

OCTOBER 25

Advisory Opinion No. 31 of the Inter-American Court of Human Rights:

Key Q&A on the Right to Care and Persons with Disabilities



CONTEXT

Care and support are essential to human life, but remain undervalued and unequally distributed. Women and girls, particularly in low- and middle-income countries, disproportionately provide care and often at the cost of their education, employment, and economic autonomy. At the same time, more and more people require care, in part due to accelerated aging, disability, and other long-term support needs. Without adequate systems, this demand is met through unpaid or underpaid labor, reinforcing gender inequality and limiting the autonomy and rights of both caregivers and those who rely on support. The global care agenda seeks to recognize, reduce, redistribute, and reward care work. This agenda has taken flight in many countries, particularly in Latin America and the Caribbean, with numerous countries developing legislation and policies to address local realities. While the care and disability rights agendas overlap, they have historically operated in silos, missing opportunities for mutual reinforcement.

Furthermore, States have typically developed legislation and policies without clear guidance on how to ensure human rights in the provision and design of public care services. It is critical that rights-based systems are developed that respond both to the needs of those providing care and to those receiving it—ensuring that people with disabilities and others with support needs can live with autonomy and dignity, while caregivers, most of them women, are supported and empowered. Moving away from institutionalization and towards community-based, inclusive services is a shared priority, where the goals of gender equality and disability rights converge.

In August 2023, Argentina requested the Inter-American Court of Human Rights of the Organization of American States (IACtHR) to develop an Advisory Opinion on the content and scope of the right to care and its relationship with other rights. After deliberations starting in April 2025, the Court publicly notified Advisory Opinion 31 (AO 31) on 12 June 2025. Below are some key questions and answers on AO 31. We cover what AO 31 says and what is missing from the opinion, especially concerning disability rights.

This document was prepared with the input from various disability rights organizations¹.

¹ This document was written in October 2025 by the following organizations: Sociedad and Discapacidad (SODIS), Asociación Civil por la Igualdad y la Justicia (ACIJ), the Center for Inclusive Policy (CIP) and The Disability Rights Fund. Documenta, Asociacion Azul, and ALCE (Abolición de Lógicas de Castigo y Encierro) provided valuable inputs and comments.

KEY QUESTIONS AND ANSWERS

1. What are the key findings set out in the AO 31?

The Court establishes that the right to care constitutes an autonomous human right, essential for a dignified life and rooted in the universal human need for care. AO 31 stresses that every person is entitled to the time, space, and resources to provide or receive care in ways that not only secure well-being but also support personal autonomy, life projects, and community inclusion. The Court recognizes care, whether paid or unpaid, as work that must be valued and supported. AO 31 highlights the collective duty of society and the State to ensure those providing care have the resources, recognition, and work conditions they need, while also guaranteeing that people who require care have the right to receive quality care that is sufficient and appropriate to foster inclusion and live with dignity.

2. How does AO 31 understand disability?

The Court affirms a social model of disability, recognizing that it is social barriers—not impairments—that limit equality of rights. This reflects the Court's ongoing interpretation of disability as a matter of human rights and is in line with the Convention on the Rights of Persons with Disabilities.

3. How does the Court view people with disabilities within the care agenda?

The Court rejects the idea that persons with disabilities are merely passive recipients of care. Instead, they are recognized as rights

holders, with autonomy and decision-making capacity. Care must therefore be based on providing the supports required for independent living, community participation, caregiving, and self-care—not limited to mere “assistance” for care or human support needs. The AO reminds States that care should not be guided by the interests of service providers, but by respect for each person’s autonomy and life project, both those giving and receiving care.

4. What is the Court’s perspective on independence and agency?

The Court clarifies that independence does not mean self-sufficiency. It does not require people to do everything on their own; rather, it means having control over one’s own decisions—from everyday choices such as bathing or dressing, to more complex decisions such as participating in social or political life. The Court rejects paternalistic or welfare-based approaches that reinforce dependence and exacerbate the risk of abuse.

5. What are the obligations of States with respect to including a disability-rights perspective in the care agenda per AO 31?

Based on AO 31, States should act in good faith to:

- Ensure care and support services that are accessible, affordable, and tailored to each person.
- Guarantee that decisions about care are made based on the will and preferences of persons with disabilities.
- Promote independence and autonomy of persons with disabilities.
- Monitor care environments to ensure dignity, safety, and a life free of violence.

6. To what extent are key disability-rights concepts and rights missing from AO 31?

AO 31 adopts the social model of disability and, therefore, emphasizes that persons with disabilities must be regarded as

rights holders and that care must be based on the provision of the supports necessary for independent living. However, AO 31 fails to address certain elements that are key within the disability rights movement. In particular:

- It does not incorporate the disability perspective in a transversal manner, but only applies it in the section that specifically refers to this group. This can be seen, for example, in the fact that the terms “care” and “support(s)” are not used jointly throughout the document, but only in the section on persons with disabilities.
- It addresses the needs of persons with disabilities together with people with illnesses. Although this is explained by the similarity of certain support needs, it is important to note that illness and disability are distinct concepts, even when they may overlap. Merging categories can be confusing and symbolically problematic, as it may reinforce misconceptions about disability.
- It does not focus on the right of persons with disabilities to provide care (whether by undertaking caregiving tasks within their own families or as remunerated work) and to the consequent provision of support for such purposes. There is only one passing reference to women with disabilities listed among groups of persons who perform unpaid care work who are in situations of particular vulnerability.
- It does not elaborate on the content of the right to self-care in relation to persons with disabilities.
- It does not expressly address the importance of implementing supports that promote deinstitutionalization and community living. Indeed, AO 31 remains mostly silent on the issue of institutionalization; when it does mention it, it foresees the possibility of institutionalization as an exceptional, temporary, and last resort measure for children with disabilities. In this sense, it departs from the CRPD standard.
- It refers more than once to people in a situation of dependency. The term “dependency” is highly problematized within the disability rights movement for various reasons.

First, within the care agenda, historically, the onus has been on reducing the care “burden” that falls on women from caring for family members who are “dependent” on said care. Having been adopted from the medicine and nursing disciplines to describe persons who have long-term medical care needs, the concept of dependency primarily focuses on self-care and physical functioning needs, such as eating and bathing, thus largely ignoring the full spectrum of functioning needs. Hence, care policies and programs that require evaluations of dependency and design programs to meet dependency-specific needs largely ignore other human support needs that beneficiaries may have (such as human guiding or sign language interpretation). Second, because of the medical origins of the concept and how doctors and nurses are often tasked with making decisions for their patients, dependency is often associated with a lack of decision-making capacity. Third, we all require support from others, and hence, there is no such thing as people being completely dependent or independent. What differs from person to person is the types and intensity of support needs.

7. What countries should comply with the Court’s opinion?

All countries that have ratified the American Convention on Human Rights should act in good faith to comply with the Opinion. This applies to 23 countries in Latin America and the Caribbean: Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, and Uruguay.

8. To what extent are these countries legally bound to subscribe to the Court’s opinion?

Advisory Opinions of the Inter-American Court of Human Rights are not legally binding. Their objective is to clarify the obligations of States to the American Convention on Human Rights. Thus, even though the Opinion is not binding, States are still expected to act in good faith to comply with these clarifications. When the Court issues an advisory opinion, the opinion can be used as an interpretation criterion by national courts. That is, national courts may use the opinion to assess whether domestic laws are compatible with the Convention (“control of conventionality”).

If laws are incompatible, judicial or legislative reforms may be started. Furthermore, States could enforce legislation and design public policy following the standards provided by the opinion.

In Costa Rica, constitutional jurisprudence assigns binding status to the Court's advisory opinions. In this case, the State is obligated to reform its laws and policies to comply with the Opinion and with its domestic binding status.

9. How can Organizations of Persons with Disabilities (OPDs) use AO 31 to advance the rights of persons with disabilities in their countries?

As States continue to develop public care systems, they must subscribe to a disability rights approach to care and support services. The care agenda has gained even more momentum in the wake of AO 31. In this context, AO 31 can be used by OPDs as an advocacy leverage point with governments, urging them to comply with the Inter-American Court for Human Rights (IACtHR). OPDs can also use AO 31 in litigation to reinforce arguments for independent living and integrate AO 31 into awareness-raising and training initiatives. While there are still key disability-rights considerations missing or not fully developed within the AO 31, it is nonetheless an important advancement towards ensuring disability rights within the care agenda.

10. How can Organizations of Persons with Disabilities (OPDs) use AO 31 to advance the rights of persons with disabilities in their countries?

The Court's Opinion can influence countries beyond those that have ratified the American Convention on Human Rights. For example, OAS member states that are not parties to the Convention (United States, Canada, Cuba, Belize, Guyana, Saint Lucia, Saint Vincent & the Grenadines, The Bahamas, Antigua & Barbuda, Saint Kitts & Nevis, Trinidad & Tobago), may experience political and normative pressure through the Inter-American Commission on Human Rights to align policies with the Court's standards.

Furthermore, the recognition of the right to care contributes to the development of international human-rights law and guidance both

in the Americas and in other regions. For instance, AO 31 can influence UN treaty bodies and regional courts to seriously address and consider the inclusion of persons with disabilities within the care agenda and the recognition of care as a right. As evidence of this, previous Inter-American Court rulings have guided courts and human rights bodies in Europe, Africa, and the UN, influencing how they interpret and protect rights.

11. Where can I access the full Advisory Opinion 31?

Advisory Opinion 31 has been published in Spanish and can be accessed at this [link](#).

The Opinion is in the process of being translated and published into English and Portuguese. When they do become available they will be published on the following links: [English](#) | [Portuguese](#)

12. Where can I access written submissions related to persons with disabilities that informed AO 31?

The submission was made by **Abolición de Lógicas de Castigo y Encierro (ALCE)**, **Asociación Azul**, **Asociación Civil por la Igualdad y la Justicia (ACIJ)**, **Center for Inclusive Policy (CIP)**, **Colectiva Nuestros Derechos en Foco**, **Disability Rights Advocacy Fund (DRAF)**, **Documenta**, **Luchando contra Viento y Marea**, and **Sociedad y Discapacidad (SODIS)**. The full list of written observations can be found [here](#).

CONCLUSION

In sum, AO 31 affirms that care and support for persons with disabilities must be grounded in services that strengthen autonomy and independent living. States must design care and support systems that guarantee human rights, value caregiving, and promote participation on an equal basis. While there are still key disability rights considerations missing or not fully developed within the AO 31, it is nonetheless an essential advancement towards ensuring disability rights within the care agenda. By bringing together the insights of feminist and disability movements, policies can strengthen autonomy, inclusion, and equality for all.

FURTHER RESOURCES

- [“Inclusion in Care: A Strategy for a Rights-based Care Agenda.”](#) (2024). Center for Inclusive Policy, Disability Rights Fund, Global Alliance for Care, International Domestic Workers Federation, Oxfam. December 2024.
- Pereira, Maria Antonella. (2025). [“Disability Policy Insights: Disability Inclusion in the Care Agenda.”](#) Center for Inclusive Policy.
- [“Good Practices of Support Systems Enabling Community Inclusion of Persons with Disabilities.”](#) (2024). A/HRC/55/34. Office of the United Nations High Commissioner for Human Rights.
- [“Human Rights Dimension of Care and Support.”](#) (2025). A/HRC/58/43. Office of the United Nations High Commissioner for Human Rights.
- Pereira, Maria Antonella, Monica Pinilla-Roncacio, and Alberto Vásquez Encalada. (2023). [“Apoyos Para La Vida En Comunidad: El Presente y Futuro de La Inclusión de Personas Con Discapacidad En América Latina.”](#) Center for Inclusive Policy, UNICEF.
- Vásquez Encalada, Alberto, Shivani Gupta, Alexandre Cote, Tom Tahchareun, Ahmed Ghanem, María Antonella Pereira, and Louisa Lippi. (2023). [“The Disability Support Gap: Community Support Systems for Persons with Disabilities in Low- and Middle-Income Countries.”](#) Center for Inclusive Policy for UNICEF, ILO and UNPRPD.

- Vázquez Encalada, Alberto, and María Antonella Pereira. (2023). ["Autonomy: A Regional Challenge - Building Systems of Support for Community Living for People with Disabilities in Latin America and the Caribbean."](#) workingPaper. CAF-Banco de Desarrollo de América Latina y el Caribe.