.2	The provision does not deny or reduce formal care and support solely because family, friends, or other informal supporters are available.
				2.1.3	The provision recognizes ongoing, episodic, fluctuating, and changing care and support needs.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			2.1.4	The provision provides flexibility where standardized age, diagnostic, or categorical eligibility rules would otherwise create a gap in needed care or support.
		2.2 Processes for establishing eligibility and accessing care and support are accessible, proportionate, affordable, and timely.	2.2.1	The provision requires application and assessment processes to be accessible and proportionate to the benefit or support sought.
			2.2.2	The provision minimizes unnecessary, duplicative, or repeated requirements to prove disability or continuing need.
			2.2.3	The provision ensures that required assessments, documentation, and certification are reasonably available and affordable.
			2.2.4	The provision provides accommodations, assistance, or alternatives to enable people to complete application, assessment, and verification requirements.
			2.2.5	The provision requires eligibility and access decisions to be made within timelines that do not result in deterioration, loss, or effective denial of needed care and support.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator	Measure
		2.3 People have accessible information and navigation support to identify, obtain, and coordinate available care and support.	2.3.1 The provision requires information about available care and support to be accessible, understandable, and proactively communicated.
			2.3.2 The provision provides navigation or coordination assistance to identify and obtain appropriate care, support, benefits, and related services.
			2.3.3 The provision establishes clear referral, coordination, or shared-planning mechanisms across relevant health, disability, care, and social-service systems.
			2.3.4 The provision requires information and navigation approaches to respond to disability, language, cultural, and other intersecting access needs.
		2.4 Needed care and support are available in the person's home and community, including in rural, remote, Northern, and Inuit communities.	2.4.1 The provision ensures access to sufficient home- and community-based care and support to meet assessed needs.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			2.4.2	The provision prevents lack of community-based services from making institutional placement the only practical means of obtaining needed care and support.
			2.4.3	The provision seeks to ensure that a person is not required to leave their community, family, cultural relationships, or informal support networks solely to obtain needed care and support.
			2.4.4	The provision addresses service-capacity, staffing, infrastructure, and continuity barriers affecting rural, remote, Northern, and Inuit communities.
		2.5 Transportation and other access-related costs do not prevent people from obtaining needed care and support.	2.5.1	The provision ensures access to transportation that is accessible and usable for people who must travel to obtain care, support, assessments, or related services.
			2.5.2	The provision provides financial assistance or reimbursement where travel is required to obtain needed care or support.
			2.5.3	The provision addresses other necessary access-related costs so that fees, documentation costs, or travel expenses do not effectively prevent access.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure	
		2.6	**Access to care and support is non-discriminatory and respects a person's identity, choices, and preferred approaches to care.**	2.6.1	The provision prohibits discriminatory exclusion or differential treatment in access to care and support on the basis of disability, Deaf identity, gender, race, Indigeneity, migration status, or other intersecting grounds.
				2.6.2	The provision requires reasonable accommodation and accessible service delivery as conditions of effective access.
				2.6.3	The provision respects culturally grounded and other preferred approaches to care and support, including Indigenous traditional health and care practices where relevant and desired, and does not treat such preferences as grounds for denial of service.
				2.6.4	The provision does not withdraw unrelated care or support solely because a person refuses, questions, or seeks an alternative to a particular treatment or intervention.
3.0	**Regulates the design and delivery of care and support services**	**3.1**	**Care and support services are adequately resourced to provide timely, continuous, and appropriate support.**	3.1.1	The provision establishes funding and service capacity sufficient to meet identified care and support needs.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			3.1.2	The provision establishes staffing, caseload, scheduling, or workload arrangements that allow workers sufficient time to provide appropriate-quality care and support.
			3.1.3	The provision provides continuity of care and support where needs are ongoing rather than assuming short-term service use.
			3.1.4	The provision requires services to be delivered within timelines that preserve their intended benefit and prevent avoidable escalation of need.
		3.2 Care and support services respect autonomy, dignity, choice, and self-determination.	3.2.1	The provision requires care and support to be directed by the person's needs, wishes, preferences, and goals.
			3.2.2	The provision enables meaningful choice and control regarding the type, location, timing, and manner of care and support received.
			3.2.3	The provision enables meaningful choice regarding care and support workers or providers, including a process to address incompatible or unsafe support relationships.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			3.2.4	The provision requires family members, agencies, and service providers to respect the person's decision-making authority and not override the person's choices solely because of disability or perceived incapacity.
		3.3 Care and support services are respectful, non-stigmatizing, culturally responsive, and informed by lived experience.	3.3.1	The provision requires respectful, non-stigmatizing, and person-centred language and practice in care and support services.
			3.3.2	The provision requires services to respond to disability, Deaf, cultural, linguistic, gender, and other identity-related needs.
			3.3.3	The provision supports access to culturally appropriate and culturally safe Indigenous and Inuit care and support, including traditional medicines, health practices, and culturally grounded forms of support where relevant and desired.
			3.3.4	The provision supports services designed or delivered 'by and for' people with relevant lived experience where appropriate.
		3.4 People can identify, communicate, and challenge unmet or inappropriate care and	3.4.1	The provision recognizes the right of people receiving care and support to identify, communicate, and advocate regarding their needs and preferences.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime		Inclusivity / Accessibility / Human Rights Indicator		Measure
			support needs without retaliation or loss of service.		
				3.4.2	The provision protects people from retaliation, punitive labelling, reduction of services, or denial of care because they raise concerns or advocate for different support.
				3.4.3	The provision establishes accessible complaint, review, or appeal mechanisms for concerns about the quality, denial, reduction, or conditions of care and support.
				3.4.4	The provision provides for correction, remedy, or service improvement when care and support is found to be inappropriate, discriminatory, or inadequate.
4.0	**Regulates paid and unpaid care and support work**	**4.1**	**Unpaid family caregiving is recognized and adequately supported, including when the caregiver has their own disability-related care and support needs.**	4.1.1	The provision recognizes unpaid family caregiving as care and support work.
				4.1.2	The provision assesses and responds to the unpaid caregiver's own disability-related, health, care, and support needs.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			4.1.3	The provision provides financial, practical, psychosocial, or other supports to sustain unpaid family caregiving where the caregiver chooses to provide it.
			4.1.4	The provision provides appropriate respite or replacement support that is acceptable to both the caregiver and the person receiving care.
			4.1.5	The provision does not assume that unpaid family caregivers have unlimited capacity or use their availability as a substitute for adequate formal services.
		4.2 Parents with disabilities are supported to exercise their parenting and caregiving roles without discrimination.	4.2.1	The provision does not presume diminished parenting capacity solely because a parent has a disability or is Deaf.
			4.2.2	The provision provides accessible and individualized supports to enable parents with disabilities to exercise parenting and child-rearing responsibilities.
			4.2.3	The provision enables the care and support needs of both the parent and child to be addressed together rather than treating one person's needs as disqualifying the other.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			4.2.4	The provision ensures that seeking disability, mental health, caregiving, or other support does not by itself trigger adverse child-protection or custody consequences.
			4.2.5	The provision provides supports that reduce avoidable additional caregiving work created by inaccessible or non-inclusive education and other child-serving systems.
		4.3 Informal peer and community care and support work is recognized and supported.	4.3.1	The provision recognizes sustained peer and community support as forms of care and support work.
			4.3.2	The provision provides resources or compensation for sustained peer and community care roles where appropriate, rather than relying automatically on unpaid labour.
			4.3.3	The provision provides supports that protect the well-being and care needs of people providing peer and community support.
			4.3.4	The provision supports peer and community care models that are responsive to gaps in formal care and support systems.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure	
		4.4	**Indigenous and Inuit family and community caregiving practices are recognized and supported in ways that respect Indigenous peoples' cultures, institutions, and self-determined priorities.**	4.4.1	The provision recognizes culturally grounded Indigenous and Inuit family and community caregiving relationships and practices.
				4.4.2	The provision provides resources and supports for Indigenous and Inuit caregiving in accordance with priorities and approaches identified by the Indigenous peoples and communities concerned.
				4.4.3	The provision does not impose licensing, regulatory, or administrative requirements that unnecessarily penalize or displace culturally grounded informal care, and regulatory approaches affecting such care are developed in consultation and cooperation with the Indigenous peoples concerned, while maintaining appropriate protections against harm.
				4.4.4	The provision enables formal care and support to complement rather than undermine valued Indigenous and Inuit networks of community care.
		4.5	**Paid care and support workers have adequate compensation, benefits, resources, and safe working conditions.**	4.5.1	The provision establishes adequate remuneration for paid care and support work.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			4.5.2	The provision provides access to employment benefits and social protections appropriate to paid care and support work.
			4.5.3	The provision establishes safe staffing, workload, scheduling, and working-time conditions that reduce chronic overwork and burnout.
			4.5.4	The provision provides workers with the equipment, training, supervision, and organizational resources required to perform their work safely and effectively.
			4.5.5	The provision provides access to supports that address the physical and mental health impacts of paid care and support work.
		4.6 The paid care and support workforce is inclusive of people with disabilities and Deaf people and values lived experience as expertise.	4.6.1	The provision prohibits disability- and Deaf-related discrimination in recruitment, hiring, retention, advancement, and working conditions in paid care and support employment.
			4.6.2	The provision ensures access to workplace accommodations, accessibility supports, and inclusive work arrangements for care and support workers with disabilities.

Care Economy Policy Regime – Data Model					
Dimension Code	**Dimension of the Care Economy Policy Regime**	**Inclusivity / Accessibility / Human Rights Indicator**			**Measure**
				4.6.3	The provision recognizes lived experience as relevant expertise in recruitment, role design, training, and service delivery.
				4.6.4	The provision creates pathways for peer and lived-experience roles to become adequately supported paid employment where comparable work is otherwise remunerated.
				4.6.5	The provision addresses intersecting employment barriers experienced by Indigenous, Black, racialized, immigrant, LGBT, and other marginalized workers with disabilities or Deaf workers.
5.0	**Establishes material and social supports related to self-care and caregiving**	**5.1**	**Income and social protection are adequate to enable people to meet essential needs, exercise self-care, and sustain caregiving responsibilities.**	5.1.1	The provision provides income and social protection sufficient to meet basic needs, including food, clothing, utilities, transportation, and other essential living costs.
				5.1.2	The provision recognizes and provides for disability-related and care-related costs that are additional to ordinary living expenses.
				5.1.3	The provision adjusts benefit levels or support amounts to respond to changes in the cost of living and the actual costs of meeting essential needs.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			5.1.4	The provision is designed so that a person is not required to forgo their own essential care or self-care in order to meet the needs of a child or other person for whom they provide care.
		5.2 People have access to adequate, affordable, accessible, and stable housing that supports self-care, independent living, and caregiving.	5.2.1	The provision supports access to housing that is affordable in relation to the person's available income.
			5.2.2	The provision supports access to housing that is accessible and suitable for the person's disability-related and care needs.
			5.2.3	The provision supports housing stability so that housing insecurity does not disrupt needed care, self-care, or caregiving relationships.
			5.2.4	The provision enables housing arrangements that support independent living and the person's chosen care and caregiving relationships.
		5.3 Policies and programs recognize that self-care may itself require time, resources, and assistance.	5.3.1	The provision recognizes self-care as an essential need rather than an optional or residual activity.

Care Economy Policy Regime – Data Model					
Dimension Code	**Dimension of the Care Economy Policy Regime**	**Inclusivity / Accessibility / Human Rights Indicator**		**Measure**	
				5.3.2	The provision does not assume that self-care must be performed independently and enables access to assistance required to carry it out.
				5.3.3	The provision provides or enables access to the time, resources, and supports reasonably required for health, well-being, dignity, and community participation.
6.0	**Establishes governance of care economy policies and programs**	**6.1**	**People who provide and receive care and support, including women with disabilities and Deaf women, participate meaningfully in the design, implementation, monitoring, and review of care-economy policies and programs.**	6.1.1	The provision requires meaningful participation of people with lived experience in the design and redesign of care and support laws, policies, programs, and funding arrangements.
				6.1.2	The provision includes people who receive care and support, unpaid caregivers, paid care and support workers, peer and community caregivers, and organizations representing them.
				6.1.3	The provision requires participation in implementation, monitoring, and review as well as initial policy or program design.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			6.1.4	The provision requires participation to reflect diverse and intersecting experiences, including disability, Deaf identity, gender, Indigeneity, racialization, migration, poverty, and other relevant circumstances.
		6.2 Participation in care-economy policy and program governance is accessible, supported, and appropriately compensated.	6.2.1	The provision requires accessibility and communication supports needed for meaningful participation.
			6.2.2	The provision provides reimbursement or direct support for disability-related, transportation, caregiving, or other costs required to participate.
			6.2.3	The provision provides appropriate compensation for substantial time, expertise, and lived-experience contributions to policy and program governance.
			6.2.4	The provision structures participation processes so that administrative, scheduling, and procedural demands do not create unreasonable barriers to participation.
		6.3 Lived-experience participation has an identifiable influence on decisions and is linked to transparent accountability.	6.3.1	The provision establishes mechanisms through which lived-experience input can influence policy, program, funding, and implementation decisions.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			6.3.2	The provision includes people with lived experience in relevant governance, advisory, oversight, or decision-making bodies rather than limiting participation to one-time consultation.
			6.3.3	The provision requires transparent reporting on how participant input was considered and how decisions were reached.
			6.3.4	The provision enables people with lived experience to participate in evaluation and accountability processes concerning care and support systems.
		6.4 Indigenous peoples have a substantive role in determining and developing care and support policies and programs that affect them and, as far as possible, in administering those programs through their own institutions.	6.4.1	The provision enables Indigenous peoples to participate through representatives chosen by themselves in accordance with their own procedures and institutions.
			6.4.2	Where legislative, policy, or administrative measures may affect Indigenous peoples, the provision requires consultation and cooperation in good faith through their representative institutions, consistent with applicable standards concerning free, prior and informed consent.

Care Economy Policy Regime – Data Model

Dimension Code	Dimension of the Care Economy Policy Regime	Inclusivity / Accessibility / Human Rights Indicator		Measure
			6.4.3	The provision recognizes Indigenous peoples' role in determining and developing priorities and strategies for care and support, including relevant health, housing, disability, and other economic and social programs.
			6.4.4	The provision enables, as far as possible, relevant care and support programs to be administered through Indigenous peoples' own institutions.

B. Normative Source Boundary and Method

The normative source base for the inclusivity/accessibility/human rights indicators is intentionally confined to sources identified in Section V, Human Rights Standards: Normative Foundations for Assessing the Care Economy Policy Regime. Where Section V identifies, quotes, summarizes, or clearly relies upon a treaty, declaration, treaty-body interpretation, concluding-observation standard, international labour standard, advisory opinion, intergovernmental commitment, or relevant Canadian implementation instrument, this assessment framework identifies the relevant provision or paragraph where it can be reliably established.

The source types do not all have the same legal status. Treaties to which Canada is a State party create international legal obligations. Treaty-body general comments, guidelines, and concluding observations interpret and apply treaty obligations but are not treaties themselves. Human Rights Council resolutions and intergovernmental commitments are non-binding standards. UNDRIP is a UN General Assembly declaration, not a treaty; Canada endorsed it without qualification in 2016, and the federal United Nations Declaration on the Rights of Indigenous Peoples Act affirms it as a universal international human rights instrument with application in Canadian law and establishes a framework for federal implementation. The Inter-American Court's Advisory Opinion OC-31/25 is an important emerging interpretation of the right to care but, as noted in this report, is not binding on Canada. ILO Convention No. 189 is an international labour treaty standard which Canada has not ratified.

C. Six-Dimension Architecture

Dimension	Descriptive regime function	Primary basis in Findings
1.0 Defines the scope and nature of care and support	Defines what the regime recognizes as care and support, who gives and receives it, and the forms and relationships included.	Cross-cutting findings on interdependence, reciprocal care, self-care, and recognition
2.0 Establishes access to care and support services	Structures eligibility, application and assessment, information and navigation, availability, location, transportation, and other conditions governing access.	III.A - Barriers to Accessing Needed Care and Support
3.0 Regulates the design and delivery of care and support services	Structures how services are organized and delivered once accessed, including resourcing, continuity, autonomy, choice, cultural responsiveness, and accountability.	III.B - Concerns about Quality of Care and Support Services
4.0 Regulates paid and unpaid care and support work	Structures recognition, support, compensation, employment conditions, and inclusion across family, parenting, peer/community, Indigenous/Inuit, and paid care work.	III.C - Care and Support Work by Women with Disabilities and Deaf Women Unrecognized and Unsupported
5.0 Establishes material and social supports related to self-care and caregiving	Structures income, social protection, housing, and other material conditions affecting the ability to care for oneself and others.	III.D - Poverty and Core Housing Need Undermining Self-Care

Dimension	Descriptive regime function	Primary basis in Findings
6.0 Establishes governance of care economy policies and programs	Structures participation, representation, support, influence, monitoring, and accountability in care-economy policymaking and program governance.	III.E - Excluded From Policy and Program Design

D. Data Model and Normative Framework

This section integrates the sources and steps in building the assessment framework. It points to the barriers underlying the indicators for each dimension of the care economy policy regime, the normative sources for those indicators (i.e., what is required to overcome the barrier and what are authoritative normative sources for doing so), and the measures for assessing specific provisions of the law and policy instruments constituting that particular feature of the policy regime.

Dimension 1. Defines the scope and nature of care and support

Regime function: Defines what the regime recognizes as care and support, who gives and receives it, and the forms and relationships included.

Indicator 1.1

Care and support are defined inclusively to encompass receiving care and support, providing care and support, and self-care.

Barrier(s) addressed

Care systems and policy framings can overlook self-care and the full range of paid and unpaid care and support relationships.

women with disabilities described care as encompassing interconnected needs and relationships.

Normative basis and rationale

Section V frames the emerging right to care as encompassing three linked dimensions: receiving care, providing care, and self-care. It also recognizes that the right to provide care concerns both paid and unpaid care, while disability-specific standards require support to be understood as a right that enables autonomy and community inclusion. These standards support an inclusive definition of care and support that treats those who give and receive care as rights-holders.

Key normative sources

- **[Emerging regional human-rights interpretation (not binding on Canada)]** Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - recognizes the rights to receive care, provide care, and exercise self-care; Section V notes that the right to provide care includes paid and unpaid care in decent conditions.
- **[Intergovernmental political commitment (non-treaty)]** Buenos Aires Commitment (2022), paras. 8 and 14 - recognizes care as a right to provide and receive care and to exercise self-care; para. 14 specifically addresses persons with disabilities, autonomy, accessible services and infrastructure.
- **[UN Human Rights Council resolution (non-binding)]** Human Rights Council resolution 54/6 (2023), Centrality of care and support from a human rights perspective - recognizes the human rights of paid and unpaid caregivers and

care/support recipients and calls for increased investment in care and support systems.

- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017) on article 19 - treats individual support as a right linked to choice, control, independent living, and community inclusion.

Measures

1.1.1 The provision recognizes receiving care and support as part of the care economy.

1.1.2 The provision recognizes both paid and unpaid provision of care and support.

1.1.3 The provision recognizes self-care as an essential dimension of care.

1.1.4 The provision recognizes both direct and indirect forms of care and support.

Indicator 1.2

Care and support policy recognizes interdependence and does not assume a binary division between caregivers and care recipients.

Barrier(s) addressed

Women with disabilities described reciprocal and changing care relationships, yet systems often treat people with disabilities only as recipients of care and overlook their roles as caregivers.

Normative basis and rationale

The analysis in Section V rejects a passive-recipient model of disability support. OC-31/25 describes persons with disabilities as rights-holders with autonomy and independence, while the CRPD Committee explains that independent living means choice and control, not self-sufficiency or separation from relationships with others. The normative framework therefore supports interdependence and recognizes that a person may both give and receive care and support.

Key normative sources

- **[Emerging regional human-rights interpretation (not binding on Canada)]** Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - Section V emphasizes recognition of persons with disabilities as rights-holders, not only recipients of care, and as persons with autonomy and independence.
- **[Treaty obligation]** CRPD, art. 19 - recognizes the equal right of persons with disabilities to live independently and be included in the community, with access to community support services.
- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017), including paras. 16-17, 21-25, 61 and 63 - independent living centres choice and control; support must be individualized and must not be replaced by institutionalization or compulsory reliance on family support.

- **[Intergovernmental political commitment (non-treaty)]** Buenos Aires Commitment (2022), paras. 8 and 14 - links care, self-care, shared responsibility, disability autonomy, and freedom to make one's own choices.

Measures

1.2.1 The provision recognizes that a person may both provide and receive care and support, including at the same time.

1.2.2 The provision recognizes people with disabilities and Deaf people as potential providers of care and support as well as recipients.

1.2.3 The provision avoids framing people who require care and support as passive, dependent, or incapable solely because they require assistance.

Indicator 1.3

Diverse family, peer, community, and culturally grounded forms of care and support are recognized.

Barrier(s) addressed

Participants described family, peer, community and culturally grounded care as essential, including Inuit forms of mutual and community care, while formal systems may fail to recognize or may displace these relationships.

Normative basis and rationale

Section V recognizes family, peer, and community relationships as legitimate parts of support systems while requiring formal supports so that informal relationships are not the only option. UNDRIP adds an Indigenous-specific foundation: its protections for Indigenous peoples' distinct social and cultural institutions and their authority to shape economic, social, and health programs support recognition of culturally grounded Indigenous and Inuit care relationships rather than their displacement by standardized service models. Together, these standards support plural forms of care and support and preservation of valued relationships alongside formal services.

Key normative sources

- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017), including paras. 25, 63 and 67 - formal support must be available; support should be individualized; family carers should receive respite, childcare, parenting and financial supports.
- **[Treaty obligation]** CRPD, arts. 23, 24 and 26 - protects family life and child-rearing responsibilities and expressly recognizes peer support in education, habilitation and rehabilitation.
- **[Treaty-body interpretive guidance]** CRPD Committee, Guidelines on deinstitutionalization, including in emergencies (2022), paras. 69-74 - recognizes informal support networks, calls for investment in peer support and circles of support, and requires adequate support for family caregivers chosen by the person.

- **[Treaty-body interpretive guidance]** CESCR, General Comment No. 14 (2000), para. 12 - requires health facilities, goods and services to be acceptable and culturally appropriate.
  [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 3, 5, 20, 23 and 24 - protects Indigenous self-determination, distinct social and cultural institutions and social systems, active involvement in health, housing and other economic and social programs, and traditional health practices.

Measures

1.3.1 The provision recognizes family and other informal care and support relationships.

1.3.2 The provision recognizes peer and community-based care and support.

1.3.3 The provision recognizes culturally grounded forms and understandings of care and support, including Indigenous and Inuit approaches, as legitimate forms of care and support within the policy regime.

1.3.4 The provision enables formal care and support to complement, rather than unnecessarily displace, valued family, peer, community, and cultural relationships.

Dimension 2. Establishes access to care and support services

Regime function: Structures eligibility, application and assessment, information and navigation, availability, location, transportation, and other conditions governing access.

Indicator 2.1

Eligibility for care and support responds to a person's actual needs and circumstances rather than rigid categories or assumptions.

Barrier(s) addressed

- Restrictive eligibility requirements.
- denial or reduction of formal supports because family members are presumed available.
- diagnosis-based eligibility that does not reflect actual need.
- categorical rules that exclude people whose needs do not fit prescribed boxes.

Normative basis and rationale

The analysis in Section V supports eligibility based on actual requirements and barriers rather than rigid diagnostic or categorical assumptions. CRPD Article 19 guidance requires human-rights-based, personalized assessment and rejects institutionalization or compulsory reliance on family as substitutes for support. Section V also summarizes CRPD Committee guidance calling for removal of age cut-offs, reduction of repeated reassessment burdens, and avoidance of sole reliance on medical reports in social-protection eligibility.

Key normative sources

- **[Treaty obligation]** CRPD, arts. 19 and 28 - links individualized community support with equal access to social protection and disability-related assistance.
- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017), paras. 61 and 63 - eligibility and support assessment should follow a human-rights approach, focus on barriers and requirements, respect will and preferences, and account for needs that vary over time.
- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017), paras. 21 and 25 - high support needs do not justify institutionalization, and the right is not realized where informal family support is the only option.
- **[Treaty-body country guidance cited/summarized in Section V]** CRPD Committee concluding-observation standards summarized in Section V - remove age cut-offs, reduce or eliminate reassessment burdens, and do not rely solely on medical reports when determining social-protection entitlements.

Measures

2.1.1 The provision bases eligibility on the person's care and support needs and circumstances, and does not rely solely on a specified diagnosis or disability category.

2.1.2 The provision does not deny or reduce formal care and support solely because family, friends, or other informal supporters are available.

2.1.3 The provision recognizes ongoing, episodic, fluctuating, and changing care and support needs.

2.1.4 The provision provides flexibility where standardized age, diagnostic, or categorical eligibility rules would otherwise create a gap in needed care or support.

Indicator 2.2

Processes for establishing eligibility and accessing care and support are accessible, proportionate, affordable, and timely.

Barrier(s) addressed

- Burdensome applications, repeated paperwork and medical assessments, high documentation and assessment costs, long delays, and exhaustion associated with proving disability or need.

Normative basis and rationale

Formal eligibility is insufficient if the process of proving eligibility is itself inaccessible, unaffordable, repetitive, or so delayed that needed support is effectively denied. Section V's references to health and social-protection standards emphasize accessibility and affordability; CRPD guidance calls for individualized, human-rights-based assessment, while Section V specifically identifies repeated reassessment and excessive medical-proof requirements as barriers that States should remove.

Key normative sources

- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017), paras. 61, 63 and 64 - assessment should be human-rights-based and personalized, and information about support services should be timely and accessible.
- **[Treaty-body country guidance cited/summarized in Section V]** CRPD Committee concluding-observation standards summarized in Section V - reduce or eliminate reassessment burdens and avoid sole reliance on medical reports for social-protection entitlements.
- **[Treaty-body interpretive guidance]** CESCR, General Comment No. 14 (2000), para. 12 - health services must be physically and economically accessible without discrimination.
- **[Treaty-body interpretive guidance]** CESCR, General Comment No. 19 (2007) on the right to social security - social-security systems and benefits must be accessible and adequate and should not exclude people through discriminatory or unreasonable access conditions.

Measures

2.2.1 The provision requires application and assessment processes to be accessible and proportionate to the benefit or support sought.

2.2.2 The provision minimizes unnecessary, duplicative, or repeated requirements to prove disability or continuing need.

2.2.3 The provision ensures that required assessments, documentation, and certification are reasonably available and affordable.

2.2.4 The provision provides accommodations, assistance, or alternatives to enable people to complete application, assessment, and verification requirements.

2.2.5 The provision requires eligibility and access decisions to be made within timelines that do not result in deterioration, loss, or effective denial of needed care and support.

Indicator 2.3

People have accessible information and navigation support to identify, obtain, and coordinate available care and support.

Barrier(s) addressed

- Lack of clear information.
- being passed between numbers and agencies.
- fragmented health and social services.
- need to rely on exceptional individual advocates to locate and connect services.
- added navigation barriers associated with language, culture, disability, and intersecting marginalization.

Normative basis and rationale

Section V indicates that effective access requires a usable support system rather than the mere existence of isolated programs. CRPD guidance requires timely, accurate and accessible information about community support, while the Human Rights Council and CEDAW Committee standards summarized in Section V call for investment in comprehensive, affordable and quality care and support systems. Navigation and coordination are the data model's operational response to the fragmentation identified in Section III.

Key normative sources

- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), para. 64 - States should provide and disseminate timely, up-to-date and accurate information on independent-living choices and community support services in accessible formats.
- **[UN Human Rights Council resolution (non-binding)]** Human Rights Council resolution 54/6 (2023) - calls for increased investment in care and support policies and infrastructure to ensure universal access to affordable, quality services.

- **[Treaty-body country guidance cited/summarized in Section V]** CEDAW Committee care-governance standards summarized in Section V - call for comprehensive national care policy and access to high-quality, affordable, gender-responsive public services.
- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 5 (2017), paras. 63-65 - support systems should be individualized, accessible and capable of being delivered by appropriately trained personnel.

Measures

2.3.1 The provision requires information about available care and support to be accessible, understandable, and proactively communicated.

2.3.2 The provision provides navigation or coordination assistance to identify and obtain appropriate care, support, benefits, and related services.

2.3.3 The provision establishes clear referral, coordination, or shared-planning mechanisms across relevant health, disability, care, and social-service systems.

2.3.4 The provision requires information and navigation approaches to respond to disability, language, cultural, and other intersecting access needs.

Indicator 2.4

Needed care and support are available in the person's home and community, including in rural, remote, Northern, and Inuit communities.

Barrier(s) addressed

- Unavailability of home care and other needed services.
- long waits and staffing shortages.
- institutionalization as the only realistic option.
- having to leave one's community, relationships, or culture to obtain care.
- especially acute gaps in Northern and rural communities.

Normative basis and rationale

Section V points to the foundational right to live independently and be included in the community. CRPD standards reject situations in which institutional placement or unpaid family care is the only realistic route to support and require formal supports to be available in the community. Right-to-health standards reinforce availability of accessible services at community level and at home, with particular attention to rural and remote areas. For Indigenous and Inuit communities, UNDRIP strengthens this foundation by protecting improvement of health and social conditions, non-discriminatory access to social and health services, traditional health practices, and Indigenous participation in developing and administering health, housing and other social programs.

Key normative sources

[Treaty obligation] CRPD, art. 19 - requires access to community support services, including personal assistance, necessary to support living and inclusion in the community and to prevent isolation or segregation.

- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), including paras. 21, 25, 63, 89, 92 and 97(g)-(k) - rejects institutionalization as the answer to high support needs; requires individualized community support, accessible housing and services, and adequate resources.
- [Treaty obligation] CRPD, art. 25 - recognizes the right to health without disability discrimination.
- [Treaty-body interpretive guidance] CESCR General Comment No. 14 and CEDAW Committee health standards summarized in Section V - require accessible, affordable and quality services, including community-level care and sufficient health facilities and trained staff in rural and remote areas.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 21, 23 and 24 - protects improvement of health and social conditions, non-discriminatory access to social and health services, traditional health practices, and Indigenous involvement in developing and administering health, housing and other social programs.

Measures

2.4.1 The provision ensures access to sufficient home- and community-based care and support to meet assessed needs.

2.4.2 The provision prevents lack of community-based services from making institutional placement the only practical means of obtaining needed care and support.

2.4.3 The provision seeks to ensure that a person is not required to leave their community, family, cultural relationships, or informal support networks solely to obtain needed care and support.

2.4.4 The provision addresses service-capacity, staffing, infrastructure, and continuity barriers affecting rural, remote, Northern, and Inuit communities.

Indicator 2.5

Transportation and other access-related costs do not prevent people from obtaining needed care and support.

Barrier(s) addressed

- Inaccessible public transportation.
- high taxi and travel costs.
- physical and sensory toll of travel.
- costs of obtaining assessments or documents.
- travel itself worsening health or causing missed meals and other hardship.

Normative basis and rationale

Section V notes obligations to ensure physical and economic accessibility to health, support and social-protection systems and stresses that persons with disabilities should not have to bear disability-related expenses themselves. CRPD Article 19 guidance also specifically identifies accessible transport as part of the environment necessary for

community inclusion. These standards support treating travel and other unavoidable access costs as part of whether care is genuinely accessible.

Key normative sources

- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), para. 12 - health services must be physically and economically accessible.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), para. 92 - appropriate and affordable services and other impairment-related assistance must be available, especially for people in poverty; persons with disabilities should not be required to pay disability-related expenses themselves.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), para. 97(j) - calls for policies and resources for affordable and accessible housing, the built environment, public spaces and transport.
- Treaty obligation] CRPD, art. 28 - requires equal access to social protection and assistance with disability-related expenses for persons with disabilities and their families living in poverty.

Measures

2.5.1 The provision ensures access to transportation that is accessible and usable for people who must travel to obtain care, support, assessments, or related services.

2.5.2 The provision provides financial assistance or reimbursement where travel is required to obtain needed care or support.

2.5.3 The provision addresses other necessary access-related costs so that fees, documentation costs, or travel expenses do not effectively prevent access.

Indicator 2.6

Access to care and support is non-discriminatory and respects a person's identity, choices, and preferred approaches to care.

Barrier(s) addressed

- Ableist and intersecting discriminatory treatment.
- denial of accessible procedures or services.
- devaluation of culturally appropriate care preferences.
- withdrawal of home support after refusal of a particular treatment.

Normative basis and rationale

As Section V notes, non-discrimination is a cross-cutting requirement. CRPD standards address multiple and intersectional discrimination against women with disabilities, while the right to health protects bodily autonomy and requires culturally appropriate services. Independent-living standards further protect choice and control and prohibit discriminatory exclusion from services. UNDRIP adds Indigenous-specific protection for traditional health practices, non-discriminatory access to social and health services, and particular attention

to the rights and needs of Indigenous women and persons with disabilities. These norms support access that does not punish a person for disability, identity, cultural preference, or the exercise of choice about treatment.

Key normative sources

- [Treaty obligation] CRPD, arts. 5 and 6 - requires equality and non-discrimination and recognizes multiple discrimination experienced by women and girls with disabilities.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 3 (2016), including para. 16 - requires targeted measures addressing multiple and intersecting forms of discrimination, including in policymaking and consultation.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), paras. 8 and 12 - protects control over one's health and body and requires non-discriminatory, culturally appropriate health services.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), paras. 52-53, 61 and 63 - support must respond to individual requirements and preferences, and discriminatory exclusion and practical/procedural barriers to services must be prevented.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 21, 22 and 24 - requires particular attention to Indigenous women and persons with disabilities, protects traditional health practices, and recognizes non-discriminatory access to social and health services.

Measures

2.6.1 The provision prohibits discriminatory exclusion or differential treatment in access to care and support on the basis of disability, Deaf identity, gender, race, Indigeneity, migration status, or other intersecting grounds.

2.6.2 The provision requires reasonable accommodation and accessible service delivery as conditions of effective access.

2.6.3 The provision respects culturally grounded and other preferred approaches to care and support, including Indigenous traditional health and care practices where relevant and desired, and does not treat such preferences as grounds for denial of service.

2.6.4 The provision does not withdraw unrelated care or support solely because a person refuses, questions, or seeks an alternative to a particular treatment or intervention.

Dimension 3. Regulates the design and delivery of care and support services

Regime function: Structures how services are organized and delivered once accessed, including resourcing, continuity, autonomy, choice, cultural responsiveness, and accountability.

Indicator 3.1

Care and support services are adequately resourced to provide timely, continuous, and appropriate support.

Barrier(s) addressed

- Underfunding.
- inadequate staffing and caseload capacity.
- insufficient service hours.
- long waits.
- short-term service models that do not fit ongoing needs.
- rushed support.
- worker burnout caused by system under-resourcing.

Normative basis and rationale

Section V links rights-respecting care and support to adequate public investment, service availability and quality. The Human Rights Council calls for increased investment in care infrastructure; the CRPD Committee requires States to resource inclusive community support; and health standards require availability, accessibility, acceptability and quality. A service that exists on paper but lacks staff, time, continuity or capacity may therefore fail to realize the underlying rights.

Key normative sources

- [UN Human Rights Council resolution (non-binding)] Human Rights Council resolution 54/6 (2023) - calls for increased investment in care and support policies and infrastructure to ensure universal access to affordable, quality services.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), including paras. 39, 63, 89, 92 and 97(k) - requires adequately resourced, individualized and accessible community support services.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), para. 12 - requires health facilities, goods and services to satisfy availability, accessibility, acceptability and quality.
- [Treaty-body country guidance cited/summarized in Section V] CEDAW Committee care-governance and health standards summarized in Section V - call for high-quality, affordable, gender-responsive public services and sufficient facilities with adequately trained staff.

Measures

3.1.1 The provision establishes funding and service capacity sufficient to meet identified care and support needs.

3.1.2 The provision establishes staffing, caseload, scheduling, or workload arrangements that allow workers sufficient time to provide appropriate-quality care and support.

3.1.3 The provision provides continuity of care and support where needs are ongoing rather than assuming short-term service use.

3.1.4 The provision requires services to be delivered within timelines that preserve their intended benefit and prevent avoidable escalation of need.

Indicator 3.2

Care and support services respect autonomy, dignity, choice, and self-determination.

Barrier(s) addressed

- Services not designed to foster autonomy.
- people unable to choose workers or support arrangements.
- people with psychosocial or other disabilities being overridden.
- family or agency directions displacing the person's own wishes.

Normative basis and rationale

Autonomy, dignity, choice and control are central to Section V's disability-support standards. CRPD Article 19 and General Comment No. 5 treat support as enabling the person to direct their life rather than as a mechanism for others to take control. OC-31/25 similarly frames persons with disabilities as autonomous rights-holders, while the right to health protects control over one's body and freedom from non-consensual treatment.

Key normative sources

- [Treaty obligation] CRPD, art. 19 - protects choice about where and with whom to live and access to community support services.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), including paras. 16-17, 52, 61 and 63 - support must be based on individual requirements, will and preferences and must preserve choice and control.
- [Emerging regional human-rights interpretation (not binding on Canada)] Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - Section V emphasizes autonomy and independence of persons with disabilities within the right to care.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), para. 8 - the right to health includes control over one's health and body and freedom from non-consensual medical treatment.

Measures

3.2.1 The provision requires care and support to be directed by the person's needs, wishes, preferences, and goals.

3.2.2 The provision enables meaningful choice and control regarding the type, location, timing, and manner of care and support received.

3.2.3 The provision enables meaningful choice regarding care and support workers or providers, including a process to address incompatible or unsafe support relationships.

3.2.4 The provision requires family members, agencies, and service providers to respect the person's decision-making authority and not override the person's choices solely because of disability or perceived incapacity.

Indicator 3.3

Care and support services are respectful, non-stigmatizing, culturally responsive, and informed by lived experience.

Barrier(s) addressed

- Dehumanizing or stigmatizing language.
- disability stereotypes.
- lack of listening and relationship.
- intersecting racism and anti-immigrant bias.
- inadequate culturally appropriate Indigenous care.
- need for services 'by and for' people with disabilities.

Normative basis and rationale

Section V identifies requirements for services to counter disability stereotypes, respect dignity, and be culturally appropriate. It also emphasizes the value of first-hand knowledge in making support services responsive to the people who use them. UNDRIP provides a distinct Indigenous-specific foundation by protecting traditional health practices, non-discriminatory access to health and social services, improvement of health and other social conditions, and Indigenous participation in determining relevant programs. The indicator therefore brings together anti-stigma duties, cultural responsiveness, disability-responsive professional practice, and lived-experience-informed design and delivery.

Key normative sources

- [Treaty obligation] CRPD, art. 8 - requires awareness-raising, combating stereotypes and prejudices, and promoting recognition of the capabilities and contributions of persons with disabilities.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), para. 12 - requires health facilities, goods and services to be acceptable and culturally appropriate.
- [Treaty-body country guidance cited/summarized in Section V] CEDAW Committee health standards summarized in Section V - call for special attention to the health needs and rights of women with disabilities and training of health professionals on human rights, dignity, autonomy and disability.
- [Treaty-body interpretive guidance] CRPD Committee, General Comments Nos. 5 and 7 - support services should be shaped with the active involvement of persons with disabilities; their lived experience and knowledge improve responsiveness and relevance.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 21-24 - protects Indigenous economic and social conditions, requires particular attention to Indigenous women and persons with disabilities, recognizes Indigenous involvement in health and social programs, and protects traditional health practices and non-discriminatory access to services.

Measures

3.3.1 The provision requires respectful, non-stigmatizing, and person-centred language and practice in care and support services.

3.3.2 The provision requires services to respond to disability, Deaf, cultural, linguistic, gender, and other identity-related needs.

3.3.3 The provision supports access to culturally appropriate and culturally safe Indigenous and Inuit care and support, including traditional medicines, health practices, and culturally grounded forms of support where relevant and desired.

3.3.4 The provision supports services designed or delivered 'by and for' people with relevant lived experience where appropriate.

Indicator 3.4

People can identify, communicate, and challenge unmet or inappropriate care and support needs without retaliation or loss of service.

Barrier(s) addressed

- Constant burden of self-advocacy.
- energy and health costs of repeatedly educating service systems.
- backlash, labelling, or denial of further care after asserting rights or needs.

Normative basis and rationale

Choice and self-advocacy are meaningful only if people can challenge inappropriate support without losing access or being punished. Section V points to protections for bodily autonomy, individualized support and non-discriminatory access, and CRPD General Comment No. 5 expressly requires legal advice, remedies and support for people seeking to enforce independent-living rights. These standards provide a stronger foundation for challenge and remedy than a purely service-quality approach.

Key normative sources

- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), para. 66 - requires access to justice, legal advice, remedies and support, including accommodations, for persons seeking to enforce the right to live independently in the community.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), paras. 52-53 - requires monitoring of service providers and prevention of discriminatory exclusion and practical or procedural barriers to services.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), para. 8 - protects control over one's health and body and freedom from non-consensual treatment.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 3 (2016) - addresses intersectional discrimination that can constrain women with disabilities' ability to exercise control over their own lives.

Measures

3.4.1 The provision recognizes the right of people receiving care and support to identify, communicate, and advocate regarding their needs and preferences.

3.4.2 The provision protects people from retaliation, punitive labelling, reduction of services, or denial of care because they raise concerns or advocate for different support.

3.4.3 The provision establishes accessible complaint, review, or appeal mechanisms for concerns about the quality, denial, reduction, or conditions of care and support.

3.4.4 The provision provides for correction, remedy, or service improvement when care and support is found to be inappropriate, discriminatory, or inadequate.

Dimension 4. Regulates paid and unpaid care and support work

Regime function: Structures recognition, support, compensation, employment conditions, and inclusion across family, parenting, peer/community, Indigenous/Inuit, and paid care work.

Indicator 4.1

Unpaid family caregiving is recognized and adequately supported, including when the caregiver has their own disability-related care and support needs.

Barrier(s) addressed

- Unsustainable family caregiving demands.
- women with disabilities being the only available caregiver.
- reciprocal caregiving being overlooked.
- formal systems assuming unpaid family members can fill service gaps.

Normative basis and rationale

Section V indicates that unpaid caregiving should be seen as a human-rights and social-protection issue rather than an unlimited private family obligation. OC-31/25 protects the right to provide unpaid as well as paid care in decent conditions and Section V notes special measures for women with disabilities who undertake unpaid care work. CRPD guidance explicitly requires respite, childcare, parenting and financial support for family carers, while social-security standards recognize informal caregivers.

Key normative sources

- [Emerging regional human-rights interpretation (not binding on Canada)] Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - recognizes the right to provide paid and unpaid care in decent conditions and the self-care needs of caregivers; Section V highlights special measures for women with disabilities undertaking unpaid care.
- [UN Human Rights Council resolution (non-binding)] Human Rights Council resolution 54/6 (2023) - calls for recognition and redistribution of care work and respect for the rights of unpaid caregivers.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), para. 67 - requires adequate support for family carers, including respite, childcare, supportive parenting services, financial support, counselling and circles of support.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 19 (2007) - Section V identifies social-security protection for people in the informal economy and, in the disability context, family members and other informal caregivers.

Measures

4.1.1 The provision recognizes unpaid family caregiving as care and support work.

4.1.2 The provision assesses and responds to the unpaid caregiver's own disability-related, health, care, and support needs.

4.1.3 The provision provides financial, practical, psychosocial, or other supports to sustain unpaid family caregiving where the caregiver chooses to provide it.

4.1.4 The provision provides appropriate respite or replacement support that is acceptable to both the caregiver and the person receiving care.

4.1.5 The provision does not assume that unpaid family caregivers have unlimited capacity or use their availability as a substitute for adequate formal services.

Indicator 4.2

Parents with disabilities are supported to exercise their parenting and caregiving roles without discrimination.

Barrier(s) addressed

- Judgment about parental capacity.
- fear of seeking support because of child-protection consequences.
- disability and lack of support contributing to loss of custody.
- gaps in supports for disabled parents and their children.
- added unpaid work caused by inaccessible schools and stigma.

Normative basis and rationale

Section V points to specific protections for parents with disabilities. The CRPD requires appropriate assistance with child-rearing responsibilities and prohibits separation of children from parents on the basis of disability. CRPD guidance further identifies supportive parenting services and assistance to parents with disabilities as part of community inclusion and deinstitutionalization.

Key normative sources

- [Treaty obligation] CRPD, art. 23 - protects family life, requires appropriate assistance to persons with disabilities in performing child-rearing responsibilities, and prohibits separation of children from parents on the basis of disability.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), para. 67 - includes childcare and supportive parenting services among supports for family carers.
- [Treaty-body interpretive guidance] CRPD Committee, Guidelines on deinstitutionalization (2022), para. 47 - States should provide parents with disabilities with support and reasonable accommodation to prevent their children from being placed in institutions.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 3 (2016) - requires responses to multiple and intersectional discrimination experienced by women with disabilities, including in family life and control over their own lives.

Measures

4.2.1 The provision does not presume diminished parenting capacity solely because a parent has a disability or is Deaf.

4.2.2 The provision provides accessible and individualized supports to enable parents with disabilities to exercise parenting and child-rearing responsibilities.

4.2.3 The provision enables the care and support needs of both the parent and child to be addressed together rather than treating one person's needs as disqualifying the other.

4.2.4 The provision ensures that seeking disability, mental health, caregiving, or other support does not by itself trigger adverse child-protection or custody consequences.

4.2.5 The provision provides supports that reduce avoidable additional caregiving work created by inaccessible or non-inclusive education and other child-serving systems.

Indicator 4.3

Informal peer and community care and support work is recognized and supported.

Barrier(s) addressed

- Women with disabilities provide extensive unpaid peer and community support that fills gaps in formal systems but is largely unrecognized, unsupported, and personally costly.

Normative basis and rationale

Peer support is expressly recognized in the Section V standards. The CRPD refers to peer support in education and habilitation/rehabilitation, and the Committee's deinstitutionalization guidelines describe peer support as self-directed and autonomously organized by persons with disabilities. The same guidelines call for public investment in peer support, self-advocacy, circles of support and independent-living networks.

Key normative sources

- [Treaty obligation] CRPD, arts. 24 and 26 - expressly recognizes peer support and mentoring as means of participation, independence and inclusion.
- [Treaty-body interpretive guidance] CRPD Committee, Guidelines on deinstitutionalization (2022), para. 70 - calls for investment in peer support, self-advocacy, circles of support, other support networks and centres for independent living.
- [Treaty-body interpretive guidance] CRPD Committee, Guidelines on deinstitutionalization (2022), para. 73 - peer support should be self-directed, independent of institutions and medical professionals, and autonomously organized by persons with disabilities.
- [UN Human Rights Council resolution (non-binding)] Human Rights Council resolution 54/6 (2023) - supports recognition and redistribution of unpaid care and investment in care/support systems.

Measures

4.3.1 The provision recognizes sustained peer and community support as forms of care and support work.

4.3.2 The provision provides resources or compensation for sustained peer and community care roles where appropriate, rather than relying automatically on unpaid labour.

4.3.3 The provision provides supports that protect the well-being and care needs of people providing peer and community support.

4.3.4 The provision supports peer and community care models that are responsive to gaps in formal care and support systems.

Indicator 4.4

Indigenous and Inuit family and community caregiving practices are recognized and supported in ways that respect Indigenous peoples' cultures, institutions, and self-determined priorities.

Barrier(s) addressed

- Colonial disruption of Indigenous and Inuit care relationships.
- essential informal community care remaining unsupported.
- fear of penalties for providing unlicensed care.
- lack of culturally safe formal alternatives.

Normative basis and rationale

Section V references UNDRIP as an Indigenous-specific human rights standard. Its protections for self-determination and distinct social and cultural institutions, economic and social systems, participation and authority in relation to health, housing and social programs, traditional health practices, and particular attention to Indigenous women and persons with disabilities directly reinforce the finding that Indigenous and Inuit caregiving relationships should be recognized and supported rather than displaced or penalized by standardized systems. They also support care and support arrangements that respect the priorities, institutions, and approaches identified by the Indigenous peoples and communities concerned. Read with CRPD standards, UNDRIP supports both preservation of valued community care relationships and access to formal supports chosen by the person and community.

Key normative sources

- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 3, 5, 8, 10 and 20-24 - protects Indigenous self-determination, distinct social and cultural institutions and social systems, protections against forced assimilation and relocation, Indigenous involvement and administration of health/housing/social programs, traditional health practices, and particular attention to Indigenous women and persons with disabilities.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 14 (2000), para. 12 - requires culturally appropriate and acceptable health services.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), paras. 50 and 87 - participation obligations extend to persons with disabilities belonging to Indigenous peoples and to persons in rural or remote

areas, including in policies concerning adequate living standards and social protection.

- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 3 (2016), including para. 16 - requires targeted measures addressing multiple and intersecting discrimination.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017) - recognizes community relationships while requiring formal supports that preserve choice and do not make family/community care the only option.

Measures

4.4.1 The provision recognizes culturally grounded Indigenous and Inuit family and community caregiving relationships and practices.

4.4.2 The provision provides resources and supports for Indigenous and Inuit caregiving in accordance with priorities and approaches identified by the Indigenous peoples and communities concerned.

4.4.3 The provision does not impose licensing, regulatory, or administrative requirements that unnecessarily penalize or displace culturally grounded informal care, and regulatory approaches affecting such care are developed in consultation and cooperation with the Indigenous peoples concerned, while maintaining appropriate protections against harm.

4.4.4 The provision enables formal care and support to complement rather than undermine valued Indigenous and Inuit networks of community care.

Indicator 4.5

Paid care and support workers have adequate compensation, benefits, resources, and safe working conditions.

Barrier(s) addressed

- Low pay, inadequate staffing and resources, unsafe working conditions, burnout, multiple roles, and lack of support for workers undermine both workforce sustainability and quality of care.

Normative basis and rationale

Section V points to clear foundations for decent-work standards for paid care and support work. ICESCR standards apply generally to workers and protect fair wages, equal remuneration, a decent living and safe and healthy working conditions. CEDAW Committee standards summarized in Section V call for equal labour protections for women care and domestic workers, while ILO Convention No. 189 supplies a specific international labour benchmark for domestic work. OC-31/25 adds the emerging right to provide paid care in decent conditions.

Key normative sources

- [Treaty obligation] ICESCR, arts. 6 and 7 - protects the right to work, fair wages and equal remuneration, a decent living, and safe and healthy working conditions.

- [Treaty-body country guidance cited/summarized in Section V] CEDAW Committee employment standards summarized in Section V - women care workers and domestic workers should enjoy protections regarding remuneration and working conditions equivalent to workers in other sectors.
- [ILO convention cited in Section V (not ratified by Canada)] ILO Convention No. 189, Domestic Workers Convention, 2011 - establishes standards on working time, weekly rest, minimum wage where applicable, overtime and social security for domestic workers. Canada has not ratified Convention No. 189.
- [Emerging regional human-rights interpretation (not binding on Canada)] Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - Section V states that the right to provide care includes paid and unpaid care in decent conditions with respect for caregivers' human rights and well-being.

Measures

4.5.1 The provision establishes adequate remuneration for paid care and support work.

4.5.2 The provision provides access to employment benefits and social protections appropriate to paid care and support work.

4.5.3 The provision establishes safe staffing, workload, scheduling, and working-time conditions that reduce chronic overwork and burnout.

4.5.4 The provision provides workers with the equipment, training, supervision, and organizational resources required to perform their work safely and effectively.

4.5.5 The provision provides access to supports that address the physical and mental health impacts of paid care and support work.

Indicator 4.6

The paid care and support workforce is inclusive of people with disabilities and Deaf people and values lived experience as expertise.

Barrier(s) addressed

- People with disabilities and Deaf people face barriers to obtaining and maintaining paid care work, especially with intersecting marginalized identities.
- lived-experience expertise is often confined to unpaid peer roles.

Normative basis and rationale

Equality and work standards referenced in Section V support full inclusion of persons with disabilities and Deaf people in paid care and support employment. The CRPD protects the right to work in an open, inclusive and accessible labour market, including reasonable accommodation, while intersectionality standards address compounded barriers faced by women with disabilities. UNDRIP adds that Indigenous individuals are entitled to the full enjoyment of applicable labour rights and must not face discriminatory conditions of employment or salary; it also expressly includes employment among the economic and social conditions requiring improvement and particular attention to Indigenous women and

persons with disabilities. Awareness and participation standards reinforce recognition of capabilities and the value of lived experience.

Key normative sources

- [Treaty obligation] CRPD, art. 27 - protects the right of persons with disabilities to work on an equal basis with others in an open, inclusive and accessible labour market and requires reasonable accommodation in the workplace.
- [Treaty obligation] CRPD, arts. 5, 6 and 8 - requires non-discrimination, addresses multiple discrimination against women with disabilities, and promotes recognition of the skills, merits, abilities and workplace contributions of persons with disabilities.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 3 (2016), including para. 16 - addresses multiple and intersectional discrimination affecting women's economic opportunities and participation.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), paras. 9 and 86 - emphasizes the value of lived experience and knowledge in decision-making and calls for inclusive, non-discriminatory, accessible employment policies with reasonable accommodation and support.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 17 and 21 - protects Indigenous individuals' labour rights and freedom from discriminatory conditions of employment or salary, and includes employment among the economic and social conditions requiring improvement with particular attention to Indigenous women and persons with disabilities.

Measures

4.6.1 The provision prohibits disability- and Deaf-related discrimination in recruitment, hiring, retention, advancement, and working conditions in paid care and support employment.

4.6.2 The provision ensures access to workplace accommodations, accessibility supports, and inclusive work arrangements for care and support workers with disabilities.

4.6.3 The provision recognizes lived experience as relevant expertise in recruitment, role design, training, and service delivery.

4.6.4 The provision creates pathways for peer and lived-experience roles to become adequately supported paid employment where comparable work is otherwise remunerated.

4.6.5 The provision addresses intersecting employment barriers experienced by Indigenous, Black, racialized, immigrant, LGBT, and other marginalized workers with disabilities or Deaf workers.

Dimension 5. Establishes material and social supports related to self-care and caregiving

Regime function: Structures income, social protection, housing, and other material conditions affecting the ability to care for oneself and others.

Indicator 5.1

Income and social protection are adequate to enable people to meet essential needs, exercise self-care, and sustain caregiving responsibilities.

Barrier(s) addressed

- Disability poverty.
- inadequate social-security levels.
- food insecurity.
- people forgoing personal care, laundry, food, and other necessities.
- mothers prioritizing children's needs over their own.
- poverty increasing care needs and undermining self-care.

Normative basis and rationale

Section V links standards related to adequate income and social protection to the central themes identified in the research of dignity, health, disability support and self-care. ICESCR and CRPD standards require an adequate standard of living and social protection, including disability-related expenses; CESCR guidance requires social-security benefits to be adequate in amount and duration. UNDRIP adds an Indigenous-specific standard: Article 21 expressly includes housing, health, social security and employment among the economic and social conditions to be improved and requires particular attention to Indigenous women and persons with disabilities. OC-31/25 adds that self-care depends on time, space and resources, directly connecting material security with the ability to care for oneself and others.

Key normative sources

- **[UN declaration / customary-law reference as characterized in Section V]** UDHR, art. 25 - Section V invokes the right to an adequate standard of living, including food, clothing, housing, medical care and necessary social services, and characterizes the UDHR as widely accepted as reflecting customary international law.
- [Treaty obligation] ICESCR, arts. 9 and 11 - recognizes the rights to social security and an adequate standard of living, including adequate food, clothing and housing and continuous improvement of living conditions.
- [Treaty-body interpretive guidance] CESCR, General Comment No. 19 (2007) - social-security systems and benefits should be available, accessible and adequate in amount and duration and should respond to relevant social risks and contingencies.
- [Treaty obligation] CRPD, art. 28; CRPD Committee, General Comment No. 5 (2017), para. 92 - requires social protection and affordable disability-related

services and assistance and rejects requiring persons with disabilities to bear disability-related expenses themselves.
- [Emerging regional human-rights interpretation (not binding on Canada)] Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - Section V describes self-care as requiring time, space and resources to pursue well-being, independence and a dignified life.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, art. 21 - recognizes Indigenous peoples' right, without discrimination, to improvement of economic and social conditions, including employment, housing, health and social security, with particular attention to Indigenous women and persons with disabilities.

Measures

5.1.1 The provision provides income and social protection sufficient to meet basic needs, including food, clothing, utilities, transportation, and other essential living costs.

5.1.2 The provision recognizes and provides for disability-related and care-related costs that are additional to ordinary living expenses.

5.1.3 The provision adjusts benefit levels or support amounts to respond to changes in the cost of living and the actual costs of meeting essential needs.

5.1.4 The provision is designed so that a person is not required to forgo their own essential care or self-care in order to meet the needs of a child or other person for whom they provide care.

Indicator 5.2

People have access to adequate, affordable, accessible, and stable housing that supports self-care, independent living, and caregiving.

Barrier(s) addressed

- Core housing need and high housing costs undermine self-care and independence.
- lack of stable housing consumes time and energy needed for health and care.
- independent housing can be a precondition for exercising autonomy.

Normative basis and rationale

Section V directly connects adequate housing with both an adequate standard of living and independent living in the community. CRPD standards require accessible housing options throughout the community, public and subsidized housing, and support that enables people to live where and with whom they choose. CEDAW Committee guidance summarized in Section V adds targeted measures to address the housing disadvantage experienced by women with disabilities. UNDRIP adds that improvement of housing is part of Indigenous peoples' economic and social rights and that Indigenous peoples have the right to be actively involved in developing and determining housing and other social programs affecting them.

Key normative sources

- [Treaty obligation] ICESCR, art. 11 - recognizes the right to an adequate standard of living, including adequate housing and continuous improvement of living conditions.
- [Treaty obligation] CRPD, arts. 19 and 28 - protects independent living and community inclusion and requires equal access to public housing programs and social protection.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), paras. 25, 92 and 97(j) - lack of accessible housing can defeat independent living; States should ensure accessible, affordable housing and community environments.
- [Treaty-body country guidance cited/summarized in Section V] CEDAW Committee housing standards summarized in Section V - calls for special measures for women with disabilities, including rental assistance and priority access to public housing.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 21 and 23 - recognizes improvement of housing as part of Indigenous peoples' economic and social rights and the right of Indigenous peoples to be actively involved in developing and determining housing and other economic and social programs affecting them.

Measures

5.2.1 The provision supports access to housing that is affordable in relation to the person's available income.

5.2.2 The provision supports access to housing that is accessible and suitable for the person's disability-related and care needs.

5.2.3 The provision supports housing stability so that housing insecurity does not disrupt needed care, self-care, or caregiving relationships.

5.2.4 The provision enables housing arrangements that support independent living and the person's chosen care and caregiving relationships.

Indicator 5.3

Policies and programs recognize that self-care may itself require time, resources, and assistance.

Barrier(s) addressed

- Participants described self-care as essential to health, dignity, independent living, and caregiving, but poverty and caregiving burdens leave little time or energy.
- self-care is not always performed independently and may require support.

Normative basis and rationale

Section V treats self-care as one of the three dimensions of the emerging right to care and explicitly recognizes that it requires time, space and resources. Disability-rights standards reinforce that independent living does not mean performing daily activities without assistance; individualized support may be necessary to exercise autonomy, health, dignity and participation. Social-protection standards further require assistance with disability-related costs.

Key normative sources

- [Emerging regional human-rights interpretation (not binding on Canada)] Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025) - Section V recognizes self-care and describes the need for time, space and resources to pursue physical, mental, emotional, spiritual and cultural well-being.
- [Intergovernmental political commitment (non-treaty)] Buenos Aires Commitment (2022), paras. 8 and 14 - recognizes the right to self-care and, for persons with disabilities, calls for accessible policies, services and infrastructure responsive to autonomy and specific needs.
- [Treaty obligation] CRPD, art. 19 - recognizes independent living and community inclusion with access to necessary support services.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), paras. 16, 63 and 92 - independent living is choice and control, support may be individualized over time, and disability-related assistance must be affordable.

Measures

5.3.1 The provision recognizes self-care as an essential need rather than an optional or residual activity.

5.3.2 The provision does not assume that self-care must be performed independently and enables access to assistance required to carry it out.

5.3.3 The provision provides or enables access to the time, resources, and supports reasonably required for health, well-being, dignity, and community participation.

Dimension 6. Establishes governance of care economy policies and programs

Regime function: Structures participation, representation, support, influence, monitoring, and accountability in care-economy policymaking and program governance.

Indicator 6.1

People who provide and receive care and support, including women with disabilities and Deaf women, participate meaningfully in the design, implementation, monitoring, and review of care-economy policies and programs.

Barrier(s) addressed

- Women with disabilities described exclusion from major policy and funding decisions despite being directly affected and possessing lived expertise.
- participants called for input from care recipients, caregivers, workers, families, and people with lived experience.

Normative basis and rationale

Participation is an explicit human-rights requirement in Section V, not merely a good-practice principle. CRPD Article 4(3) requires close consultation and active involvement in decisions concerning persons with disabilities, and Article 33(3) extends participation to monitoring. General Comment No. 7 specifies early and continuous involvement, diverse representation, participation across design, implementation and monitoring, and particular inclusion of women, Indigenous persons and people in rural or remote areas. For Indigenous peoples, UNDRIP adds distinct collective participation and self-determination standards: participation through their own representative institutions, consultation and cooperation in good faith to obtain free, prior and informed consent before legislative or administrative measures that may affect them, and active involvement in developing and determining health, housing and other economic and social programs.

Key normative sources

- [Treaty obligation] CRPD, arts. 4(3) and 33(3) - requires close consultation and active involvement of persons with disabilities through their representative organizations and participation of civil society, especially persons with disabilities, in monitoring.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), paras. 15, 43, 50, 54-56, 73, 83 and 87 - requires early, continuous and diverse participation in law, policy, service planning, implementation, monitoring and review.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), para. 9 - participation is necessary because persons with disabilities bring lived experience and knowledge of the rights to be implemented.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 5 (2017), including paras. 93 and 97(i) - persons with disabilities should participate

in decisions affecting community development and in transforming support services and communities.

- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 18, 19 and 23 - protects Indigenous participation through their own institutions, consultation and cooperation to obtain free, prior and informed consent before measures that may affect them, and active involvement in developing and determining health, housing and other economic and social programs.
- [Canadian implementation statute] United Nations Declaration on the Rights of Indigenous Peoples Act, S.C. 2021, c. 14, ss. 5-6 - requires the Government of Canada, in consultation and cooperation with Indigenous peoples, to take all measures necessary to ensure federal laws are consistent with UNDRIP and to prepare and implement an action plan to achieve its objectives.

Measures

6.1.1 The provision requires meaningful participation of people with lived experience in the design and redesign of care and support laws, policies, programs, and funding arrangements.

6.1.2 The provision includes people who receive care and support, unpaid caregivers, paid care and support workers, peer and community caregivers, and organizations representing them.

6.1.3 The provision requires participation in implementation, monitoring, and review as well as initial policy or program design.

6.1.4 The provision requires participation to reflect diverse and intersecting experiences, including disability, Deaf identity, gender, Indigeneity, racialization, migration, poverty, and other relevant circumstances.

Indicator 6.2

Participation in care-economy policy and program governance is accessible, supported, and appropriately compensated.

Barrier(s) addressed

- People with disabilities are asked to provide guidance and expertise without compensation.
- participation itself can be taxing and may require accessibility, communication, transportation, care, or other supports.

Normative basis and rationale

Meaningful participation must itself be accessible and practically possible. General Comment No. 7 requires accessible information and consultation procedures, reasonable accommodation, support and funding, and realistic timelines; it also supports sufficient funding for representative organizations. These standards strongly support reimbursement

and participation supports. They are less explicit about an individual entitlement to an honorarium for lived-experience consultation.

Key normative sources

- [Treaty obligation] CRPD, art. 4(3) - requires close consultation and active involvement in decisions concerning persons with disabilities.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), paras. 43, 45-46 and 54 - requires transparent and accessible consultation, accessible formats, reasonable accommodation, support, funding and reasonable timelines.
- [Treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), para. 63 and recommendations 94(i), (m) and (n) - supports sufficient funding for organizations of persons with disabilities and accessible, supported participation in public decision-making and monitoring.
- [Treaty obligation] CRPD, art. 28; CRPD Committee, General Comment No. 5 (2017), para. 92 - recognizes State responsibility for disability-related costs and access to appropriate and affordable supports.

Measures

6.2.1 The provision requires accessibility and communication supports needed for meaningful participation.

6.2.2 The provision provides reimbursement or direct support for disability-related, transportation, caregiving, or other costs required to participate.

6.2.3 The provision provides appropriate compensation for substantial time, expertise, and lived-experience contributions to policy and program governance.

6.2.4 The provision structures participation processes so that administrative, scheduling, and procedural demands do not create unreasonable barriers to participation.

Indicator 6.3

Lived-experience participation has an identifiable influence on decisions and is linked to transparent accountability.

Barrier(s) addressed

- Participants described policy consultation as too often superficial and disconnected from decision-making.
- lived experience may be solicited without clear evidence that it changes policy, funding, program design, or oversight.

Normative basis and rationale

Participation standards pointed in Section V go beyond one-time consultation. General Comment No. 7 requires that views be given due weight, consultation results be reflected in decisions, participants be informed of outcomes, and transparent mechanisms exist to consider those views when public decisions are made. It also requires participation in

monitoring and evaluation. For Indigenous peoples, UNDRIP strengthens this expectation by protecting participation through Indigenous representative institutions, consultation and cooperation aimed at obtaining free, prior and informed consent, and active involvement in determining relevant health, housing and social programs, including administration through Indigenous institutions as far as possible. These standards directly support the indicator's focus on influence, accountability and continuing governance roles.

Key normative sources

- **[Treaty obligation]** CRPD, arts. 4(3) and 33(3) - requires active involvement in decisions and participation in monitoring implementation of the Convention.
- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 7 (2018), paras. 48-49 - views should be given due weight, consultation results reflected in decisions, participants informed of outcomes, and transparent mechanisms established to consider views when motivating public decisions.
- **[Treaty-body interpretive guidance]** CRPD Committee, General Comment No. 7 (2018), paras. 53 and 56 - supports formal involvement, including seats on committees/task forces, and participation in monitoring and evaluation with clear procedures and timelines.
- **[Treaty-body country guidance cited/summarized in Section V]** CEDAW Committee care-governance standards summarized in Section V - calls for robust data collection on women with disabilities and for data on unpaid care work to support recognition and compensation.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, arts. 18, 19 and 23 - protects Indigenous participation through their own institutions, consultation and cooperation aimed at obtaining free, prior and informed consent, and substantive involvement in determining and, as far as possible, administering relevant programs.

Measures

6.3.1 The provision establishes mechanisms through which lived-experience input can influence policy, program, funding, and implementation decisions.

6.3.2 The provision includes people with lived experience in relevant governance, advisory, oversight, or decision-making bodies rather than limiting participation to one-time consultation.

6.3.3 The provision requires transparent reporting on how participant input was considered and how decisions were reached.

6.3.4 The provision enables people with lived experience to participate in evaluation and accountability processes concerning care and support systems.

Indicator 6.4

Indigenous peoples have a substantive role in determining and developing care and support policies and programs that affect them and, as far as possible, in administering those programs through their own institutions.

Barrier(s) addressed

- Indigenous and Inuit participants described colonial disruption of community care relationships and distrust of externally imposed systems.
- Decisions about the design, funding, administration, and location of care and support can be made through institutions that do not adequately reflect Indigenous priorities, governance, cultures, or community relationships.
- In Northern and Inuit communities, externally structured service systems and limited local capacity can require people to leave family, community, and culture to obtain needed care and support.

Normative basis and rationale

UNDRIP establishes a distinct collective governance standard that is not fully captured by general requirements for stakeholder participation. Articles 18 and 19 protect Indigenous peoples' participation through representatives chosen by themselves in accordance with their own procedures and require consultation and cooperation in good faith through their representative institutions in order to obtain free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Article 23 further recognizes the right of Indigenous peoples to determine and develop priorities and strategies for exercising their rights to development, including active involvement in developing and determining health, housing, and other economic and social programs affecting them and, as far as possible, administering such programs through their own institutions. Read with the CRPD participation standards relevant to Indigenous persons with disabilities, these provisions support a distinct indicator focused on Indigenous self-determination and governance within the care economy policy regime rather than treating Indigenous peoples simply as one stakeholder group within general consultation processes.

Key normative sources

- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, art. 18 - protects the right of Indigenous peoples to participate in decision-making in matters affecting their rights through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own Indigenous decision-making institutions.
- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, art. 19 - requires States to consult and cooperate in good faith with Indigenous peoples through their own representative institutions in order to obtain free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

- [UN General Assembly declaration; application in Canada affirmed by federal statute] UNDRIP, art. 23 - protects Indigenous peoples' right to determine and develop priorities and strategies for exercising their right to development, including active involvement in developing and determining health, housing, and other economic and social programs affecting them and, as far as possible, administration through their own institutions.
- [Canadian implementation statute] United Nations Declaration on the Rights of Indigenous Peoples Act, S.C. 2021, c. 14, ss. 5-6 - requires the Government of Canada, in consultation and cooperation with Indigenous peoples, to take all measures necessary to ensure federal laws are consistent with UNDRIP and to prepare and implement an action plan to achieve its objectives.
- [Treaty obligation] CRPD, art. 4(3), and [treaty-body interpretive guidance] CRPD Committee, General Comment No. 7 (2018), including paras. 50 and 87 - require close consultation and active involvement of persons with disabilities, including persons with disabilities belonging to Indigenous peoples and those in rural and remote areas.

Measures

6.4.1 The provision enables Indigenous peoples to participate through representatives chosen by themselves in accordance with their own procedures and institutions.
6.4.2 Where legislative, policy, or administrative measures may affect Indigenous peoples, the provision requires consultation and cooperation in good faith through their representative institutions, consistent with applicable standards concerning free, prior and informed consent.
6.4.3 The provision recognizes Indigenous peoples' role in determining and developing priorities and strategies for care and support, including relevant health, housing, disability, and other economic and social programs.
6.4.4 The provision enables, as far as possible, relevant care and support programs to be administered through Indigenous peoples' own institutions.

E. Normative Source Register and Legal Status

This register summarizes the principal sources used above. It is not a new source list: each source is identified, quoted, summarized, or clearly relied upon in Section V. The status descriptions distinguish the force of the source without treating interpretive or emerging standards as equivalent to treaty obligations.

Source / standard	Status used in this framework	Role in the model
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Treaty obligation - Canada is a State party	Primary treaty basis for work, social security, adequate standard of living, and health.

Source / standard	Status used in this framework	Role in the model
Convention on the Rights of Persons with Disabilities (CRPD)	Treaty obligation - Canada is a State party	Primary disability-rights basis for non-discrimination, community inclusion, family, peer support, work, social protection, and participation.
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Treaty obligation - Canada is a State party	Gender-equality framework; Section V relies especially on CEDAW Committee standards concerning health, work, social protection, housing, and care governance.
International Covenant on Civil and Political Rights (ICCPR) and Convention on the Rights of the Child (CRC)	Treaty obligations - Canada is a State party	Identified in Section V as relevant treaty sources; they are not primary anchors for most current indicators because Section V develops other sources more specifically.
Universal Declaration of Human Rights (UDHR)	Declaration; Section V characterizes it as widely accepted as reflecting customary international law	Used in Section V for adequate standard of living and social security.
CESCR General Comment No. 14 (Right to Health)	Treaty-body interpretive guidance	Clarifies bodily autonomy and the availability, accessibility, acceptability and quality of health facilities, goods and services.
CESCR General Comment No. 19 (Right to Social Security)	Treaty-body interpretive guidance	Clarifies coverage, accessibility, adequacy and inclusion in social-security systems.
CRPD General Comment No. 3 (Women and Girls with Disabilities)	Treaty-body interpretive guidance	Clarifies multiple and intersectional discrimination and targeted measures for women and girls with disabilities.

Source / standard	Status used in this framework	Role in the model
CRPD General Comment No. 5 (Article 19)	Treaty-body interpretive guidance	Central source on choice, control, individualized support, community services, family-carer support, accessible housing, disability-related costs and remedies.
CRPD General Comment No. 7 (Articles 4(3) and 33(3))	Treaty-body interpretive guidance	Central source on meaningful participation, accessibility, funding/support, due weight, transparent influence, and monitoring.
CRPD Guidelines on deinstitutionalization, including in emergencies (2022)	Treaty-body interpretive guidance	Used particularly for peer support, family support, parenting, individualized community support and non-institutional alternatives.
CEDAW and CRPD Committee concluding observations summarized in Section V	Treaty-body country guidance	Section V summarizes standards on rural/remote health access, women with disabilities, social protection, housing, work and care governance. The revised report does not provide source footnotes for each observation, so this framework does not invent document symbols.
Human Rights Council resolution 54/6 (2023), Centrality of care and support from a human rights perspective	Non-binding Human Rights Council resolution	Supports recognition and redistribution of care work and investment in affordable, quality care/support systems.
Buenos Aires Commitment (2022)	Intergovernmental political commitment; not a treaty	Recognizes the right to provide and receive care and to exercise self-care; para. 14 expressly addresses disability autonomy and accessible care infrastructure.

Source / standard	Status used in this framework	Role in the model
Inter-American Court of Human Rights, Advisory Opinion OC-31/25 (2025)	Advisory opinion; not binding on Canada	Emerging regional articulation of rights to receive care, provide paid/unpaid care, and self-care, including disability-specific autonomy and support.
ILO Convention No. 189, Domestic Workers Convention, 2011	ILO treaty standard cited in Section V; not ratified by Canada	Specific decent-work benchmark for domestic workers; used as a supplementary standard alongside general ICESCR work rights.
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (2007)	UN General Assembly declaration; not a treaty. Canada endorsed it without qualification in 2016; its application in Canadian law is affirmed by federal statute.	Indigenous-specific foundation for self-determination, distinct social and cultural institutions, labour rights, economic and social conditions, health and social services, traditional health practices, and Indigenous participation in determining and administering relevant programs.
United Nations Declaration on the Rights of Indigenous Peoples Act, S.C. 2021, c. 14	Federal statute; ss. 4-6 affirm UNDRIP as a universal international human rights instrument with application in Canadian law and establish a framework for federal implementation, consistency of federal laws, and an action plan.	Canadian implementation context for UNDRIP; particularly relevant to federal law and policy review, consultation and cooperation with Indigenous peoples, and implementation and accountability.