



REALIZATION OF THE SUSTAINABLE DEVELOPMENT GOALS BY, FOR AND WITH PERSONS WITH DISABILITIES

UN Flagship Report on Disability
and Development 2018



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Foreword

by António Guterres

Secretary-General of the United Nations

The Sustainable Development Goals can only be achieved with the full participation of everyone, including persons with disabilities. Upholding the rights and ensuring the full inclusion of the world's one billion persons with disabilities is a moral imperative. It is also a practical necessity if we are to build healthy, sustainable societies to the benefit of all people of all ages and abilities.

Despite the strong commitment expressed by the international community to an inclusive, accessible and sustainable 2030 Development Agenda, persons with disabilities continue to face significant challenges to their full inclusion and participation in society and development. These include negative attitudes, stigma and discrimination and lack of accessibility in physical and virtual environments. We must all find new approaches and tools to work for and with persons with disabilities. The present report is a step forward towards doing so to reach our common goal: the realization of the SDGs for all.

Together, we can remove barriers and make concrete difference for and with persons with disabilities to be empowered and lead positive changes in their lives and the communities they live in around the world. I hope this first report on progress made to date on disability in the context of the 2030 Agenda will serve as a useful tool for decision-makers in their ongoing work to design evidence-based policies that leave no one behind.

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Table of Contents

Acronyms and abbreviations	22
Executive Summary	24
Introduction	43
Definition of disability	44
Sources of evidence.....	45
Chapter I. Overview of the History of the Work of the United Nations towards Disability- inclusive, Accessible and Sustainable Society and Development	46
Background	46
A shift in perspective	46
Building momentum	47
UN Development Conferences	48
UN General Assembly High Level Meeting on Disability and Development and Toward Disability- Inclusive 2013 Global Agenda for Sustainable Development.....	51
Conclusion	52
Chapter II. Realizing the Sustainable Development Goals for persons with disabilities 54	
A. Ending poverty and hunger for all persons with disabilities (SDGs 1 and 2).....	55
International normative frameworks on poverty, hunger and disability.....	55
The situation of persons with disabilities concerning poverty, hunger and nutrition.....	57
Current practices on addressing poverty and hunger among persons with disabilities.....	65
Conclusions and the way forward	68
B. Ensure healthy lives and promote well-being for all persons with disabilities (SDG3)....	70
International normative framework on health and disability.....	70
The situation of persons with disabilities: health status and access to health services	72
Current practices on health and disability	83
Conclusions and the way forward	85

C.	Access to sexual and reproductive health-care services and reproductive rights for all persons with disabilities (SDGs 3.7 and 5.6)	87
	International normative framework on disability and sexual and reproductive health and reproductive rights.....	87
	Situation of persons with disabilities regarding sexual and reproductive health and healthcare services, as well as reproductive rights	88
D.	Ensuring inclusive and equitable quality education (SDG 4).....	97
	International normative framework on disability and education	97
	The situation of persons with disabilities in education	100
	Current practices on disability and education	115
	Conclusions and the way forward	121
E.	Achieving gender equality and empowering all women and girls with disabilities (SDG 5) 124	
	International normative framework on disability and gender	124
	The situation of women and girls with disabilities	126
	Current practices on gender and disability.....	148
	Conclusions and the way forward	150
F.	Ensure availability of water and sanitation for persons with disabilities (SDG 6)	152
	International normative frameworks on WASH and disability	152
	The situation of persons with disabilities: access to water and sanitation.....	154
	Current practices on WASH and disability	164
	Conclusions and the way forward	166
G.	Ensuring access to energy for persons with disabilities (SDG 7).....	169
	International normative frameworks on disability and access to energy	169
	Situation of persons with disabilities: access to energy	173
	Current practices on energy and disability.....	182
	Conclusions and the way forward	184
H.	Full and productive employment and decent work for persons with disabilities (SDG 8) 186	
	International framework on disability and employment.....	187

	The situation of persons with disabilities in employment	189
	Current practices on disability and employment	196
I.	Increase access to ICT for persons with disabilities (SDG 9.c).....	207
	International normative framework on disability and ICT	207
	The situation of persons with disabilities: access to ICT	211
	Current practices on disability and ICT	223
	Conclusions and the way forward	225
J.	Reducing inequality for persons with disabilities (SDG 10).....	228
	Eliminating discriminatory laws, policies and practices concerning persons with disabilities (SDGs 10.3, 16.b)	232
	International normative framework on non-discrimination	232
	Discrimination against persons with disabilities	234
	Overcoming discriminatory laws and policies for persons with disabilities	235
	Conclusions and the way forward	237
	Reducing inequalities through enhanced access to assistive technology for persons with disabilities	238
	International normative framework on assistive technology	238
	The situation of persons with disabilities regarding access to assistive technology.....	239
	Current practices on promoting access to assistive technology	242
	Conclusions and the way forward	243
	Promote inclusion of persons with disabilities through deinstitutionalization.....	245
	International normative frameworks	245
	Persons with disabilities living in institutions: status and current practices	247
	Reducing inequalities for persons with mental impairments or psychosocial disabilities	249
	International normative framework on persons with psychosocial disabilities.....	249
	The situation of persons with psychosocial disabilities	250
	Current practices	256
	Conclusions and the way forward	258

K.	Making cities and human settlements inclusive and sustainable for persons with disabilities (SDG 11)	260
	International normative frameworks on inclusive cities and human settlements	260
	The situation of cities and human settlements regarding inclusion of persons with disabilities ..	262
	Current practices in making cities and human settlements inclusive	272
	Conclusions and the way forward	276
L.	Building resilience of persons with disabilities and reducing their exposure to and impact from climate-related hazards and other shocks and disasters (SDGs 1.5, 11.5 and 13).....	278
	International normative frameworks on disability-inclusive disaster risk reduction	278
	Situation of persons with disabilities in shocks, disasters and other emergencies.....	282
	Current practices to address the needs of persons with disabilities in disasters and other emergencies.....	284
	Conclusions and the way forward	285
M.	Promoting peaceful and inclusive societies for sustainable development, providing access to justice and building effective, accountable and inclusive institutions at all levels for persons with disabilities (SDG 16)	289
	Reduce all forms of violence against persons with disabilities and end abuse, exploitation, trafficking and all forms of violence against children with disabilities (SDG 16.1 and 16.2).....	289
	_____ International normative frameworks on protecting persons with disabilities from violence	289
	_____ The situation of persons with disabilities: exposure to violence	290
	_____ Current practices to protect persons with disabilities from violence	294
	_____ Conclusions and the way forward	295
	Ensure equal access to justice for all persons with disabilities (SDG 16.3)	295
	_____ International normative framework on access to justice and disability	295
	_____ Situation of persons with disabilities in access to justice	296
	_____ Current practices	298
	_____ Conclusions and the way forward	299
	Inclusive institutions and decision-making for persons with disabilities (SDG 16.6, SDG 16.7) .	300
	_____ International normative framework.....	300

_____	The situation of public institutions and decision-making vis-à-vis inclusion of persons with disabilities.....	300
_____	Current practices	307
_____	Conclusions and the way forward	308
	Provide legal identity to all children with disabilities, including birth registration (SDG 16.9).....	309
_____	International normative frameworks on disability and birth registration.....	309
_____	The situation of the birth registration of children with disabilities	309
_____	Current practices	310
_____	Conclusions and the way forward	310
	Access to information (SDG 16.10)	311
_____	International normative frameworks on access to information for persons with disabilities 311	
_____	The situation of persons with disabilities in accessing information.....	312
_____	Current practices	313
_____	Conclusions and the way forward	314
N.	Increasing the availability of data disaggregated by disability (target 17.18)	315
	International normative frameworks.....	315
	National experiences in data collection on disability.....	320
	Conclusions and the way forward	322
	Chapter III. The way forward for disability-inclusive sustainable development	324
	Explanatory notes	330
	Endnotes	330

Figures

Figure II.1. International normative frameworks relevant for the achievement of SDGs 1 and 2 for persons with disabilities.	56
Figure II.2. Percentage of persons with and without disabilities living under the national poverty line, in 6 countries, in 2011-2016.	57
Figure II.3. Percentage of households with and without persons with disabilities living under the international poverty line (US\$1.90 a day), in 3 countries, in 2010-2011.	58
Figure II.4. Multidimensional poverty rates, for persons with and without disabilities, in 22 countries, in 2002-2014.	60
Figure II.5. Percentage of persons with disabilities who consider banks are not accessible, in 5 countries, around 2011.	62
Figure II.6. Inability to afford a meal with meat, chicken, fish or vegetarian equivalent every second day for persons aged 16 and over with and without disabilities, in 35 countries, in 2016.	63
Figure II.7. Percentage of persons or households who did not always have food to eat, by disability status, in 8 countries, around 2012.	64
Figure II.8. Percentage of persons with disabilities who needed but did not receive welfare services, in 9 countries, around 2012.	65
Figure II.9. Overview of cash disability benefit programmes anchored in national legislation, by type of programme and benefit, 2012-2013, in 183 countries.	67
Figure II.10. International normative frameworks relevant for the achievement of SDG 3 for persons with disabilities.	72
Figure II.11. Percentage of persons who report poor health versus GDP per capita, by disability status, in 43 countries, around 2013.	73
Figure II.12. Percentage of persons who self-assess their mental health as poor, by disability status, in 6 countries, around 2012.	74
Figure II.13. Percentage of persons who needed but could not get health care, by disability status, in 37 countries, around 2016.	76
Figure II.14. Percentage of persons with unmet health needs for outpatient care, by severity of disability, in Cameroon (MDS) and Sri Lanka (MDS), in 2015-2016.	76

Figure II.15. Percentage of persons with disabilities who needed but could not receive rehabilitation services, in 9 countries, around 2011.....	77
Figure II.16. Percentage of persons with disabilities with unmet health needs, by reason for not getting health care, in 35 countries, around 2016.....	78
Figure II.17. Percentage of persons with unmet health needs, by reason for not getting health care, by disability status, in Sri Lanka (MDS), in 2016.	79
Figure II.18. Percentage of persons with disabilities who report that health care facilities are hindering or not accessible, in eight countries, around 2011.....	80
Figure II.19. Percentage of smokers of cigarettes, among persons aged 15 years and over, by disability status, in 21 countries, around 2010.....	82
Figure II.20. International normative frameworks relevant for the achievement of SDG targets 3.7 and 5.6 for persons with disabilities.	88
Figure II.21. Percentage of live births attended by a skilled health personnel, by disability status of the mother, in 5 countries, around 2014.....	89
Figure II.22. Percentage of live births attended by a skilled health personnel, by location of residence of the mother with disabilities, in 3 countries, around 2014.	90
Figure II.23. Percentage of married women aged 15 to 49 having an unmet need for family planning, by disability status, in 7 countries, around 2014.....	91
Figure II.24. Percentage of married women aged 15 to 49 with disabilities having an unmet need for family planning, by location of residence, in 4 countries, around 2014.....	92
Figure II.25. International normative framework relevant for the achievement of SDG 4 for persons with disabilities.....	99
Figure II.26. Percentage of youth aged 15 to 29 years old who ever attended school, by disability status, in 41 developing countries, around 2012.....	101
Figure II.27. Percentage of children of primary school age who are out of school, by disability status, in 6 countries, around 2012.	102
Figure II.28. Percentage of adolescents of lower secondary school age who are out of school, by disability status, in 5 countries, around 2010.....	102
Figure II.29. Completion rate for primary education, by disability status, in 5 countries, around 2011.	103
Figure II.30. Completion rates for lower secondary education, by disability status, in 5 countries, around 2011.	104

Figure II.31. Percentage of persons 25 years and older who completed tertiary education, by disability status, in 41 countries, around 2012.....	105
Figure II.32. Mean years of schooling, for the population 25 years and older, by disability status, in 23 countries or territories, around 2010.....	106
Figure II.33. Adult literacy rate for population 15 years and older, by disability status, in 36 countries, around 2010.....	107
Figure II.34. Percentage of persons with disabilities who have ever been refused entry into a school or pre-school because of their disability, in 7 countries, around 2009.....	108
Figure II.35. Percentage of persons with disabilities who mainly attended pre - school, primary, secondary or tertiary school in a special school or a special class, in 7 countries, around 2008.....	109
Figure II.36. Percentage of children with disabilities attending primary school in a special school, in 21 countries, around 2015.....	109
Figure II.37. Percentage of students with disabilities who stopped attending school because it was too expensive, it was too far or there was no transport, or there was a communication or language barrier, in 4 countries, around 2010.....	110
Figure II.38. Percentage of students with disabilities who found that schools were not accessible or hindering, in 6 countries, around 2010.....	112
Figure II.39. Accessibility of schools for wheelchair users, in a selected region in southern Asia, in 2017 (crowd-sourced data).....	113
Figure II.40. Accessibility of schools for wheelchair users, in a selected region in Europe, in 2017 (crowd-sourced data).....	114
Figure II.41. Percentage of persons with disabilities who use but need more assistive products for education, in 2 countries, in 2016.....	115
Figure II.42. Percentage of countries which implemented selected measures to promote inclusive education, among 87 to 101 countries, from 2013 to 2017.....	116
Figure II.43. International normative frameworks relevant for the achievement of SDG 5 for persons with disabilities.....	126
Figure II.44. Percentage of persons living under the national poverty line, by disability status and sex, in 6 countries, around 2014.....	128
Figure II.45. Percentage of persons who are unable to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day, by disability status and sex, around 2016.....	129

Figure II.46. Percentage of persons who in the past two weeks did not always have food to eat in the household because of lack of resources, by disability status (WG) and sex, in Botswana, in 2014.	130
Figure II.47. Percentage of persons who needed but could not get health care, by disability status and sex, in 37 countries, around 2016.	132
Figure II.48. Percentage of youth aged 15 to 29 years old who ever attended school, by disability status and sex, in 29 developing countries, around 2012.	134
Figure II.49. Percentage of persons aged 17 to 24 years having completed at least primary school, by disability status and sex, in 17 countries, around 2010.	135
Figure II.50. Percentage of persons 25 years and older who completed tertiary education, by disability status and sex, in 41 countries, around 2012.	136
Figure II.51. Literacy rate for population 15 years and older, by disability status and sex, in 36 countries, around 2010.	137
Figure II.52. Average employment-to-population ratios, for persons aged 15 years and over, by disability status and sex, in 6 regions, 2006-2016.	138
Figure II.53. Percentage of employed women aged 15 and over in unpaid work, by disability status, in 8 countries, around 2008.	139
Figure II.54. Percentage of employed persons aged 15 and over who work as legislators, senior officials and managers, by disability and sex, in 19 countries, around 2010.	142
Figure II.55. Percentage of members from organizations of persons with disabilities and from other organisations in national coordination mechanism on disability matters, by sex, in 17 countries or areas, around 2017.	143
Figure II.56. Percentage of persons who use internet, by disability status and sex, in 13 countries, around 2011.	144
Figure II.57. Percentage of women and men with disabilities who have ever experienced violence because of their disabilities, in 2 countries, around 2006.	145
Figure II.58. Percentage of women with disabilities who have ever been beaten or scolded because of their disabilities, in 4 countries, in 2010.	146
Figure II.59. Percentage of girls aged 15 to 18 and who are or have been previously married, by disability status, in 14 countries, around 2011.	148
Figure II.60. International normative frameworks relevant for the achievement of SDG 6 for persons with disabilities.	154

Figure II.61. Difference between the percentage of persons without and with disabilities in access to improved sanitation versus improved water, in 34 countries, 2002-2004.....	155
Figure II.62. Percentage of persons without toilet in their dwelling, by disability status, in 44 countries, around 2014.....	156
Figure II.63. Persons with no bath or shower in their dwelling aged 16 and over, by disability status, in 35 countries, around 2016.	157
Figure II.64. Percentage of persons with disabilities who report that their toilet at home is hindering or not accessible, in 8 countries, around 2013.....	158
Figure II.65. Accessibility of public toilets for wheelchair users, in Australia, 2017 (crowd-sourced data).	161
Figure II.66. Accessibility of public toilets for wheelchair users, in the south region of Malawi, 2017 (crowd-sourced data).	162
Figure II.67: Proportion of primary schools with any sanitation facility and a sanitation facility accessible for people with reduced mobility, in Brazil, from 2006 to 2016.	163
Figure II.68. Percentage of persons aged 17 and over reporting a lot of or extreme problems with toileting, by disability status, versus GDP per capita, 2015-2016.	164
Figure II.69. International normative frameworks relevant to achieving SDG 7 for persons with disabilities.	172
Figure II.70. Percentage of households, with and without persons with disabilities, with access to electricity, in 44 countries, 2001-2015.....	174
Figure II.71. Gender gap (women minus men) and percentage of persons unable to keep home adequately warm for persons aged 16 and over with and without disabilities, in 35 countries, in 2016.	175
Figure II. 72. Energy requirements of WHO Priority Assistive Products List.	176
Figure II.73. Percentage of households with and without persons with disabilities cooking with wood or coal, in 14 countries, around 2010.	179
Figure II.74. Percentage of households with persons with disabilities cooking with wood or coal, by location of household, in 14 countries, around 2010.....	180
Figure II.75. Minimum, average and maximum values of national percentages of primary schools with electricity, by region, in 2012.....	181
Figure II.76. International normative frameworks relevant for the achievement of SDG 8 for persons with disabilities.....	189

Figure II.77. Employment to population ratios for persons aged 15 years and over, by disability status, by geographical region, in 2006-2016.	190
Figure II.78. Percentage of persons with disabilities who report that their workplace is hindering or not accessible, in 8 countries, around 2013.....	191
Figure II.79. Percentage of persons with disabilities who need assistive products at work, in Chile and Sri Lanka, 2015.	192
Figure II.80. Employment to populations for persons aged 18 to 60, by disability status, 2002-2004.	193
Figure II.81. Percentage of employed persons with disabilities who are self-employed, by disability status, 2002-2017.	194
Figure II.82. Share of part-time employment in total employment, by disability status, in 29 countries, 2003-2008.	195
Figure II.83. Wage gap between persons with and without disabilities (persons with disabilities minus persons without disabilities), 2012-2013.....	196
Figure II.84. Percentage of employed persons with disabilities (employees, employers and own-account workers) receiving less and more than the minimum salary, by sex and area of residence, in Peru in 2012.	196
Figure II.85. Minimum, average and maximum employment quotas for persons with disabilities, by region.	199
Figure II.86. Employment quotas for persons with disabilities versus employment-to-population (EPR) ratio gap (persons without disabilities minus persons with disabilities), around 2010.....	200
Figure II.87. International normative frameworks, and examples of regional frameworks, relevant for the achievement of SDG 9.c for persons with disabilities.....	209
Figure II.88. Percentage of persons who use Internet, by disability status, in 14 countries, around 2011.	211
Figure II.89. Percentage of households, with and without one or more persons with disabilities, that have Internet access, in 26 countries, in 2000-2016.	213
Figure II.90. Average percentage of persons with disabilities using and having access at home to the Internet, by age, in 11 countries in Latin America and the Caribbean, around 2010.	214
Figure II.91. Percentage of households with and without persons with disabilities which can afford Internet costs, in 3 countries, around 2013.	214

Figure II.92. Average percentage of persons using Internet, by age, in 11 countries in Latin America and the Caribbean, around 2010.	215
Figure II.93. Percentage of households, with and without persons with disabilities, that own a mobile phone, in 36 countries, in 2001-2016.....	217
Figure II.94. Percentage of persons who own a mobile phone and who use a mobile phone for financial transactions, by disability status and gender, in Uganda (WG), in 2016.	218
Figure II.95. Percentage of persons who use radio and TV, by disability status, in 4 countries, in 2008-2016.	218
Figure II.96. Percentage of households with and without persons with disabilities which cannot afford radio, mobile phone or TV, in 3 countries, around 2012.	219
Figure II.97. Percentage of persons aged 16 and over who can afford a computer, telephone and TV, and gender gap, by disability status, in 35 countries, in 2016.	220
Figure II.98. Percentage of countries with online national portals offering features which promote accessibility, in 193 countries, 2012.	221
Figure II.99. Percentage of countries with accessibility barriers in their online national portals, in 193 countries, in 2012.	221
Figure II.100. Average and maximum gap between persons with and without disabilities (or households with and without persons with disabilities) for 14 selected indicators.	229
Figure II. 101. Gaps between persons with and without disabilities, for 4 selected indicators, in 2006 and 2016, in Uganda.	230
Figure II.102. The international normative frameworks relevant for the achievement of SDG 10.3 and 16.b for persons with disabilities.	233
Figure II.103. Percentage of persons with disabilities who have experienced discrimination, in 6 countries, around 2011.	234
Figure II.104. Percentage of UN Member States that prohibit or not discrimination against persons with disabilities in the laws regulating labour, among 193 UN Member States, around 2016.	236
Figure II.105. International normative frameworks relevant so enhance access to assistive technology for persons with disabilities.	239
Figure II.106. Percentage of persons with disabilities who need but do not have assistive devices (e.g. sign language interpreter, wheelchair, hearing/visual aids, Braille etc.), in 10 countries, around 2013.....	241

Figure II.107. Percentage of persons with disabilities who stopped using an assistive device, by reason for stopping, in 5 countries, around 2012.....	242
Figure II.108. International normative frameworks relevant to achieving SDG 10 on reduction of inequality for persons with disabilities	246
Figure II.109. Percentage of persons with disabilities who have ever lived in an institution or special home for people with disabilities, in 9 countries, 2004-2015.	248
Figure II.110. Percentage of persons aged 18 and over who are married, by psychosocial disability and disability statuses, in 8 countries, around 2011.	251
Figure II.111. Percentage of persons aged 15 and over who are literate, by psychosocial disability and disability statuses, in 5 countries, around 2011.	252
Figure II.112. Percentage of persons aged 15 and over who are employed, by psychosocial disability and disability statuses, in 9 countries, around 2011.	252
Figure II.113. Percentage of persons who find health facilities hindering or very hindering, by psychosocial disability and disability statuses, in 3 countries (MDS), around 2015.....	255
Figure II.114. Percentage of persons who consider their overall health bad or very bad, by psychosocial disability and disability statuses, in 3 countries (MDS), around 2015.....	255
Figure II.115. Percentage of persons who report challenges participating in selected family and community activities, by psychosocial disability and disability statuses, in Sri Lanka (MDS), in 2015.	256
Figure II.116. Percentage of countries with legislation allowing persons with psychosocial disabilities to marry, to be recruited for work, to vote, to be elected for public office and to enter into contract, on an equal basis with others, around 2017.	257
Figure II.117. Percentage of persons aged 16 and over living in severely deprived housing, by disability status, in 35 countries, in 2016.	263
Figure II.118. Percentage of persons aged 16 and over living in households where the total housing costs represent more than 40 % of disposable income, by disability status, in 2016.	264
Figure II.119. Percentage of persons with disabilities who (i) consider their dwelling hindering and (ii) do not use but need modifications at home, in 3 countries (MDS), around 2015.....	265
Figure II.120. Percentage of persons with disabilities who consider that transportation is not accessible or hindering, 2004-2016.	267
Figure II.121. Percentage of persons with disabilities, by reasons for being unable to use public transportation, in Australia, in 2015.	268

Figure II.122. Percentage of persons with disabilities who report that recreational facilities (e.g. cinema, theatre, pubs, etc.) are generally not accessible to them, in 9 countries, around 2009.	269
Figure II.123. Four selected indicators on education, health, employment and access to ICT, by disability and by urban versus rural place of residence.	272
Figure II.124. International normative frameworks relevant for the achievement of SDGs 1, 11, 13 for persons with disabilities.	281
Figure II.125. Percentage of households, with and without persons with disabilities, affected negatively by a shock, in 4 countries, around 2011.	284
Figure II.126. Percentage of persons who report that crime, violence and vandalism are common in their accommodation or area of residence, by disability status, in 35 countries, in 2016.	291
Figure II.127. Percentage of persons with disabilities who have ever been beaten or scolded because of their disability, in 4 countries, around 2010.	292
Figure II.128. Percentage of persons with disabilities who have ever experienced violence because of their disabilities, in 2 countries, around 2006.	292
Figure II.129. Percentage of persons aged 15 to 49 who have experienced sexual violence, at least once in their life time and in the past 12 months, by disability status and sex, in Uganda, in 2016.	294
Figure II.130. Percentage of persons with disabilities who needed but were not able to receive legal advice, in 4 countries, around 2012.	297
Figure II.131. Percentage of persons with disabilities who reported that magistrate’s office/traditional courts and police stations are not accessible, in 5 countries, in 2004-2015.	298
Figure II.132. Persons with disabilities who report being discriminated against in public services, in 2 countries, around 2013.	301
Figure II.133. Percentage of countries with online government services for persons with disabilities, in the world and by region, among 193 UN Member States, in 2014, 2016 and 2018.	302
Figure II.134. Public spending on social programmes for persons with disabilities as a percentage of GDP, in 56 countries, around 2014.	303
Figure II.135. Number of UN Member States with exclusions for persons with disabilities in their legislation on voting and on election for office, 2018.	304
Figure II.136. Percentage of persons who, in the last election, did not vote or found voting problematic, in 4 countries, around 2014.	305

Figure II.137. Percentage of employed persons aged 15 and over who work as legislators, senior officials and managers, by disability, in 19 countries, around 2010.....	306
Figure II.138. Percentage of children with disabilities who have been registered at birth and who have a birth certificate, in two countries, around 2012.	310
Figure II.139. International normative frameworks relevant for the achievement of SDG 16.10 for persons with disabilities	312
Figure II. 140. Percentage of households without access to newspapers, by households with and without disabilities, in 2 countries, around 2015.....	313

Tables

Table II. 1. Estimates of the extra costs associated with disability, by degree of disability, in 8 countries, in 1998-2008.....	61
Table II. 2. Percentage of countries in the Western Pacific region who had initiatives in place to improve health care for persons with disabilities, in 24 countries, in 2015.....	84
Table II. 3. Mobile phone and platform features which enhance accessibility.....	223

Boxes

Box 1. Addressing common pitfalls in income poverty indicators to assess poverty among persons with disabilities – a case study from Vietnam.....	59
Box 2. What is health and well-being?.....	71
Box 3. Accessible toilets at schools.....	163
Box 4. Energy assistance programs accessible for persons with disabilities.....	182
Box 5. Regional normative frameworks on ICT and disability	210
Box 6. Web Content Accessibility Guidelines (WCAG) 2.0	224
Box 7. In Uganda, the gap between persons with and without disabilities has been decreasing in a number of areas	230
Box 8. Inclusivity and accessibility of public transportation prioritized in Australia.....	268
Box 9. Regional initiatives on disaster risk reduction and management for persons with disabilities	280
Box 10. Operationalization of the WG-SS through the Demographic and Health Survey Program	321

Acronyms and abbreviations

CBR:	Community Based Rehabilitation
CEDAW:	The Convention on the Elimination of All Forms of Discrimination Against Women
CRC:	The Convention on the Rights of the Child
CRPD:	Convention on the Rights of Persons with Disabilities
DESA:	see UN DESA
DHS:	Demographic and Health Surveys
DISD:	Division for Inclusive Social Development of UN DESA
ECLAC:	Economic Commission for Latin America and the Caribbean
ECOSOC:	Economic and Social Council
EPR:	Employment to population ratio
ESCAP:	United Nations Economic and Social Commission for Asia and the Pacific
ESCWA:	United Nations Economic and Social Commission for West Asia
GA:	General Assembly
GDP:	gross domestic product
GPS:	Global Positioning System
ICF:	International Classification of Functioning, Disability and Health
ICT:	Information and Communications Technology
ICT:	Information and communication technologies
IDPD	International Day of Persons with Disabilities
ILO:	International Labour Organization
IPS:	individual placement and support
IPUMS:	Integrated Public Use Microdata Series
ISO:	International Organization for Standardization
LDCS:	Least Developed Countries
MDG:	Millennium Development Goals
MDS:	Model Disability Survey

NEP:	National employment policies
NGO:	non-governmental organization
ODA:	Official Development Assistance
OECD:	The Organisation for Economic Co-operation and Development
SCRPD:	Secretariat for Convention on the Rights of Persons with Disabilities
SDG:	Sustainable Development Goal
SIDS:	Small Island Developing States
SINTEF:	Stiftelsen for industriell og teknisk forskning
TVET:	Technical Vocational Education and Training
UDHR:	Universal Declaration of Human Rights
UHC:	Universal Health Coverage
UN DESA:	United Nations Department of Economic and Social Affairs
UN:	United Nations
UNESCO:	United Nations Educational, Scientific and Cultural Organization
UNICEF:	United Nations Children's Fund
UNISDR:	United Nations Office for Disaster Risk Reduction
UNSD:	United Nations Statistics Division
WASH:	Water, Sanitation and Hygiene
WCAG:	Web Content Accessibility Guidelines
WHO:	World Health Organization
WHS:	World Health Survey
WPA:	World Programme of Action Concerning Disabled Persons

Executive Summary

Realization of the Sustainable Development Goals by, for and with persons with disabilities

Disability and the 2030 Agenda for Sustainable Development

This report represents the first UN systemwide effort to examine disability and the Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development at the global level. The report reviews data, policies and programmes and identifies good practices; and uses the evidence it reviewed to outline recommended actions to promote the realization of the SDGs for persons with disabilities.

Over 200 experts from UN agencies and International Financial Institutions, Member States and civil society, including research institutions and organizations of persons with disabilities, contributed to this report. The report covers new areas for which no global research was previously available, for example, the role of access to energy to enable persons with disabilities to use assistive technology. It also contains the first global compilation and analysis of internationally comparable data using the Washington Group on Disability Statistics short set of questions. Reviews of legislation from 193 UN Member States were conducted and analysed for this report to highlight good practices and to assess the current status of discriminatory laws on voting, election for office, right to marry and others. More than 12 major databases of disability statistics, from international agencies and other organizations, were analysed – covering an unprecedented amount of data from over 100 countries. In addition, more than 1.2 million data points of crowd-sourced data have been examined to inform analysis of the accessibility of physical spaces.

The report shows that despite the progress made in recent years, persons with disabilities continue to face numerous barriers to their full inclusion and participation in the life of their communities. It sheds light on their disproportionate levels of poverty, their lack of access to education, health services, employment, their under-representation in decision-making and political participation. This is particularly the case for women and girls with disabilities. Main barriers to inclusion entail discrimination and stigma on the ground of disability, lack of accessibility to physical and virtual environments, lack of access to assistive technology, essential services, rehabilitation and support for independent living that are critical for the full and equal participation of persons with disabilities as agents of change and beneficiaries of development. Data and statistics compiled and analysed in the present report indicate that persons with disabilities are not yet sufficiently included in the implementation, monitoring and evaluation of the SDGs.

The 2030 Agenda for Sustainable Development and its 17 SDGs provide a powerful framework to guide local communities, countries and the international community toward the achievement of disability-inclusive development. The 2030 Agenda pledges to leave no one behind, including persons with disabilities and other disadvantaged groups, and has recognized disability as a cross-cutting issue, to be considered in the implementation of all of its goals. The Agenda also includes seven targets and 11 indicators explicitly

making reference to persons with disabilities, covering access to education and employment, availability of schools sensitive to students with disabilities, inclusion and empowerment of persons with disabilities, accessible transport, accessible public and green spaces, and building capacity of countries to disaggregate data by disability.

The 2030 Agenda is guided by the purposes and principles of the Charter of the United Nations and grounded, *inter alia*, in the Universal Declaration of Human Rights and international human rights treaties. The 2030 Agenda is therefore linked to the Convention on the Rights of Persons with Disabilities (CRPD), and its implementation, by, for, and with persons with disabilities should be in line with the CRPD to incorporate the disability perspective in all aspects of its realization, monitoring and evaluation.

The commitment of Governments to disability inclusive development has also been demonstrated in other recent development agreements, which provide further guidance in their respective areas of focus. The outcome document of the Rio+20 Conference - "The future we want" - underscored the importance of accessibility and disability-inclusion in supporting strategies for sustainable development. The Sendai Framework for Disaster Risk Reduction, adopted in March 2015, included persons with disabilities as agents of change. The Addis Ababa Action Agenda, adopted in July 2015, addressed the needs of persons with disabilities in social protection, employment, education, infrastructure, financial inclusion, technology and data. The World Humanitarian Summit, held in May 2016, launched the first-ever Charter on Inclusion of Persons with Disabilities in Humanitarian Action. Habitat III in October 2016 adopted a disability-inclusive New Urban Agenda, guiding urban development with the principles of universal design and accessibility for all.

Striving to achieve disability-inclusive development is not only the right thing to do. It is also the practical thing to do: sustainable development for all can only be attained if persons with disabilities are equally included as both agents and beneficiaries as countries strive for a sustainable future. The success of the 2030 Agenda requires a participatory and inclusive approach in which all stakeholders, including persons with disabilities, are engaged. The 2030 Agenda therefore presents an important opportunity to advance the goal of the United Nations: to promote economic and social progress and human rights toward a peaceful and prosperous world for all.

Ending poverty and hunger for all persons with disabilities (SDGs 1 and 2)

Persons with disabilities are more likely to live in poverty than persons without disabilities due to barriers in society such as discrimination, limited access to education and employment and lack of inclusion in livelihood and other social programmes. National data on income poverty disaggregated by disability remain scarce, but **available data show that the proportion of persons with disabilities living under the national or international poverty line is higher, and in some countries double, than that of persons without disabilities.** Regarding food security, in developed countries, available data shows that the

average percentage of persons with disabilities who are unable to afford a meal with protein every second day is almost double that of persons without disabilities. More women with disabilities than men with disabilities are in such a situation, and the gender gap between women and men in terms of access to meals with protein is wider among persons with disabilities. In developing countries, data shows that persons with disabilities and their households are more likely to not always have food to eat, than persons without disabilities and their households. While financial inclusion can help persons with disabilities out of poverty, access to financial services such as banks remains restricted by lack of physical and virtual accessibility of these services. In some countries, persons with disabilities find that more than 30% of banks are not accessible.

Social protection programmes for persons with disabilities, which can be vital in facilitating an escape from poverty, have been adopted in many countries. **At least 168 countries have disability schemes that provide periodic cash benefits to persons with disabilities, while lump-sum benefits are provided in 11 countries.** In half of the countries with periodic benefits, these benefits cover mainly workers and their families in the formal economy, excluding children with disabilities and persons with disabilities who have not had the opportunity to contribute to social insurance for a sufficient period to be eligible for benefits. But in other countries – 87 countries – schemes are fully or partially financed through taxes and have improved coverage. Only in one third of these countries, schemes cover all persons with assessed disabilities regardless of their income status; in the rest of the countries, programmes cover only persons or households whose economic means fall below a certain threshold. Despite their existence, many persons with disabilities are not able to access social protection. **In some countries, more than 80% of persons with disabilities who need welfare services cannot receive them.**

To end poverty and hunger for persons with disabilities, a number of actions should be considered:

- Design social protection policies and programmes to include persons with disabilities.
- Remove barriers and obstacles that persons with disabilities face in accessing and fully benefiting from social protection on an equal basis with others.
- Sensitize personnel of grant offices about barriers experienced by persons with disabilities to access social protection and approaches to overcome these barriers.
- Improve access to and accessibility of banking and other financial services, including mobile banking.
- Disaggregate data on poverty and hunger by disability status.
- Establish national monitoring and evaluation systems that periodically assess all social protection programmes regarding inclusion and positive impact on the situation of persons with disabilities.

Ensuring healthy lives and promoting well-being (SDG 3)

Persons with disabilities generally have more healthcare needs than others – both standard needs and needs linked to impairments – and are therefore more vulnerable to the impact of low quality or inaccessible healthcare services than others. Compared to persons without disabilities, persons with disabilities are more likely to have poor health: **among 43 countries, 42% of persons with disabilities versus 6% of persons without disabilities perceive their health as poor.** In some countries, less than 20% of persons with disabilities report poor health, while in others more than 70% of persons with disabilities report so. The number of persons with disabilities who report poor health tends to be higher in countries with lower gross domestic product per capita, suggesting that increased availability of financial resources may provide the accessible health, basic and community services needed to achieve better health.

Access to health-care services remains a challenge for persons with disabilities, who are more than three times as likely to be unable to get health care when they need it. Access to rehabilitation services is also a challenge. In some countries, more than 50% of persons with disabilities have an unmet need for these services. Lack of financial resources, lack of access to and accessibility of medical facilities and transport, as well as inadequate training of health personnel to accommodate persons with disabilities remain major challenges. Some countries have endeavoured to reform legal and policy frameworks and/or to address access to health-care services directly, including through anti-discrimination laws related to the health sector, disability laws or policy plans, and laws that guarantee access to healthcare for persons with specific health conditions (e.g. spinal cord injury) or specific populations (e.g. veterans). Although many of these laws are general and do not target disability-specific barriers, **six countries have explicit laws that guarantee access to health care for persons with disabilities.**

To achieve the highest attainable standard of health for persons with disabilities, the following actions should be considered:

- Strengthen national legislation and policies on health care in line with the CRPD.
- Identify and eliminate obstacles and barriers to accessibility in health care facilities.
- Improve healthcare coverage and affordability for persons with disabilities as part of universal approaches to health care.
- Train health care personnel on disability inclusion and improve service delivery for persons with disabilities.
- Empower persons with disabilities to take control over their own health care decisions, on the basis of informed consent.
- Prohibit discriminatory practices in health insurance and promote health insurance coverage for assistive devices and rehabilitation services.

- Improve research and data to monitor, evaluate and strengthen health systems to include and deliver for persons with disabilities.

Access to sexual and reproductive health-care services and reproductive rights for persons with disabilities (SDGs 3.7 and 5.6)

Persons with disabilities have equal needs to access sexual and reproductive health as those without disabilities and have similar requirements for family planning and childbirth. However, misperceptions about persons with disabilities and the assumption that persons with disabilities are not sexually active has contributed to little attention being paid to ensuring that persons with disabilities have access to sexual and reproductive health. **Limited evidence in a few developing countries, shows that 29% of births by mothers with disabilities are not attended by a skilled health worker and 22% of married women with disabilities have an unmet need for family planning.** These percentages are higher in rural areas. Without access to sexual and reproductive health, persons with disabilities are at higher risk of unwanted pregnancies and sexually transmitted infection including HIV/AIDS.

Apart from the societal stereotypes, the barriers that persons with disabilities face to accessing sexual and reproductive health services include lack of accessibility of services and information. Persons with disabilities, particularly women and those with intellectual disabilities, also fear abuse and violation of their reproductive rights when accessing these services because many persons with disabilities have been subjected to involuntary sterilization in various countries.

While examples exist of national sexual and reproductive health policies and programmes that are inclusive of persons with disabilities, in most countries, persons with disabilities remain invisible in such frameworks, as well as in their monitoring and evaluation. A number of actions should be considered to ensure that persons with disabilities have access to sexual and reproductive health and reproductive rights:

- Develop national policies and laws that guarantee access to sexual and reproductive health and reproductive rights for persons with disabilities.
- Make sexual and reproductive health care facilities and information accessible for persons with disabilities.
- Train sexual and reproductive care workers, combat discriminatory practices and improve service delivery for persons with disabilities.
- Educate persons with disabilities, including adolescents with disabilities, on sexual and reproductive health and reproductive rights.
- Establish a monitoring and evaluation mechanism to track the implementation of policies and programmes on access to sexual and reproductive health for persons with disabilities.

- Improve research and data to monitor, evaluate and strengthen sexual and reproductive health and services for persons with disabilities.

Ensuring inclusive and equitable quality education (SDG 4)

Persons with disabilities remain less likely to attend school and complete primary education and more likely to be illiterate than persons without disabilities. Available data reveals that, on average, one in three children with disabilities of primary school age is out of school, compared with one in seven children without disabilities. Primary school completion is also lower for children with disabilities. These trends are reflected in the lower literacy rate of persons with disabilities: **54% of persons with disabilities compared to 77% of persons without disabilities are literate. In some countries, more than 10% of persons with disabilities has been refused entry into school because of their disability; and more than a quarter of persons with disabilities reported schools were not accessible or were hindering to them.** Crowd-sourced data, mostly from developed countries, indicates that only 47% of more than 30,000 education facilities are accessible for persons using wheelchairs.

Many countries continue to strengthen national policies and legal frameworks to improve access to education for persons with disabilities, with 34 out of 193 UN member States guaranteeing in their constitutions the right to education for persons with disabilities or providing protection against discrimination based on disability in education. Yet, **in 44% of UN member States, students with disabilities cannot be taught in the same classroom as other students. But progress has been made in recent years: 41% of countries in 2017, as opposed to 17% in 2013, provided, in their schools, appropriate materials and communication to support the inclusion of students with disabilities.**

To achieve SDG 4 for persons with disabilities, in line with the CRPD, efforts are needed to implement and scale up the following actions:

- Strengthen national policies and the legal system for ensuring access to quality education for all persons with disabilities.
- Build capacity of policy makers as well as other decision-makers at both community and national levels to enhance their knowledge on disability inclusion in education.
- Make schools and educational facilities accessible by creating an enabling environment for students with disabilities and by making physical and virtual environments accessible.
- Provide training to teachers and other education specialists to gain knowledge and experience in inclusive education for persons with disabilities.
- Adopt a learner-centred pedagogy which acknowledges that everyone has unique needs that can be accommodated through a continuum of teaching approaches.

- Engage civil society and local communities in inclusive education.
- Establish monitoring mechanisms to evaluate the implementation of policies and laws on inclusive education.
- Improve national collection and disaggregation of education indicators by disability.
- Explore crowd-sourcing applications to obtain bottom-up information on the accessibility of schools for persons with disabilities.

Achieving gender equality and empowering all women and girls with disabilities (SDG 5)

Women with disabilities are often subjected to double discrimination due to their gender and disability status and continue to be at a disadvantage in most spheres of society and development. Available data suggests that **the gap is stark compared with men without disabilities: women with disabilities are three times more likely to have unmet needs for health care; three times more likely to be illiterate; two times less likely to be employed and two times less likely to use the internet. Among those employed, women with disabilities are two times less likely to work as legislators, senior officials or managers.** Women with disabilities tend also to be in a worse position than women without disabilities. Moreover, women with disabilities are at heightened risk of suffering sexual violence compared to those without disabilities.

Compared with men with disabilities, women with disabilities are more likely to have unmet health-care needs; more likely to be unemployed or inactive in the labour market; and less likely to work as legislators, senior officials or managers. In poverty, lack of access to education and internet as well as physical violence, the evidence does not seem to indicate a further disadvantage of women with disabilities relative to men with disabilities, suggesting that in several countries attitudinal and environmental barriers against disability, not gender, are the major factor driving the disadvantage experienced by women with disabilities. However, for lack of access to employment and sexual violence, environmental barriers and negative attitudes against both gender and disability seem to be playing a significant role.

Many countries still address gender and disability issues separately without focusing on the intersection between the two, but there are increasingly positive initiatives. For instance, in Latin America, 17 out of 20 countries include disability in their gender national plans. However, only 6 out of 19 countries address gender in their disability laws. To fully achieve gender equality and empower all women and girls with disabilities, efforts should focus on:

- Addressing the needs and perspectives of women and girls with disabilities in national strategies or action plans on disability and on gender.

- Develop policies and programmes focused on women and girls with disabilities aiming at their full and equal participation in society.
- Support the empowerment of women and girls with disabilities by investing in their education and supporting their transition from school to work.
- Raise awareness on the needs of women and girls with disabilities and eliminate stigma and discrimination against them.
- Enhance the collection, dissemination and analysis of data on women and girls with disabilities and disaggregate and disseminate data by sex, age and disability.

Ensuring availability of water and sanitation (SDG 6)

Persons with disabilities, especially those living in developing countries, encounter challenges in access to water, sanitation and hygiene, including physical, institutional, social and attitudinal barriers. This is particularly true for persons with severe disabilities. Furthermore, in many countries persons with disabilities are less likely to live in households with access to improved water and sanitation, and less likely to live in a dwelling with hygiene and sanitation facilities on the premises. This can create difficulties for persons with disabilities who experience difficulties in mobility, in locating the bathroom or in waiting in line. Moreover, **evidence from a limited number of developing countries indicates that more than one in seven persons with disabilities finds the toilet at home hindering or not accessible.** Lack of accessibility of toilets outside the home is also a challenge and prevents persons with disabilities from participating in society. **Crowd-sourced data, mostly from developed countries, indicates that only 69% of public toilets are accessible for wheelchair users.** Evidence also suggests that many primary schools do not have sanitation facilities accessible for persons with reduced mobility.

Assistive technologies, such as specially designed handles for water pumps or toilets, ramps and handrails and wider doors that are designed for persons with disabilities, have been used to overcome such challenges and make water, sanitation and hygiene accessible. Some countries have also made communal wells safe and physically accessible for persons with disabilities and provided moveable toilet seats to households that had latrines, which helped persons with disabilities having leg and/or back problems and reduced the need to sit or crawl on a wet latrine floor.

To achieve SDG 6 for persons with disabilities, it is imperative to focus on programs that target challenges in access to water and sanitation through various steps:

- Involve all stakeholders, especially persons with disabilities.

- Invest and allocate financial resources to accessible water, sanitation and hygiene facilities in households and in settings outside the home, prioritizing schools, workplaces, health facilities and communal facilities.
- Adopt a twin-track approach, i.e. mainstream disability in water and sanitation policies and programmes while at the same time developing disability specific programmes.
- Share information and build capacity about low-cost inclusive interventions to scale them up.
- Raise awareness and end discrimination and stigma.
- Monitor progress through the collection of individual data.
- Collect, analyse and disseminate census and survey data on water, sanitation and hygiene access for persons with disabilities and disaggregate these data by type of disability, age and sex.
- Explore crowd-sourcing applications to obtain bottom-up information on the accessibility of water and sanitation facilities for persons with disabilities to inform accessibility policies.
- Mainstream disability in international fora and global mechanisms working on water, sanitation and hygiene.

Ensuring access to energy (SDG 7)

Access to affordable, reliable, sustainable and modern energy is vital for persons with disabilities. Assistive technology, used by many to facilitate equal participation in society and independent living, often requires electricity. Persons with disabilities are more likely to spend longer periods in their homes and therefore to consume more electricity, for example, to maintain adequate room temperature. Higher electricity consumption contributes to higher energy bills.

In many countries, persons with disabilities face more challenges in accessing modern energy than persons without disabilities. In 37 out of 44 developing countries, the percentage of households with access to electricity is lower for households with persons with disabilities than households without persons with disabilities. **In 17 countries, less than 50% of households with persons with disabilities have access to electricity.** In developed countries, persons with disabilities, especially women with disabilities, are less likely than persons without disabilities to be able to keep their homes warm.

Traditional fuels, such as biomass and coal, are also more commonly used for cooking in households with persons with disabilities than in other households. Longer periods spent at home can lead to greater exposure to indoor pollution from those fuels. **In several countries, more than half of the households with persons with disabilities still use wood and coal for cooking.** Access to clean energy is therefore crucial for the well-being of persons with disabilities.

Initiatives taken to address the needs of persons with disabilities in accessing energy remain limited. Good practices include the provision of financial support for adjusting room temperature in winter and summer and distribution of energy-efficient stoves in refugee camps focusing on persons with disabilities.

The following eight steps could contribute to address the energy needs and implement SDG 7 for persons with disabilities by 2030:

- Take into account the extra energy costs which persons with disabilities are faced with in determining social protection measures.
- Include targeted measures for persons with disabilities in energy programs.
- Close the gap in energy access between persons with and without disabilities.
- Prioritize electricity access for persons with disabilities who require electricity-dependent assistive technology for independent living and for participation in society.
- Reduce use of solid fuels and promote modern forms of energy in households of persons with disabilities.
- Promote electricity in schools to increase the use of assistive technology in education and enhance the opportunities for students with disabilities to participate equally in educational systems.
- Include persons with disabilities in national governing bodies working on energy access.
- Raise awareness within ministries and promote inter-ministerial coordination to address fuel and energy poverty among persons with disabilities.

Promoting full and productive employment and decent work for persons with disabilities (SDG 8)

Persons with disabilities continue to have limited access to the labour market. **The employment-to-population ratio of persons with disabilities aged 15 and older is almost half that of persons without disabilities** and employed persons with disabilities tend to earn lower wages than their counterparts without disabilities. Lack of accessible workplaces and reasonable accommodation poses further obstacles in the employment of persons with disabilities. **In 8 developing countries, 32% of persons with disabilities consider their workplace hindering or not accessible.**

To improve the employment situation of persons with disabilities, **quota systems, which oblige employers to hire a certain number or percentage of persons with disabilities, have been adopted by at least 100 countries. Quotas typically range from 1% to 15%.** The most effective quota systems include the payment of a levy by the non-complying company for every position not held by a person with disabilities. These levies typically contribute to a special fund used to finance measures promoting the employment of persons with disabilities. Countries have also adopted employment laws and policies that

ensure the right of persons with disabilities to equal employment opportunities and prohibit discrimination on the grounds of disability. **In 22 countries, national constitutions explicitly guarantee the right to work for persons with disabilities. More than 60% of countries include provisions in their labour laws prohibiting discrimination in employment and guaranteeing equal pay for persons with disabilities.** Moreover, some national programmes provide financial support for persons with disabilities in accessing mainstream technical and vocational education and training.

To address the current employment gaps and realize SDG 8 for persons with disabilities, States should ensure that:

- National legislation protects persons with disabilities from discrimination on the basis of disability in all matters of employment.
- The public sector hires persons with disabilities.
- Public procurement policies and systems include provisions that encourage the employment of persons with disabilities.
- Public employment services are inclusive of persons with disabilities.
- Mainstream vocational education has provisions to include persons with disabilities.
- Mainstream entrepreneurship development training and microfinance systems include persons with disabilities.
- Policies are in place that facilitate job retention and return to work for persons who acquire a disability, including for persons with mental health conditions.
- Support is provided for persons with disabilities in sheltered employment to benefit and enter the mainstream labour market.
- Social protection systems are designed to provide income security and support for disability-related needs and extra costs to promote the participation of persons with disabilities in the labour market.
- Robust evaluation plans are built for the implementation of programmes to improve the employment of persons with disabilities.
- A database of available information and disaggregated data on disability and employment is developed and available in an accessible format.

Moreover, States should encourage employment of persons with disabilities in the private sector and, where employment quota legislation exists, in the public and/or the private sector, the State should ensure its implementation with an effective evaluation system throughout the career development of employees with disabilities.

Increasing access to information and communications technology (SDG target 9.c)

Persons with disabilities have more limited access to information and communications technology (ICT) than persons without disabilities. There is a significant gap between persons with and without disabilities in the use of the internet. **Among 14 countries, only 19% of persons with disabilities compared to 36% of persons without disabilities use the internet.** This may be attributed to lack of accessibility of such technology, as well as the lower capacity of households with persons with disabilities to afford internet access. For instance, **more than a third of online national portals includes features that are not accessible for persons with disabilities. Evidence from three sub-Saharan countries indicates that only 8% of households with persons with disabilities can afford the internet, about half the percentage for households without persons with disabilities.** Compared to households without persons with disabilities, households with persons with disabilities are also less likely to own a mobile phone.

National policies and programmes have been developed to promote equal access to ICT for persons with disabilities, including captioning or signing of television programmes, ensuring accessible government websites, accessible public electronic kiosks or automated teller machines and provision of telephone services for persons who are deaf and/or speech impaired.

Looking forward, the following recommendations offer guidance on how to strengthen the ICT ecosystem to ensure inclusion and accessibility for persons with disabilities:

- Raise awareness and enhance knowledge of ICT accessibility.
- Involve persons with disabilities at every stage of ICT development.
- Promote the principles of Universal Design in the mainstream ICT industry and the public sector.
- Adopt national ICT accessibility policies and regulations.
- Create dedicated focal points in relevant ministries or departments dealing with ICT accessibility.
- Provide affordable Internet access for persons with disabilities.
- Provide funding mechanisms to support the development of open-source software.
- Involve all relevant stakeholders and increase funding to support universal design and low-cost ICTs for persons with disabilities.
- Develop and publish comparable data on access to and use of ICTs disaggregated by disability as well as on accessibility of ICTs.

Reducing inequality (SDG 10)

Persons with disabilities face persistent inequality in social, economic and political spheres and are disadvantaged in all areas covered by the SDGs. **Although gaps between persons with and without disabilities vary among countries, in some countries the gaps reach more than 20 percentage points in income poverty, 15 percentage points in the ability to afford a meal with protein every second day, 50 percentage points in experiencing good health, in literacy rates and in employment to population ratios.** Persons with disabilities are also at disadvantage in terms of accessing and affording essential services including water and sanitation, energy, and the internet. Besides these gaps, persons with disabilities are under-represented in political participation.

Combating discrimination is key to reducing inequality for persons with disabilities. Discrimination is a major cause of exclusion of persons with disabilities. **In some countries, more than 50% of persons with disabilities have experienced discrimination.** Even though most countries have ratified the Convention on the Rights of Persons with Disabilities, discriminatory laws and policies still exist in some countries, especially in the areas regulating right to marry, legal capacity and political participation. **Only 36% of countries have no legal restrictions for persons with disabilities to marry, only 13% have no restrictions to vote and only 9% have no restrictions to be elected for public office.**

Ensuring access to assistive technology is crucial to enable independent living of persons with disabilities and their ability to fully participate in society. Efforts have been made by some countries to make this technology more available and affordable for persons with disabilities by developing national plans. However, available evidence shows that **in several developing countries more than half of the persons with disabilities who need assistive devices are not able to receive them, mainly because available devices are inadequate, unaffordable or no transport is available to the providers of these devices.**

Social, economic and political inclusion of persons with disabilities will also require deinstitutionalization. Persons with disabilities living in institutions remain excluded from society and are often unable to obtain education, to exercise the right to vote and to make their own decisions. **In some countries, more than 10% of persons with disabilities still live in institutions and special homes for persons with disabilities.**

Among persons with disabilities, persons with intellectual and psychosocial disabilities are even more disadvantaged. They are more likely to experience forced institutionalization, poor living conditions and abuses occurring in psychiatric hospitals as well as harmful and coercive treatment practices. In addition, they are less likely to be literate and employed and are more likely to find health facilities hindering and to be excluded from family and community activities. Only in a few countries does legislation promote the social, economic and political inclusion of persons with psychosocial disabilities.

Making cities and communities inclusive and sustainable for persons with disabilities (SDG 11)

Transportation systems, public spaces and facilities and businesses are not always accessible for persons with disabilities. Available data indicates that **in some countries more than 30% of persons with disabilities finds transportation and public spaces not accessible**. Persons with disabilities also experience difficulties in accessing adequate housing. Barriers include lack of physical accessibility, discrimination and stigmatization and lack of social housing or community support. Limited access to employment can also pose challenges in securing the financial conditions for renting or financing adequate housing. As a result, a disproportionate number of persons with disabilities are homeless. Furthermore, those who find a home may not be able to afford modifications to make their home accessible. **In some countries, more than 15% of persons with disabilities find their dwelling hindering**. In several countries, persons with intellectual or psychosocial disabilities face an additional obstacle: they have limited security of tenure because their legal capacity is not recognized, and they are rarely able to obtain a formal housing contract.

Persons with disabilities living in rural areas tend to face more challenges than persons with disabilities living in urban areas: they are less likely to attend school and to live in a household that owns a mobile phone. Births from mother with disabilities living in rural are also less likely to be attended by a skilled health worker.

More and more countries have been taken measures to improve physical accessibility in public transportation, public playgrounds, cultural facilities, and sidewalks and pedestrian crossings. Some countries also have guidelines for accessible housing. To make cities and communities inclusive and sustainable for persons with disabilities, more efforts are needed to:

- Ensure that national policies and laws on accessible housing, public infrastructure, transport, and services are in place and implemented.
- Develop national policies and laws that guarantee access to adequate and affordable housing for persons with disabilities.
- Raise-awareness on disability among communities and decision-makers and create the enabling environment where persons with disabilities are included without discrimination and can participate equally in the communities.
- Share knowledge and good practices and build capacity to implement measures promoting accessibility and inclusion.
- Improve research and data to monitor, evaluate and strengthen urban development to be more accessible and inclusive for persons with disabilities.

Building resilience of persons with disabilities and reducing their exposure to and impact from climate-related hazards and other shocks and disasters (SDGs 1.5, 11.5 and 13)

Persons with disabilities are particularly vulnerable during natural disasters, extreme climate events, conflict and humanitarian emergencies. They are often unprepared as 72% have no personal preparedness plan for disasters and 79% would not be able to evacuate immediately without difficulty in the event of a disaster. Persons with disabilities tend to be left behind during evacuations, are disproportionately affected by adverse impacts of disasters and suffer higher death rates. Moreover, they are often under-identified in humanitarian and post-disaster contexts. The needs of persons with disabilities are often overlooked in the early phases of response to humanitarian emergencies and difficulties are often faced in accessing services and assistance, including rehabilitation and assistive devices which are critical for recovery. Refugees with disabilities are often exposed to discrimination in the places where they seek to live.

The needs of persons with disabilities should be factored into disaster risk reduction planning and response. Many countries are taking measures to do so, for example, by incorporating the needs of persons with disabilities in national policies, laws, and plans on humanitarian actions and in post-disaster reconstruction processes and by engaging persons with disabilities in disaster risk analysis and assessment. In addition, guidance on disability-inclusive humanitarian response have been developed and are available for humanitarian actors to ensure the needs of persons with disabilities are met.

The following steps can contribute to ensure disability-inclusive disaster risk reduction and response as well as disability-inclusive humanitarian action:

- Ensure that persons with disabilities participate in decision-making processes and are active stakeholders at all stages of disaster response and humanitarian action from planning to implementation, evaluation and monitoring.
- Ensure that national policies and programmes include operational standards and indicators for the inclusion of persons with disabilities in emergency preparedness, planning and response.
- Ensure that emergency information, commodities, infrastructures and services are inclusive and available in accessible formats.
- Mobilize adequate, timely and predictable resources to operationalise commitments for inclusive emergency preparedness and response.
- Raise-awareness amongst persons with disabilities on disaster management plan at the local level.
- Enhance the capacities and knowledge of aid workers on the needs and strengths of persons with disabilities in humanitarian actions.

- Undertake evidence-based research and develop a data collection system on persons with disabilities relevant to conflicts and disasters.

Furthermore, States should ensure that:

- All post crisis recovery efforts, including reconstruction and rebuilding, are inclusive of persons with disabilities, protection mechanisms are in place in emergency and post crisis contexts to recognize and respond to the heightened risk of persons with disabilities, particularly women and children with disabilities, to violence, abuse and exploitation.
- Accountability mechanisms are implemented at national level for acts or omissions leading to discrimination and exclusion of persons with disabilities in the context of humanitarian action and disaster response.

Promoting peaceful and inclusive societies for sustainable development, providing access to justice for all and building effective, accountable and inclusive institutions at all levels (SDG 16)

Persons with disabilities experience a heightened risk of violence, in part as a result of stigma, discrimination and exclusion from society. **Evidence from five developing countries suggests that about one in five persons with disabilities has been beaten or verbally abused because of their disability.** In several developed countries, persons with disabilities are more likely to live in a household or area of residence where crime, violence and vandalisms are common. Persons with psychosocial disabilities experience even more violence than persons with other forms of disabilities. Likewise, women and girls with disabilities experience higher exposure to sexual violence compared to women without disabilities and men with and without disabilities.

Equal recognition before the law and legal protections that guarantee the rights of persons with disabilities are fundamental for equal access to justice for all. While some countries explicitly guarantee the rights of persons with disabilities in their constitutions, some allow for exceptions. Issues that prevent persons with disabilities from accessing justice also include lack of accessibility in courts and of legal documents, and limited disability awareness amongst those who work in the justice system. **In some countries, more than 30% of courts and police stations are not accessible and more than 90% of persons with disabilities who need legal advice are not able to receive it.**

Public institutions need to be inclusive of persons with disabilities but, too often, are not. **In some countries, more than one in ten persons with disabilities experiences discrimination in public services. Globally, only two thirds of countries have online government services for persons with disabilities.** Persons with disabilities tend to be underrepresented in decision-making bodies. Their participation in politics, including voting and being elected for office, is key for inclusive decision-making. However, many persons with disabilities, particularly those with psychosocial disabilities, are frequently denied their rights

to political participation due to discriminatory laws that deprive them of their right to vote and to be elected for office. Public sector employment can also promote inclusive and effective institutions, and quota requirements for the employment of persons with disabilities in the public sector have been enforced in many countries.

Participation of persons with disabilities is also hindered by a lack of access to information. Many countries adopt and implement freedom of information acts, which secure access by the public to data and information held by the Government. Yet, few countries have considered the needs of persons with disabilities regarding the accessibility of information in these acts.

Children with disabilities are often not registered at birth because of stigma and families' decision to hide family members with disabilities. Although some countries have already managed to achieve similar levels of registration for children with disabilities, they still remain largely unregistered in some communities.

Increasing the availability of disaggregated data by disability (SDG target 17.18)

National disability statistics are increasingly available. This is, in part, due to the growing number of countries that collect disability data in censuses. **At least 120 out of 214 countries or areas that conducted a census during the 2010 round included a set of questions on disability, a significant increase from the approximately 19 countries or areas that did so during the 1970 census round.** Moreover, there has been a positive trend in using internationally recommended methodologies in data collection, such as those developed by the Washington Group on Disability Statistics.

A number of United Nations entities have been working on methodologies to improve the quality of disability statistics worldwide. The World Health Organization (WHO) supports countries to collect data on disability and functioning through the model disability survey. The Washington Group on Disability Statistics developed a short set of disability questions and an extended set of questions on functioning for the identification of persons with disabilities, as well as, in collaboration with the United Nations Children's Fund (UNICEF), a child functioning module to identify children with functional difficulties and an inclusive education module to assess school environment and participation. Efforts have also been made to build capacity in countries to use these methodologies.

To increase the availability of data disaggregated by disability, there is a need to:

- Continue building capacity in countries to collect, process, analyse and disseminate data disaggregated by disability.
- Regularly update international guidelines on the production of data disaggregated by disability.
- Invest in an international repository of disability data, compiling data at the country level to monitor progress towards the SDGs for persons with disabilities.

A way forward for disability-inclusive development

The evidence in this report demonstrates that persons with disabilities are at a disadvantage in comparison to those without disabilities in the attainment, monitoring and evaluation of the SDGs. Although progress has been observed in terms of the adoption or harmonization of existing laws and policies in line with the CRPD, progress in implementing such measures has been slow. Discriminatory laws are also still in place in many countries.

To meet the SDGs by 2030, international and national development programmes will need to prioritize inclusive development. In particular, concrete action is needed to make persons with disabilities and their situations visible in policymaking and to build just and inclusive societies. This action should focus on four fronts:

1. Addressing fundamental barriers causing exclusion of persons with disabilities. The fundamental barriers causing the exclusion of persons with disabilities need to be urgently addressed: discriminatory laws and policies, lack of accessibility in physical and virtual environments, negative attitudes, stigma and discrimination, lack of access to assistive technology and to rehabilitation and lack of measures to promote independent living of persons with disabilities.

2. Mainstreaming disability in the implementation of the SDGs. Areas of particular importance for the realization of disability inclusive development include social protection (SDG 1.3), education (SDG 4), employment (SDG 8) and basic services, including healthcare services (SDG 3), water and sanitation (SDG 6), and energy (SDG 7). Accessible infrastructural development in urban and rural environments, public spaces and facilities (SDG11) is also of paramount importance to participation of persons with disabilities in all aspects of society and development. Progress in these areas can catalyse progress across all SDGs.

3. Investing in monitoring and evaluation of progress towards the SDGs for persons with disabilities. The lack of data and research on the situation of persons with disabilities severely constrains the international community from monitoring the situation of children, youths and adults with disabilities. Countries should focus on establishing indicators to be collected and disseminated regularly to assess the situation of persons with disabilities and the challenges they face (such as lack of accessibility), including disability-specific indicators to capture progress in implementing policies and programmes aimed at their inclusion. Studies on the impact of policies and programmes will also be needed to guide the implementation of the 2030 Agenda for persons with disabilities, in particular to help policy makers in designing new policies and in deciding to scale up, refine or discontinue existing policies.

4. Strengthening the means of implementation of the SDGs for persons with disabilities: finance, technology, capacity-building, policy and institutional coherence and multi-stakeholder partnerships. On finance, adequate resources should be allocated to support (i) the enforcement of laws protecting the rights of persons with disabilities; (ii) the implementation of national disability policies and

plans and (iii) the delivery of essential services to persons with disabilities. Member States, donor agencies and international organizations should regularly monitor financial commitments to the inclusion of persons with disabilities. On technology, the promotion of accessible technology, following the approach of universal design, should be prioritized. Incentivizing research and development of assistive technology can help further accelerate the availability of these technologies. International trade policies and agreements can also facilitate access to affordable assistive products in developing countries where assistive devices are often limited. Capacity-building is urgently needed for policy makers to formulate disability-inclusive laws and policies, for organizations working on programmes related to the implementation of SDGs and for service providers to increase the quantity and quality of their services for persons with disabilities, for persons with disabilities themselves to gain knowledge to exercise their rights and to better access available services and products that may benefit them, for development and humanitarian actors on how to address the needs of persons with disabilities in humanitarian crises and disasters. To promote policy and institutional coherence, a national institutional mechanism promoting the rights, inclusion and wellbeing of persons with disabilities and coordinating at the national level is critical for the effective implementation of the SDGs, as is the participation of persons with disabilities in the institutional arrangements. In addition, as countries revise laws and policies to align them with the CRPD, there is a need to ensure that national legislation and development plans are coherent and that legal and policy provisions do not contradict each other. Multi-stakeholder partnerships have an important role in realization the SDGs for persons with disabilities. Such partnerships may involve Member States, United Nations agencies, development, humanitarian and human rights actors, peace and security actors, local authorities and communities, private sector actors and civil society, in particular persons with disabilities and their representative organizations. These partners can collectively ensure that development activities and programmes include the perspectives and consider comprehensively the needs of persons with disabilities.

Introduction

Despite the progress made in recent years, persons with disabilities the world over continue to face numerous barriers to their full inclusion and participation in the life of their communities. In order to help address this challenge, the General Assembly requested the Secretary-General, in coordination with all relevant United Nations entities, “to compile and analyse national policies, programmes, best practices and available statistics regarding persons with disabilities, reflecting progress made in addressing the relevant internationally agreed development goals and the provisions of the Convention on the Rights of Persons with Disabilities (CRPD), to be submitted to the General Assembly in a Flagship Report during 2018”¹. The *UN Flagship Report on Disability and Development| 2018 - Realizing the SDGs by, for and with persons with disabilities*, comes at a critical time. It is a first stock-taking of where we stand on key aspects of mainstreaming disability globally in light of the 2030 Agenda; to identify what is needed to monitor progress made for persons with disabilities in society and development; and to provide wide-ranging recommendations for transformative change. Ultimately, the 2030 Agenda, together with the Convention on the Rights of Persons with Disabilities (CRPD), offers a road map towards a more inclusive and sustainable world.

The 2030 Agenda for Sustainable Development and its 17 sustainable development goals (SDGs) and 169 targets were adopted by all 193 Member States of the United Nations in 2015. It sets out a transformative vision for preserving our planet, promoting peace and ensuring that prosperity is shared by all. The central pledge of the 2030 Agenda is to leave no one behind and to reach those furthest behind first. This historic and ambitious Agenda has direct relevance to persons with disabilities, who face numerous barriers to their full inclusion and participation in the life of their communities. The global commitment to the 2030 Agenda recognizes the promotion of the rights, perspectives and well-being of persons with disabilities as a cross-cutting issue in line with the CRPD. With 177 ratifications and over a decade of implementation of the Convention (as of 1 October 2018), progress has been made for the inclusion of persons with disabilities in society and development.

In line with the 2030 Agenda and the CRPD, this report aims to place disability squarely at the centre of the sustainable development agenda. It reviews progress towards relevant internationally agreed development goals; and shows that efforts need to be stepped up to ensure that the goals and targets are achieved for persons with disabilities.

Chapter I provides an historical overview of the steps taken by the United Nations to advance inclusive, accessible and sustainable society and development by, for and with persons with disabilities.

Chapter II focuses on the 2030 Agenda goals and targets relevant for persons with disabilities in line with the pertinent international normative frameworks for their achievement, providing available evidence on the situation of persons with disabilities in relation to each SDG, as well as related good practices.

Chapter III analyses how disability, as a cross-cutting development issue, will impact the on-going efforts of the international community towards inclusive and sustainable development. It also identifies possible strategies to mainstream disability in the implementation, monitoring and evaluation of the SDGs and concludes with recommendations on mainstreaming the needs, rights and perspectives of persons with disabilities in achieving the SDGs at all levels for an inclusive and accessible 2030 Agenda that leaves no one behind.

Definition of disability

In the International Classification of Functioning, Disability and Health (ICF),² disability is defined as a limitation in a functional domain that arises from the interaction between a person's intrinsic capacity, and environmental and personal factors. From this perspective, functioning occurs at three levels: body function and structures, activities and participation. For example, if an individual cannot move their legs, he/she experiences a limitation in functioning at the body function level. If an individual has difficulty walking, he/she experiences a limitation at the basic activity level, in other words difficulty combining body functions to perform a particular task. If an individual cannot work, because of environmental barriers (e.g. an inaccessible work place), then he/she is restricted at the participation level. Similarly, the CRPD recognizes "that disability is an evolving concept and that disability results 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".³

The overall experience of disability is diverse as it is the combination of limitations in functioning across multiple domains (e.g. walking, seeing), each on a spectrum, from little or no disabilities to severe disabilities, either within a particular domain or across multiple domains. For each domain, the level of functioning a person experiences depends both on the intrinsic capacity of the individual's body and the features of his or her environment that can either lower or raise, the person's ability to participate in society. Since domains of functioning are on a continuum, in order to determine prevalence of disability some threshold level of functioning needs to be established to distinguish between "persons with disabilities" and "persons without disabilities".

Countries, in their data collection activities, do not define persons with disabilities uniformly and have adapted practical definitions and thresholds for their own data collections on the basis of their policy needs. National definitions differ in both meaning and scope and severity of disability. This report uses country-led data where these exist, in order to respond to current national circumstances and priorities, while taking into account the development of methodologies for internationally comparable data by international organizations and groups operating under the aegis of UN entities. In particular, data produced using the Washington Group Short Set of Questions⁴ and the WHO Model Disability Survey⁵ are identified throughout the report.

Sources of evidence

Over 200 experts from UN agencies and International Financial Institutions, Member States and civil society (including research institutions and organisations of persons with disabilities) contributed to this report and five expert meetings were organized to produce an inventory existing evidence and repositories. Over a dozen major databases of disability statistics, from international agencies and other organizations, were analysed – covering an unprecedented amount of disability data from over 100 countries. These included databases from Demographic and Health Surveys;⁶ Economic Commission for Latin America and the Caribbean; Economic and Social Commission for Western Asia;⁷ Economic and Social Commission for Asia and the Pacific; Eurostat; International Labour Organization (ILO); Integrated Public Use Microdata Series;⁸ SINTEF;⁹ United Nations Statistics Division; United Nations Educational, Scientific and Cultural Organization; United Nations Children’s Fund (UNICEF); the World Bank Group; and World Health Organization (WHO).

The report covers new areas for which no global research was previously available (for example, the role of access to energy to enable persons with disabilities to use assistive technology) and contains the first global compilation and analysis of internationally comparable data using the Washington Group short set of questions on disability. In addition, more than 1.2 million data points of crowd-sourced data were examined to inform an analysis of the accessibility of physical spaces. Finally, reviews of legislation from all 193 UN Member States were conducted and analysed for this report to highlight good practices and to assess the current status of discriminatory laws on voting, election for office, right to marry and others.

Chapter I. Overview of the History of the Work of the United Nations towards Disability-inclusive, Accessible and Sustainable Society and Development

The aim of this chapter is to highlight the achievements of the international community and to set its course for advancement of the rights of persons with disabilities.

Background

Prior to the establishment of the United Nations (UN), the League of Nations discussed the nascent ideas for basic human rights, including promoting rights for minorities, religious freedoms, women and labour. However, the international community saw the beginning of a new era for universal human rights in the UN Charter, – a result of an International Organization Conference in 1945 –, which placed human rights as a core principle of the organization, committing to uphold the dignity and worth of all human beings. The commitment of the international community to promote the full and effective participation of persons with disabilities in all aspects of society and development is deeply rooted in the principles of the United Nations' Charter.¹⁰ In 1948, the General Assembly (GA) of the UN adopted the Universal Declaration of Human Rights (UDHR)¹¹ which promotes the right to life, liberty and security of all persons in society, including the fostering of all such rights in the event of, among other circumstances, disability. Although it conceptualized disability as a condition, as opposed to a status or a result of a person's interaction with the way in which society is organized, the UDHR is widely recognized for establishing the core principle of equality for all.

The reference to disability in the UDHR as early as 1948, though overdue, provided positive and progressive steps to the advancement and rights of persons with disabilities. Global recognition of persons with disabilities as equals has progressed significantly since then. In 1976, the UN adopted the International Covenant on Civil and Political Rights (ICCPR)¹² and the International Covenant on Economic, Social and Cultural Rights (ICESCR)¹³, which alongside the UDHR formed a triad of international human rights treaties, and what is called the International Bill of Human Rights. The "International Bill of Human Rights" is applicable to all and provided a basis for the universal human rights of persons with disabilities.

A shift in perspective

While there was major progress in the corpus of international human rights law and expansion of the United Nations human rights treaty system, disability largely remained a social protection and welfare issue. The General Assembly, the Economic and Social Council (ECOSOC) and its subsidiary body, the Commission for Social Development (CsocD), promoted well-being and welfare of persons with disabilities through

technical cooperation, rehabilitation and vocational programmes. For example, the CsocD during its sixth session in 1950 adopted the reports entitled “Social rehabilitation of the physically handicapped” and “Social rehabilitation of the blind”,¹⁴ leading ECOSOC to establish rehabilitation programmes for persons with physical disabilities and blindness respectively. Following the decisions by the United Nations organs in 1950, the UN and its entities (including the International Labour Organization (ILO), the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) agreed to establish international standards for education, treatment, training and placement of persons with disabilities. This, in turn, led to a shift in focus in the way disability was conceptualized, moving away from defining the role of persons with disabilities as recipients of welfare and services to persons who are entitled to exercise their basic human rights. In 1969, the GA adopted a declaration, emphasizing the need to protect the rights and welfare of persons with disabilities¹⁵, thus calling for their full participation in society. The international recognition that it is society that creates barriers for participation of persons with disabilities emerged during this period, leading to the adoption of the two international instruments on the rights of persons with disabilities.

The first was the Declaration on the Rights of Mentally Retarded Persons, adopted by the GA in 1971¹⁶, representing a significant step in raising awareness on the rights of persons with intellectual disabilities and the importance of the role of education for persons with intellectual disabilities to reach their full potentials. At the time, this Declaration was an important tool to advance disability as part of a global agenda—particularly the issue of intellectual disabilities. The Declaration, however, still retained a ‘medical/social welfare model’ approach to disability in some parts, referring to persons with disabilities as reliant on social security and welfare and requiring separate services and institutions.

A second declaration on disability followed in 1975 - the Declaration on the Rights of Disabled Persons¹⁷ - which promoted social integration of persons with disabilities, on the basis of their inherent dignity and human rights, setting standards for equal treatment and accessibility to services. Compared to the 1971 declaration, this second declaration reflected the transition from the ‘medical/social welfare model’ approach to disability to “social/human rights” model of promoting the equal rights and opportunities for persons with disabilities.

Building momentum

By 1980 the UN had garnered support from Member States to take further steps for the full participation of persons with disabilities in society and development, which resulted in the designation of 1981 as the International Year of Disabled Persons (IYDP).¹⁸ The IYDP promoted the full integration of persons with disabilities into society, increasing awareness and encouraging the formation of disability organizations to give an active voice to persons with disabilities worldwide. During the year, great many conferences, symposiums and events at global, regional and national levels were held to commemorate the progress made in inclusion of persons with disabilities in society and to strengthen policy innovation. The IYDP was

therefore a pivotal year for the advancement of the rights of persons with disabilities in society and development.

In 1982, the General Assembly adopted the World Programme of Action Concerning Disabled Persons (WPA)¹⁹, to achieve the goal of the full and effective participation of persons with disabilities with central theme the equalization of opportunities for persons with disabilities, and the effective measures for the prevention of disability and rehabilitation. The WPA was thus an important and pivotal shift towards a rights-based approach to disability as a global issue. It focused on how societal and other barriers - be they environmental or attitudinal - should be removed so that persons with disabilities can participate in society as agents of change and beneficiaries of development gains. To advance the goal of the WPA, the United Nations General Assembly designated the Decade of Disabled Persons, spanning from 1983 to 1992²⁰, which spurred a number of activities designed to improve the situation and status of persons with disabilities, including better education and employment opportunities, and increasing their participation in the life of their communities and countries. During the Decade, a number of conferences took place, including the adoption of the “Tallinn Guidelines for action on Human Resources Development in the Field of Disability” in 1989. The Decade resulted in the establishment of the International Day of Disabled Persons, to be observed on 3 December. It also resulted in the establishment of the first global network of persons with disabilities, Disabled People’s International, and subsequent formation of national and local organizations of persons with disabilities. The message of “persons with disabilities as agents and beneficiaries of development” thus started to take concrete forms in the international normative framework on disability and development as well as in global, national and regional policy frameworks and global networks of persons with disabilities to define their own rights, well-being and perspectives in society.

The Standard Rules on Equalization of Opportunities for Persons with Disabilities was one of the main results of the UN Decade of Persons with Disabilities, bringing the importance of equalization of opportunities to the forefront of the global development agenda. The Standard Rules were adopted in 1993 by the General Assembly to advance the central objective of the World Programme of Action concerning Disabled Persons as a set of rules for action by Governments and other stakeholders. The monitoring mechanism of the Standard Rules included the appointment of a Special Rapporteur to report to the Commission for Social Development on the implementation of the rules.²¹

UN Development Conferences

In addition to key milestones reached by the UN in advancing disability rights and development, international and world conferences held during the 1990s following the Decade of Disabled Persons emphasized the need for a ‘society for all’, thus providing scope to advocate for participation of persons with disabilities in all spheres of society. Conferences promoted initiatives to improve health care,

education, elimination or reduction of violence and the lessening of the poverty rate for persons with disabilities, thus realizing their rights in all aspects of social, economic and cultural life. The World Conference on Human Rights in 1993 saw the generation of the Vienna Declaration and Programme of Action,²² adopted by the General Assembly to advance human rights in line with the changing scope of society. It recognized that the human rights and freedoms granted to all members in society unreservedly include persons with disabilities,²³ and for this reason, discrimination against them is a violation of human rights.

Additionally, the World Summit for Social Development in 1995 adopted the Copenhagen Declaration on Social Development,²⁴ which stipulates that advances in economic, social and environmental dimensions are mutually reinforcing components of sustainable development. The declaration also noted that development cannot be accomplished in the absence of all human rights and without participation from all groups and representations in society. Though core human rights treaties were universal in their coverage, they did not address the specific barriers, needs and concerns that persons with disabilities faced, paving the way toward an international convention on disability.

The UN, in collaboration with Member States, organizations of persons with disabilities and academic institutions were exploring further how the Standard Rules and the existing international normative framework on disability – consisting of international instruments on human rights and development- could advance the rights of persons with disabilities. For this objective, a number of technical meetings were organized throughout the late 1990s to early 2000. A pivotal meeting was the UN Consultative Expert Group Meeting on International Norms and Standards relating to disability (1998), which explored specific ways to utilize existing norms and standards for the advancement of the rights of persons with disabilities, including specific recommendations for mainstreaming disability in the UN development and human rights agenda, mechanisms, processes and resulting documents. The following year, a UN inter-regional conference on international norms and standards relating to disability was held in collaboration with the Equal Opportunities Commission of Hong Kong, SAR, China, which brought together global, regional and national leaders and experts in the field of disability, development and human rights. The Conference adopted a set of recommendations for the advancement of the rights of persons with disabilities at global, regional and national levels, including a possibility for promoting an international convention on the rights of persons with disabilities.²⁵

At the 56th session of the General Assembly, the Government of Mexico at its highest level proposed an international convention on disability to be considered by the General Assembly, based on the programme of action adopted by the World Conference on Human Rights in Durban (South Africa, 2001). The consultations on this proposal involved many new and traditional stakeholders in the field of disability, creating a momentum for a new era of “disability movement” within and outside the United Nations. The General Assembly established the Ad Hoc Committee in 2001, which was initially proposed for “considering

proposals for an international convention to uphold the dignity and rights of persons with disabilities.” The Committee engaged civil society (in its meeting in 2002), establishing a Working Group to prepare a draft text of a convention (in 2003), with final negotiations on the draft text and its Optional Protocol, which were both adopted by the GA in December 2006.²⁶

The Convention on the Rights of Persons with Disabilities (CRPD) was envisaged from the very beginning as the instrument for inclusive development and for the realization of the universal human rights for persons with disabilities. It entered into force in 2008 and has established two monitoring mechanisms: i) the Committee on the Rights of Persons with Disabilities and ii) the Conference of States Parties. While the Committee is part of the UN human rights treaty monitoring system, the Conference of States Parties to the CRPD is a unique global mechanism, which has no parallel entity in other human rights conventions. The Conference is established as a unique forum to exchange experiences and new ideas for the implementation of the Convention and to improve policies and programmes, with a focus on practical solutions to the obstacles encountered by persons with disabilities on the ground.

This landmark Convention is truly a benchmark instrument to ensure the equal enjoyment of universal human rights and fundamental freedoms by persons with disabilities. Together with other international human rights and development instruments, it provides a comprehensive framework for national policy-making and legislation, including international cooperation, for building inclusive society, and development. The international disability “architecture” constitutes a tool for strengthening legal protection, policymaking and planning for development. At the international level these instruments may be utilized to support disability-inclusive policies and practices. At the national level, they may be used to support harmonization of national legislation, policies and programmes. The World Programme of Action and the Standard Rules focus on planning and strategic implementation, monitoring and evaluation, and adopt a different approach from the monitoring of an international human rights convention. The Convention adds the strength of human rights practice from the disability perspective to the existing international normative framework.

Broadly speaking, there are two core aspects to the implementation of the Convention: (a) harmonization of laws relating to disability and adaptation of policies and programmes; and (b) non-legal strategies in innovative use of an international convention for advocacy and social change. Implementation of the Convention calls for the formulation of strategic options for policies, programmes and evaluation measures that promote the full and equal participation of persons with disabilities in society and development.

While the international normative framework on disability was further strengthened by the Convention, the international community was facing a lack of information in data, statistics and analysis of the situation of persons with disabilities for mainstreaming disability in the development goals, including the Millennium Development Goals (MDGs). As a response to such need, a flagship report was published by the WHO and the World Bank - the World Report on Disability (2011). The report estimated that there were one billion persons living with some forms of disability worldwide and included its analysis, which correlated

disability with poverty, a lack of education, and increased likelihood to harmful practices to health. The report articulated that disability is a critical developmental issue, and that the global development agenda must include persons with disabilities in all sectors of development.

UN General Assembly High Level Meeting on Disability and Development and Toward Disability-Inclusive 2013 Global Agenda for Sustainable Development

As the international community was beginning its dialogues to develop an inclusive and sustainable global development agenda, the GA called for a High-Level Meeting on Disability and Development (HLMDD) to be held at the level of Heads of States and Governments in 2013²⁷, under the theme: “The Way Forward: a disability inclusive development agenda towards 2015 and beyond”. At this meeting, Member States adopted an outcome document,²⁸ stressing the importance of giving due consideration to all persons with disabilities in the post-2015 United Nations development agenda. The outcome document “*encourages the international community to seize every opportunity to include disability as a cross-cutting issue in the global development agenda*”. In the Meeting,²⁸ Member States emphasized the need to translate these international commitments into concrete actions and results for persons with disabilities.

The international community, on the basis of the outcome of the HLMDD, specifically addressed the inter-linkages between disability and sustainable development in the course of negotiations of the 2030 Agenda for Sustainable Development. It underscored the importance of a disability-inclusive global development agenda and successfully included references to disability in the draft document of the Agenda. The international community continued its review of and consideration for disability-inclusion in the indicators for the monitoring and evaluation of the 2030 Agenda in 2016.

Since the adoption of the Convention, which emphasizes the importance of mainstreaming disability as an integral part of relevant strategies of sustainable development,²⁹ the rights, well being and perspectives of persons with disabilities have garnered growing political commitments, especially in the post-2015 development agendas. In 2015, Member States adopted the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs), which recognize disability as a cross-cutting issue and explicitly address it in five SDGs, namely on education, growth and employment, inequality, accessibility of human settlements, data, monitoring and accountability. In addition, persons with disabilities are recognized among disadvantaged groups for whom progress must be particularly monitored, as Member States aim to achieve universal goals concerning basic needs, including the eradication of poverty and hunger, ensuring healthy lives and well-being, and securing access to clean water and sanitation.

Moreover, a series of post-2015 development frameworks incorporated the rights and well-being of persons with disabilities, and engaged the participation and contribution of persons with disabilities in the deliberation and development of relevant strategies, including Small Island Developing States (SIDS) Accelerated Modalities of Action (SAMOA) Pathway,³⁰ Addis Ababa Action Agenda,³¹ the Sendai

Framework for Disaster Risk Reduction 2015-2030,³² the Paris Agreement, the New York Declaration for Refugees and Migrants,³³ the New Urban Agenda,³⁴ and the Global Compact for Safe, Orderly and Regular migration.

In the Addis Ababa Action Agenda, adopted at the Third International Conference on Financing for Development in July 2015, Member States included a disability perspective in the context of financing for development. More specifically, this Agenda commits to providing access to quality education, including accessible and disability-sensitive educational facilities, employment, social protection and accessible technologies, as well as collecting and using data disaggregated by disability status for monitoring and evaluation of the Agenda.

The Sendai Framework for Disaster Risk Reduction 2015-2030, adopted at the Third UN World Conference in March 2015, emphasized the importance of disability-inclusive disaster risk, calling for the inclusion of persons with disabilities in design and implementation of policies, plans and standards on disaster risk reduction, and for promoting the contribution of persons with disabilities in the process. The first World Humanitarian Summit held in Istanbul, Turkey, further increased the visibility of persons with disabilities in situations of humanitarian crises, with the Charter on Inclusion of Persons with Disabilities in Humanitarian Action.

The New Urban Agenda, adopted at the United Nations Conference on Housing and Sustainable Development (Habitat III) in Quito in October 2016, underlined the connection between urban development agenda and the 2030 Agenda especially its Goal 11 on sustainable cities and communities. Member States took a twin-track approach to promote inclusive urban development for all, and pledged to eliminate discrimination, provide equal access to technology, employment and public services, including transport infrastructure, for persons with disabilities, and ensure their participation in decision-making processes in urban planning. It also supports science, research and innovation, including a focus on social, technological, digital and nature-based innovation, robust science-policy interfaces in urban and territorial planning and policy formulation and institutionalized mechanisms for sharing and exchanging information, knowledge and expertise.

Conclusion

Since its inception, the United Nations has pursued the advancement of the rights of persons with disabilities in society and development in close collaboration with Member States, organizations of persons with disabilities and other civil society organizations, academic institutions and the private sector, at local, national and global levels. Remarkable progress has been made over the past decades in this endeavour and the United Nations' commitment to promote the full and effective participation of persons with disabilities as agents of change and beneficiaries of development has been translated into concrete action. As previously discussed, there are a number of benchmarks, including the adoption of an international

convention on the rights of persons with disabilities, the disability-inclusion in the global development agenda, their processes, mechanisms, and monitoring and evaluation, including the 2030 Agenda for Sustainable Development.

“Persons with disabilities as beneficiaries and agents of change in society and development” – the central message of the work of the UN in disability³⁵ is therefore taking increasingly concrete forms in global, regional, and national development agendas. Persons with disabilities are advocating for their rights to actively participate and lead the communities they live. Nonetheless, persons with disabilities still face great many challenges for their full and equal participation in society and development. With the realization of the 2030 development agenda by, for and with persons with disabilities, the international community has an extraordinary opportunity to create an inclusive, accessible and sustainable world, which brings peace and prosperity for all.

Chapter II. Realizing the Sustainable Development Goals for persons with disabilities

Disability has been included in various targets and as a cross-cutting issue in the 2030 Agenda. Efforts need to be stepped up to ensure that the goals and targets will be achieved for persons with disabilities too, in line with the CRPD. This chapter reflects on overall progress towards the SDGs from the perspective of persons with disabilities. In particular, the following SDGs are addressed in detail in the following sections of this chapter: poverty and hunger (SDGs 1 and 2), health and well-being (SDG 3), sexual and reproductive health and reproductive rights (SDGs 3.7 and 5.6), education (SDG 4), gender equality and empowerment of women and girls with disabilities (SDG 5), availability of water and sanitation (SDG 6), access to energy (SDG 7), employment and decent work (SDG 8), access to ICT (SDG 9.c), inequality (SDG 10), inclusive cities and human settlements (SDG 11), disasters, environmental shocks and climate change (SDGs 1.5, 11.5 and 13) and finally inclusive societies and institutions, representative decision-making and access to justice and to information (SDG 16). These sections provide an overview of the selected SDGs from a disability perspective, discussing relevant international normative frameworks, current situation of persons with disabilities, current practices highlighting good practices, with the aim of informing the implementation of the 2030 Agenda for persons with disabilities.

A. Ending poverty and hunger for all persons with disabilities (SDGs 1 and 2)

This section reflects on the situation of persons with disabilities with respect to poverty and hunger, in line with SDGs 1 and 2. SDG 1 makes a call “to end poverty in all its forms” and SDG 2 “to achieve zero hunger”. This section presents various international normative frameworks on poverty, hunger and disability, provides an overview of the situation of persons with disabilities vis-à-vis SDGs 1 and 2 and discusses national policies and good practices in these areas. The section includes recommendations for achieving these two SDGs for persons with disabilities.

The section focuses on selected SDG 1 and SDG 2 targets relevant for persons with disabilities: reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions (1.2); end hunger and ensure access by all people to safe, nutritious and sufficient food all year round (2.1); implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable (1.3); ensure access to financial services, in particular to the vulnerable (1.4).

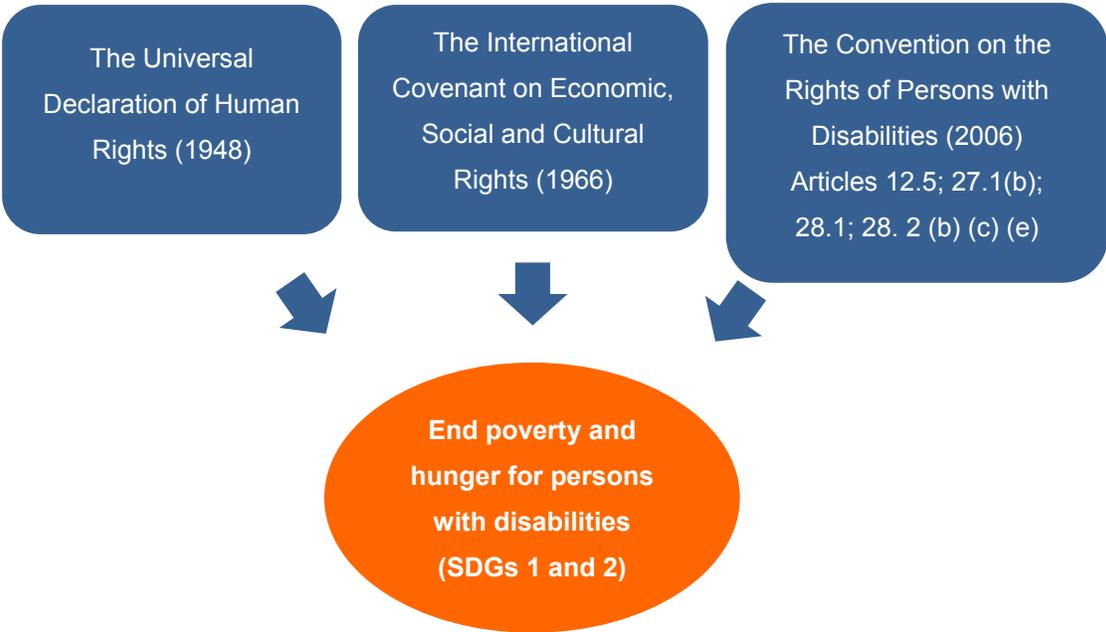
Achieving these targets for persons with disabilities remains a path full of obstacles. Persons with disabilities face physical or social, economic and environmental barriers to participation, which may lead to poverty and hunger. For instance, lack of accessibility of the physical environment and discrimination may prevent persons with disabilities from entering the school system, restricting their skills, knowledge and future ability to perform labour and produce economic value. Those same barriers may prevent persons with disabilities from entering the labour market, or may limit the kind and amount of work they can do, lowering their incomes. In addition, increased expenditures related to disability may have an adverse impact on financial resources and push persons with disabilities into poverty. Though social protection schemes can help alleviate poverty, persons with disabilities encounter various barriers in accessing social protection programmes.³⁶ These barriers include lack of accessible information provided to persons with disabilities about social protection programmes and how to apply for them, absence of the requisite documentation, limited accessibility of grant offices to persons with disabilities and pervasive discrimination by grant offices, in particular, towards those with mental disabilities, as well as the lack of clarity in the disability evaluation process.³⁷

International normative frameworks on poverty, hunger and disability

The eradication of poverty and hunger are key commitments of the SDGs, reflected in SDGs 1 and 2. SDG 1 commits “to end poverty in all its forms” and SDG 2 “to achieve zero hunger”. The universality of these goals covers all, including persons with disabilities. Although there are no direct references to disability in Goals 1 and 2, indicator 1.3.1 measures the proportion of population covered by social protection floors/systems, by sex, distinguishing persons with disabilities, amongst others.

The international normative framework on disability and development, consisting of CRPD and other international instruments, also includes provisions/references concerning poverty, hunger and social protection for persons with disabilities (Figure II.1). Poverty among persons with disabilities is a key concern in the CRPD and disability-specific legislation. Article 28 of the CRPD calls on States Parties: ‘to ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes’. CRPD emphasizes equality in social and economic dimensions, including equal remuneration for work of equal value (Article 27.1(b)) and equal access to retirement benefits and programmes (Article 28.2 (e)). CRPD also stresses autonomy the right for persons with disabilities to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit (Article 12, paragraph 5), and rights to an adequate standard of living and social protection (Articles 28 , paragraph 1, and , paragraph 2 (b)(c)) and also connects with SDG 2 through provisions for adequate food, standard of living (Article 28.1), and land control (Articles 12, paragraph 5). Other international human rights instruments contain provisions concerning the right to social protection of persons with disabilities. For example, the Universal Declaration of Human Rights (1948)³⁸ and the International Covenant on Economic, Social and Cultural Rights (1966)³⁹ contain a general recognition of this right.

Figure II.1. International normative frameworks relevant for the achievement of SDGs 1 and 2 for persons with disabilities.



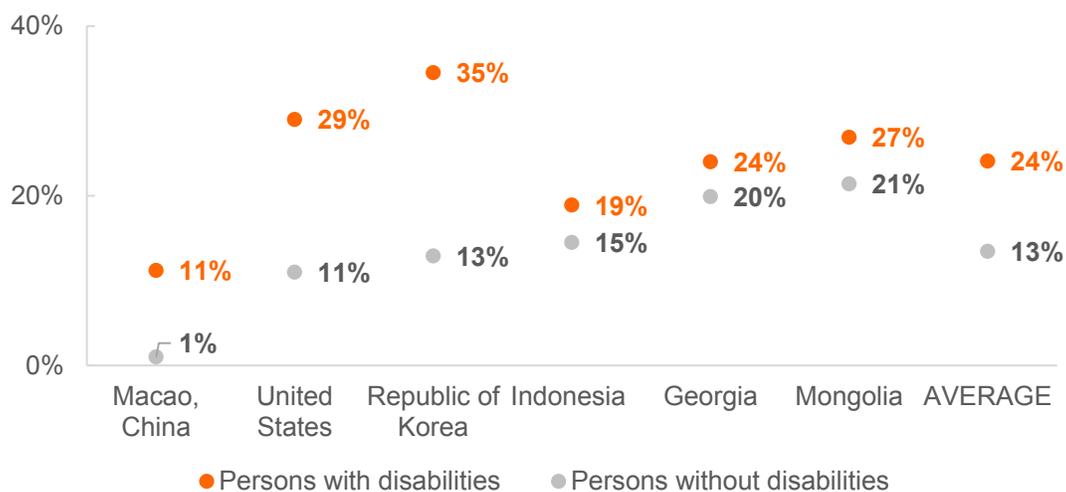
The situation of persons with disabilities concerning poverty, hunger and nutrition

Poverty

Persons with disabilities, and their households, are more likely to live in poverty. The evidence is based on hunger indicators, traditional poverty indicators (income, household expenditures, asset ownership), and multidimensional poverty, i.e. the experience of multiple deprivations by the same households or individuals.

Regarding the traditional poverty indicators, data from 2011-2016 for six countries and areas, showed that a higher percentage of persons with disabilities was living under the national poverty line;⁴⁰ in some countries the difference reached 22 percentage points (Figure II.2). Using international poverty lines, persons with disabilities were more likely to be poor in 3 countries in 2010-2011 (Figure II.3), with the highest gap between persons with and without disabilities being 12 percentage points in Uganda.

Figure II.2. Percentage of persons with and without disabilities living under the national poverty line, in 6 countries, in 2011-2016.



Source: UNESCAP (2018)⁴¹ and Brucker et al (2014).^{42,43}

Figure II.3. Percentage of households with and without persons with disabilities living under the international poverty line (US\$1.90 a day), in 3 countries, in 2010-2011.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions. An asterisk (*) indicates that the difference is statistically significant at 10% or less.

Source: Mitra (2018).⁴⁴

For high-income countries, the evidence in figures Figure II.2 and Figure II.3 is consistent with other studies suggesting that persons with disabilities are more likely to be income poor.^{45,46,47} In lower and middle-income countries, in some studies point to higher poverty rates among persons with disabilities, in line with the national poverty rates in Figure II.2 and Figure II.3, but others did not find a clear association between disability and poverty. For instance, several studies show that households with disabilities have fewer assets and worse living conditions compared to other households;⁴⁸ or a higher prevalence in lower asset quintiles;^{49,50,51} or that households with disabilities have lower expenditures than households without.^{52,53} However, other studies found no significant association^{54,55} or varied results across countries.⁵⁶ In lower and middle-income countries, due to the variability of income over time and the difficulty of measuring it for workers in the informal sector, poverty is often measured through assets/living conditions or consumption expenditures. It is, however, problematic to use household expenditures to assess the well-being of households with disabilities, as they may reflect additional expenditures associated with a disability (see Box 1).

The poverty gap between persons with and without disabilities is not necessarily uniform, even within a country. For instance, data from the 2006 Vietnam Household Living Standards Survey (see Box 1) showed that, there was a very small gap in some districts, but a very large one in other districts. Further analysis found that the gaps were the largest in districts with the poorest infrastructure and least access to health

care services, suggesting that improvements in the environment and in-service delivery have the potential to narrow the poverty gap between persons with and without disabilities.⁵⁷

Apart from the association with income poverty, several studies have also found that disability is associated with a higher likelihood of experiencing multiple deprivations, also referred to as multidimensional poverty.⁵⁸ Figure II.4 shows estimates of the multidimensional poverty headcounts for 22 countries. A multidimensional poverty gap between persons with and without disabilities is found in all countries and is the largest in Uganda with a headcount of 90% for persons with disabilities and 57% for persons without disabilities. While disability is correlated with the experience of multidimensional poverty, the very nature of deprivations may vary across countries. For instance, it could be in terms of employment and health care access in one country, but in terms of educational attainment and living conditions in another.

Box 1. Addressing common pitfalls in income poverty indicators to assess poverty among persons with disabilities – a case study from Vietnam

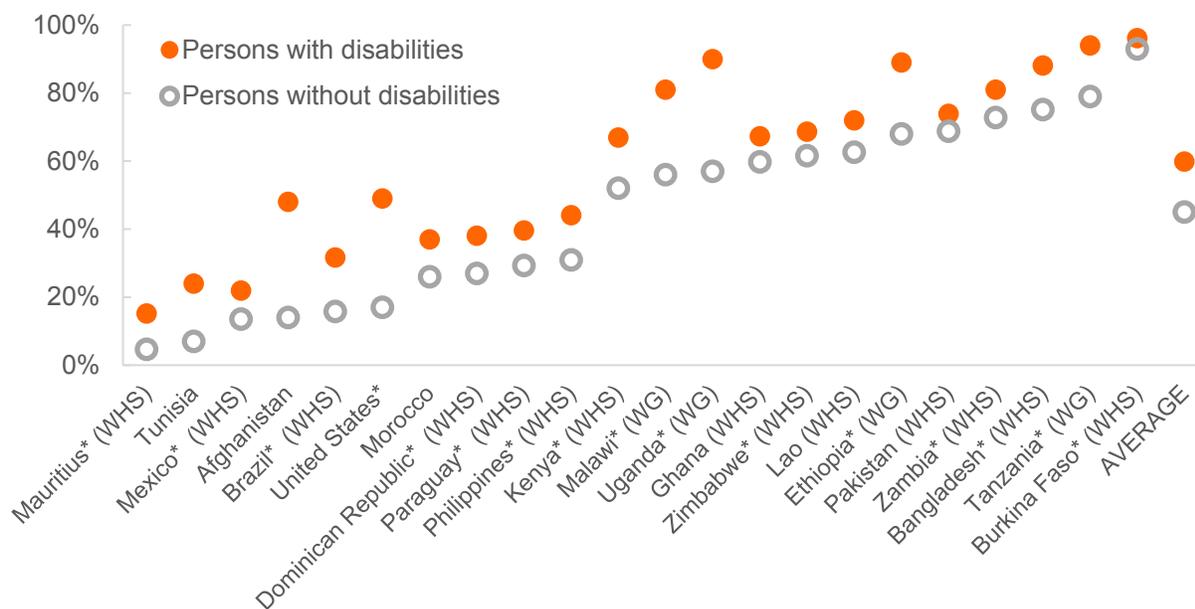
Consumption-based measures, which assume that the less one consumes the poorer one is, are typically used to assess poverty in developing countries. However, a case study from Vietnam shows the importance of digging below the surface when using these measures to assess poverty among persons with disabilities. Data from the 2006 Vietnam Household Living Standards Survey showed that 17% of persons with disabilities were poor compared to 15% of persons without disabilities, revealing a modest poverty gap. However, that assumes that the poverty line for persons with and without disabilities is the same, when in fact persons with disabilities face extra costs of living due to higher medical bills, cost of assistive technology or special transport. With this additional consumption persons with disabilities will seem wealthier than they are. When the poverty line was adjusted for estimating of these costs, the poverty rate for persons with disabilities rose to 23%.

However, even this adjustment did not capture the complexity of the situation. The timing of the onset of disability can also have an important impact on poverty. The effect of disability on poverty with an onset in old age, after people have received their education and spent years generating a livelihood, may not be as large as when a disability occurs earlier in life. In fact, while the poverty rate for Vietnamese aged 19-40 without disabilities was also 15%, the rate for their peers with disabilities was 25%, which rose to 31% once extra costs were accounted for.

Consumption-based poverty indicators need to account for extra costs related to disability and disaggregate by age in order to provide a more accurate assessment of poverty among persons with disabilities and inform poverty-reduction policies adequately.

Source: Mont and Nguyen (2017).⁵⁹

Figure II.4. Multidimensional poverty rates,⁶⁰ for persons with and without disabilities, in 22 countries, in 2002-2014.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions; (WHS) identifies countries with data collected using the World Health Survey. An asterisk * indicates that the difference is statistically significant at 5% or less. Data from Morocco and Tunisia were carried out in selected geographical regions in each country; data from Ethiopia is representative of rural areas and small towns.

Source: Brucker et al (2014);⁴² Mitra et al (2013);⁶¹ Mitra (2018);⁴⁴ Trani et al (2015);⁶² Trani et al (2016).^{63,64}

Extra costs associated with disability

Persons with disabilities bear costs associated with health care, transportation, personal assistance or assistive devices, modified residences, etc.⁶⁵ The result is that two households with the same level of consumption (or income) – one with a member with a disability and one without – are not enjoying the same standard of living due to the extra costs associated with disability for persons with disabilities.

Table II. 1 presents the estimated costs of living with a disability in 8 countries. Such additional costs are sizeable, especially for severe disabilities. Smaller sized households tend also to be more affected as the costs relative to the household income tend to be higher.⁶⁶ While the estimated costs of living with a moderate disability range from 21 to 40% of average income, and from 39 to 70% for a severe disability, a rough estimate would be that having a moderate disability increases the cost of living by about a third of

average income, and having a severe disability increases the cost of living by more than 40% of average income.

Table II. 1. Estimates of the extra costs associated with disability, by degree of disability, in 8 countries, in 1998-2008.

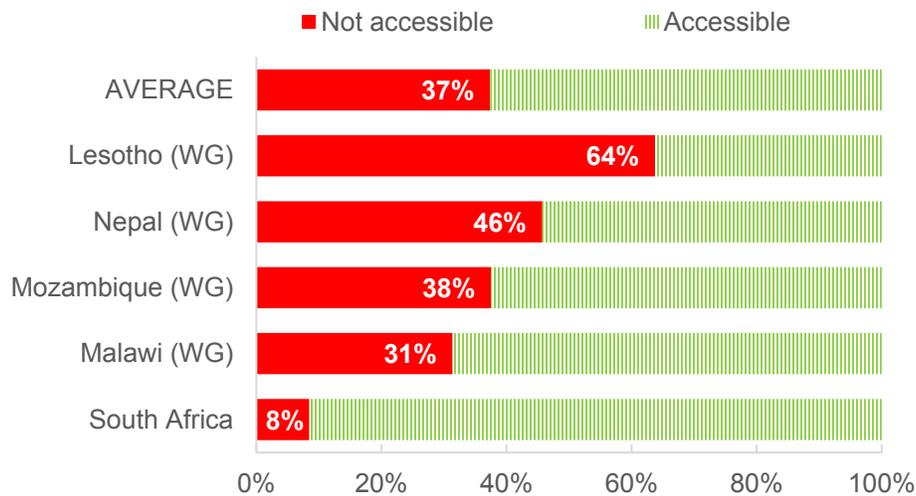
Country	Year	Extra costs associated with disability as percentage of average income		
		Any disability	Moderate disability	Severe disability
Australia ⁶⁷	1998–1999	29%	30%	40%
Bosnia and Herzegovina ⁶⁸	2001-2004	14%	-	-
China ⁶⁹	2006	8% to 43% (adults); 18% to 31% (children)	-	-
Ireland ⁷⁰	2001	40% (adults aged 65 and over)	-	-
Spain ⁷¹	2007	-	40%	70%
UK ⁷²	2007-2008	-	21%	39%
Vietnam ⁷³	2006	12%	-	-

Access to financial services

Access to financial services has been recognized as key to lift people out of poverty. Without a bank account, for instance, individuals often face higher costs for conducting financial transactions through other alternative financial service providers. Such individuals find it more difficult to save and plan financially for the future, leaving them more vulnerable to medical or job emergencies that may endanger their financial stability. The lack of longer-term savings undermines their ability to improve skills, purchase a home, or pay for the education of their children.

Financial services are not always accessible for persons with disabilities. Banks may not be physically accessible and online financial services may not be virtually accessible. For instance, in five developing countries, between 8 and 64% of persons with disabilities consider that banks are not accessible (Figure II.5). Crowd-sourced data mostly from developed countries indicated that as of 2017, 28% of banks and 12% of ATMs were not accessible for persons with wheelchairs.^{74,75}

Figure II.5. Percentage of persons with disabilities who consider banks are not accessible, in 5 countries, around 2011.



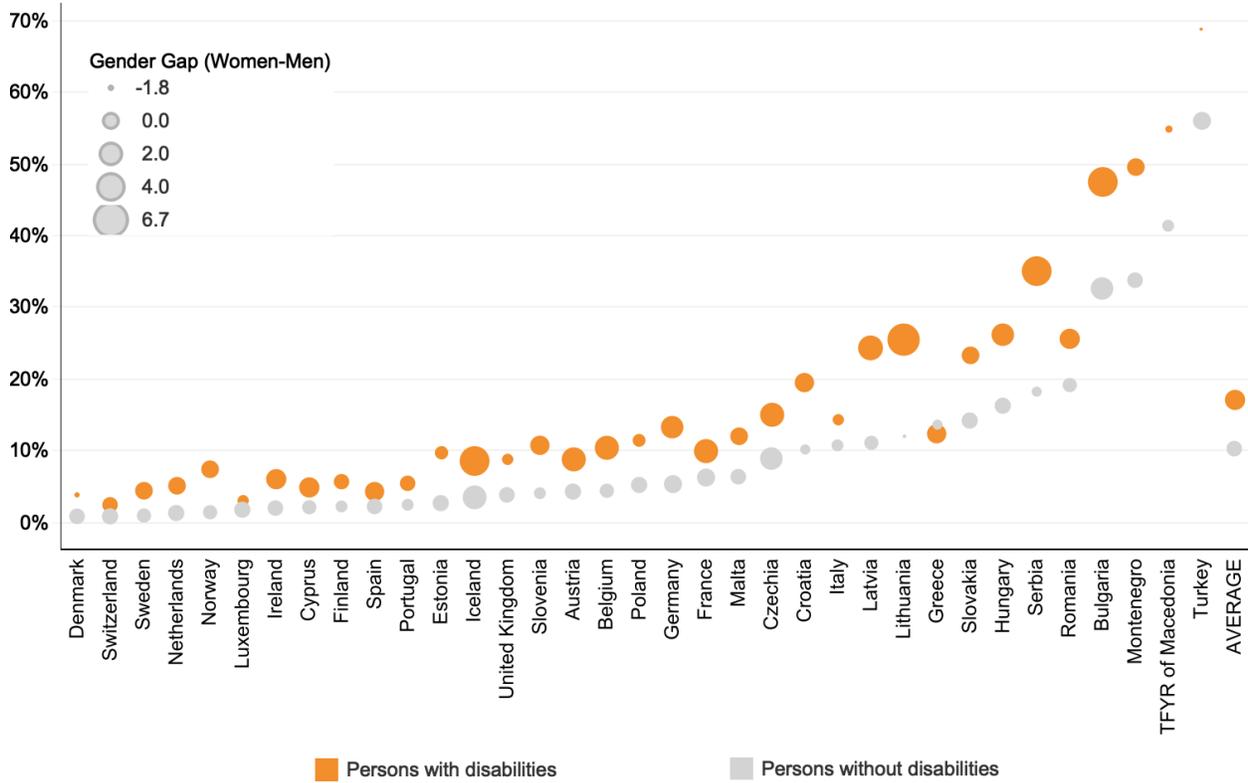
Note: (WG) indicates surveys that used the Washington Group short set of questions. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF surveys on the living conditions of persons with disabilities.⁷⁶

Hunger and nutrition

Persons with disabilities are more likely to live in food insecure households.^{42,77} In 34 out of 35 countries, mostly in Europe, the inability to afford a meal with protein – i.e. meat, chicken, fish or vegetarian equivalent – every second day was higher among persons with disabilities than among persons without disabilities (Figure II.6). On average, the percentage of persons with disabilities who are unable to afford such a meal is almost double, 17% as compared to 10% for persons without disabilities. In 27 countries, more women than men with disabilities had this challenge. The gender gap between women and men is wider among persons with disabilities – gap up to 7 percentage points - than among persons without disabilities – gap up to 3 percentage points. Other evidence, from 8 countries, around 2012, shows that persons with disabilities and their households are more likely to not always have food to eat, than persons without disabilities and their households (Figure II.7). Children and youth with disabilities are also less likely to benefit from school-based malnutrition reduction efforts because they are less likely to attend school than their peers without disabilities.⁷⁸

Figure II.6. Inability to afford a meal with meat, chicken, fish or vegetarian equivalent every second day for persons aged 16 and over with and without disabilities⁷⁹, in 35 countries, in 2016.⁸⁰



Source: Eurostat.⁸¹

Figure II.7. Percentage of persons or households who did not always have food to eat, by disability status, in 8 countries, around 2012.



Note: (WG) indicates surveys that used the Washington Group short set of questions. Data from the United States refer to percentage of persons; all other data refers to percentage of households. Data from Botswana, Eswatini and Lesotho refer to the experience of the household in the past two weeks; all other data refer to the past 12 months.

Source: Brucker et al (2014),⁴² Mitra (2018)⁸² and SINTEF.⁹

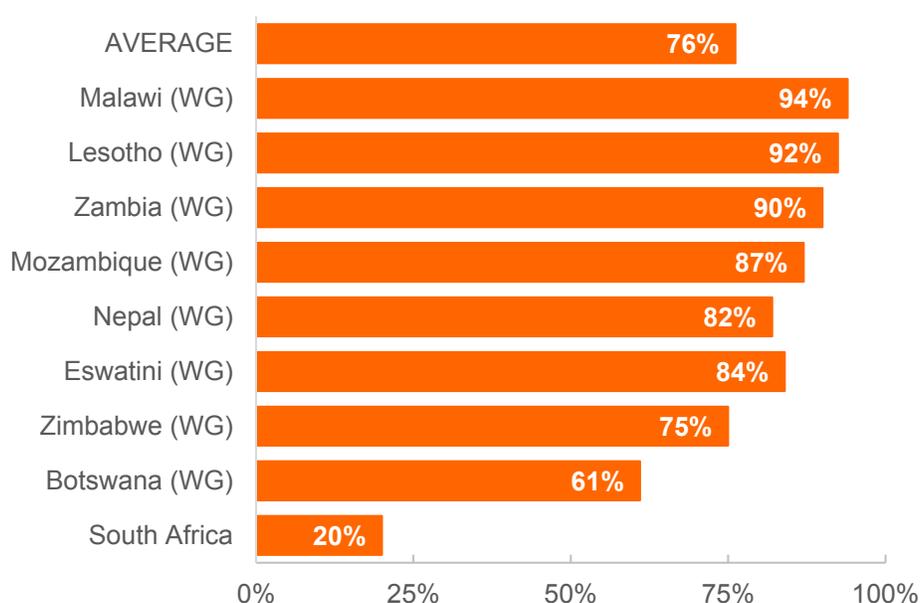
Access to social protection

Although the need for social protection programs tends to be higher among persons with disabilities compared to the general population, this is not always matched by higher enrolment.⁸³ A recent global estimate suggested that, as of 2016, only 27% of persons with severe disabilities collected disability social protection benefits.⁸⁴ Evidence from nine developing countries indicated that, on average, among persons with disabilities who needed welfare services, 76% of them were not able to receive these services (Figure II.8). In Asia and Pacific countries, the coverage of disability specific countries varies widely, with some countries having almost universal coverage for persons with disabilities and other countries have no coverage at all.^{85,86}

Access to social protection programs, even disability-targeted ones, has been shown to be restricted by a variety of barriers.⁸⁷ Persons with disabilities are not always informed of social protection programs in their area and benefit packages offered may not be adapted to their needs.⁸⁸ For those aware of such programs, other barriers may prevent them from enrolling. A study conducted in the poorest areas of Johannesburg showed that only 41% of the sample of persons with disabilities were receiving the disability grant, although

71% were aware of it.³⁷ Reasons provided for not receiving the grant vary from not knowing how to apply, absence of documentation, lack of accessibility of grant offices, lack of clarity in the disability evaluation process and prejudice of staff at the grant offices towards certain types of disabilities, particularly mental illness. The disability grant was used in 50% of the cases to cover essential needs (food, healthcare, water and electricity). In some countries, unclear disability eligibility criteria have also been shown to be a barrier to programme participation.⁸⁹

Figure II.8. Percentage of persons with disabilities who needed but did not receive welfare services, in 9 countries, around 2012.



Note: (WG) indicates surveys that used the Washington Group short set of questions. Data from Lesotho is based on 25 to 49 observations and should be interpreted with caution. Data from South Africa was collected in selected regions and is not nationally representative.

Source: SINTEF.⁹

Current practices on addressing poverty and hunger among persons with disabilities

Many countries attempt to reduce poverty and eliminate hunger among persons with disabilities through direct policies and programmes, in particular, social protection schemes, or indirect measures that empower individuals with disabilities with the skills to move out of poverty. This includes promoting inclusive education

and access to the labour market through for example policies on non-discrimination and reasonable accommodation at the workplace. Indeed, policies and programmes promoting inclusion of persons with disabilities are likely to have a positive impact on the well-being and standard of living of persons with disabilities, and are discussed in other chapters in this report, for other SDGs. This section will focus only on two direct measures: social protection schemes and community-based rehabilitation.

Social protection schemes help manage and alleviate situations that adversely affect a person's well-being. Disability-targeted benefits have demonstrated effectiveness in helping the household meeting basic needs.⁹⁰ For instance, a study in Johannesburg, South Africa, showed that the disability grant was used in 50% of the cases to cover essential needs (food, healthcare, water and electricity).³⁷

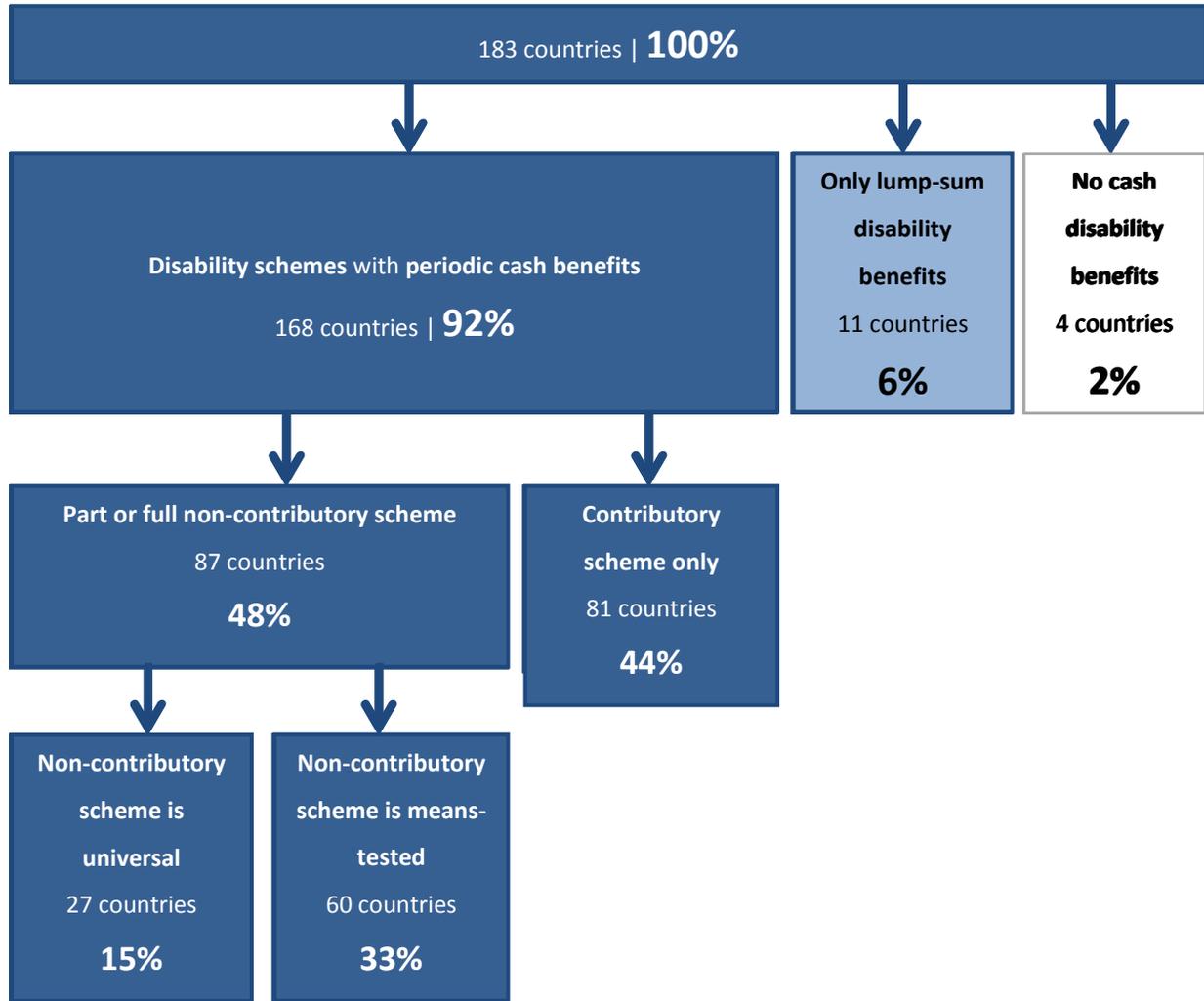
Since the 1960s, more and more countries have adopted social protection programmes for persons with disabilities, reaching 179 out of 183 countries in 2012-13 (Figure II.9). In 168 countries, disability schemes provide *periodic* cash benefits to persons with disabilities, while in another 11 countries there are only lump-sum benefits. In 81 countries, benefits mainly cover workers and their families in the formal economy and thus leave out children with disabilities and persons with disabilities who did not have the opportunity to contribute to social insurance long enough to be eligible to benefits. However, 87 countries use fully or partially tax financed schemes and thus have improved coverage. In 27 countries, schemes cover all persons with assessed disabilities without regard to their income status; in 60 countries, they protect only persons or households whose economic means fall below a certain threshold.⁹¹ Disability benefits tend to be lower than the average wage of a fulltime employee, as well as lower than old-age pensions and unemployment benefits. In countries for which data are available, disability benefits vary from 2% to 51% of GDP per capita.⁹²

There are schemes financed by social security who support participation of persons with disabilities in the labour force by financing vocational rehabilitation and training if the person needs to learn a new job or has to acquire new skills to do their previous job, thus contributing to progress towards SDG 1 and SDG 8. Malaysia for example has such a scheme.⁹³ The problem with these schemes is that they do not cover persons who already have a disability or are not covered by social security.

Community Based Rehabilitation (CBR) programmes aim to enhance the social inclusion for persons with disabilities and their families while reversing the vicious cycle of poverty and disability.⁹⁴ More recently, in India and Afghanistan, two studies have explored the impact of various components of CBR programs on the well-being of persons with different type of disabilities, both adults and children. They have shown some positive impact of the CBR programs on various outcomes. A study showed that persons with disabilities experienced an improvement in their lives through CBR programs –although of different intensity– in multiple dimensions of quality of life (health, income or employment, inclusion in family and community life) after 4 years and 7 years of programme.⁹⁵ The effects after 4 and 7 years on each dimension are similar which indicates that the CBR programme has major results in a first period that are maintained through

time. Indicators of inclusion keep increasing in the long run and have a spill over effect on those persons with disabilities who chose not to participate in the CBR programme but living in its catchment area, illustrating the complex pattern of sensitization and awareness processes in a given community.

Figure II.9. Overview of cash disability benefit programmes anchored in national legislation, by type of programme and benefit, 2012-2013, in 183 countries.



Source: ILO (2014).⁹⁶

Conclusions and the way forward

Affirming the current assumption, a growing body of research studies has demonstrated that persons with disabilities and their families are more likely to be subjected to hunger and poverty. Persons with disabilities, particularly those with severe disabilities that require a higher level of care and support, are more likely to be economically vulnerable. In addition, persons with disabilities are more likely to live in food insecure households, especially women with disabilities. Social protection programmes could help overcome these situations, but the coverage of persons with disabilities is limited due to lack of awareness about social protection, lack of accessibility of and discrimination by grant offices, amongst others. Many countries have social protection schemes through contributory disability benefit programs that are restricted to those who worked in the formal economy, and non-contributory programmes open to all persons with disabilities remain limited. To eradicate poverty and end hunger for persons with disabilities, a number of actions should be considered:

- 1) Design social protection policies and programmes that include persons with disabilities.** Implement social protection schemes, including floors, available to cover persons with disabilities and ensuring adequate income security. Implement disability-specific schemes that effectively address disability-related additional costs (for example, assistive devices, personal care, rehabilitation). These schemes should be accessible to persons with disabilities and promote greater participation, autonomy and choice by persons with disabilities themselves. Moreover, these programmes should advance the participation of persons with disabilities in the labour force by supporting and financing training and rehabilitation services needed for persons with disabilities to work. This support should be available for persons with disabilities who have previously worked and not worked.
- 2) Remove barriers and obstacles that persons with disabilities face in accessing and fully benefiting from social protection on an equal basis with others.** Public facilities, transportation and banks, information on social protection programmes including application processes and procedures should be made available and accessible to persons with disabilities.
- 3) Sensitize the personnel of grant offices about the barriers experienced by persons with disabilities to access social protection (discrimination, lack of accessibility of grant offices, etc.), and approaches to overcome these barriers.** Improve service delivery for persons with disabilities through training programmes for such sensitization. Integrate the rights of persons with disabilities and their well-being and perspectives into the training materials and curriculum for the personnel working at grant offices, including the possibility of engaging persons with disabilities. Develop strategies for improving

disability-inclusive service delivery to ensure that persons with disabilities can access and maximize their social benefits.

4) Improve access to banking and other financial services, including mobile banking, and ensure accessibility for persons with disabilities in overall financial services. Physical barriers, travel barriers or time restrictions can represent serious obstacles for persons with disabilities for their financial inclusion. Digital technology has the potential to be a great equalizer. Mobile financial services are a convenient “anytime, anyplace” option. But if that technology is not accessible, it only further excludes people with disabilities from engaging. To remove barriers, financial service institutions can build websites and mobile apps that follow Web Content Accessibility Guidelines (WCAG) 2.0.

5) Disaggregate data on poverty and hunger by disability status to better inform national policies concerning poverty and hunger, including social protection schemes. The Multidimensional Poverty Index (MPI) and SDG indicators on poverty and hunger should be disaggregated based on disability status.

6) Establish national monitoring and evaluation systems that periodically assess all social protection programmes regarding inclusion and positive impact on the situation of persons with disabilities. The development of social protection programmes for persons with disabilities should be guided by solid evidence and information on the situations of persons with disabilities, their standard of life and well-being, as well as information on the barriers to access the programmes and their impact on the ability of persons with disabilities to participate in society.

B. Ensure healthy lives and promote well-being for all persons with disabilities (SDG3)

This section discusses the implementation of SDG 3 through the lens of disability. SDG 3 call for ensuring health lives and promote well-being for all. To establish an evidence-base to guide the achievement of this goal, this chapter provides an overview of the situation of persons with disability, as well as a review of national and international efforts to promote the implementation of SDG 3 in line with the CRPD.

The highest attainable standard of health and well-being is a precondition for a full and productive life for persons with disabilities because one's health and well-being affects the ability to participate fully in work, in education and in the community. This section is mainly focusing on health in line with SDG 3 target 3.4, which focuses on well-being, in particular on mental health and well-being. Assessing well-being remains elusive (see Box 2), and even more so for persons with disabilities for which data is scarcer.

To achieve a standard of health, access to good quality, effective and affordable health care services is essential. Access is still a challenge due to numerous barriers including availability, accessibility and affordability of the full range of quality health care services, limitations on health insurance as well as attitudinal barriers and stigma arising from health care personnel not properly trained to deliver health care to persons with disabilities. For instance, people with sensory or mobility impairments encounter physical obstacles to health care, including inaccessible diagnostic equipment and facilities. Healthcare professionals may not consider the impact of impairments when they provide health care. Persons with disabilities may be prevented from accessing health care because of discriminatory practices and policies, lack of access to information, and private or public insurance schemes may limit the availability of coverage for pre-existing conditions.

International normative framework on health and disability

The 2030 Agenda for Sustainable Development in its SDG 3 calls for healthy lives and well-being for all, implicitly establishing the goal for persons with disabilities. This aligns with other international normative frameworks responding to the need to secure access by persons with disabilities to health care services, from the first Declaration on the Rights of Disabled Persons in 1975 calling for assuring welfare and rehabilitation⁹⁷ and the World Programme of Action Concerning Disabled Persons in 1982 focusing on enhancing rehabilitation and equalization of opportunities in health services,⁹⁸ to the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, in 1993, emphasizing the need to ensuring the provision of health services for persons with disabilities.⁹⁹ The CRPD, adopted in 2006, is a legally binding international treaty with respect to disability and must be read as a whole to fully understand the impact of its rights and development approach to persons with disabilities in the domain of health. In addition to Article 25 which reaffirms the right for persons with disabilities to enjoy the highest standard of health,

there are other Articles addressing enhanced participation in work, employment, in economic, community and political life – in short, full social participation and inclusion – which have an impact on a person’s state of health. In addition, Article 26 on rehabilitation and habilitation should be considered with Article 25 on health, since rehabilitation is part of universal health coverage (UHC)¹⁰⁰ and refers to mainstreamed services provided along with health promotion, treatment and palliative services¹⁰¹ to anyone who needs them. CRPD Article 25 calls for access to free or affordable health services for persons with disabilities, on an equal basis with others, and further requires that health professionals provide care on the basis of free and informed consent. Article 25 also requires the removal of discriminatory barriers that prevent full access to health care services, including prohibition of discriminatory practices in health insurance and preventing denial of health care on the basis of disability. In addition, Article 9 asks States Parties to take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to medical facilities and further clarifies that these measures shall include the identification and elimination of obstacles and barriers to accessibility in these facilities.

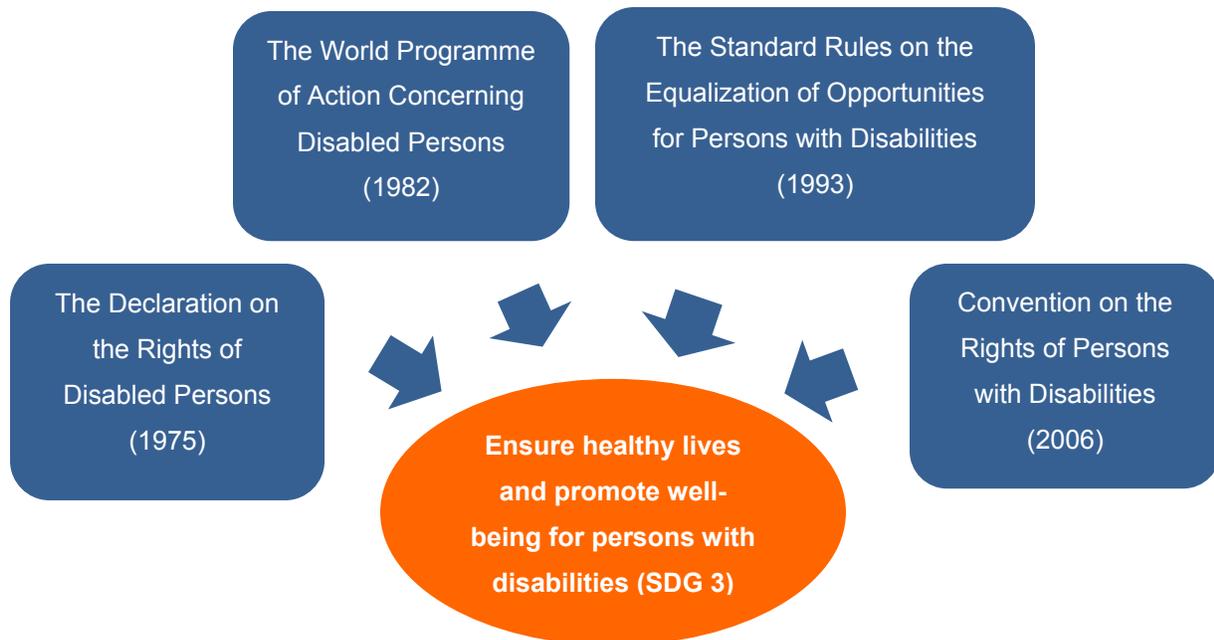
Box 2. What is health and well-being?

The World Health Organization defined health, in its 1948 Constitution, as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The definition made the point that health has social as well as physical and psychological dimensions and suggested that the ultimate goal is not just better health but also increased wellbeing. Health does not equate with wellbeing, but health is both an intrinsic component of wellbeing and a determinant of wellbeing.

The current consensus on the conceptualization of wellbeing, or ‘subjective wellbeing’ as it is also called, relies on two perspectives: (i) one perspective emphasizes the direct experience of pleasure or positive emotions (ii) the other is often expressed in terms of the extent to which an individual has realized one’s talents and potentialities or discovered the purpose in life. As both of these perspectives are subjective, information about subjective wellbeing can only come through self-report from individuals. A considerable body of literature now exists operationalizing the measurement of this construct and the use of this information in informing policy.

Additionally, wellbeing can also be inferred by measuring things that make a life go well, such as income, family life, education, and health. Strictly speaking these objectively good things in life are determinants of subjective wellbeing. The fact, however, that these objective conditions are easier to collect data about, and measure, has made them popular in wellbeing research.

Figure II.10. International normative frameworks relevant for the achievement of SDG 3 for persons with disabilities.



SDG 3 on health needs to be interpreted in alignment with other SDGs because of their impact on health. This is because the determinants of health are an integral part of many other goals. A person’s state of health is determined by features of the social environment -- poverty (SDG 1), hunger (SDG2), education (SDG 4), work (SDG 8) and gender (SDG 5) and economic inequality (SDG 10) and peace (SDG 16) -- and the physical environment -- clean water and sanitation (SDG 6), energy (SDG 7) and climate (SDG 13). The health of persons with disabilities, like everyone’s health, is affected by these determinants. Moreover, all of the specified targets of SDG 3 are relevant to everyone both persons with and without disabilities. Target 3.8 concerning UHC is of notable importance, because it is the primary mechanism for achieving other SDG 3 targets and because persons with disabilities tend to have less access to health care.

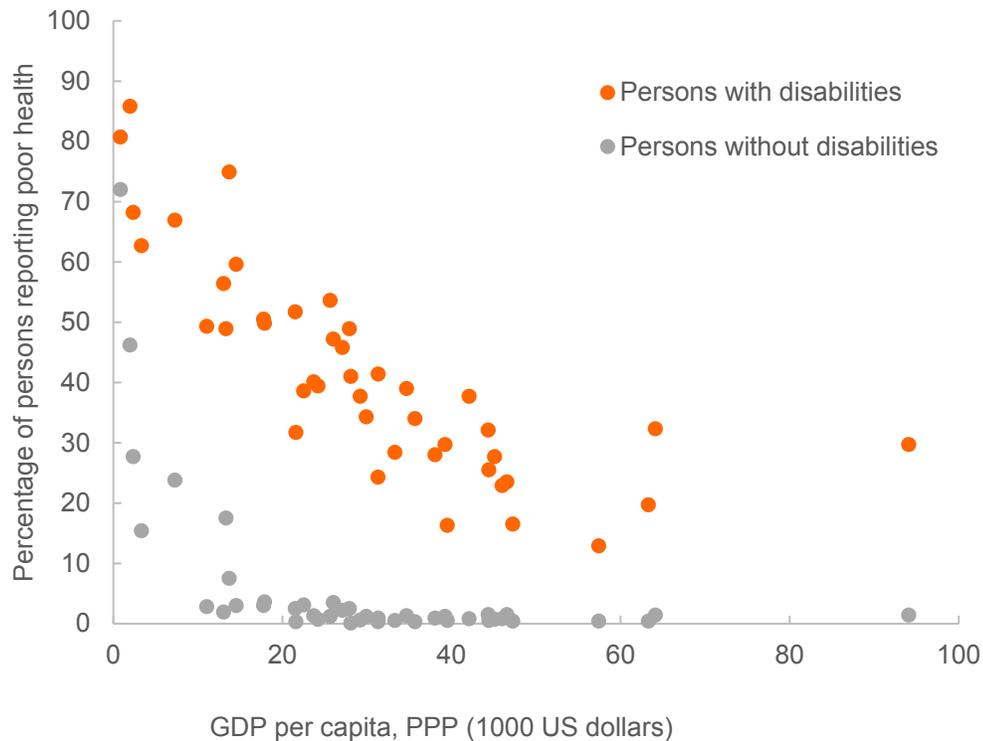
The situation of persons with disabilities: health status and access to health services

Persons with disabilities are more likely to have poor health and poor mental health and well-being

Persons with disabilities have shorter life expectancy and are at greater risk of developing secondary, co-morbid and age-related health conditions, such as depression, pain and osteoporosis.^{102,103, 104} In Uganda, for example, the age-adjusted odds of dying within two years for women with severe disabilities are 26

times those of women without.¹⁰⁵ People with mental or psychosocial disorders have an increased risk of all-cause mortality compared with the general population.¹⁰⁶

Figure II.11. Percentage of persons who report poor health versus GDP per capita, by disability status, in 43 countries, around 2013.



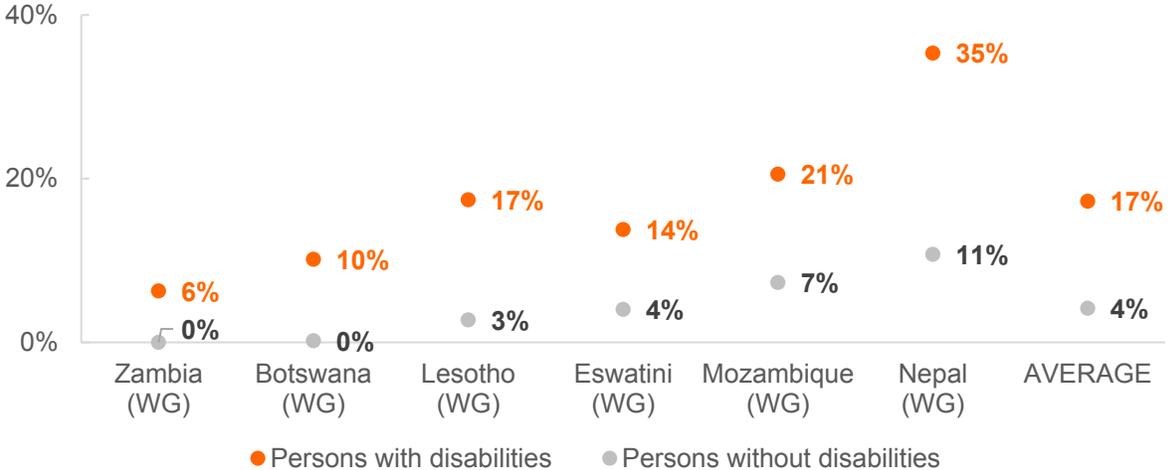
Source: Eurostat,⁸¹ SINTEF⁹, WHO¹⁰⁷ and World Bank.^{108,109}

In 43 countries, around 2013, health was self-perceived as very good or good by an average of 21% of persons with disabilities as compared to 80% of persons without disabilities.^{110,111,112} Relatedly, 42% of persons with disabilities perceived their health as poor or very poor as compared to 6% persons without disabilities. Persons with disabilities report poorer health than persons without disabilities in all 43 countries. Women with disabilities are more likely to report poorer health than men with disabilities. Persons with disabilities tend to report poorer health in countries with lower gross domestic product (GDP) per capita (Figure II.11). In countries with lower levels of GDP per capita, as many as 80% of persons with disabilities report poor health. In countries with the highest levels of GDP per capita, in which more resources are available, only about 20% of persons with disabilities report poor health.

The association observed in Figure II.11 between having a disability and reporting poor health may be linked to underlying health conditions or environmental barriers such as lack of social support or access to health services. The lower the GDP per capita of a country, the higher the proportion of persons with disabilities who report poor health, suggesting that increased availability of financial resources at national level may provide the accessible health, basic and community services persons with disabilities needed to achieve better health.

Regarding mental health, Figure II.12 shows that in six developing countries the percentage of persons self-assessing their mental health as poor is higher for persons with disabilities than for persons without disabilities. Looking at objective measures of well-being (Box 2), evidence in other sections of this report on poverty, hunger, lack of access to education, and social exclusion suggests that persons with disabilities face barriers which are detrimental to their well-being.

Figure II.12. Percentage of persons who self-assess their mental health as poor, by disability status, in 6 countries, around 2012.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: SINTEF.⁹

Persons with disabilities have more healthcare needs but they are less likely to be able to meet these needs

Persons with disabilities generally have more healthcare needs than others – both standard needs such as immunization, cancer screening and treatment of infections and needs linked to underlying health conditions and impairments. They are not only more susceptible to worsening health,^{113,114} but they are

more frequently in need of healthcare services. Because of this, persons with disabilities are more vulnerable to the impact of low quality or inaccessible healthcare services than others.¹¹⁵ At the same time, since they face greater barriers to accessing services, persons with disabilities consistently have a poorer uptake of both general and specialised healthcare services when they are needed.¹¹⁶

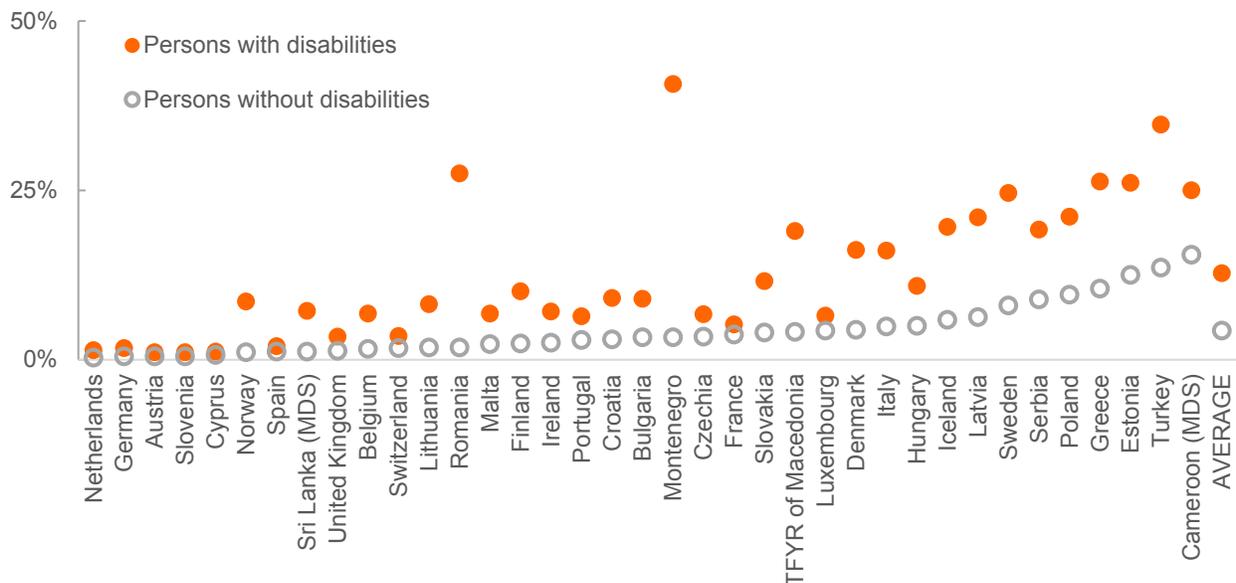
In 37 countries, mostly developed countries, persons with disabilities are on average more than three times as likely as persons without disabilities to be unable to get health care when they need it (

Figure II.13): 13% of persons with disabilities versus 4% of persons without disabilities indicated that they needed but could not get health care. In 9 of these countries, more than 20% of persons with disabilities are not able to get health care when they need it. In another 5 developing countries, between 10 and 40% of persons with disabilities did not receive the health services they knew, or were told they required.^{117, 118, 119, 120, 121} In Guatemala, only 43% and 70% of those needing respectively medical rehabilitation care and specialist health services actually got these services.¹²² Furthermore, persons with more severe disabilities have more difficulties accessing health care. For example, in 2015-2016, in Sri Lanka and Cameroon, the percentage of those underserved in outpatient care¹²³ settings increased with the severity of the disability (Figure II.14). In Cameroon, persons with severe disabilities are twice as likely to have unmet needs for outpatient care; in Sri Lanka they are 12 times as likely. The lack of health care can impact also mothers, new-borns and children with disabilities. In selected areas in Cameroon, in 2013, all women without disabilities aged 15-49 had received antenatal care but 8% of women with disabilities had not; a higher percentage of children and youth with disabilities aged 5 to 17, 12%, had not been vaccinated as opposed to only 7% of children and youth without disabilities.¹²⁴

Rehabilitation services, like physiotherapy, occupational therapy, speech and hearing therapy, are also not always available for persons with disabilities who need them. Data available for 9 countries, around 2011, indicates that on average 64% of persons with disabilities who needed rehabilitation services could not get them, from 28% in South Africa to 82% in Nepal (Figure II.15).

Health service gaps are due to the physical, financial, attitudinal, informational and communication barriers that are faced by persons with disabilities when they try to access healthcare services.¹²⁵ Physical barriers such as inaccessible buildings and medical diagnostic and treatment equipment are often cited as problems; but also, in the broader environment, issues of inaccessible public transport, poorly paved roads and the lack of rural health facilities create obvious obstacles for people with sensory, mobility and cognitive impairments.^{126, 127} When sign language communication is not available, communication barriers between patients with hearing impairments and physicians has also been shown to negatively impact on the quality health care, including less use of preventive services.^{128, 129, 130}

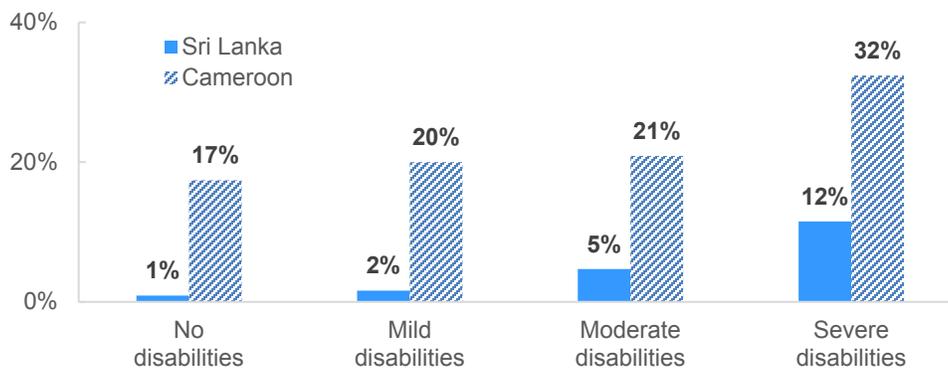
Figure II.13. Percentage of persons who needed but could not get health care, by disability status, in 37 countries, around 2016.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

Source: Eurostat,⁸¹ WHO.¹⁰⁷

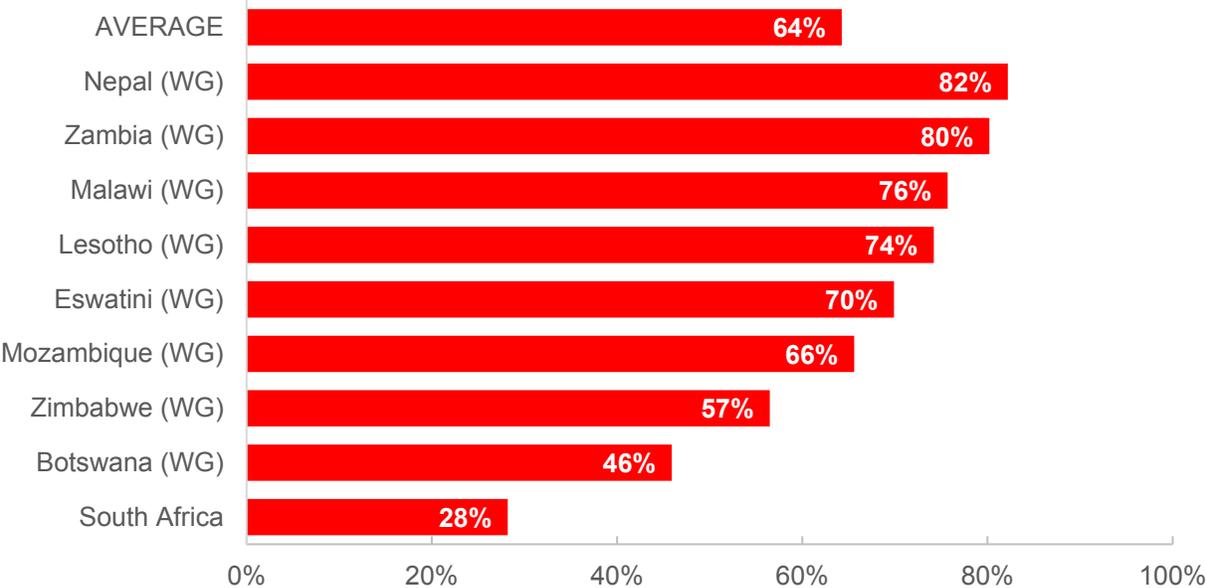
Figure II.14. Percentage of persons with unmet health needs for outpatient care,¹³¹ by severity of disability, in Cameroon (MDS) and Sri Lanka (MDS), in 2015-2016.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

Source: WHO.¹⁰⁷

Figure II.15. Percentage of persons with disabilities who needed but could not receive rehabilitation services, in 9 countries, around 2011.



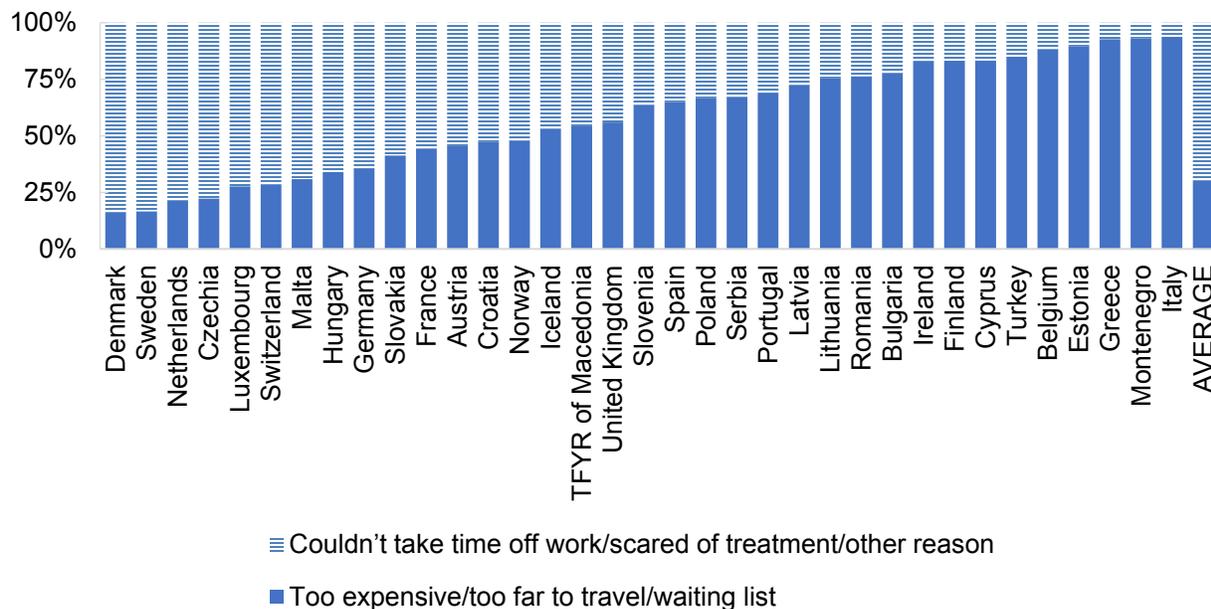
Note: (WG) identifies countries with data collected using the Washington Group short set of questions. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF.⁹

Cost of health care and lack of health insurance are major barriers for persons with disabilities

The reasons for higher unmet health needs for persons with disabilities vary depending on the country context, but in many countries healthcare cost is the major challenge. In 2016, in 35 countries in Europe and Western Asia, among persons with disabilities who needed but could not get health care, on average 30% of them indicated as the reason for not getting care that the care was too expensive, too far or had waiting lists; while 70% indicated they could not take time off work, feared treatment or had other reasons (Figure II.16). However, these averages mask wide variations: in Denmark, the affordability, distance to and waiting lists in health care services are least of a problem: only 16% of persons with disabilities who needed but could not get health care indicated this as the reason. However, other reasons, including inability to take time off work or being scared of treatment, seem to play a bigger role. On the other extreme, in Italy, most persons with disabilities who needed but could not get health care, 94%, indicated that the health care services were too expensive, too distant or with waiting list as the reasons for not getting health care.

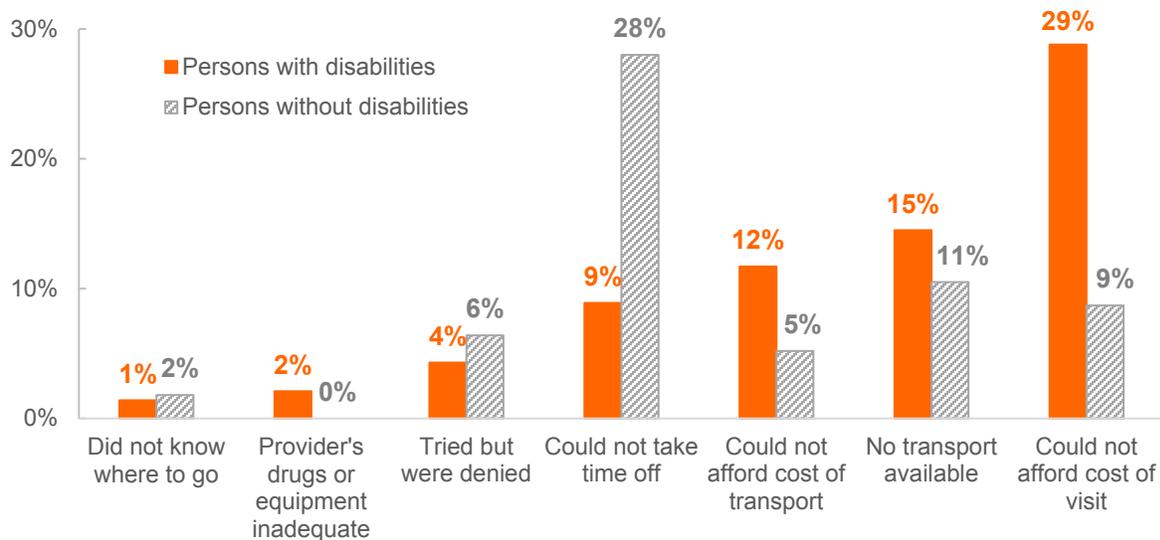
Figure II.16. Percentage of persons with disabilities with unmet health needs, by reason for not getting health care, in 35 countries, around 2016.



Source: Eurostat.⁸¹

In developing countries, lack of ability to pay the cost of health care or inability to get transport to the health care tends to be a major issue for persons with disabilities. In Turkey, 85% of persons with disabilities who needed but could not get health care, indicated affordability, distance to and waiting lists as the barrier (Figure II.16). In Sri Lanka, in 2016, 29% indicated they could not afford the health care service, 12% could not afford the cost of transport to the health facilities and 15% had no transport available to get to the facilities (Figure II.17). The inability to afford the cost of health services is more often a barrier for persons with disabilities. In Sri Lanka, in 2016, 29% of persons with disabilities versus 9% of persons without disabilities were not able to afford the cost of a health care visit. In the same country, 2% of persons with disabilities – as compared to no one without disabilities - indicated that the provider's drugs or equipment were inadequate, illustrating one of the difficulties persons with disabilities may face when they seek treatment. Cost of health care is especially a challenge for persons with more severe disabilities. For instance, in 2015-2016, in Sri Lanka and in selected regions in Cameroon, the most common reason people with severe disabilities gave for not getting health when needed was that they could not afford the cost of the service.¹³²

Figure II.17. Percentage of persons with unmet health needs, by reason for not getting health care, by disability status, in Sri Lanka (MDS), in 2016.

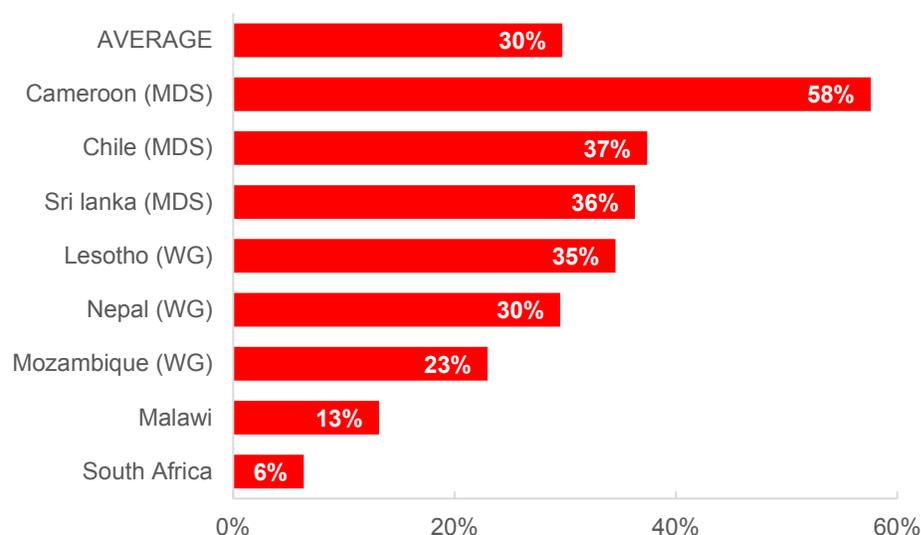


Note: (MDS) identifies countries with data collected using the Model Disability Survey.

Source: WHO.¹⁰⁷

The cost of health services compounded with the unavailability of health insurance prevents persons with disabilities from accessing the health services they need or continuing a course of treatment once it begun. Globally, households with persons with disabilities tend to have higher out-pocket medical expenditures compared to other households.^{133,134,135,136,137,138,139,140} However, these extra expenses are not always covered by available private or public financial supports. In 2002-2004, worldwide, persons with disabilities were 50% more likely to have catastrophic health expenditures¹⁴¹ compared to others.¹⁴²

Figure II.18. Percentage of persons with disabilities who report that health care facilities are hindering or not accessible, in eight countries, around 2011.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions; (MDS) identifies countries with data collected using the Model Disability Survey. All data refers to not accessible primary health care clinics, except MDS data which refers to hindering health facilities. Data from Cameroon and South Africa were collected in selected regions and are not nationally representative.

Source: SINTEF⁹ and WHO.¹⁰⁷

Many health facilities are not accessible and do not have trained staff to work effectively with persons with disabilities

In some countries, more than 35% of persons with disabilities report that healthcare facilities are hindering or not accessible (Figure II.18). Among 8 developing countries, around 2011, on average, 30% of persons with disabilities reported so. In selected regions in Cameroon, 58% of persons with disabilities encounter health facilities which are hindering. Crowd-sourced data mostly from developed countries found that, as of 2017, 20% of hospitals and 32% of pharmacies were not wheelchair accessible.^{143,144} Attitudinal barriers have also been compromising access to health services for persons with disabilities as often health professionals have little experience interacting with or providing services to persons with severe and complex disabilities, or have negative, stigmatizing attitudes towards these patients. This has not only been limiting access to services but also lowering the quality of care people receive: persons with disabilities are more likely to report that their doctor did not listen to them, did not treat them with respect, did not take enough time, did not involve them in treatment decisions or explain treatments properly.^{145,146} Persons with

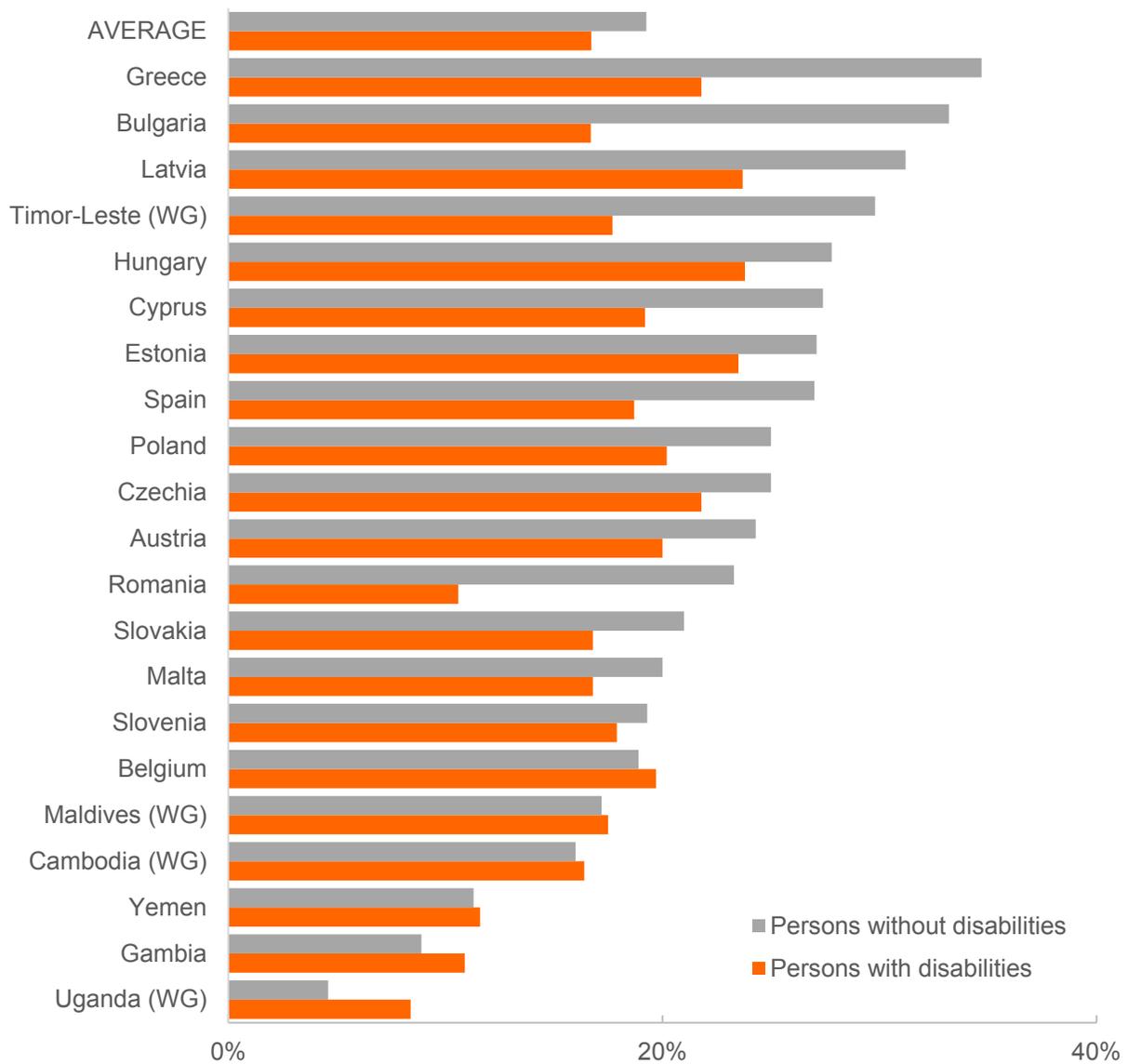
mental/psychosocial and intellectual disabilities tend to receive a worse service from health professionals, which can contribute to poorer outcomes.¹⁴⁷ At the same time, the lack of information patients with disabilities themselves have about the care that is available to them is also a barrier. For instance, in India and Cameroon, awareness of health services among persons with disabilities is extremely low. In India, only 49% have even heard of any general health services, whereas in Cameroon only 73% have.¹⁴⁸

Persons with disabilities tend to smoke less than persons without disabilities

One of the SDG targets and indicators focuses on control of tobacco use (SDG target 3.a and SDG indicator 3.a.1). Among 21 countries, around 2010, on average 17% persons with disabilities and 19% of persons without disabilities smoked (Figure II.19). In all countries except Belgium, Gambia and Uganda, a higher proportion of persons without disabilities smoke than persons with disabilities. The percentage of persons with disabilities who smokes daily varies from 8% in Uganda to 24% in Estonia, Hungary and Latvia. These data suggest that in several countries strategies for tobacco control should be inclusive of and accessible for persons with disabilities.

In all countries, women have lower rates of daily cigarette smoking than men, for persons with as well as without disabilities; and the average gender gap of daily smokers of cigarettes is similar for persons with and without disabilities (17 and 16 percentage points, respectively). Among persons with disabilities, an average of 11% women are smokers as compared to 29% men.

Figure II.19. Percentage of smokers of cigarettes, among persons aged 15 years and over,¹⁴⁹ by disability status, in 21 countries, around 2010.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

Source: Eurostat¹⁵⁰ and DHS.^{151,152}

Current practices on health and disability

Only a small minority of countries have made systematic legal and policy reforms that have specifically targeted the provisions found in CRPD Article 25, or addressed access to health care services directly. Six basic approaches have been taken by countries to legally ensure access to health care services: A) constitutional or rights act provisions applicable to persons with disabilities; B) anti-discrimination laws and regulations applicable to all; C) anti-discrimination laws and regulations with reference to the health sector; D) other laws targeting provision and access to healthcare; E) national disability laws or policy plans; F) laws concerning specific health conditions (e.g. spinal cord injury) or specific populations (e.g. veterans) guaranteeing access to healthcare.^{153,154}

As of 2014, the right to health was guaranteed to persons with disabilities in national constitutions of 10% of UN member States.¹⁵⁵ Although this approach and approach A) are common, they are general and do not explicitly target any disability-specific barriers. The same is true of anti-discrimination laws (approaches B) and C)), whether they explicitly mention access to healthcare or not. At best they give a person with disabilities the option of launching legal action against the State. Only six countries¹⁵⁶ use approach D) and have an explicit law that guarantees access to health care for persons with disabilities. Approaches E) and F) are common but take a wide variety of forms.

Regarding policies and programmes, some countries have adopted these to strengthen health systems and increasingly making health and rehabilitation services available, accessible and affordable to persons with disabilities. Among 24 countries in the Western Pacific region (Table II. 2), many countries have taken steps to improve accessibility in the infrastructure used for providing health care services: 79% of them through developing accessibility standards and 42% through ensuring alternative communication formats such as radio services, closed captioning, easy-read format, sign languages and braille/audio formats. Furthermore, 88% of these countries involve persons with disabilities or their organizations in planning of health care services. Almost half of the countries, 42%, now prohibit health insurers from discriminating against pre-existing impairments and health conditions, and a majority of the countries in the region are working to improve health care affordability through social protection and health financing mechanisms: 88% of them have established exemptions, waivers or reductions for health care services and 67% have adopted mechanisms to reduce transport costs to health services.

Table II. 2. Percentage of countries in the Western Pacific region who had initiatives in place to improve health care for persons with disabilities, in 24 countries, in 2015

Initiatives	% countries
Anti-discrimination measures and inclusion of persons with disability in planning	
Participation of persons with disabilities or organisations of persons with disabilities in planning of healthcare services most of the time	88%
Prohibit health insurers from discriminating against pre-existing disability	42%
Accessible of health care services	
Adoption of accessibility standards for healthcare services	79%
Use of alternative communication formats in health care services such as radio services, closed captioning, easy read format, sign languages and braille/audio formats	42%
Affordable health care services	
Government exemptions/waivers or reductions for health care services	88%
Mechanisms to reduce transport cost to regular health care services	67%

Source: WHO (2017).¹⁵⁷

Other successful initiatives at country level, initiated by governments, international agencies or civil society organisations in the country, focused on various areas: developing education and training for medical professionals to enhance their abilities to provide care for persons with disabilities;^{158,159,160} investing in making healthcare facilities accessible;¹⁶¹ investing in early intervention by screening students and giving them access to healthcare services;¹⁶² establishing rehabilitation services and home-based care.¹⁶³ Some of these initiatives focus on health needs which may affect more frequently certain types of disabilities, like heart disease among persons with intellectual disabilities. Others have focused on basic health care needs, like eye care.

In many countries, social welfare services at times fail to provide coverage for assistive devices and rehabilitation services; or the coverage is only provided if the person is employed or if the family pays the premium. National¹⁶⁴ and local governments¹⁶⁵ have stepped in in some countries to fill this gap through health insurance schemes offering coverage for assistive devices and rehabilitation services. Sometimes the services are only available to persons who have been legally recognized as having a 'disability',

defeating the principle of the universal availability of assistive devices for all who need them.

Conclusions and the way forward

Despite the increasing number of States ratifying the CRPD and the steps these countries have taken to implement Article 25, persons with disabilities continue to experience unmet health needs and barriers to accessing health services in comparison to the general population. Moreover, persons with disabilities report poorer health and poorer mental health and continue to face barriers to economic, social and political inclusion. This exclusion has negative impacts on their well-being. All these constitute a genuine obstacle to the implementation of SDG 3. To improve this situation, it is essential that changes must be fully collaborative among all stakeholders, including persons with disabilities, to promote health and well-being, with a focus on systematic actions across national health care systems.

The SDG 3 targets focusing on health status and services can only be realized for persons with disabilities if their implementation is in line with Article 25 of CRPD. In order to achieve the highest attainable standard of health for persons with disabilities the following actions should be taken into account:

- 1) Strengthen national legislation and policies on health care in line with CRPD.** The process of assessing existing laws and policies should involve all stakeholders in the process, including organizations of persons with disabilities, and be based on information about health inequalities as well as evidence-based assessments of the gaps in health care service delivery and of the policy and legal barriers to accessing health care services. To legally ensure access to health care services, and because of the wide range of accessibility issues that need to be addressed, national strategies should ensure wider, general protections to the right to the highest standard of health, either through constitutional, anti-discrimination or other national disability legislation, and then pursue the detailed accessibility issues by means of regulations and guidelines at the community level.
- 2) Identify and eliminate obstacles and barriers to accessibility in health care facilities.** Develop national accessibility guidelines for health care facilities in consultation with persons with disabilities. Conduct accessibility assessments in medical facilities and make use of crowd-sourced information and users feedback to have bottom-up information on accessibility. Ensure that persons with disabilities have accessible transportation to health care facilities.
- 3) Improve healthcare coverage and affordability for persons with disabilities as part of universal approaches to health care.** Implement Universal Health Coverage by identifying national actions, in consultation with persons with disabilities, to progressively close the gap in health care service

utilization, improve the quality and range of health care services, and reduce health care costs for persons with disabilities.

4) Train health care personnel and improve service delivery for persons with disabilities.

Integrate disability-inclusive education into the curriculum and training for health professionals. Involve persons with disabilities in the design and provision of training, to the extent possible. Develop strategies for holistic, people-centred care so as to both improve the quality and continuity of care for persons with disabilities.

5) Empower persons with disabilities to take control over their own health care decisions, on the basis of free and informed content.

Ensure access to and accessibility of health-related information, including through alternate means of communication accessible to persons with disabilities. Disseminate health information through training of persons with disabilities and peer support, so that persons with disabilities are better prepared to make decisions about their own health and become aware of the health care services they can benefit from.

6) Prohibit discriminatory practices in health insurance and promote health insurance schemes offering coverage for assistive devices and rehabilitation services.

Private and public insurance schemes should not limit the availability of coverage for pre-existing conditions for any one. These discriminatory practices disproportionately affect persons with disabilities. In addition, discriminatory practices on the basis of disability should be prohibited. Countries should promote health insurance schemes addressing the needs of persons with disabilities, particularly for assistive devices and rehabilitation services

7) Improve research and data to monitor, evaluate and strengthen health systems to include and deliver for persons with disabilities.

Conduct further research on the needs for high quality health care services, public health promotion and disease prevention programmes, the barriers that persons with disabilities encounter to access these services. Establish health system monitoring and evaluation mechanisms that can track the outcomes of health system reforms that address barriers to accessing health services for persons with disabilities. In addition, more studies are needed to understand the reasons for poorer self-reported health for persons with disabilities and for their increased morbidity and mortality. Studies are also needed to assess whether these poor health outcomes are linked to the underlying health condition or environmental barriers such as lack of social support or access to health services. For health and social care service planning, it is important to investigate this causation more closely, in particular, more longitudinal research is needed.

C. Access to sexual and reproductive health-care services and reproductive rights for all persons with disabilities (SDGs 3.7 and 5.6)

SDG target 3.7 calls for universal access to sexual and reproductive health-care services and SDG target 5.6 further calls for ensuring access to sexual and reproductive health and reproductive rights. Sexual and reproductive health services include family planning, maternal health care, preventing and managing gender-based violence, and preventing and treating sexually transmitted infections.¹⁶⁶ Reproductive rights rest on the “recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence”.¹⁶⁷

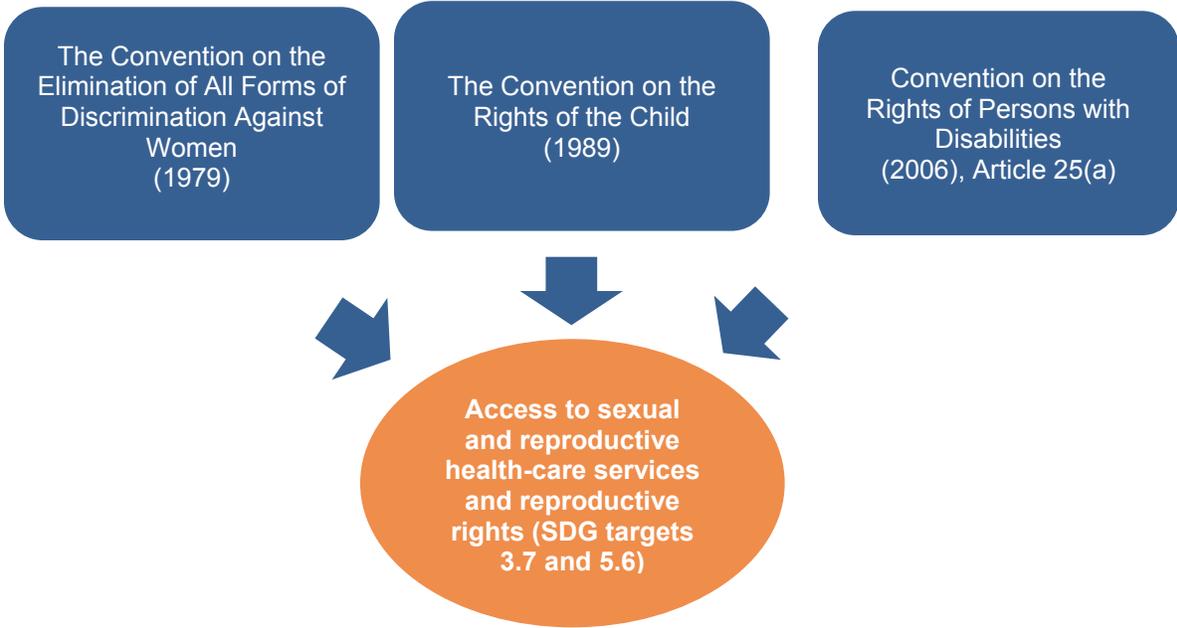
The objective of this section is to review, in the context of the SDGs and the CRPD, progress toward the realisation of sexual and reproductive health and reproductive rights for persons with disabilities. First, an overview of current international normative frameworks on sexual and reproductive health, and services, and reproductive rights is presented. This is followed by an overview of the situation of persons with disabilities regarding access to sexual and reproductive services and a summary of the main obstacles faced by persons with disabilities in accessing these services. The section then presents current practices to promote access to sexual and reproductive health and reproductive rights for persons with disabilities, before concluding with recommendations for the way forward.

International normative framework on disability and sexual and reproductive health and reproductive rights

In the context of promoting health lives and well-being for all at all ages SDG 3, through its target 3.7, calls for universal access to sexual and reproductive health-care services including for family planning, information and education. SDG target 5.6, which is placed under the goal calling for gender equality and empowerment of all women and girls, calls for ensuring universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. The Convention on the Rights of Persons with Disabilities’ (CRPD) is the first Convention to explicitly recognise the need for sexual and reproductive health for persons with disabilities. Article 25(a) underscores the need to provide persons with disabilities with the same range, quality and standard of free or affordable sexual and reproductive health care and programmes as provided to other persons.

Other major international frameworks also emphasize the rights of women and girls with disabilities to sexual and reproductive health as part of broader provisions for all women, as well as all children and adolescents. These includes the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979, which requires States to ensure that women and girls with disabilities have access to reproductive health care, and are protected from coercive pressures.^{168, 169} The Convention on the Rights of the Child (CRC) (1989) further protects the rights of children and adolescents with disabilities to ensure that they have effective access to health care services (Article 23).¹⁷⁰

Figure II.20. International normative frameworks relevant for the achievement of SDG targets 3.7 and 5.6 for persons with disabilities.



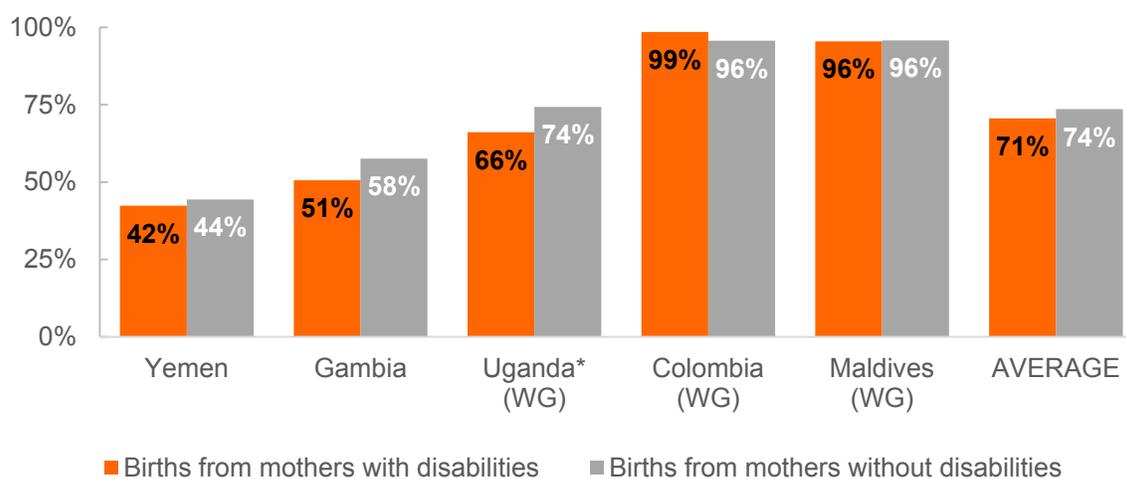
Situation of persons with disabilities regarding sexual and reproductive health and healthcare services, as well as reproductive rights

Access to sexual and reproductive health-care services

Improved access to skilled health personnel for childbirth is crucial to improve maternal health and an important component of sexual and reproductive health care. A skilled birth attendant is an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of women and newborns for complications.¹⁷¹

Evidence from five countries around 2014 (Figure II.21), indicates that, on average, births from mothers with disabilities are slightly less likely to be attended by a skilled health worker than births from mothers without disabilities (71% versus 74%). The widest gap was found in Uganda - 8 percentage points - where 66% of births from mothers with disabilities versus 74% from mother without disabilities were attended by a skilled health worker. In Colombia and the Maldives, almost all births from mothers with disabilities, 99% and 96%, were attended by a skilled health worker. The gap between births from mothers with and without disabilities could be due to income disparities and subsequent greater inability of mothers with disabilities to afford this service. It could also be due to negative attitudes by skilled health workers of lack of awareness of mothers with disabilities, for which such information on these services may not be available in accessible formats.

Figure II.21. Percentage of live births attended by a skilled health personnel, by disability status of the mother, in 5 countries, around 2014.

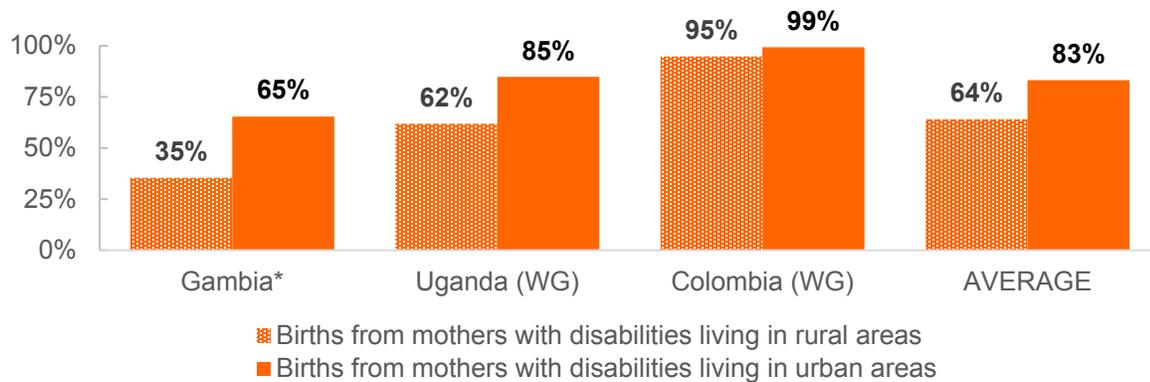


Note: (WG) identifies countries with data produced using the Washington Group short set of questions. An asterisk (*) indicates that the difference between births from women with and without disabilities is statistically significant at 5% level.

Source: DHS.^{151,172}

These country averages mask differences between urban and rural areas (Figure II.22). On average, skilled birth professionals attended to 64% of births from mothers with disabilities living in rural areas versus 83% living in urban areas. In the three countries, access to a skilled health professional during childbirth was higher in urban areas. The gap was particularly wide for Gambia (30 percentage points), where only 35% of births from mothers with disabilities were assisted by a skilled health professional during childbirth.

Figure II.22. Percentage of live births attended by a skilled health personnel, by location of residence of the mother with disabilities, in 3 countries, around 2014.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. An asterisk (*) indicates that the difference between births from women with and without disabilities is statistically significant at 5% level.

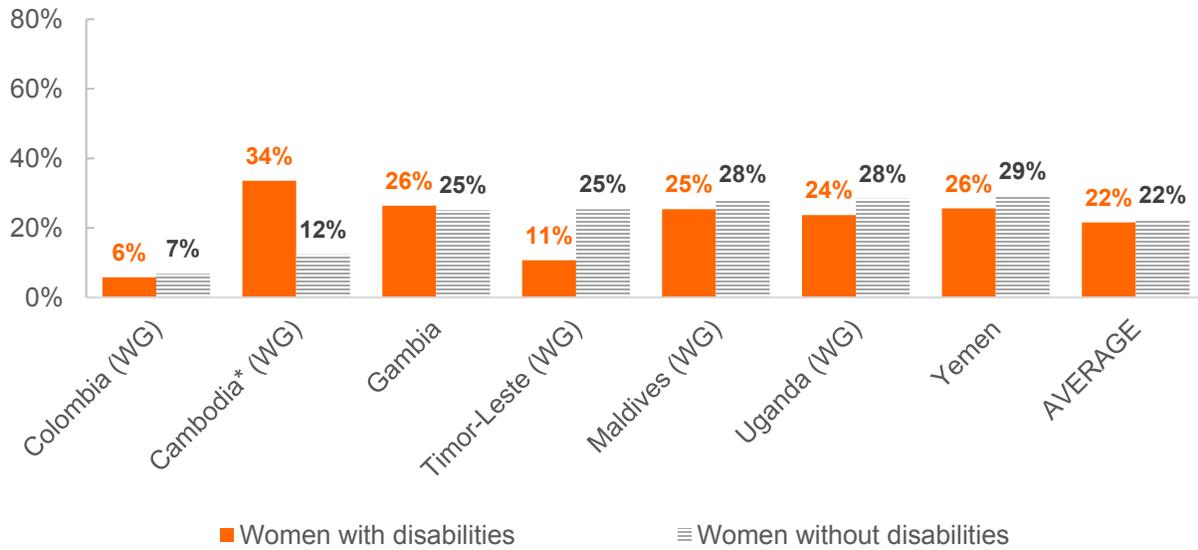
Source: DHS.^{151, 173}

Support for family planning is another important component of sexual and reproductive health services. For women with disabilities with family planning needs - i.e. women with disabilities who want to stop or delay childbearing – but who are not using any method of contraception, these needs are often unmet.

Figure II.23 shows the percentage of married women having an unmet need for family planning, by disability status, in 7 countries, around 2014. According to this data, the family planning needs of, on average, 22% of women with disabilities aged 15 to 49 were unmet. In 6 out of the 7 countries, women with disabilities were less or similarly likely to have unmet needs as women without disabilities. But in Cambodia women with disabilities were more likely to have unmet needs for family planning (34%) than women without disabilities (12%). Unmet need for family planning varies depending on the location of residence of the woman with disabilities (Figure II.24). On average, among 4 developing countries, women in rural areas (25%) were more likely to have unmet needs than women with disabilities in urban areas (18%).

Little is known about access to sexual and reproductive health-care services for men in general, and even less is known for men with disabilities. Given the barriers to access (see section below), it is expected that men with disabilities will also show lower levels of access to sexual and reproductive health-care services than their peers without disabilities. A study in Ethiopia of young persons with disabilities of both sexes indicated that 88% had poor knowledge about ways to prevent HIV transmission.^{174, 175} The study also found that young persons with intellectual disabilities were the least informed about sexual and reproductive health.

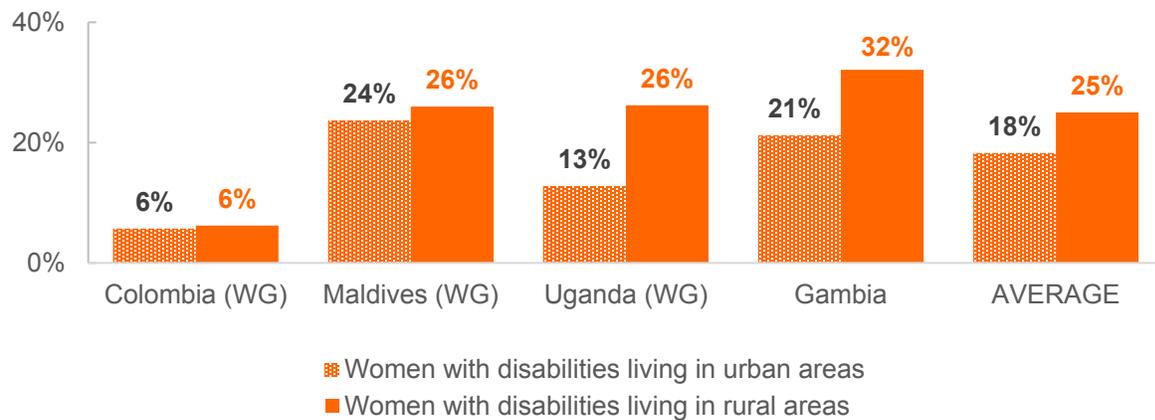
Figure II.23. Percentage of married women aged 15 to 49 having an unmet need for family planning, by disability status, in 7 countries, around 2014.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. An asterisk (*) indicates that the difference between births from women with and without disabilities is statistically significant at 5% level. Data from Cambodia and Timor-Leste are based on 25 to 49 observations and should be interpreted with caution.

Source: DHS.^{151,176}

Figure II.24. Percentage of married women aged 15 to 49 with disabilities having an unmet need for family planning, by location of residence, in 4 countries, around 2014.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. For all countries, the difference between births from women with disabilities in urban and rural areas is not statistically significant at 5% level.

Source: DHS.^{151, 177}

Barriers to access sexual and reproductive health services

Persons with disabilities face many environmental barriers toward accessing sexual and reproductive healthcare. Sexual and reproductive health facilities in developing countries are often physically inaccessible, lacking adjustments such as ramps or moveable equipment^{178, 179} and frequently have long-waiting times.¹⁸⁰ A study in Ethiopia in 2012 indicated that 62% of young persons with disabilities interviewed¹⁸¹ pointed to inaccessibility of service providers as the main barrier to accessing sexual and reproductive health services.¹⁸² Even when sexual and reproductive health services are physically accessible, information is often not available in formats that are accessible. For example, only rarely do sexual and reproductive health clinics and AIDS clinics have access to sign language interpreters for the deaf.¹⁸³

Distance to healthcare facilities is also a barrier for many persons with disabilities. Public transport is often inaccessible and unreliable, while private transportation can be prohibitively expensive.^{184, 185} The need for some persons with disabilities to have someone accompany them on the health visit not only increases transportation costs, but also raises issues of confidentiality for many.

A growing body of data confirms the fact that persons with disabilities are as sexually active as their peers^{186, 187, 188, 189} and have similar needs for family planning and childbirth.¹⁹⁰ However, there is a widespread false belief within the general population that persons with disabilities are asexual, are not desired as sexual partners, have few or no sexual rights, and do not derive the same benefit from sexual

and reproductive healthcare as persons without disabilities.¹⁹¹ This stigmatisation of persons with disabilities and their sexual lives begins early and is shaped by negative and dismissive attitudes displayed by family members and communities.^{192,193} Combined with environmental and other barriers, such attitudes ultimately deter many persons with disabilities from seeking sexual and reproductive healthcare.¹⁹⁴

Moreover, persons with disabilities, particularly women and girls with disabilities, may also fear seeking sexual and reproductive health care. In Ethiopia, in 2012, 23% of young persons with disabilities indicated fear of going for services as one of the reasons for not seeking sexual and reproductive health services.^{195, 196} These fears are anchored in practices of violation of reproductive rights and abuse of persons with disabilities. Many persons with disabilities, particularly those with intellectual disabilities and women, have been subjected to involuntary sterilisation in various countries.^{197,198} For instance, a small study among women with intellectual disabilities in Mexico in 2015 indicated that half of them had been recommended for sterilisation by a member of their family, and close to half had been sterilized; 6% of them had not been informed that the surgery they had undertaken was a sterilization at the time it was conducted.¹⁹⁹ In the same study, it was found that 43% of the women had been sexually abused at the gynaecologist's office.

Healthcare professionals often share the negative attitudes about disability and sexuality that are entrenched within society,^{200,201} which can lead to distressing experiences for persons with disabilities. Adolescents and adults with disabilities are often denied sexual and reproductive health information and resources, discouraged from becoming sexually active by health professionals and in extreme cases, expectant parents with disabilities report receiving unsolicited advice to abort their child, because it is assumed that the child is unwanted or that the child will inherit the same disability as their parent.²⁰² Such barriers to sexual and reproductive health services and support for persons with disabilities arise from the fact that those working in public health and clinical services often have very little knowledge or training on disability^{203, 204} and do not consider persons with disabilities when planning interventions, long-term services or public information campaigns.

Compounding the aforementioned barriers to sexual and reproductive health, adults and children with disabilities are frequently excluded in other domains of life, such as in education, employment and socialisation (see sections on SDG 4, SDG 8 and SDG 10). This means that persons with disabilities often lack the education, income and social support systems that would allow them to make informed decisions about their sexual and reproductive health options. Furthermore, many persons with disabilities continue to live in institutions for persons with disabilities (see section on SDG 10), where they are often not allowed to access and decide over their sexual and reproductive health care.

These barriers to sexual and reproductive health are exacerbated for persons with disabilities during humanitarian emergencies. During such emergencies, the needs of the rest of the population are prioritized and services for persons with disabilities – including sexual and reproductive health services – are left for future programmes or without sufficient resource allocation. For example, a multi-country study

of refugee communities found that persons with disabilities could not access sexual and reproductive healthcare services, because there were no translators available for sign-language.²⁰⁵

Vulnerability

Compared to persons without disabilities, both young people and adults with disabilities are at equal or increased risk of unwanted pregnancies, sexually transmitted infections^{206,207,208} and sexual violence (see section on SDG 16). Such vulnerability is not inherently part of disability, but instead reflects the various barriers that persons with disabilities face regarding sexual and reproductive health. For example, exclusion from sexual and reproductive health services frequently means that adolescents with disabilities engage in risky sexual behaviours, increasing the likelihood they will contract a sexually transmitted disease. This highlights the importance of access by persons with disabilities to sexual and reproductive health services.

Current practices toward improving sexual and reproductive health of persons with disabilities

Initiatives to improve the sexual and reproductive health of persons with disabilities include: the adoption of national policies on sexual and reproductive health of persons with disabilities;²⁰⁹ ensuring access by persons with disabilities to relevant information and services; engaging them in the planning, implementation, monitoring and evaluation of sexual and reproductive health and rights programmes;²¹⁰ creating effective community supportive networks; and formulating evidence-based revisions of legislation, policies, strategies and guidelines concerning the sexual and reproductive health and rights of adolescents with disabilities.²¹¹ Participatory action research²¹² in the domain of sexual reproductive health has also been undertaken with participation of persons with disabilities, which led to several positive outcomes such as enhanced knowledge and access of persons with disabilities to sexual and reproductive healthcare and their increased participation within local communities.²¹³

Another area of positive developments has been the establishment of global and national guidelines. At the global level, guidelines have been produced to advise on the provision of sexual and reproductive health services for persons with disabilities,²¹⁴ and examples of national standards for sexuality education and sexual and reproductive health training also exist.²¹⁵ The application of these standards was facilitated by capacity building activities for health professionals.²¹⁶

Conclusions and the way forward

Sexual and reproductive health is of no less importance to persons with disabilities than for all members of society. Persons with disabilities are as sexually active as others and have similar needs for family planning. Without access to sexual and reproductive health services, they are at higher risk of unwanted pregnancies and sexually transmitted infections. Persons with disabilities are also more likely to experience

sexual violence. Sexual and reproductive health services are especially important to make them less vulnerable to these risks. Yet, persons with disabilities are regularly excluded from the provision of sexual and reproductive health services due to environmental and attitudinal barriers, such as lack of physical accessibility in healthcare facilities and public transport, low level of awareness and misperceptions of the sexual and reproductive health needs of persons with disabilities. The false but widespread assumption that persons with disabilities are not sexually active has meant that, little attention and few resources have been devoted to ensuring that persons with disabilities have equal access to sexual and reproductive health.

Various countries have taken actions to address these challenges including through the development of national policies and programmes on sexual and reproductive health that are inclusive of persons with disabilities, in-depth studies on their situation regarding access to sexual and reproductive healthcare services, and capacity development programmes to enhance accessibility to such services. However, there remains insufficient collection and analysis of viable data and information on the situation of persons with disabilities regarding access to sexual and reproductive health services, and the barriers they face. The lack of data causes challenges in programmatic planning and in monitoring and evaluating the success of sexual and reproductive health services in reaching and providing adequate services for persons with disabilities.

A number of actions should be considered to ensure that persons with disabilities have access to sexual and reproductive health and reproductive rights:

- 1) **Develop national policies and laws that guarantee access to sexual and reproductive health and reproductive rights for persons with disabilities.** Eliminate discriminatory laws that prevent persons with disabilities from exercising their reproductive rights and prevent discriminatory actions, including unconsented sterilization. Ensure the participation of persons with disabilities, as a part of national programme planning and decision-making processes.
- 2) **Remove environmental barriers by making sexual and reproductive health care facilities and information accessible.** Healthcare facilities must be physically accessible, and the information on sexual and reproductive health must be provided in an accessible format for persons with disabilities.
- 3) **Train sexual and reproductive health care workers, combat negative attitudinal barriers and improve service delivery for persons with disabilities.** Prohibit discriminatory practices against persons with disabilities. Incorporate disability in training modules to enhance understanding on the needs of persons with disabilities and engage persons with disabilities in training sessions where appropriate.
- 4) **Educate persons with disabilities, including adolescents with disabilities, on sexual and reproductive health and reproductive rights.** Develop guidelines for educators in order to deliver high

quality, age appropriate education on sexual and reproductive health and reproductive rights for all, including those with disabilities. The training materials should be provided in accessible format.

5) **Establish a monitoring and evaluation mechanism to track the implementation of policies and programmes on access to sexual and reproductive health for persons with disabilities.** Ensure that all stakeholders, including persons with disabilities, participate in the evaluation process.

6) **Improve research and data to monitor, evaluate and strengthen sexual and reproductive health and services for persons with disabilities.** Conduct empirical research on the sexual and reproductive health of persons with disabilities as well as on their access to sexual and reproductive health services, including the barriers they face. Collect data disaggregated by disability, sex, age in this context. Engage persons with disabilities in the studies.

D. Ensuring inclusive and equitable quality education (SDG 4)

This section focuses on the realization of SDG 4 for persons with disabilities. SDG 4 calls for ensuring inclusive and equitable quality education and promoting life-long learning opportunities for all. While all targets of SDG 4 are crucial in achieving equal education for persons with disabilities, only two targets explicitly mention disability, namely target 4.5 which aims inter-alia at ensuring equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities; and target 4.a that calls for building and upgrading education facilities that are disability sensitive and providing inclusive learning environments for all. This section presents the international normative framework on disability and education and obstacles and addresses the challenges persons with disabilities face in accessing education on the basis of available evidence. It also discusses current practices in countries regarding access to education of persons with disabilities and presents examples of national policies and good practices as well as recommendations to advance inclusive education.

Education is a fundamental human right and an essential condition for individual development and full and effective participation in society. However, still too many persons with disabilities continue to face the denial of this fundamental right due to numerous barriers and obstacles to access education, including prejudice and discrimination against those with disabilities, the lack of qualified teachers to accommodate the needs of persons with disabilities as well as inaccessible schools and educational materials. Lack of disaggregated data and research also impede the development of effective policies and programmes to promote inclusive education. Available evidence shows that persons with disabilities are less likely to attend school, less likely to complete primary or secondary education, and less likely to be literate. Education is fundamental for social inclusion and participation in the labour market and plays a critical role in the acquisition of skills and knowledge.

International normative framework on disability and education

The right of persons with disabilities to education has been declared in a number of international instruments, including the World Declaration on Education for All, stemming from the World Conference on Education for All (1990), which stressed the importance of equity and equal access to basic education for all, with attention to persons with disabilities.²¹⁷ The Standard Rules on Equalization of Opportunities for Persons with Disabilities (1993) represented the strong political commitment to equalization of opportunities for education for persons with disabilities. In 2000, the global community reaffirmed its commitment to the Education for All movement by adopting the Dakar Framework for Action, Education for All: Meeting our Collective Commitments at the World Education Forum. The Dakar Framework for Action reinforced the previous efforts and commitments of the international community to progress inclusive education for all including persons with disabilities.²¹⁸ CRPD (2006) includes Article 24 that stipulates that States Parties should ensure access to inclusive, quality and free primary education and secondary education on an equal

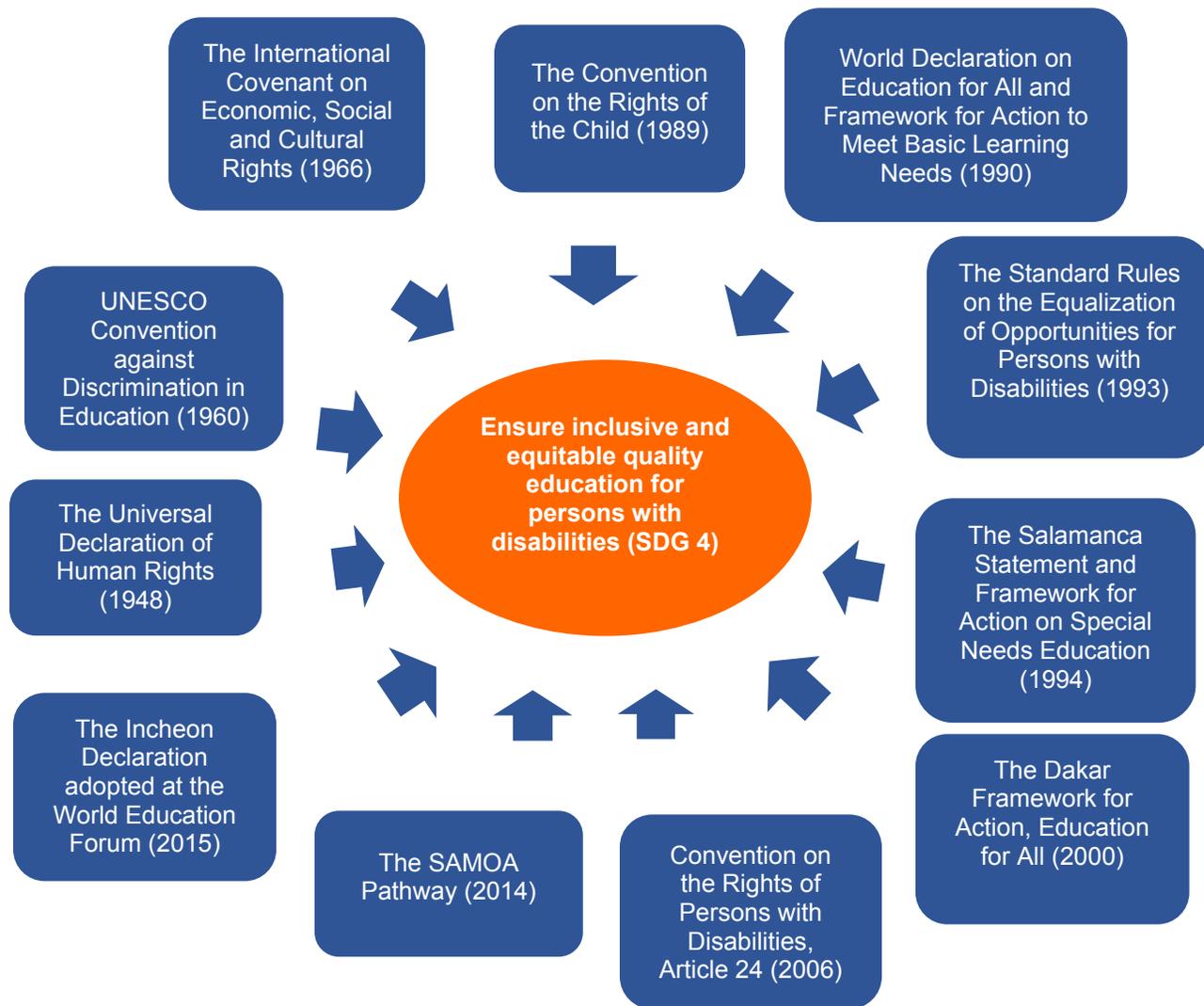
basis with others.²¹⁹ In order to realize this right, the CRPD includes a provision on the employment of teachers qualified in sign language and/or Braille and on disability awareness training of professionals and staff who work at all levels of education. Article 24 also calls for reasonable accommodation and for making learning environments accessible including through accessible educational materials.

More recently, in 2015, the 2030 Agenda for Sustainable Development recognized that persons with disabilities should have access to life-long learning opportunities that help them acquire the knowledge and skills needed to exploit opportunities and to participate fully in society.²²⁰ Persons with disabilities are also covered in SDG 4. In addition, the Small Island Developing States Accelerated Modalities of Action (SAMOA) Pathway (2014) addressed the importance of providing high-quality education and training and called for enhancing international cooperation and investment in education including support for transitions from basic to secondary education and from school to work for persons with disabilities.²²¹

Two frameworks focus on education for children with disabilities. The United Nations Convention on the Rights of the Child (1989) enshrines the right to education as a right of the child (Articles 28-29) and specifically addresses education of children with disabilities (Article 23).²²² Moreover, Article 23 (3) asks State Parties to encourage extended assistance that should be designed to ensure that children with disabilities have effective access to and receive education and training.²²³ The Salamanca Statement and Framework for Action on Special Needs Education, which was adopted at the World Conference on Special Needs Education in 1994, outlined challenges faced by children with disabilities and called for equality of opportunity for children, youth and adults with disabilities in integrated settings.²²⁴ The framework also encouraged countries to adopt complementary legislative measures in other related fields such as health, social welfare, and employment and urged for better coordination at the national level for coherence and maximizing results.

Several international instruments establish education as an integral part of the universal human rights. The Universal Declaration of Human Rights (1948) states in Article 26 that “everyone has the right to education”.²²⁵ Furthermore, the right to education has been detailed in the UNESCO Convention against Discrimination in Education (1960),²²⁶ the first international Convention, specifying the core elements of the right to education. It is worth noting that the Convention obligates States Parties not only to prohibit all forms of discrimination in education but also to provide equal educational opportunities. Among the United Nations human rights treaties, Article 13 of the International Covenant on Economic, Social and Cultural Rights (1966) covers the right to education in a comprehensive manner.²²⁷

Figure II.25. International normative framework relevant for the achievement of SDG 4 for persons with disabilities.



The situation of persons with disabilities in education

Many youths with disabilities remain excluded from education

The proportion of the population aged 15 to 29 years who ever attended school indicates the percentage of this age cohort with any formal education, regardless of duration. Figure II.26 shows that on average among 41 developing countries 87% of persons without disabilities versus 75% of persons with disabilities aged 15 to 29 ever attended school. In 10 of these countries, the gap between youth with and without disabilities is higher than 15 percentage points; but in 13 countries the gaps are below 5 percentage points. The largest gaps between persons with and without disabilities are observed in Cambodia (51 versus 94%), Indonesia (53% versus 98%), Timor-Leste (52% versus 90%) and Viet Nam (63% versus 98%). The lowest percentage of youth with disabilities who ever attended school is observed in Burkina Faso (25%). However, in 12 of these developing countries, the percentage of youth with disabilities who ever attended school is higher than 90%.

Many children with disabilities are out of school

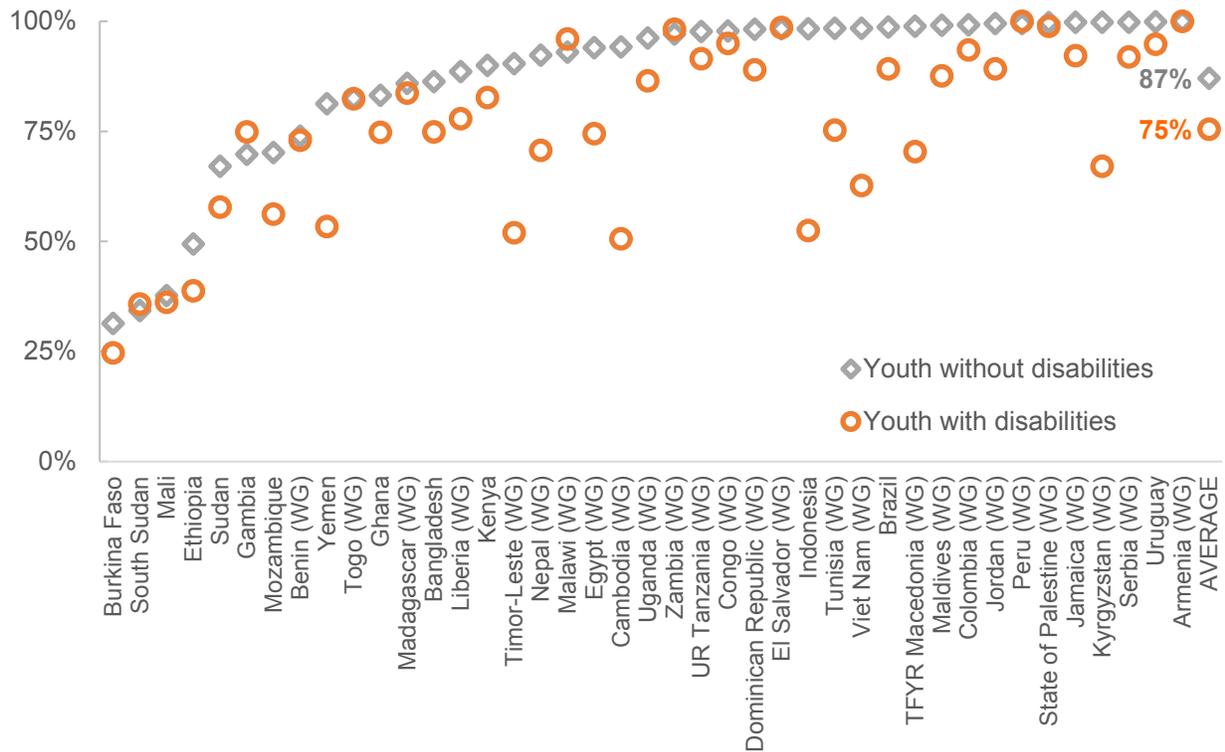
The out-of-school rate of children of primary and lower secondary school age is the proportion of children in a given age group who are not attending primary or secondary school. Some of these children may have attended school in the past and dropped out, some may enter school in the future, and some may never go to school.²²⁸ Data from six developing countries indicates that, on average, children with disabilities of primary school age (about 6 to 11 years in most countries) are more likely to be out of school than their peers without disabilities (

Figure II.27).²²⁹ The largest gap between children with and without disabilities was reported for Cambodia, with a 50-percentage point difference between the out-of-school rate of children with and without disabilities (57% versus 7%), which means that children with disabilities are 8 times as likely to be out of school as their peers without disabilities. In other countries, the gap is not as wide as in Cambodia but still proves the stark inequality between children with and without disabilities. The out-of-school rates of children with disabilities are two to three times as high as those of children without disabilities in Colombia, the Maldives, Uganda and Yemen. On average, in these countries, children with disabilities are more than twice as likely to be out of school as children without disabilities.

Figure II.28 shows the out-of-school rate of adolescents of lower secondary school age (about 12 to 14 years in most countries). In all countries with data, adolescents with disabilities are more likely to be out of school than adolescents without disabilities. The average out-of-school rate across the countries with data is 18% for adolescents without disabilities and 26% for adolescents with disabilities. In Uganda, Yemen and Gambia more than 30% of children without disabilities of lower secondary school age are out of school. In Maldives and Colombia, 13% and 16% respectively of children without disabilities of lower secondary

school age are out of school.

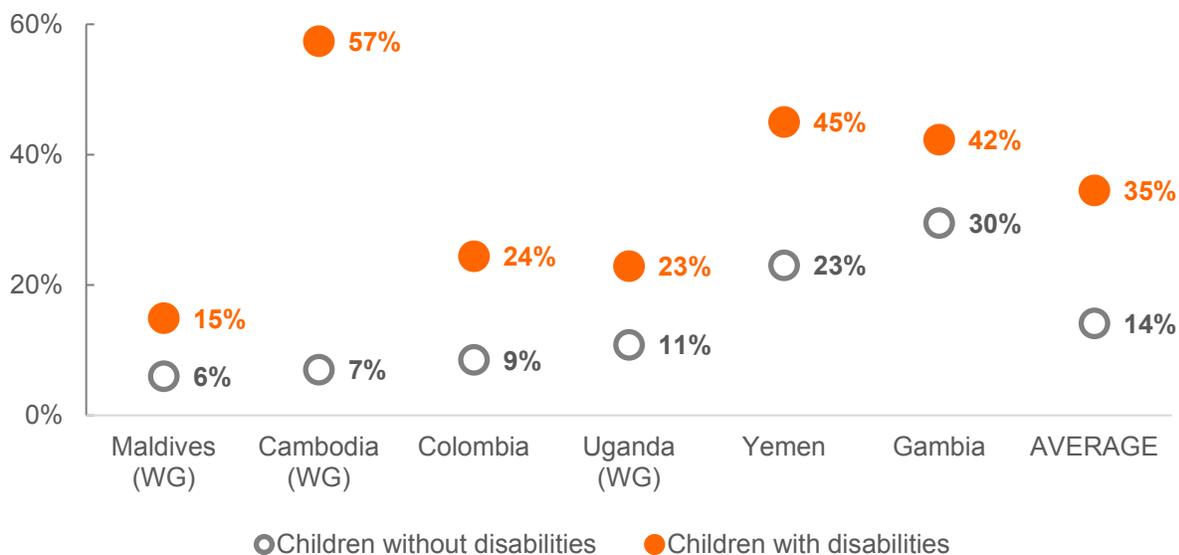
Figure II.26. Percentage of youth aged 15 to 29 years old who ever attended school, by disability status, in 41 developing countries, around 2012.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data on youth with disabilities from El Salvador, Jamaica, Kyrgyzstan, Liberia, Malawi, Nepal, Peru, Serbia, TFYR Macedonia, and Vietnam are based on 25 to 49 observations and should be interpreted with caution.

Source: DHS²³⁰ and UNESCO Institute for Statistics (on the basis of data from IPUMS²³¹ and School to Work Transition Surveys²³²).

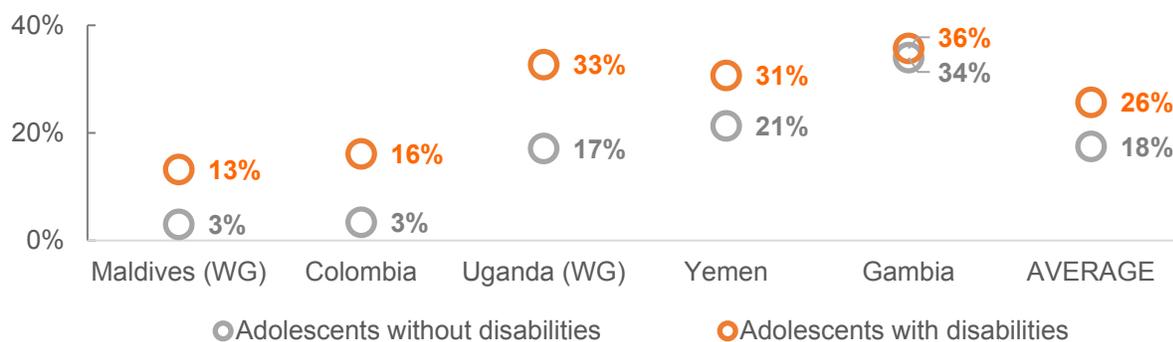
Figure II.27. Percentage of children of primary school age who are out of school, by disability status, in 6 countries, around 2012.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

Source: UNESCO Institute for Statistics (on the basis of data from DHS²³³).

Figure II.28. Percentage of adolescents of lower secondary school age who are out of school, by disability status, in 5 countries, around 2010.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

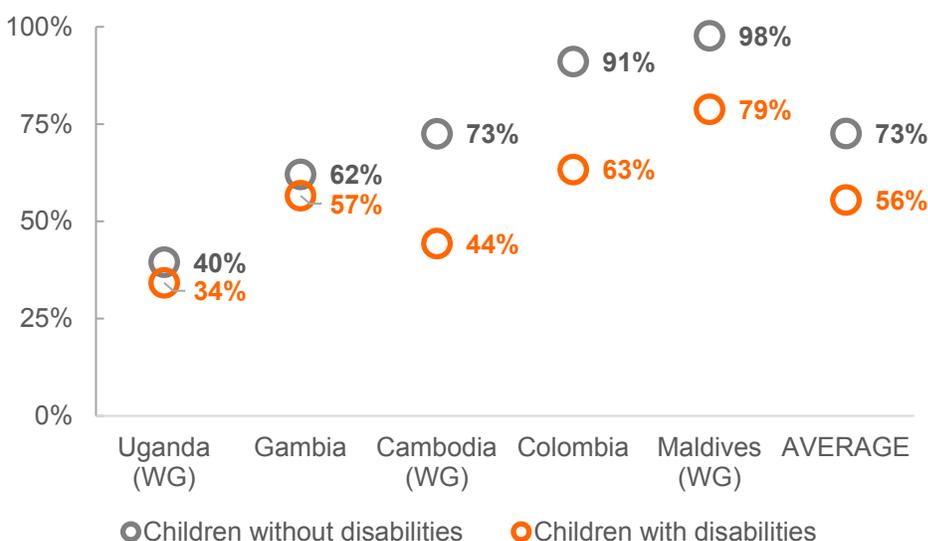
Data on adolescents with disabilities from Gambia are based on 25 to 49 observations and should be interpreted with caution.

Source: UNESCO Institute for Statistics (on the basis of data from DHS²³⁴).

Persons with disabilities are less likely to complete primary, secondary and tertiary education than persons without disabilities

Children with disabilities are less likely to complete primary education than children without disabilities. Data from five developing countries shows that, on average, the primary completion rate is 73% for children without disabilities and 56% for children with disabilities (Figure II.29). For this small group of countries, the disability parity index is 0.76,²³⁵ meaning that children with disabilities are less likely to complete primary education than children without disabilities. The widest gaps between the two groups exist in Cambodia and Colombia: 73% of 14- to 16- year-olds Cambodian without disabilities have completed primary education, compared to only 44% of their peers with disabilities; in Colombia, the completion rate is 91% for those without disabilities and 63% for those with disabilities. In the Maldives, almost all 15- to 17-year-olds without disabilities completed primary education (98%), whereas only four out of five adolescents in the same cohort with disabilities (79%) completed primary education. Countries that have achieved higher completion rates for primary education for children without disabilities show wider gaps vis-à-vis children without disabilities, suggesting that efforts to improve completion rates need to be more inclusive.

Figure II.29. Completion rate²³⁶ for primary education, by disability status, in 5 countries, around 2011.

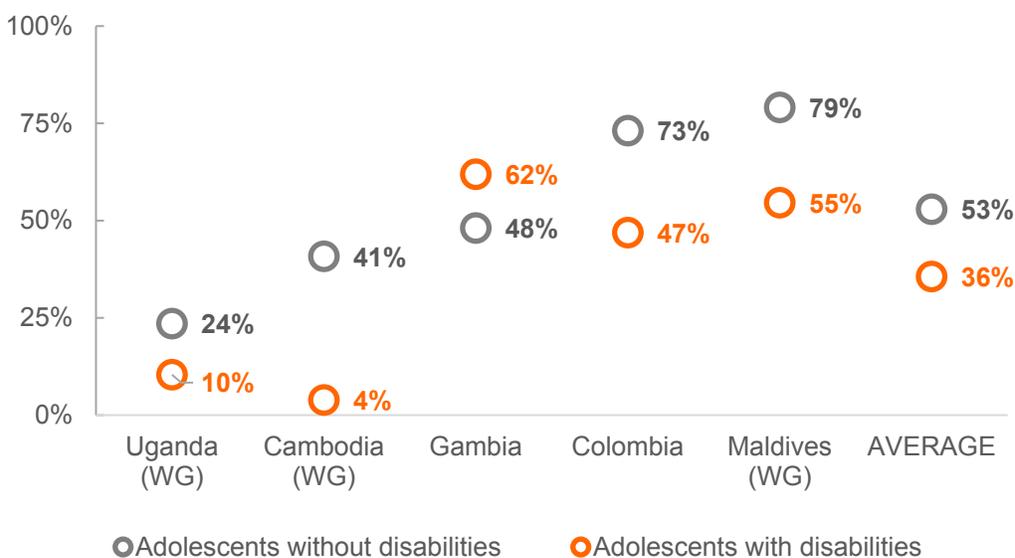


Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data on children with disabilities from Cambodia and Gambia are based on 25 to 49 observations and should be interpreted with caution.

Source: UNESCO Institute for Statistics (on the basis of data from DHS²³⁷).

As a direct consequence of lower primary completion rates, children with disabilities are also less likely to continue their education to higher levels of education. Figure II.30 shows the completion rate for lower secondary education. In four of the five countries with data, adolescents with disabilities are less likely to complete lower secondary education than adolescents without disabilities. The average completion rate is 53% for adolescents without disabilities and 36% for adolescents with disabilities. In Cambodia, only 4% of adolescents with disabilities have completed lower secondary education, compared to 41% of their peers without disabilities – a larger gap than in any other country with data. The Gambia is the only country with an opposite pattern: completion rates are higher for adolescents with disabilities than for those without disabilities.

Figure II.30. Completion rates for lower secondary education, by disability status, in 5 countries, around 2011.



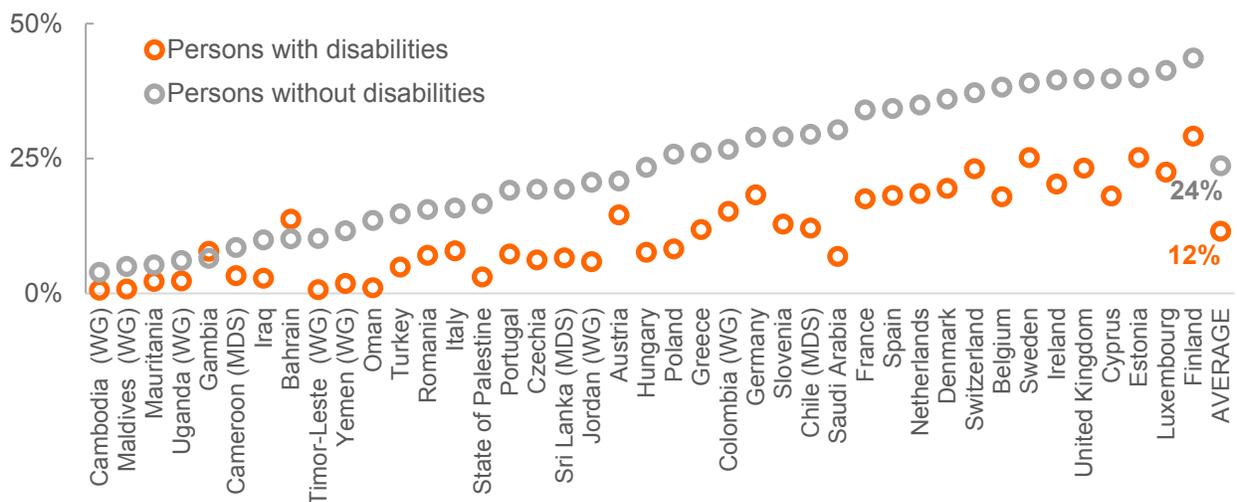
Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data on children with disabilities from Cambodia and Gambia are based on 25 to 49 observations and should be interpreted with caution.

Source: UNESCO Institute for Statistics (on the basis of data from DHS²³⁸).

Persons with disabilities are also less likely to complete tertiary education (Figure II.31). Among 41 countries, around 2012, 24% of persons 25 years of age or older without disabilities versus 12% with disabilities completed tertiary education. The highest gap between persons with and without disabilities is

observed in Saudi Arabia, where 30% of adults without disabilities versus 7% of adults with disabilities completed tertiary education. In two other countries, Belgium and Cyprus, the gaps are also wider than 20 percentage points. In another 11 of these countries, the gap is higher than 15 percentage points. The percentage of persons with disabilities who completed tertiary education ranges from 1% in Cambodia, Maldives, Oman and Timor-Leste to 29% in Finland.

Figure II.31. Percentage of persons 25 years and older²³⁹ who completed tertiary education, by disability status, in 41 countries, around 2012.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions; (MDS) identifies countries with data produced using the Model Disability Survey. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

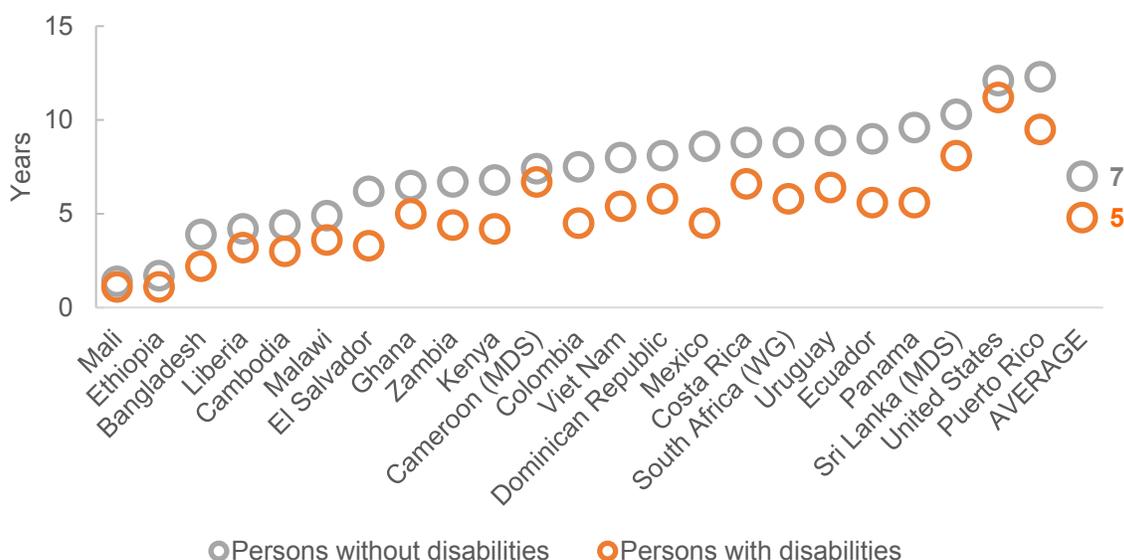
Source: DHS,²⁴⁰ ESCWA,²⁴¹ Eurostat⁸¹ and WHO.¹⁰⁷

Persons with disabilities spend fewer years in school than persons without disabilities

Mean years of schooling is the number of completed years of formal education at the primary level or higher, not counting years spent repeating individual grades. Figure II.32 shows this indicator for the population 25 years and older, in 23 countries or territories. In all countries, persons with disabilities spend a lower average number of years in school than their counterparts without disabilities. On average, persons without disabilities have 7 years of schooling and persons with disabilities 5 years, in other words, persons 25 years and older without disabilities have 40% more years of schooling than persons with disabilities. In Ecuador, Mexico and Panama, the largest gaps can be identified. In Mexico and Panama, the difference in the years of schooling between persons with and without disabilities is 4.1 and 4.0 years, respectively, and in

Ecuador, it is 3.4 years. In all other countries, the difference in the number of years of schooling between individuals with and without disabilities is at least one year. The exception is Mali, where the difference is only 0.3 years, but the mean years of schooling for the population 25 years and older is very low at 1.1 years for persons with disabilities and 1.4 years for persons without disabilities. In El Salvador and Mexico, persons without disabilities have nearly twice as many years of schooling as persons with disabilities, while in the United States persons with disabilities have almost as many years of schooling as their peers without disabilities.

Figure II.32. Mean years of schooling, for the population 25 years and older, by disability status, in 23 countries or territories, around 2010.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions; (MDS) identifies countries with data produced using the Model Disability Survey. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

Source: UNESCO Institute for Statistics (on the basis of data from IPUMS²³¹) and WHO.¹⁰⁷

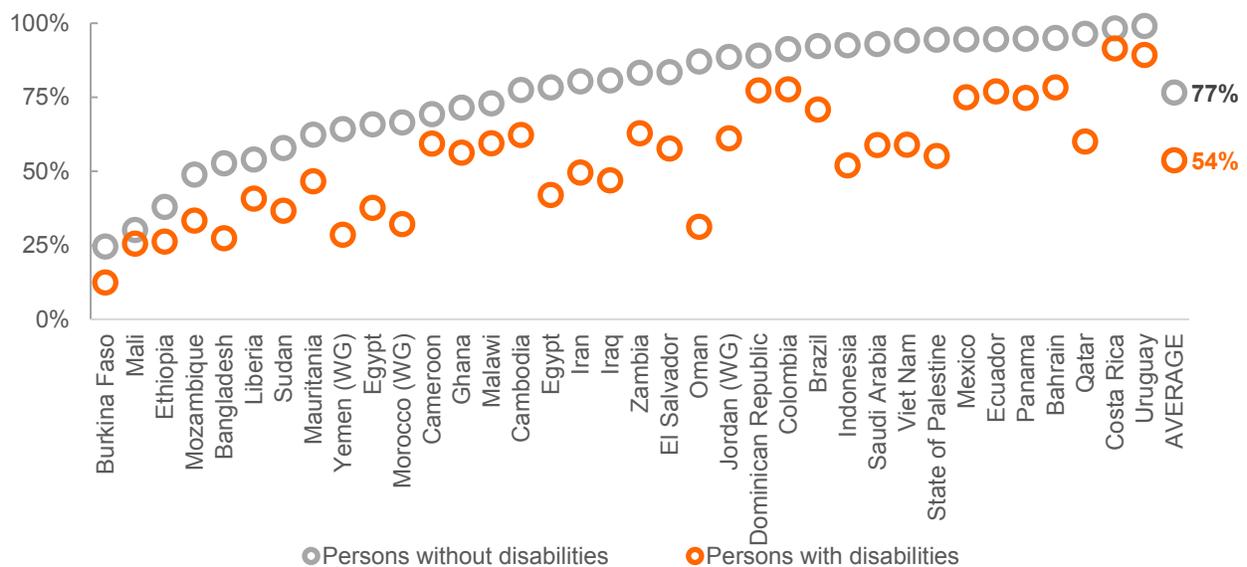
In all countries, persons with disabilities have lower literacy rates than persons without disabilities

Literacy is typically defined as the ability to read and write, with understanding, a short, simple statement about everyday life.²⁴² The adult literacy rate for the population 15 years and older is shown in

Figure II.33 for 36 countries. In all countries, persons with disabilities have lower literacy rates than persons without disabilities. The gaps range from 5 percentage points in Mali (2009 census) to 56 percentage points

in Oman, where a large majority of adults (87%) without disabilities have basic literacy skills, compared to only a third (31%) of adults with disabilities. Large gaps in adult literacy rates between persons with and without disabilities are also present in Egypt, Indonesia, Iran, Iraq, Morocco, Qatar, Saudi Arabia, State of Palestine, Viet Nam and Yemen. In Viet Nam, the high adult literacy rate of 94% for persons without disabilities is in stark contrast with the 59% literacy rate among persons with disabilities. In Iran, there is a difference of 31 percentage points between the literacy rate of persons with disabilities (50%) and adults without disabilities (80%). The parity index, calculated by dividing the literacy rate of adults with disabilities by the literacy rate of adults without disabilities, is 0.69 on average and ranges from 0.36 in Oman – where the literacy rate is almost three times as high among adults without disabilities as among adults with disabilities – to 0.93 in Costa Rica.

Figure II.33. Adult literacy rate for population 15 years and older, by disability status, in 36 countries, around 2010.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

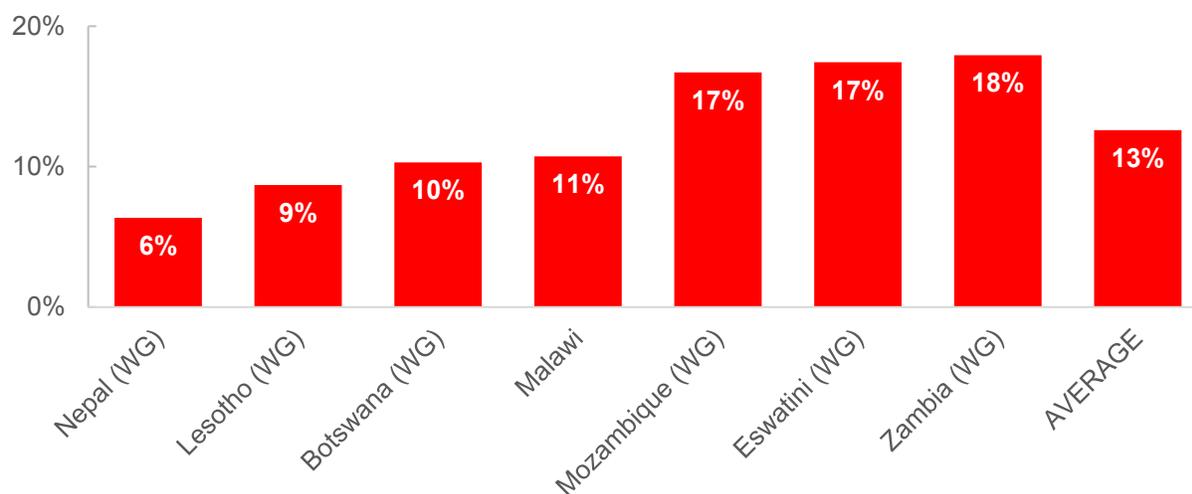
Source: ESCWA²⁴¹ and UNESCO Institute for Statistics (on the basis of data from IPUMS²³¹).

Persons with disabilities still face many barriers to education

Persons with disabilities are sometimes refused entry into schools because of their disability. Data from 7 countries around 2008, shows that between 6% of persons with disabilities in Nepal to 18% in Zambia have been refused entry into a school or a pre-school because of their disability (

Figure II.34). In Mozambique and Eswatini, percentages are almost as high as in Zambia, 17%. On average among these 7 countries, 13% of persons with disabilities have been refused entry into a school or pre-school at least once because of their disability.

Figure II.34. Percentage of persons with disabilities who have ever been refused entry into a school or pre-school because of their disability, in 7 countries, around 2009.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

Source: SINTEF.⁹

Those who enter school still face other challenges. In 7 countries around 2008, on average 8% of students with disabilities mainly attended special schools and 3% special classes in primary, secondary or tertiary school (

Students with disabilities are sometimes obliged to stop attending school because of financial and environmental barriers. In 4 countries, around 2010, on average, 17% of students with disabilities stopped attending school because it was too expensive, 13% because school was too far or no transport was available to take them to school, and 4% because of communication and language barriers (Figure II.37).

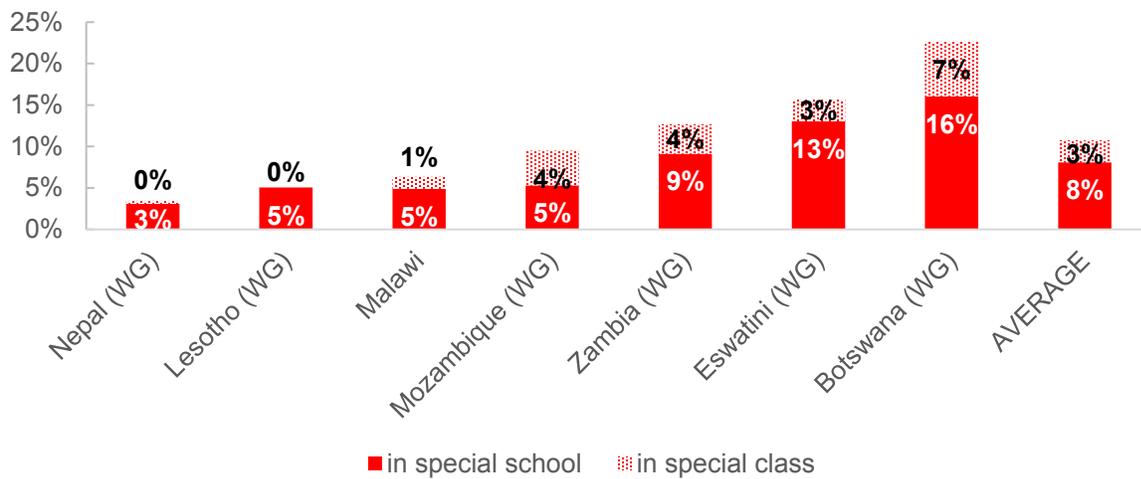
Figure II.35). In Eswatini and Botswana more than 10% of students with disabilities attend special schools. Evidence from 21 countries and territories in the Asia and the Pacific region suggests that in some countries there were still many children with disabilities learning in special primary schools: on average 19% of them (

Figure II.36). Kyrgyzstan shows the highest percentage, – 97%, – and four countries and territories, China,

Nauru, Bhutan, and New Caledonia, show percentages above 40%.

Students with disabilities are sometimes obliged to stop attending school because of financial and environmental barriers. In 4 countries, around 2010, on average, 17% of students with disabilities stopped attending school because it was too expensive, 13% because school was too far or no transport was available to take them to school, and 4% because of communication and language barriers (Figure II.37).

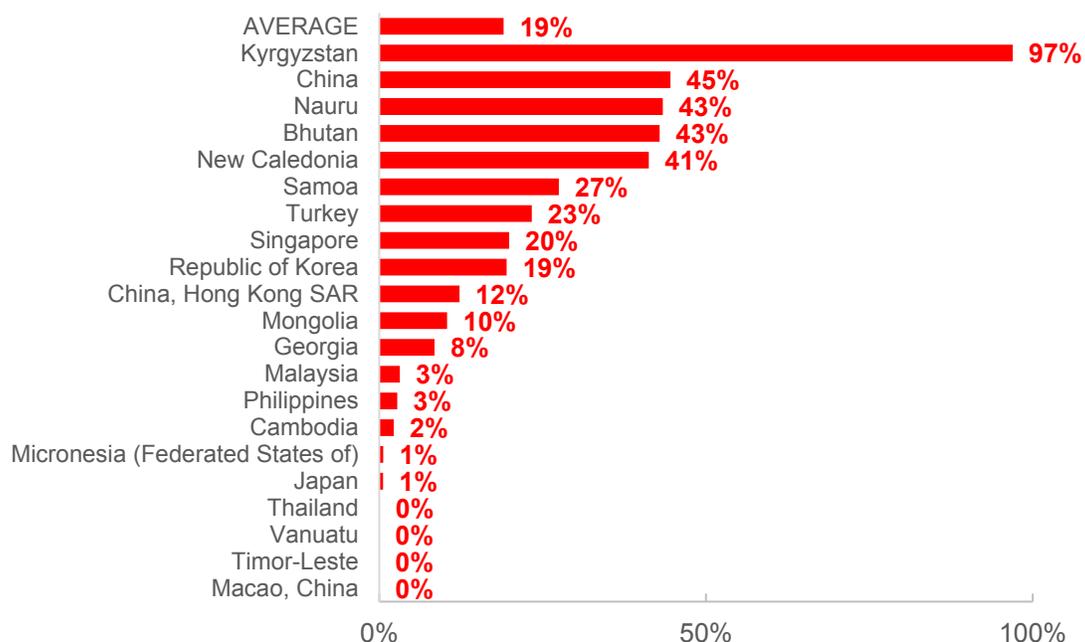
Figure II.35. Percentage of persons with disabilities who mainly attended pre-school, primary, secondary or tertiary school in a special school or a special class, in 7 countries, around 2008.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

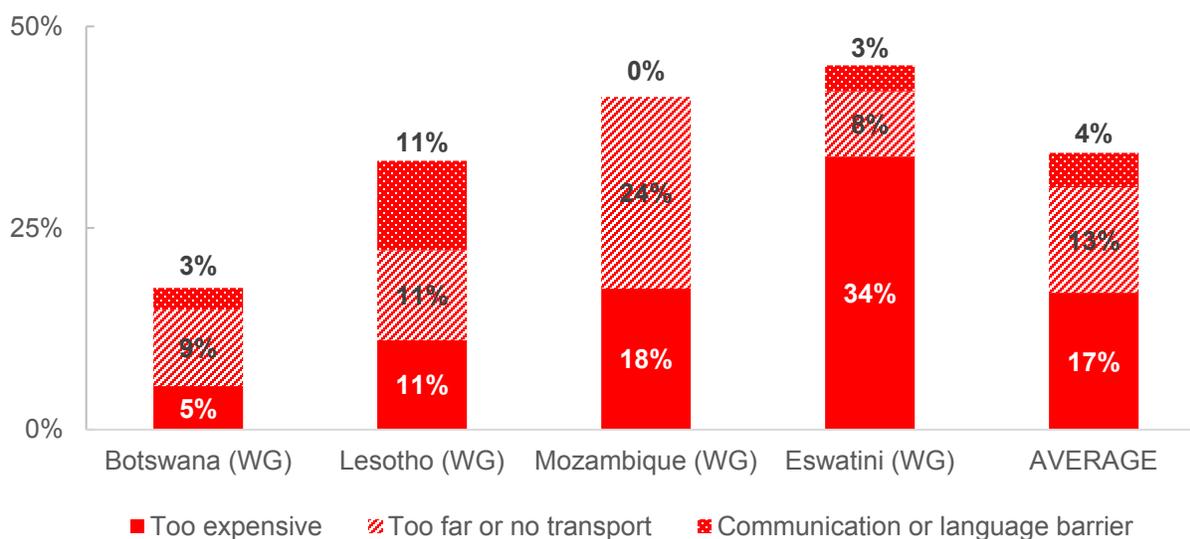
Source: SINTEF.⁹

Figure II.36. Percentage of children with disabilities attending primary school in a special school, in 21 countries, around 2015.



Source: ESCAP.⁴¹

Figure II.37. Percentage of students with disabilities who stopped attending school because it was too expensive, it was too far or there was no transport, or there was a communication or language barrier, in 4 countries, around 2010.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

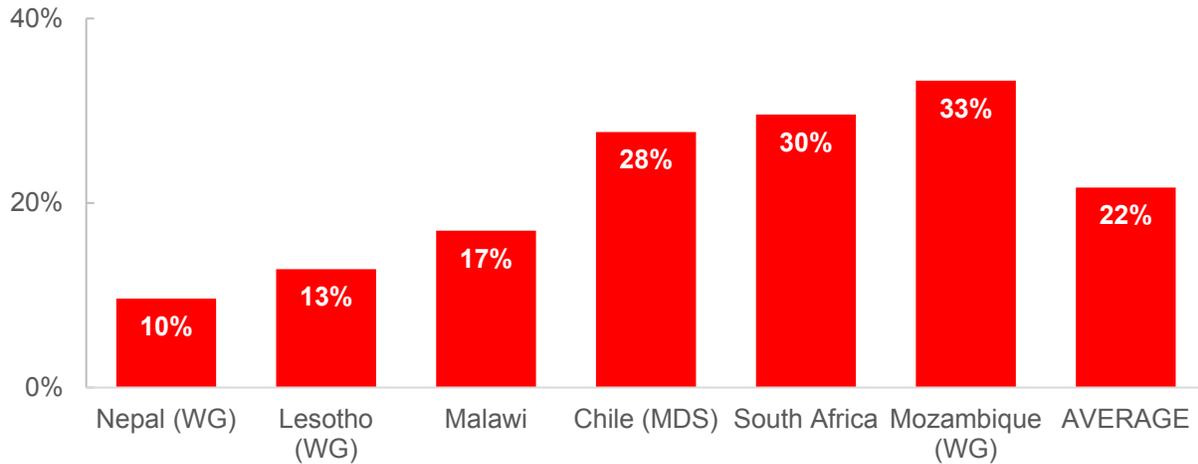
Source: SINTEF.⁹

Moreover, physical and virtual barriers at schools make it difficult for students with disabilities to participate. In 6 countries, around 2010, on average 22% of persons with disabilities reported that schools were not accessible or hindering (Figure II.38 **Error! Not a valid bookmark self-reference.**). Percentages vary between 10% in Nepal to 33% in Mozambique.

According to crowd-sourced accessibility data analysed in various countries (mostly developed), only 47 per cent of more than 30,000 education facilities were considered accessible for persons using wheelchairs.²⁴³ Zooming in on selected regions in Southern Asia and Europe (Figure II.39 and

Figure II.40) shows that in both regions there is a mix of accessible and non-accessible schools for wheelchair users.

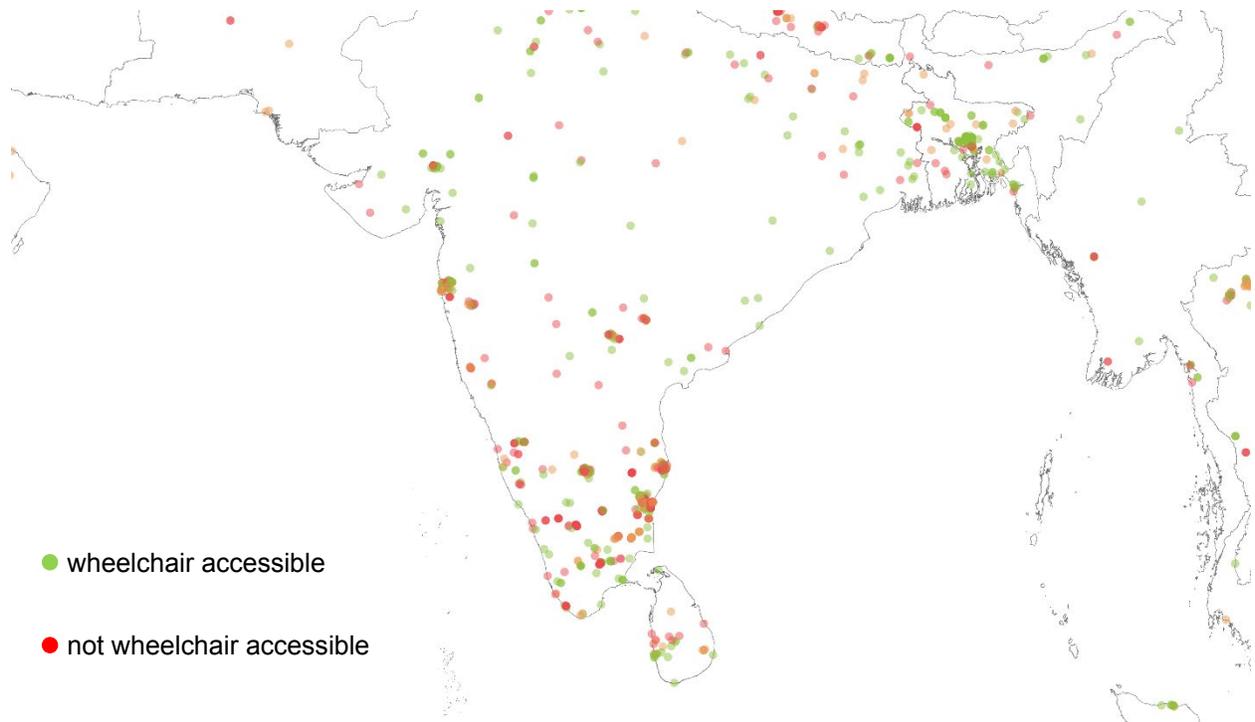
Figure II.38. Percentage of students with disabilities who found that schools were not accessible or hindering, in 6 countries, around 2010.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions; (MDS) identifies countries with data produced using the Model Disability Survey. MDS data refers to “hindering schools”; all other data refers to “not accessible schools”. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF⁹ and WHO.¹⁰⁷

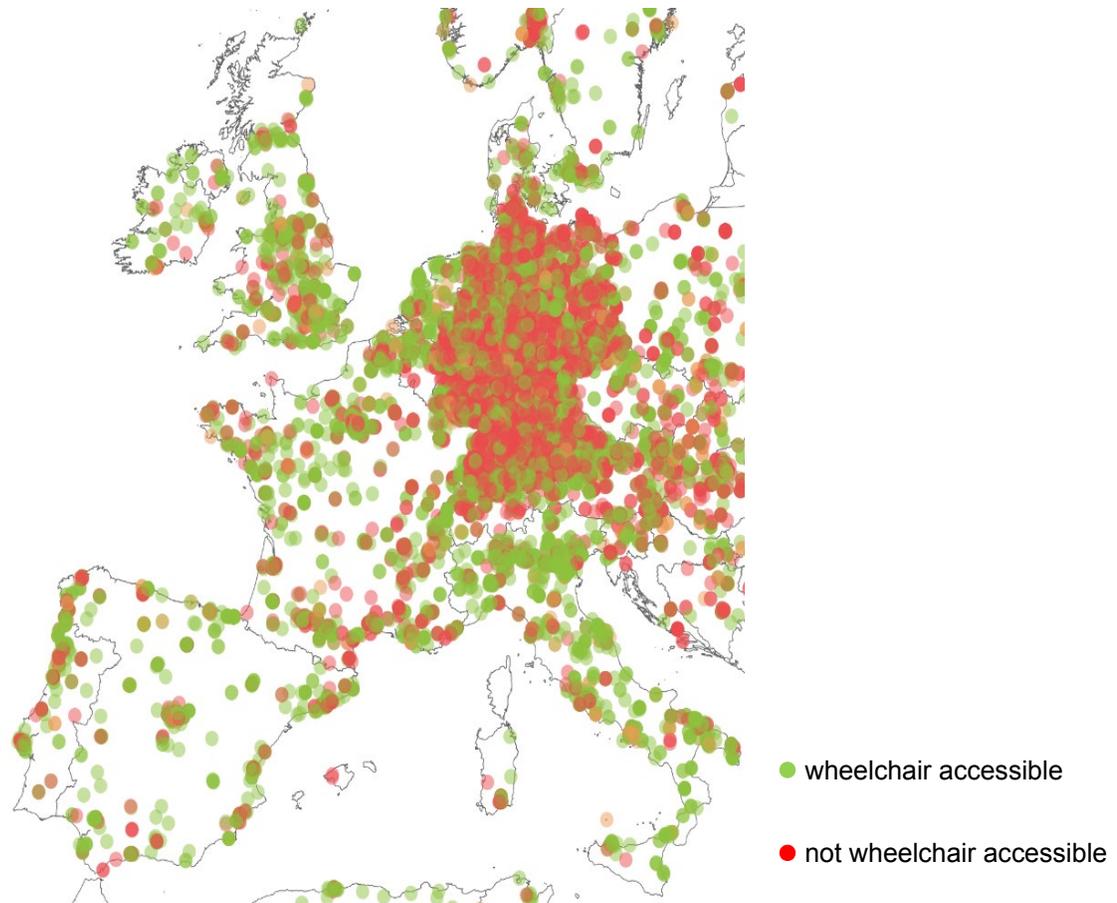
Figure II.39. Accessibility of schools for wheelchair users, in a selected region in southern Asia, in 2017 (crowd-sourced data).



Note: The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

Source: Sozialhelden.²⁴⁴

Figure II.40. Accessibility of schools for wheelchair users, in a selected region in Europe, in 2017 (crowd-sourced data).

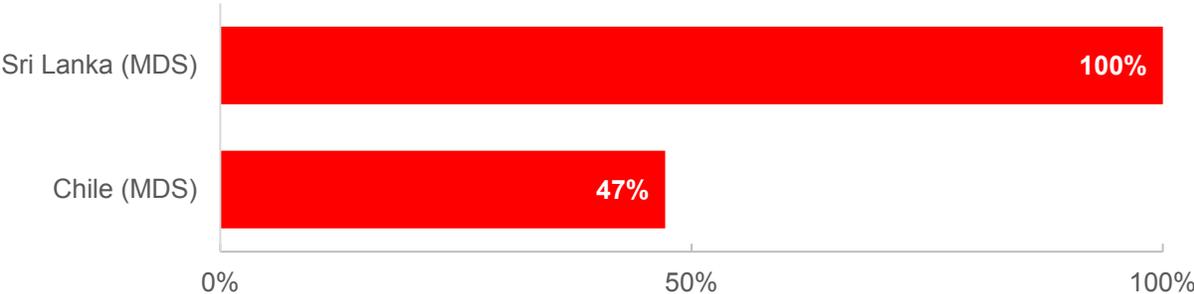


Note: The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

Source: Sozialhelden.²⁴⁵

Unavailability of adequate assistive technologies can also create barriers for persons with disabilities. In 2016, in Chile and Sri Lanka, respectively 47% and 100% of persons with disabilities used but needed more assistive products to participate in education (Figure II.41). Unaffordability and lack of availability of assistive technology is a common barrier. Lack of electricity in many schools worldwide also compromises the use of assistive technology for education (see section on SDG 7).

Figure II.41. Percentage of persons with disabilities who use but need more assistive products for education, in 2 countries, in 2016.



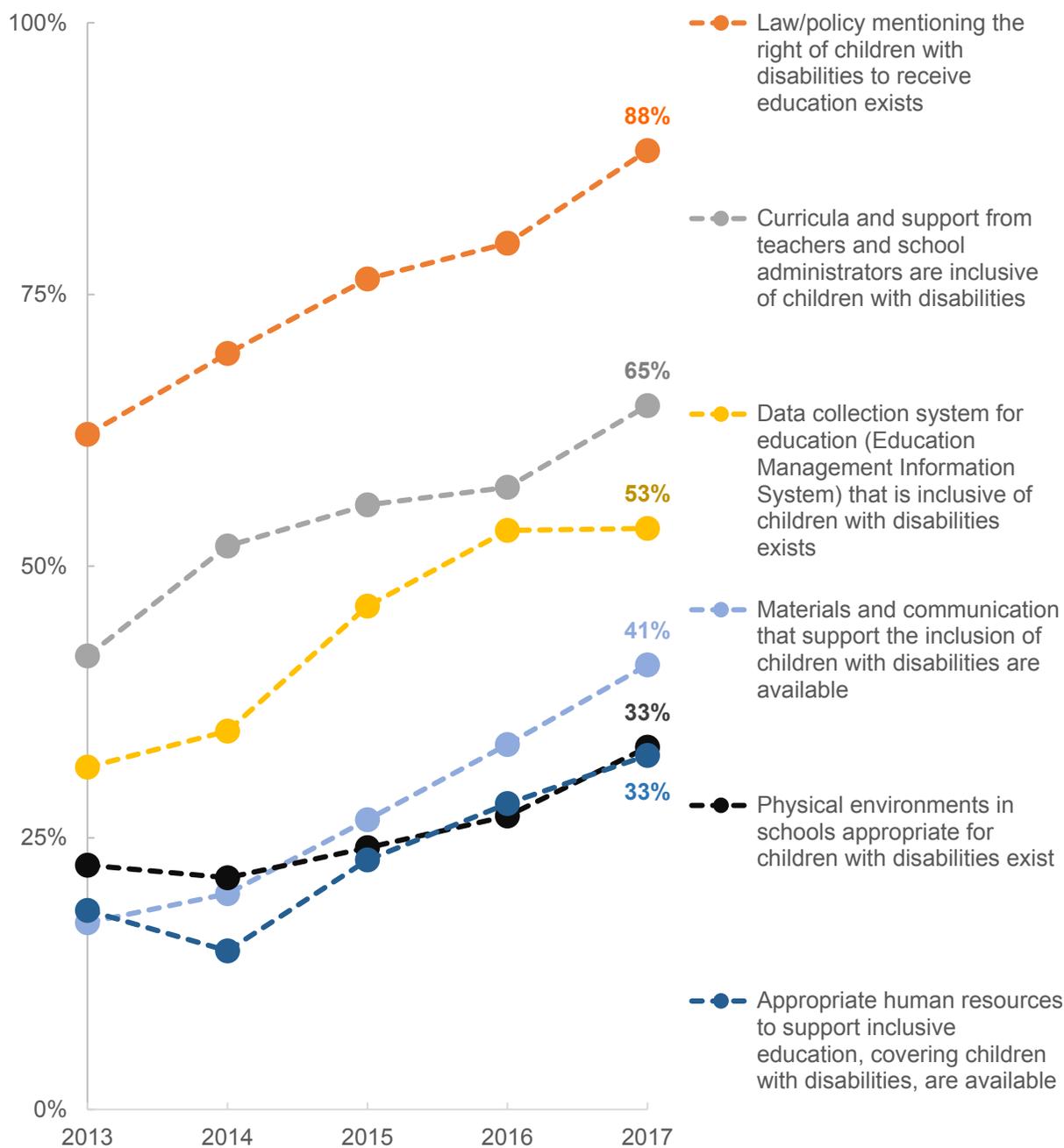
Note: (MDS) identifies countries with data produced using the Model Disability Survey.

Source: WHO.¹⁰⁷

Current practices on disability and education

More and more countries have been making efforts to make the educational system inclusive of persons with disabilities, removing barriers and addressing discrimination on the ground of disability. In particular, many countries have included protections in their constitutions, laws or policies. Out of 193 UN Member States, 34 guarantee the right to education for persons with disabilities or protect against discrimination on the basis of disability in education in their constitutions.²⁴⁶ In 2017, 88% out of 102 countries surveyed had a law or policy mentioning the right of children with disabilities to receive education, up from 62% in 2013 (Figure II.42). A majority of countries, 65% out of 88 countries, also provide curricula inclusive of children with disabilities, as compared to only 42% in 2013. And many governments made progress in collecting disability data through the Education Management Information System (EMIS): in 2017, 53% out of 101 countries had such a data collection system, an increase from 31% in 2013. The collection of data is key to enable governments to make evidence-based plans for their education systems, or on changing attitudes towards children with disabilities.

Figure II.42. Percentage of countries which implemented selected measures to promote inclusive education, among 87 to 101 countries,²⁴⁷ from 2013 to 2017.



Source: UNICEF.²⁴⁸

However, many obstacles still remain for persons with disabilities to be included in mainstream educational systems. Around 2013, only in 44% of UN Member States students with disabilities could be taught in the

same classroom as others without disabilities. In 39% of Member States, students with disabilities might attend the same schools but not necessarily the same classrooms, in 12% students with disabilities could attend special schools and in 5% children with disabilities received inadequate support in pursuing education.²⁴⁹ Most importantly, there remain considerable gaps at the school level: in materials and communication (including assistive devices for learning), human resources (including teachers) and the physical environment (including the construction of accessible school buildings). Without these vital front-line resources in place, it is practically impossible to enable children with disabilities to go to school. These gaps can clearly be seen in Figure II.42. Despite progress made since 2013, by the year of 2017, only 41% out of 88 countries provided in their schools appropriate materials (up from 17% in 2013), and even fewer countries, 33%, provided adequate human resources (up from 18% in 2013) and physical environments (up from 22% in 2013) for students with disabilities.²⁵⁰

Promoting inclusive education

Several countries implemented enacted legislation, policies and guidelines to promote the inclusion of students with disabilities. Iraq developed the National Project of Comprehensive Educational Integration that aims at improving the quality of education provided to children with disabilities.²⁵¹ Viet Nam established the National Action Plan for Education for All (2003-2015) with a provision of inclusive educational opportunities for children with disabilities.²⁵² Ethiopia adopted its first strategy of Special Needs Education in 2006 to help ensure that children with disabilities have access and quality education.²⁵³ South Sudan's Child Act stipulates the right to education for all, including persons with disabilities.²⁵⁴ A law in Czechia adopted in 2004 mandates schools to provide textbooks and teaching aids adapted to the needs of students with disabilities.²⁵⁵ In Canada, a guideline on inclusive education for schools was developed to encourage educational institutions to be equal and inclusive for all including students with disabilities.²⁵⁶

There are also various initiatives to encourage the inclusion of students with disabilities into mainstream schools.^{257,258} Some countries promote enrolment of students with disabilities through direct admission to universities, accommodation in student dormitories, and scholarships.²⁵⁹ Advisory school assistance, support and guidance have also been provided in five countries to assess the situation and learning outcomes of students with disabilities.²⁶⁰ Germany gives annual awards to schools that provide equal opportunities for education to all students and promote diversity.²⁶¹

Many countries offer education plans inclusive of students with disabilities through tailored curricula or programs.²⁶² Some countries have provisions of granting alternative arrangements for exams and assessments, allowing exemptions, adaptation of the conditions or the format of the exam or revalidation activities.²⁶³

Efforts have also been made for teaching and learning environments to be more adaptable to the diverse needs of students. Some schools are equipped with assistive technology and devices in support of

learners,²⁶⁴ ICT tools such as speech synthesizers, spelling tools, digital books,²⁶⁵ and computer technology and software.²⁶⁶ Some schools provide education in sign language or in Braille,^{267,268} through the use of audio-visual materials, games and activities,²⁶⁹ or e-books for children who are deaf or with a hearing impairment,²⁷⁰ or with an accessible online library with audio books.²⁷¹ In Europe, educational materials are made available in sign languages in the library²⁷² and an online English language course is offered to persons who are deaf or with a hearing impairment.²⁷³ In Asia and the Pacific, a regional sign language archive was developed to store sign languages that are searchable for teaching, development, and research purposes.²⁷⁴

In many countries, art, such as drama, music, and drawing has been used as a pedagogical method for disability-inclusive education. For example, in South Africa, a school uses African drumming as a means of harnessing creativity in learners with disabilities,²⁷⁵ and in Egypt, a project provided an opportunity for students with and without disabilities to discuss what will happen in life in the year 2050 through drawings.²⁷⁶ In the United States, drama, dance and music were incorporated at schools for children with intellectual disabilities,^{277,278} whereas in the United Kingdom, students in primary school design and write series of books on disability as a resource for new students to enhance their understanding on of disability.²⁷⁹

Physical and virtual accessibility at schools

Many countries took actions to enhance the physical accessibility at schools through reviewing school buildings, facilities and identified physical obstacles that prevent persons with disabilities from enjoying their right to education, and installing or modifying ramps, lifts, and public facilities. 280,281 In Barbados, a school installed an elevator, acoustic floors that vibrate with music for the dancing classes, and large screens, braille printers and assistive audio software.²⁸² Measures have also been in place to equip schools, and social service centres with specialized information technology (IT) solutions for persons with disabilities.²⁸³ In South Sudan, construction standards were revised to ensure that schools are accessible for students with disabilities.²⁸⁴

Offering financial support for inclusive education

Financial support is vital for students to meet the extra costs incurred due to disability. Such financial aid is provided in forms of students grants and loans, and coverage of transport costs to schools. For example, Mauritius provides a scholarship scheme for students with disabilities to pursue secondary and tertiary studies and allows reimbursement of taxi fares for university students with severe disabilities who have difficulties taking public transport.²⁸⁵

Some countries provide financial support to schools to promote inclusive education. For instance, Australia and Armenia have a provision of funding to educational institutions to strengthen the capacity of schools and teachers to meet the needs of students with disabilities.²⁸⁶ Latvia requires higher education institutions

to prioritize a candidate with disabilities in granting a stipend.²⁸⁷

Building capacity of teachers

Building capacity of teachers in inclusive education is essential to meet the needs of students with disabilities. Teachers training classes and/or the provision of training manuals for teachers have been offered in some countries.²⁸⁸ For example, a train-the-trainer program was provided to prepare educators from national and provincial universities and colleges across Viet Nam to expand inclusive education into all preschool, primary and secondary schools.²⁸⁹ Ethiopia offered new teacher programs on education of children with disabilities.²⁹⁰ A school in Finland provided opportunities for teachers of students with disabilities to share knowledge on methods for inclusive education and for mainstreaming equality among students.²⁹¹ Similarly, in Cambodia, a programme was established for primary school teachers to enhance their understanding of students with disabilities and to prevent bullying in schools.²⁹² Initiatives in other countries included a software to create public educational materials in Sign Language to assist teachers²⁹³ and university courses to produce teachers who can teach in sign language.²⁹⁴ In Mexico and Spain, methods for teaching students with special educational needs have been developed.^{295,296}

Awareness-raising on inclusive education

Various awareness-raising activities have been undertaken. Many examples include awareness-raising activities on the rights of students with disabilities in schools or in the communities.^{297,298,299} For instance, Malta provided opportunities for students with and without disabilities to interact.³⁰⁰ In Ireland, a show with puppets that illustrates relationships between persons with and without disabilities was utilized to educate primary school students about autism and deafness.³⁰¹

Monitoring the implementation of inclusive education

Various countries established monitoring mechanisms at local or national levels, for example, through formulation of commissions, a task team, or a group that provide guidance on education to ensure the needs of students with disabilities are met and to monitor the progress.^{302,303} Some countries have established follow-up services or mechanisms which rely on monitoring by the communities: for instance, a disability helpline was developed to accommodate concerns reported by families of students with disabilities and to offer solutions in cooperation with local education authorities and school inspectorates,³⁰⁴ and parents have been included in the process of monitoring the effectiveness of the measures taken for inclusive education.³⁰⁵

Countries made also efforts to collect, record and analyse data on disability in the context of education. Argentina developed an information system with data on pupils with disabilities at schools. In developing indicators that track educational performances, New Zealand disaggregates the information in a way in

which the progress of students with disabilities can be accurately measured.³⁰⁶

At a regional level, the European Agency for Development in Special Needs Education developed an assessment resource guide on inclusive education.³⁰⁷ And at the international level, the International Observatory and Inclusion in Education was established to produce methodological guidelines, foster research, and disseminate internationally-comparable data for SDG 4.³⁰⁸

Conclusions and the way forward

The findings confirm that, among the countries with data, persons with disabilities encounter multiple barriers in accessing education and they are nearly always worse off than persons without disabilities: the former are less likely to attend school, they are more likely to be out of school, they are less likely to complete primary or secondary education, they have fewer years of schooling, and they are less likely to possess basic literacy skills. Several countries made efforts to strengthen national legal frameworks and devise policies and actions to address these gaps, by enacting anti-discrimination laws, making schools physically accessible, adapting teaching methods, providing financial support, enhancing capacities for teachers and staff, and raising awareness on inclusive education. An increased number of countries has also invested in education data collection systems inclusive of children with disabilities. Despite this progress, persons with disabilities continue facing barriers as many of these actions remain concentrated in a few countries or communities.

There is an urgent need to improve access to education for persons with disabilities because educational disadvantage could lead to higher exposure to social exclusion and poverty and therefore have long-term implications for their capacity to participate in employment. The disability education gap could undermine the achievement of SDG 4 as well as other SDGs. To achieve SDG 4 for persons with disabilities, in line with the CRPD, more political commitment and efforts are needed, particularly in implementing and scaling up the following actions:

- 1) **Strengthen national policies and the legal system for ensuring access to quality education for all persons with disabilities.** Ensure that national legal and policy frameworks reflect the rights of persons with disabilities to education and eliminate discriminatory policies and laws. Promote enrolment of persons with disabilities into mainstream education. Carry out educational system reforms, with the view to promote inclusive education, and to ensure equal learning opportunities. This would also help prevent risks of segregation and contribute to ensuring a truly inclusive learning environment for all.
- 2) **Build capacity of policy makers as well other decision-makers at both community and national levels** to enhance their knowledge on educational needs for persons with disabilities and to identify and implement strategies on inclusive education.
- 3) **Make schools and educational facilities accessible by creating an enabling environment for students with disabilities and by making physical and virtual environments accessible.** It is essential that students with disabilities can access all school buildings and other educational and recreational facilities, including classrooms, common rooms, libraries, dining areas, toilets and playgrounds. Universal design, a set of principles that can be applied in the construction or refurbishment of buildings, should be used as a guide for improving school accessibility as well as analysing the current situation in schools.

- 4) **Provide training to teachers and other education specialists to gain knowledge and experience in inclusive education for persons with disabilities.** Teachers as well as other educators are at the centre of education systems and should receive appropriate pre-service and in-service training and continued support in adopting inclusive pedagogy to meet the diverse needs of learners.
- 5) **Adopt a learner-centred pedagogy which acknowledges that everyone has unique needs that can be accommodated through a continuum of teaching approaches.** It is essential that teaching and learning materials are available, accessible, well-designed, affordable and adapted to ensure that diverse learning needs of different learners are met. An inclusive curriculum should address all learners' cognitive, emotional, social and creative development. Accessible and assistive technologies, including digital technologies and communication aids, can play a significant role in this regard by enhancing the accessibility of teaching and learning materials. For example, some persons with disabilities require hearing aids, easy-to-read or large print texts, books and other reading materials in Braille, as well as recognition of and support for sign language.
- 6) **Engage civil society and local communities in inclusive education.** It is essential that local communities are fully engaged in improving the quality of education for persons with disabilities. Parents should be empowered to participate in the education of their children with disabilities. Prejudice and negative attitudes in the communities pose a serious barrier against equal opportunities for persons with disabilities to receive education, and should be combatted.
- 7) **Establish monitoring mechanisms** to regularly monitor and evaluate the implementation of policies and laws on inclusive education. The monitoring and evaluation process should involve persons with disabilities, including children with disabilities and their parents and/or caregivers, where appropriate. Disability-inclusive indicators should be developed and used in line with the indicators for SDG 4.
- 8) **Improve national collection and disaggregation of education data by disability.** A national census can be an important source of information on disability, since the data can usually be disaggregated by sex, age, location and other dimensions. Household surveys also provide valuable education data by disability, but sample sizes should be sufficiently large to allow disaggregation by sex, location and other status including age, income and ethnicity. Especial attention should be given to producing education data on children with disabilities. Moreover, information on accessibility of school buildings and learning materials should be requested in routine administrative data collection systems.
- 9) **Explore crowd-sourcing applications to obtain bottom-up information on the accessibility of schools for persons with disabilities to inform accessibility policies.** Assessing accessibility of schools is expensive and complex. Several online and smartphone applications already allow users to publicly review the accessibility for wheelchair users of any facility in the world, including schools. Current information on schools covers mainly developed countries and future efforts should focus on gathering

crowdsourced information in developing countries and to update these applications to capture information on accessibility for any type of disability. Crowd-sourced information reflects the direct experience of the users and can be helpful to inform national accessibility policies for education.

E. Achieving gender equality and empowering all women and girls with disabilities (SDG 5)

SDG 5 aims to achieve, by 2030, gender equality and the empowerment of all women and girls. This section focuses on women and girls with disabilities, analysing the international normative framework and providing an overview of their situation, as well as presenting national and international efforts to promote their inclusion and participation in society. The section concludes with suggestions on the way forward, based on current evidence.

International normative framework on disability and gender

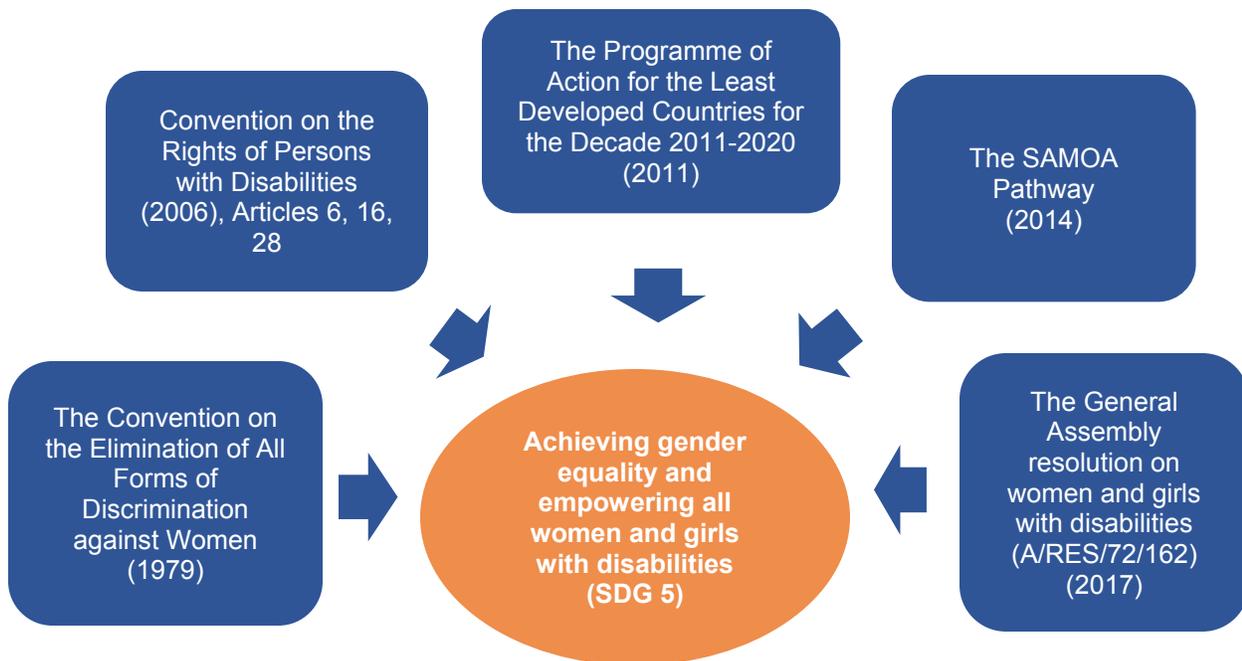
SDG 5 calls for elimination of all forms of discrimination and violence against all women and girls, including those with disabilities. It also stresses the importance of their full and effective participation and equal opportunities in political, economic and public life. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted in 1979 addresses the advancement of the status of women. While CEDAW does not make explicit reference to women and girls with disabilities, the Beijing Declaration and the Platform for Action recognizes that women and girls with disabilities face multiple barriers to full equality and advancement, and the enjoyment of human rights, and identifies specific actions to ensure the empowerment of women with disabilities in various areas, including: enhancement of the self-reliance of women with disabilities (paragraph 175 (d)); equal access to appropriate education and skills-training for their full participation in life (paragraph 280 (c)), improvement of their work opportunities (paragraph 82(k)); health programmes and services that address the specific needs of women with disabilities (paragraph 106 c)); equity and positive action programmes to address systemic discrimination against women with disabilities in the labour force (paragraph 178 (f)); and improving concepts and methods of data collection on the participation of women and men with disabilities, including their access to resources (paragraph 206 (k)).

However, it was not until the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) that the international community set out specific provisions dedicated to women and girls with disabilities. The CRPD calls for a twin track approach in this regard: gender equality is established as a general principle, to be taken into account in the implementation of each Article of the Convention and, the CRPD also includes a stand-alone Article on women with disabilities, Article 6. This article recognizes that women and girls with disabilities are subjected to multiple forms of discrimination and establishes that States Parties should take all appropriate measures to ensure their full development, advancement and empowerment. The CRPD further stipulates that State parties should put in place effective legislation and policies with a focus on women with disabilities to protect them from exploitation, violence and abuse (Article 16, paragraph 5), and should pay special attention to women and girls with disabilities in access to social protection programmes and poverty reduction programmes (Article 28, paragraph 2(b)).

Relatedly, the General Assembly resolution on Implementation of the Convention on the Right of Persons with Disabilities and the Optional Protocol thereto: Situation of women and girls with disabilities (A/RES/72/162),³⁰⁹ adopted in 2017, focuses on the special needs of and challenges faced by women and girls with disabilities. The resolution calls for eliminating multiple and intersecting forms of discrimination and all forms of violence, supporting women and girls with disabilities to exercise legal capacity to have freedom to make their own choices on an equal basis with others in all aspects of life, promoting their empowerment and leadership, as well as ensuring equal access to education, employment and health services, including sexual and reproductive health services. The resolution emphasizes the importance of collecting and analysing data disaggregated by income, sex, race, age, ethnicity, migratory status, disability, geographic location and other characteristics relevant to national contexts to guide policy planning. It also calls upon States to improve data collection systems for adequate monitoring and evaluation frameworks on the implementation of the CRPD and the SDGs for women and girls with disabilities.

Gender equality is also addressed in the context of Small Island Developing States (SIDS) and the Least Developed Countries (LDCs). The Small Island Developing States Accelerated Modalities of Action (SAMOA) Pathway, adopted in 2014, emphasizes the importance of reducing structural and socioeconomic inequalities and multiple intersecting forms of discrimination that affect women and girls, including those with disabilities, that hinder progress and development.³¹⁰ Commitments to women and girls with disabilities in the SAMOA Pathway included support for the provision of high-quality education and training, and disaggregation of data by sex, age and disability. The Programme of Action for the Least Developed Countries for the Decade 2011-2020 commits to pursuing policy measures to promote gender equality for women with disabilities.³¹¹

Figure II.43. International normative frameworks relevant for the achievement of SDG 5 for persons with disabilities.



The situation of women and girls with disabilities

This subsection presents available evidence on the status of inclusion, on an equal basis with others, of women and girls with disabilities. It focuses on data and information available in relation to key areas of the SDGs, including poverty and hunger, access to healthcare services, education and employment. The subsection also presents evidence to illustrate the situation of women and girls with disabilities regarding several SDG 5 targets. This includes available data on exposure to violence (target 5.2), child marriage (5.3), unpaid work (target 5.4), opportunities for leadership (target 5.5) and use of internet (target 5.b).

Poverty and hunger

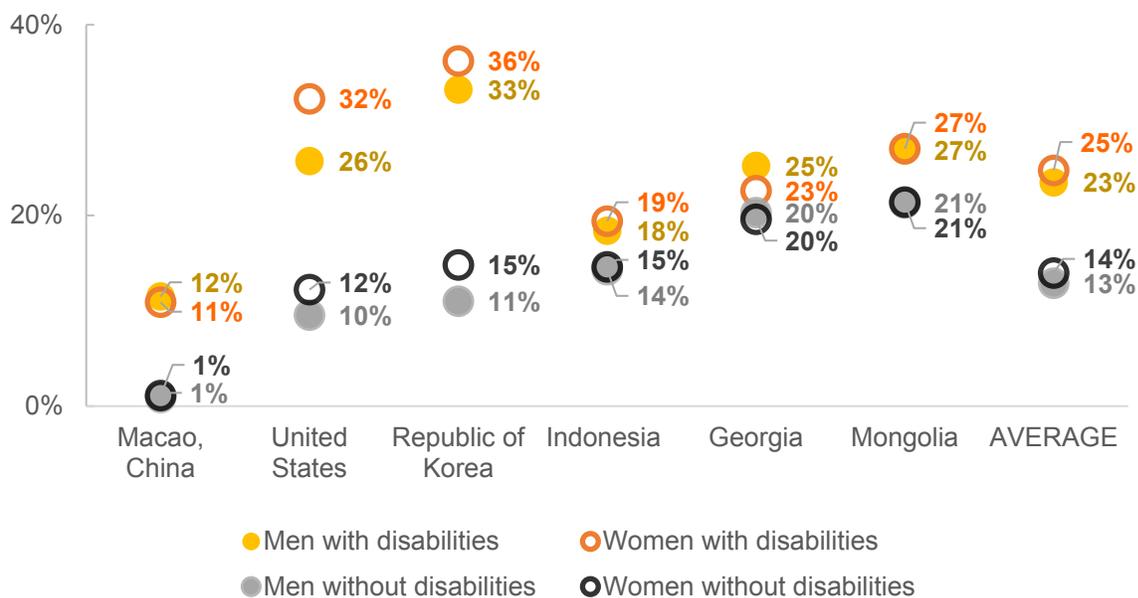
There is limited data on poverty that has been disaggregated by disability and sex. Data on the percentage of persons living under the national poverty line, from 6 countries, around 2014, albeit limited in the number of countries, shows a consistent pattern (Figure II.44). While women with disabilities experience higher poverty rates than men and women without disabilities in all countries, the poverty rates among women and men with disabilities are similar. The highest gap in poverty rates between women and men with disabilities

is observed in the United States (6 percentage points) and the lowest gap in Mongolia (no gap). Poverty rates among women with disabilities vary from 11% in Macao, China to 36% in the Republic of Korea.

Regarding food security and nutrition, data from 35 countries, mostly in Europe, shows that on average 18% of women with disabilities are unable to afford a meal with a protein component every second day, from 2% in Iceland to 68% in Turkey (

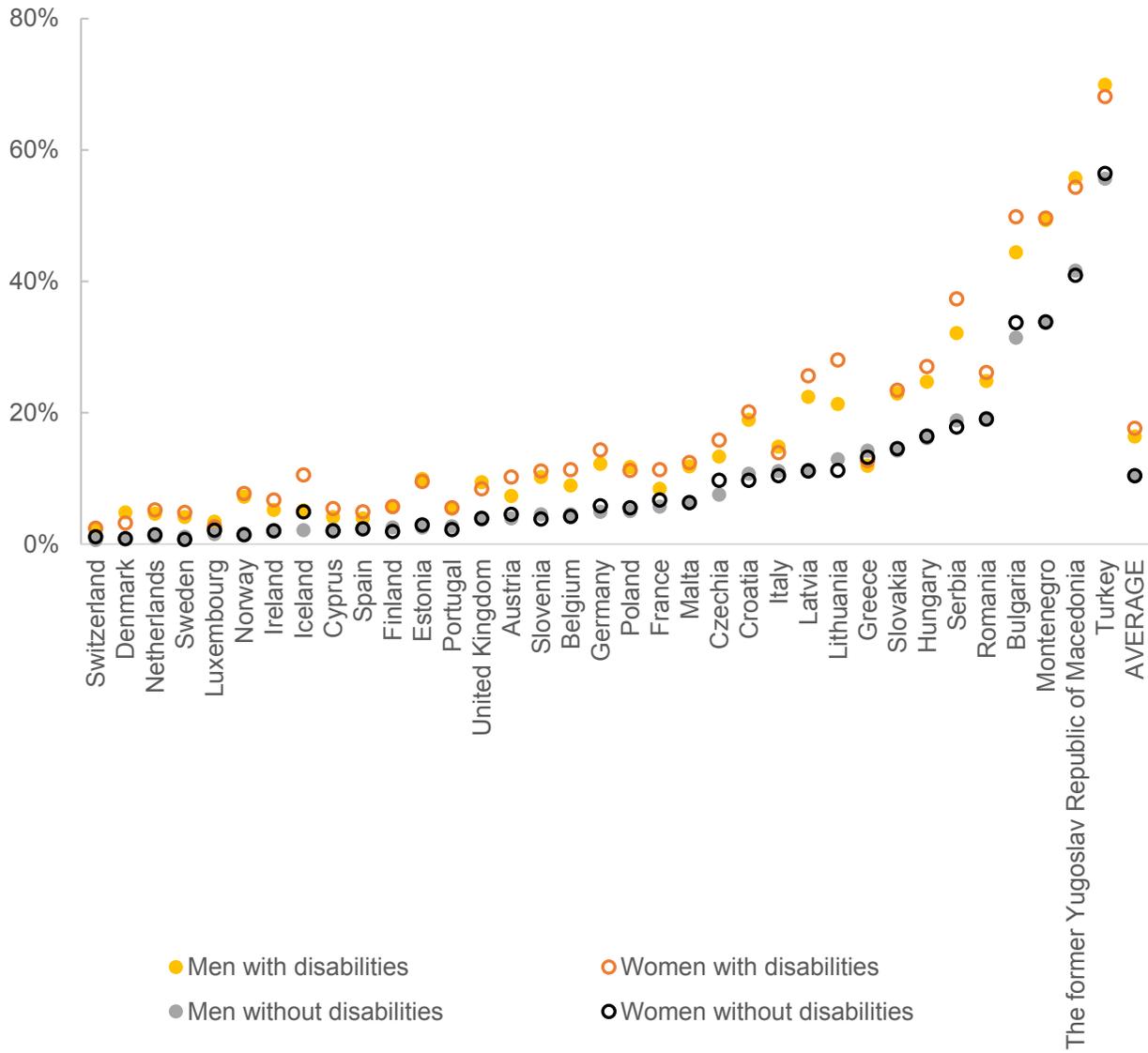
Figure II.45). Women and men with disabilities show on average similar percentages regarding inability to afford a meal with a protein component every second day. The highest gaps between women and men with disabilities – over 5 percentage points – appear in Bulgaria, Iceland, Lithuania, Serbia. The highest gap between women with disabilities and men without disabilities – over 15 percentage points – are observed in Bulgaria, Lithuania, Montenegro and Serbia. Evidence from Botswana points to similar rates of food insecurity between women and men with disabilities (Figure II.46), but women with disabilities are almost twice as likely to not have food in the household, due to lack of resources, than men without disabilities.

Figure II.44. Percentage of persons living under the national poverty line, by disability status and sex, in 6 countries, around 2014.



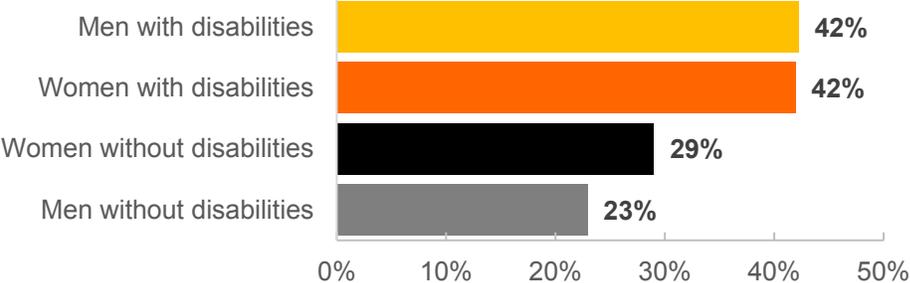
Source: ESCAP (2018)⁴¹ and Brucker et al (2014).^{312,313}

Figure II.45. Percentage of persons who are unable to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day, by disability status and sex, around 2016.



Source: Eurostat.⁸¹

Figure II.46. Percentage of persons who in the past two weeks did not always have food to eat in the household because of lack of resources, by disability status (WG) and sex, in Botswana, in 2014.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.
Source: SINTEF.⁹

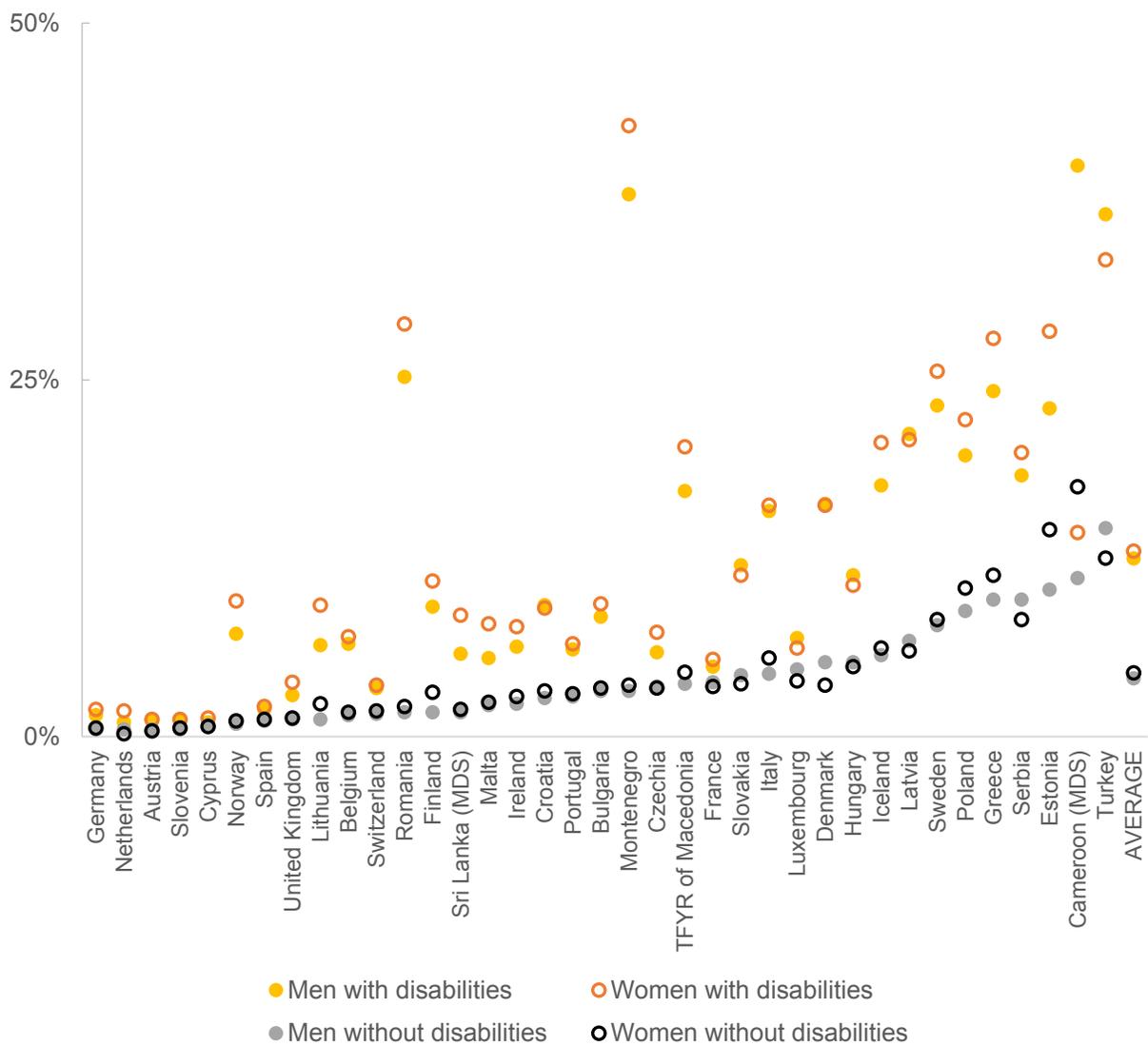
Access to health care

Among 37 countries, 13% of women with disabilities, on average, cannot get health care when they need it (

Figure II.47). In Austria, Cyprus and Slovenia, the health care needs of women with disabilities are largely met: only 1% of women with disabilities are unable to meet their health needs – the lowest values among the 37 countries. However, in 10 of these countries, more than 20% of women with disabilities are not able to meet their health needs. In Montenegro this affects 43% of women with disabilities. Differences between women and men with disabilities tend to be small (up to 5 percentage points), while the differences between women with disabilities and men without disabilities are wider (up to 40 percentage points, and 9 percentage points on average).

On average, women with disabilities have similar rates of unmet health needs as men with disabilities (13% and 12%, respectively), but higher than both men and women without disabilities (4%). This suggests that overall, barriers for persons with disabilities are a major factor impeding access to health care for women with disabilities. This is consistent with other findings showing that physical, financial and attitudinal barriers are an obstacle for persons with disabilities in accessing health care (see section on SDG 3).

Figure II.47. Percentage of persons who needed but could not get health care, by disability status and sex, in 37 countries, around 2016.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

Source: Eurostat⁸¹ and WHO.¹⁰⁷

Education

Youth aged 15 to 29 who ever attended school

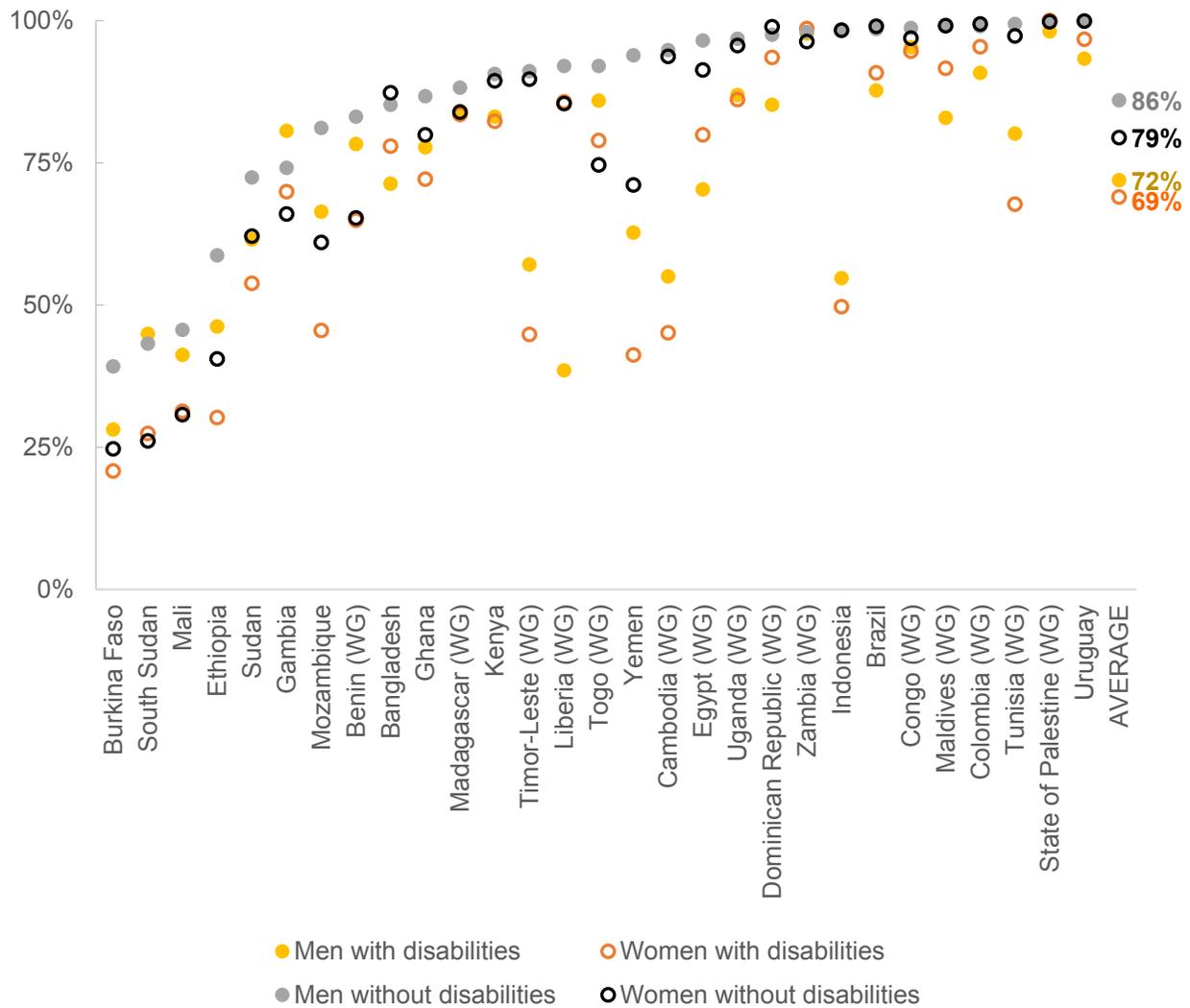
Among 29 developing countries, on average only 69% of women with disabilities ever attended school, compared to 72% of men with disabilities, 79% of women without disabilities and 86% of men without disabilities (Figure II.48). In most countries, for both persons with and without disabilities aged 15 to 29, men are more likely to have ever attended school than women. The percentage of women with disabilities who have ever attended varies among these 29 countries, from 21% in Burkina Faso to 97% in Uruguay. The gaps vis-à-vis men without disabilities are small in eight countries (under 5 percentage points); but are wider than 20 percentage points in 7 countries.

The evidence suggests that, depending on the country, gender discrimination or barriers for persons with disabilities (e.g. lack of accessibility, discrimination) may play a bigger role. In Benin, Mali, South Sudan and Togo, the gap is wider between women (both with and without disabilities) and men, but narrower between women with and without disabilities. And the ratios of men with disabilities who have ever attended school are closer to those of men without disabilities. This suggests that gender discrimination is playing a major role. In Brazil, Indonesia, Tunisia, and Timor-Leste, the gap is wider between persons with disabilities (both women and men) and persons without disabilities. In these countries, the percentage of women without disabilities who have ever attended school is close to that of men without disabilities, thus suggesting that attitudinal and physical barriers against persons with disabilities are a factor explaining the low rates of women with disabilities.

Primary education

Evidence from 17 countries, around 2010, shows that in all countries but Gambia, young women and men with disabilities aged 17 to 24 are less likely to complete primary education than their peers without disabilities (Figure II.49). Depending on the country, young women have higher or lower rates of completion than boys, regardless of their disability status. In eight of these countries, young women with disabilities have higher rates than boys with disabilities, and in five of these eight, the same is true for their peers without disabilities. Young women with disabilities show higher completion rates than young men with disabilities mostly in countries in which the overall completion rate is high or in which young women without disabilities shows higher completion rates than young men without disabilities.

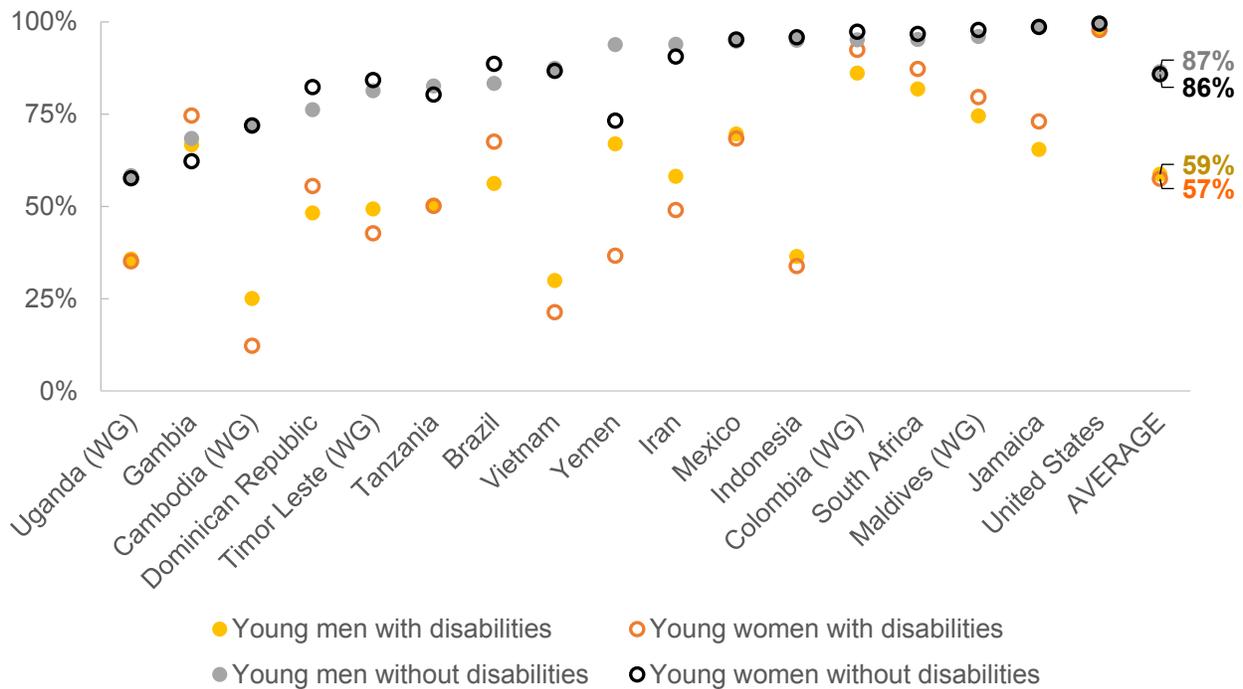
Figure II.48. Percentage of youth aged 15 to 29 years old who ever attended school, by disability status and sex, in 29 developing countries, around 2012.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data points from Liberia are based on 25 to 49 observations and should be interpreted with caution.

Source: DHS¹⁵¹ and UNESCO Institute for Statistics (on the basis of data from IPUMS²³¹ and School to Work Transition Surveys³¹⁴).

Figure II.49. Percentage of persons aged 17 to 24 years having completed at least primary school, by disability status and sex, in 17 countries, around 2010.



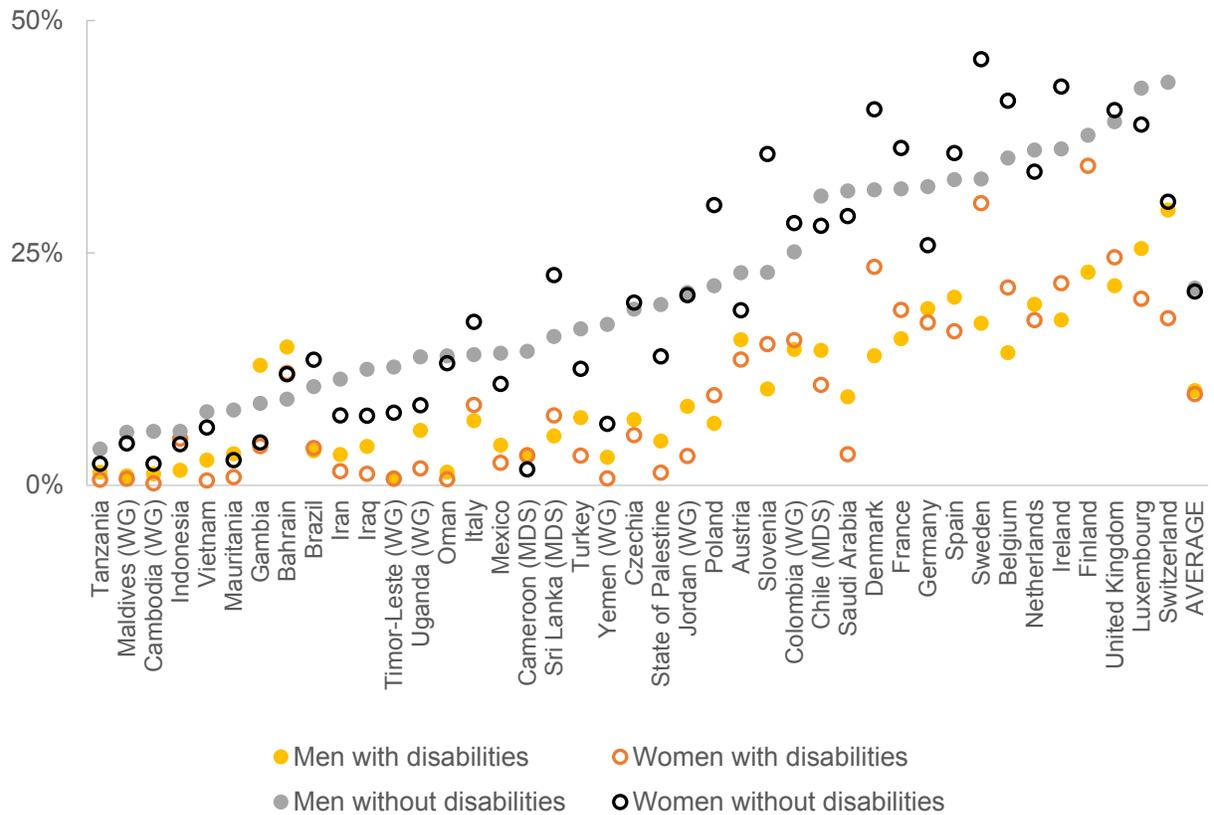
Note: (WG) identifies countries with data produced using the Washington Group short set of questions.

Source: DHS¹⁵¹ and IPUMS.^{231,315}

Tertiary education

Among 41 countries, around 2012, on average, 10% of women with disabilities have completed tertiary education, which is similar the rate for men with disabilities (also 10%), but lower than rates for women and men without disabilities (21%), as shown in Figure II.50. There is a wide variation among countries on completion of tertiary education for women with disabilities: in Cambodia only 0.2% but in Finland as many as 34% of women with disabilities complete tertiary education. In more than half of the countries - 27 - the tertiary completion rates for women with disabilities are lower than for men with disabilities. In almost all countries – 40 - the tertiary completion rates for women with disabilities are lower than for men without disabilities. In 38 countries, the tertiary completion rates for women with disabilities are lower than for women without disabilities.

Figure II.50. Percentage of persons 25 years and older³¹⁶ who completed tertiary education, by disability status and sex, in 41 countries, around 2012.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions; (MDS) identifies countries with data produced using the Model Disability Survey.

Source: DHS,^{317,318} ESCWA,²⁴¹ Eurostat⁸¹ and WHO.¹⁰⁷

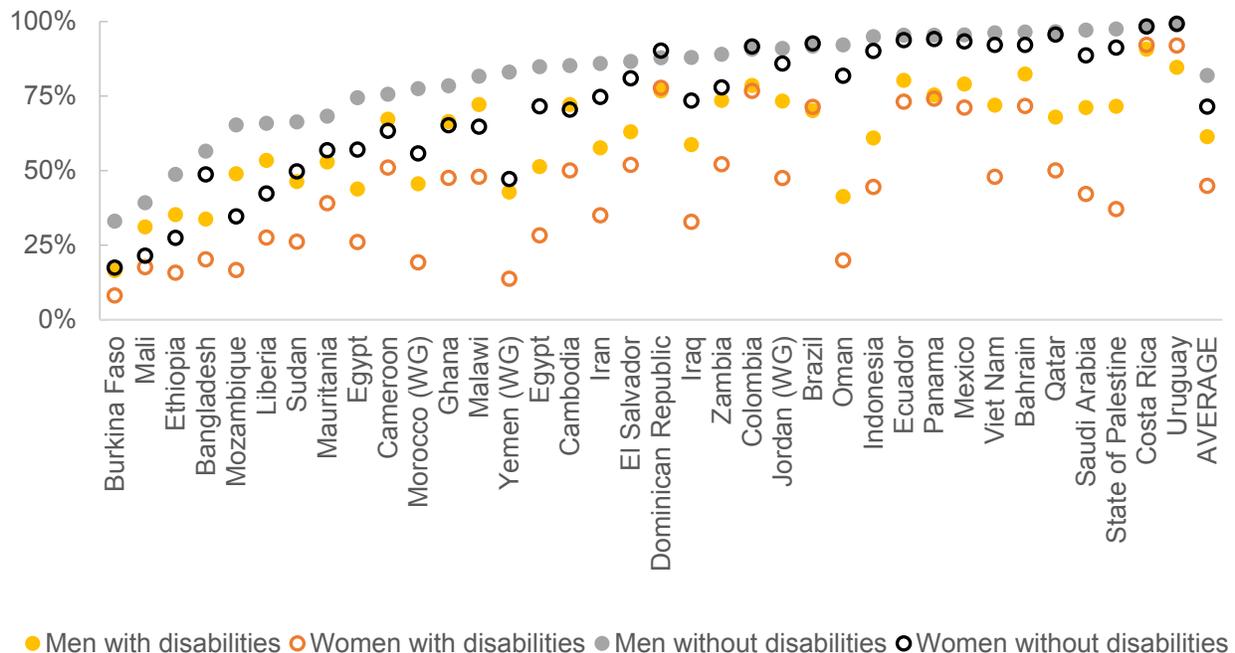
Literacy rates

Evidence from 36 countries around 2010 shows that, in the majority of countries (32), women with disabilities have lower literacy rates than men with disabilities (

Figure II.51). The widest gaps occur in Mozambique, where the difference is 32/48 percentage points, and State of Palestine, where the difference is 34 percentage points. In Mozambique, almost one in two men with disabilities (49%) can read and write, compared to only one in six women with disabilities (17%). In the State of Palestine, three in four men with disabilities is literate but only one in four women with disabilities. In four countries, women with disabilities have higher literacy rates than men with disabilities: Brazil, Costa Rica, Dominican Republic and Uruguay, with differences ranging from 1 to 7 percentage points. In countries

where women with disabilities have lower literacy rates than men without disabilities, the gap between these two ranges from 6 percentage points in Costa Rica to 72 percentage points in Oman. Among the 36 countries, on average, 45% of women with disabilities are literate compared to 61% of men with disabilities, 71% of women without disabilities and 82% of men without disabilities.

Figure II.51. Literacy rate for population 15 years and older, by disability status and sex, in 36 countries, around 2010.



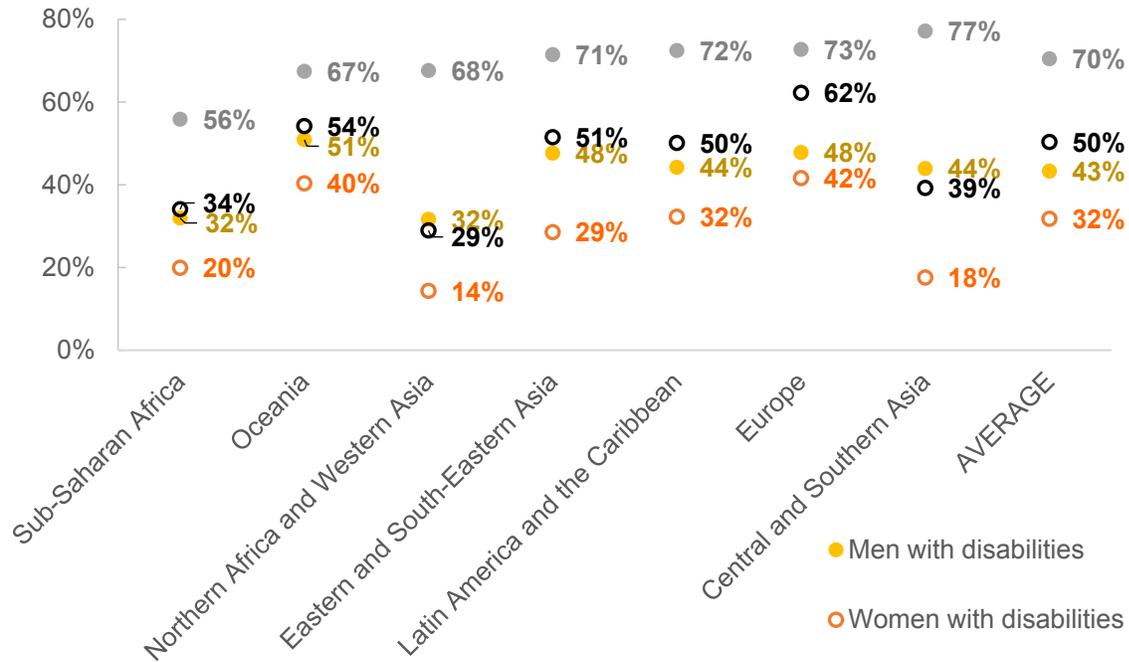
Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Source: ESCWA²⁴¹ and UNESCO Institute for Statistics (on the basis of data from IPUMS²³¹).

Employment

A direct result of limited access to education among women with disabilities is their significant disadvantage upon entering the job market, in comparison with men with disabilities, and also with women and men without disabilities. According to evidence from six regions, women with disabilities are less likely to be employed than men with disabilities and persons without disabilities in all regions (Figure II.52). The ratios for women with disabilities are lowest in Northern Africa and Western Asia (14%) and highest in Europe (42%). In Northern Africa and Western Asia, women with disabilities are 5 times less likely to be employed as men without disabilities, in Europe they are 2 times less likely. The gap between women and men with disabilities varies between 6 percentage points in Europe to 26 percentage points in Central and Southern

Asia.

Figure II.52. Average employment-to-population ratios, ³¹⁹ for persons aged 15 years and over, ³²⁰ by disability status and sex, in 6 regions, ³²¹ 2006-2016. ³²²

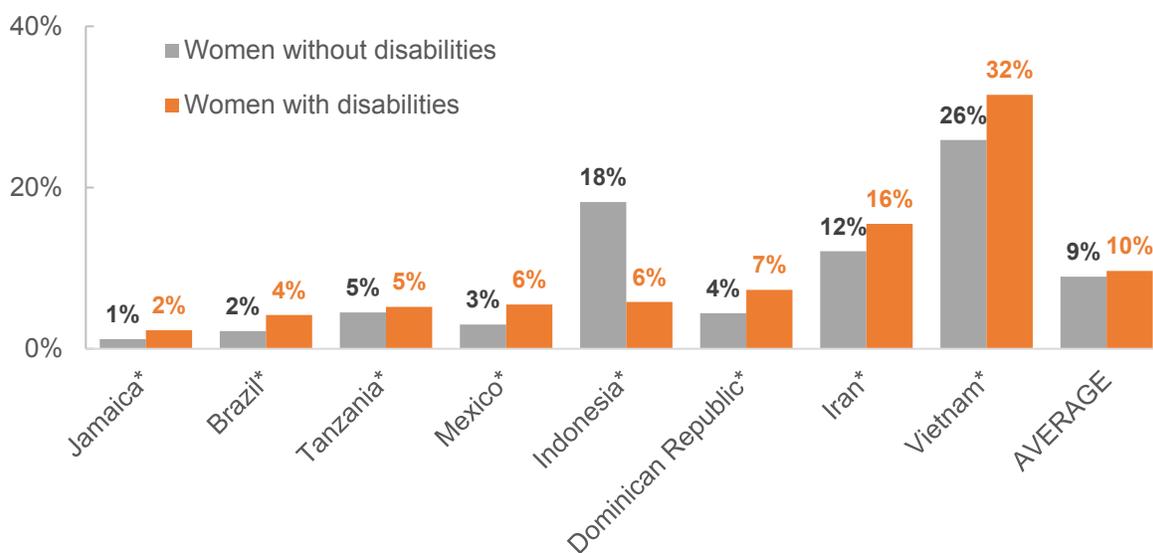


Source: ESCAP,⁴¹ ESCWA,²⁴¹ Eurostat,⁸¹ ILO³²³, IPUMS²³¹ and SINTEF⁹

Unpaid work

There has been an increased recognition of the value of unpaid care and domestic work of women, but the role of the women with disabilities in this type of work is less known. Contrary to paid work in which women with disabilities participate less than women without disabilities, available evidence shows that in 7 out of 8 developing countries, women with disabilities are more likely to be engaged in unpaid work than women without disabilities. On average, among these 8 countries, 10% of women with disabilities versus 9% of women without disabilities are engaged in unpaid work (Figure II.53). The percentages of women with disabilities in unpaid work vary from 2% in Jamaica to 32% in Vietnam. Since women in disabilities have more difficulty finding paid employment in the formal or informal sectors than those without disabilities, then they may be left with unpaid work as the only option, especially within the household.

Figure II.53. Percentage of employed women aged 15 and over in unpaid work, by disability status, in 8 countries, around 2008.



Note: An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at 5% level.

Source: IPUMS.^{231 324}

Opportunities for leadership at all levels of decision-making

The glass ceiling is harder to break for women with disabilities. Evidence from 19 countries shows that on women with disabilities are less likely to assume a position as a legislator, senior official or manager than their peers without disabilities and men: 2.3% of women with disabilities compared to 2.8% of men with disabilities, 3.4% of women without disabilities and 4% of men without disabilities hold these positions (Figure II.54). Women with disabilities are the least likely to hold these positions in 9 out of these 16 countries and are less likely than men without disabilities to assume such leadership position in all countries except in Ghana and Jamaica.

There is limited data available on women with disabilities in political leadership roles. The data available suggests that representation remains extremely low. According to data collected in 2017, among 14 out of 18 countries in Asia and the Pacific Region, there was no female parliamentarian with disabilities in the national legislative body. In the other 4 countries, the percentage of female parliamentarian with disabilities ranged from 0.3% to 6.3%.³²⁵

The representation of women from organisations of persons with disabilities tends also to be low in national coordination mechanisms on disability matters. For instance, among 17 countries or areas from the Asia

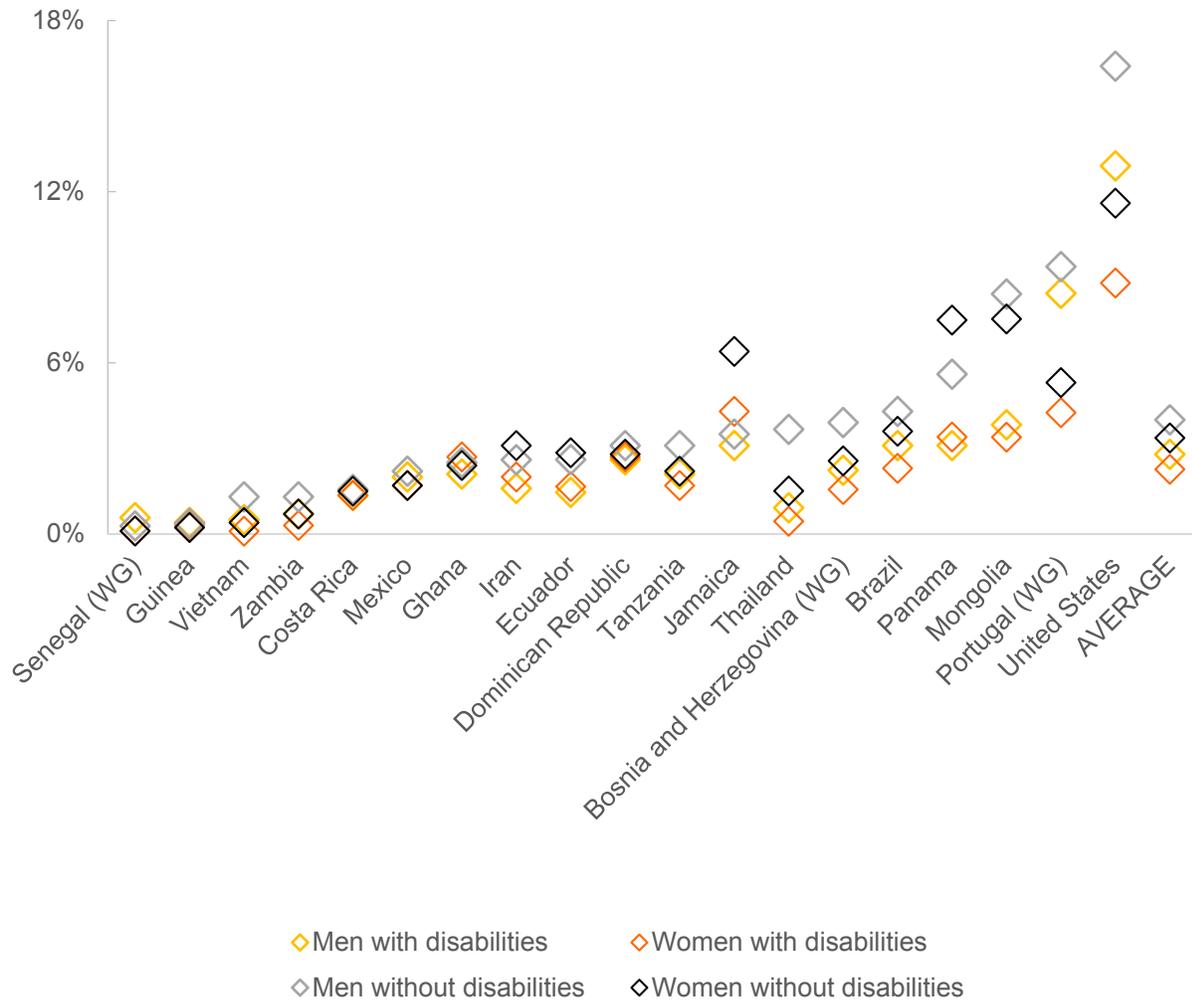
and Pacific region, the percentage of female members from organisations of persons with disabilities is on average 12%, compared to 21% of men from these organisations and 24% of women and 43% of men from other organisations (

Figure II.55). In three of these countries, there are no women from organisations of persons with disabilities represented. Nauru has the highest representation of women from organisations of persons with disabilities (29%). Among representatives from organisations of persons with disabilities, the number of women is equal or higher than men in only 5 countries or areas.

The representation of women with disabilities in national machinery for gender equality is even lower. In 7 out of 12 countries in the Asia and Pacific region, none of the members are women with disabilities. In the remainder 5 countries, on average 9% of the representatives are women with disabilities.³²⁶

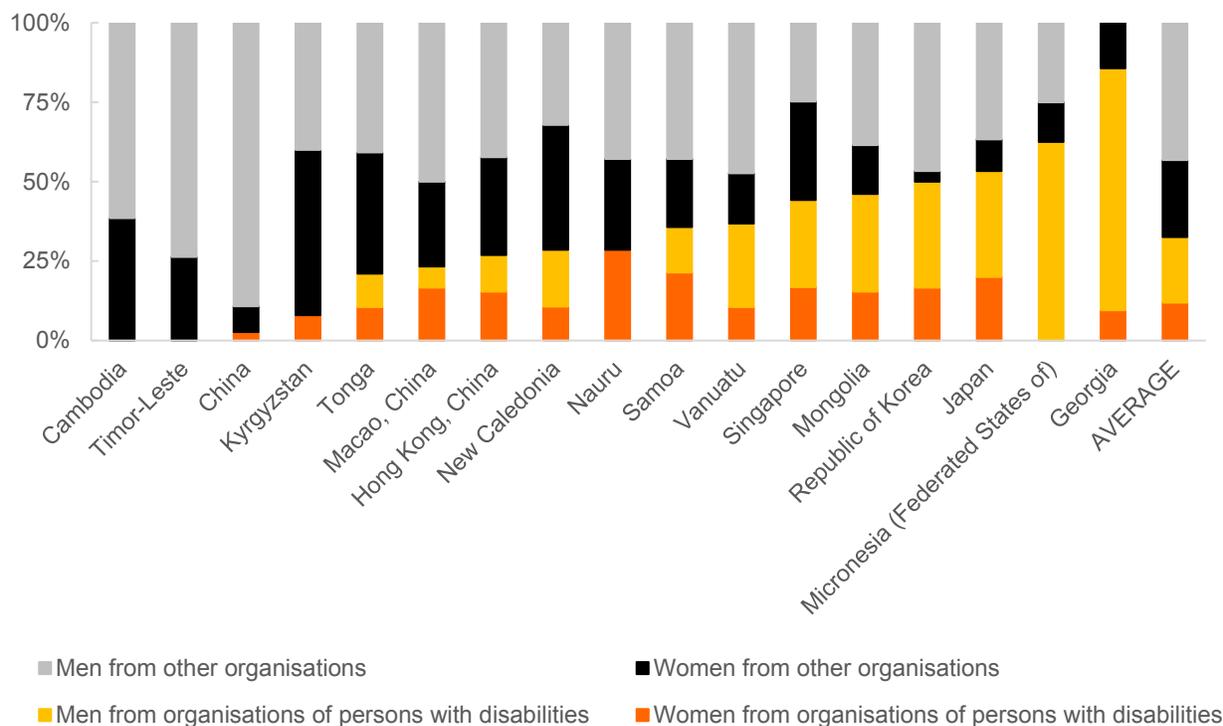
According to available evidence, gender gaps also persist in the leadership of organizations of persons with disabilities. An analysis of social media data,³²⁷ in 2017, indicated that 42% of women versus 58% of men held leadership positions in Spanish speaking organizations working on disability issues or with persons with disabilities.³²⁸

Figure II.54. Percentage of employed persons aged 15 and over who work as legislators, senior officials and managers, by disability and sex, in 19 countries, around 2010.



Source: IPUMS²³¹ and UNSD.

Figure II.55. Percentage of members from organizations of persons with disabilities and from other organisations in national coordination mechanism on disability matters, by sex, in 17 countries or areas, around 2017.

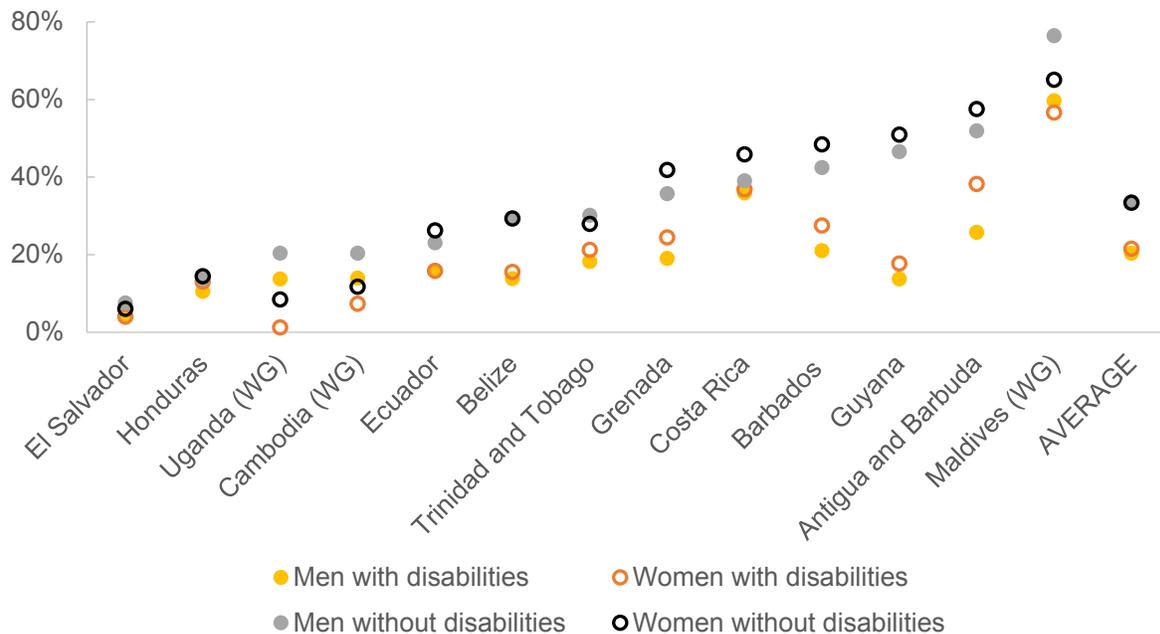


Source: ESCAP.⁴¹

Access to ICT

Evidence from 13 developing countries indicates that the percentage of women with disabilities using the internet varies from 1% in Uganda to 57% in the Maldives (Figure II.56). Usage of the internet among women with disabilities is lower than among persons without disabilities (both men and women) in all countries. But compared to men with disabilities, the percentage of women with disabilities using the internet is higher in 10 out of the 13 countries. On average, among these 13 countries, 21% of women with disabilities use the internet, compared to 20% of men with disabilities, 33% of women without disabilities and 34% of men without disabilities. This suggests that more barriers exist for disability than for gender. The lowest gaps between women with disabilities and men with and without disabilities are observed in Costa Rica and Honduras, with all of these showing similar rates of internet usage.

Figure II.56. Percentage of persons who use internet, by disability status and sex, in 13 countries, around 2011.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: ECLAC;³²⁹ World Bank (based on data from DHS);³³⁰ UK Office for National Statistics.³³¹

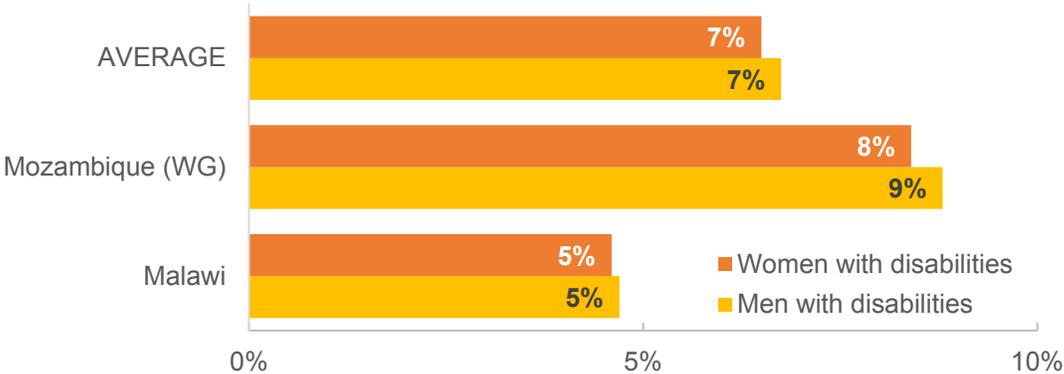
Physical and sexual violence

Evidence from two countries in Africa shows that 7% of women with disabilities have experienced violence because of their disability, ranging from 5% in Malawi to 8% in Mozambique (Figure II.57). In these two countries, women and men with disabilities experience similar rates of violence. In another 4 countries, 24% of women with disabilities, on average, report that they have been beaten or scolded because of their disabilities, from 17% in Botswana to 32% in Nepal (Figure II.58). For more than half of these women, the perpetrator was a family member. Values for men with disabilities are similar (on average 23% have been beaten or scolded because of their disabilities, and for 12% the perpetrator was a family member).^{332,333,334}

In 35 countries, mostly in Europe, in 2016,³³⁵ 13% of women with disabilities on average reported that crime, violence and vandalism were common in their accommodation or area of residence, in similar rates to men with disabilities (13%) and compared to 10% of persons without disabilities (see section on SDG 16).³³⁶ There is evidence indicating that women with disabilities are more likely to suffer sexual violence than women without disabilities and men. In Uganda, in 2016, 34% of women with disabilities had experienced sexual violence; 22% had experienced sexual violence in the last 12 months (see Figure II.129

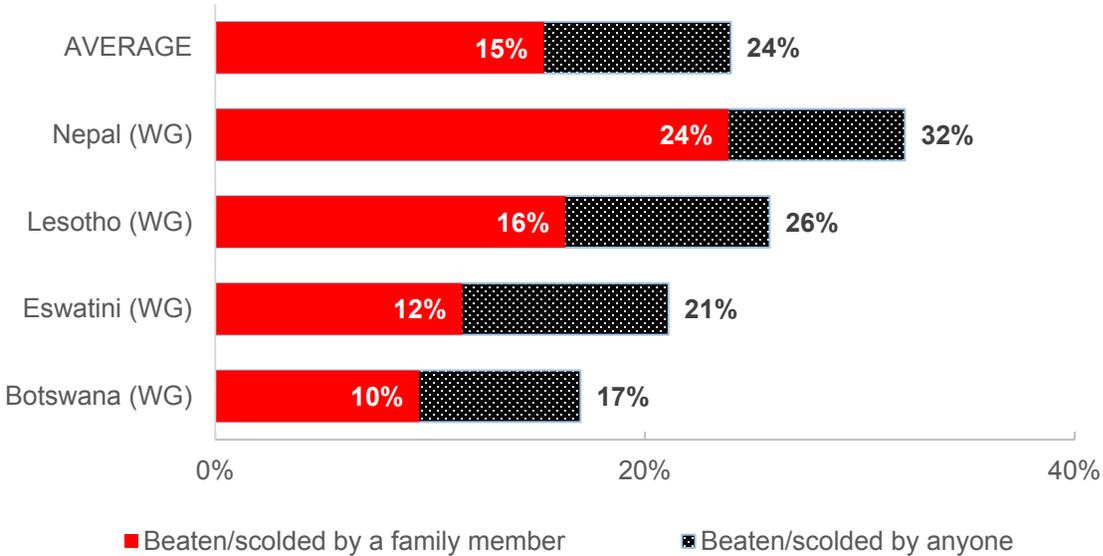
under section 16).³³⁷ When referring to the past 12 months, women with disabilities were almost twice as likely to suffer sexual violence as women without disabilities, almost four times as likely as men with disabilities, and almost six times as likely as men without disabilities. Women and girls with sensory or intellectual disabilities often experience higher levels of abuse as communication challenges mean that they are perceived to be less likely to be able to report abuse (see section on SDG 16).

Figure II.57. Percentage of women and men with disabilities who have ever experienced violence because of their disabilities, in 2 countries, around 2006.



Note: For all countries, the difference between women and men is not statistically significant at 5% level.
 Source: SINTEF.^{9,338}

Figure II.58. Percentage of women with disabilities who have ever been beaten or scolded because of their disabilities, in 4 countries, in 2010.



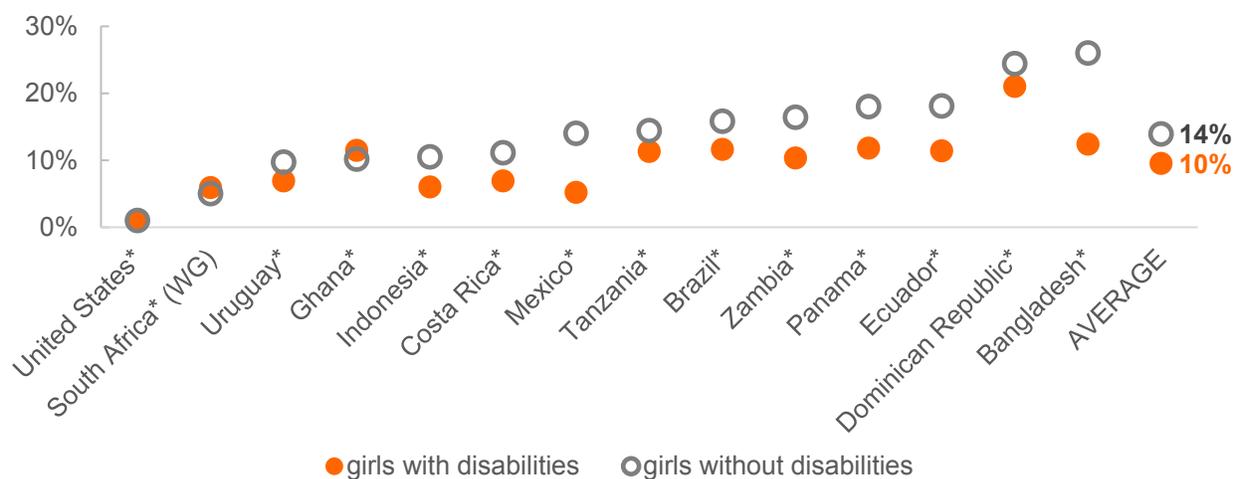
Source: SINTEF. 9, 339

Child marriage

Regarding early marriage, evidence from 14 countries, around 2011, shows that on average 10% of girls aged 15 to 18 with disabilities are or have been previously married or in union, ranging from under 1% in the United States to 21% in the Dominican Republic (

Figure II.59). In three out of the 14 countries girls with disabilities are more likely to be married or to have been married than their peers without disabilities.

Figure II.59. Percentage of girls aged 15 to 18 and who are or have been previously married,³⁴⁰ by disability status, in 14 countries, around 2011.



Note: An asterisk (*) indicates significance at 5% level of the difference between girls with and without disabilities.

Source: IPUMS.^{231,341}

Current practices on gender and disability

Women and girls with disabilities are often invisible in national policies and programmes.³⁴² Many countries address gender and disability issues separately without focusing on the intersection between the two. A study in Latin America points to increasing awareness in this region of the need to address this intersection. Seventeen out of 20 countries in the region include disability in their gender national plans and 12 of these countries have gender plans with specific measures targeting women with disabilities. However, only 6 out of 19 countries address gender in their disability laws.³⁴³

While some countries promote the inclusion and empowerment women and girls with disabilities through general laws, development plans and strategies, others develop national strategies specifically focusing on women and girls with disabilities.³⁴⁴ Examples include national action plans for women with disabilities,^{345,346} acts that focus on girls with disabilities in rural areas, reserve seats for women with disabilities in parliament and local governments, and promotion of access to healthcare services for women and girls with disabilities.³⁴⁷ There are also initiatives that prioritize projects that improve the status of women with disabilities when attributing government grants.³⁴⁸ A number of countries have also put in place initiatives to promote education of girls with disabilities through targeted scholarships for them and by promoting employment of women with disabilities through training.³⁴⁹ One of these programs builds on the recognition of the value added of including women and girls with disabilities: blind and visually impaired

women were trained as clinical breast examiners as they are able to detect up to 50% more and up to 28% smaller changes in the breast than doctors.³⁵⁰

At the international level, an initiative has been taken to establish specific funding for projects focusing on women with disabilities in the United Nations Trust Fund to End Violence against Women. In 2018, these funds granted financial support to nine projects that aim to end violence against women and girls with disabilities and to strengthen the response capacity of local grassroots organizations working with women and girls who are survivors of violence.³⁵¹

Conclusions and the way forward

The findings in this section are limited to a subset of countries, but they confirm that many women and girls with disabilities face multiple discrimination and barriers to their full and equal inclusion in society and development. Compared to men without disabilities, women with disabilities are at a severe disadvantage. The evidence presented here shows that, compared to men without disabilities, women with disabilities are: two times more likely to be poor, two times more likely to not have nutritious and sufficient food, three times more likely to have unmet needs for health care, three times more likely to be illiterate, two times less likely to be employed, and two times less likely to use the internet. Among those employed, women with disabilities are two times less likely to work as a legislator, senior official or manager. Overall, women with disabilities are also in a worse position than women without disabilities.

In a couple of areas, the evidence does not seem to indicate a further disadvantage of women with disabilities relative to men with disabilities, suggesting that attitudinal and environmental barriers against disability, not gender, are the major factor driving the disadvantage experienced by women with disabilities. This is the case for poverty, access to education, use of internet, and physical violence. However, for access to employment and sexual violence, barriers against both gender and disability seem to be playing a role.

These findings will vary across countries. To guide policy design, it is important for development actors and decision-makers to determine whether and to what extent the disadvantage that women with disabilities experience is driven by their disability status or by their gender. Gender policies will not succeed if barriers against disability prevent women with disabilities from benefiting from them – in that case gender policies need to address these barriers too. Similarly, policies promoting disability inclusion will not succeed if gender discrimination prevents women with disabilities from benefiting from them – in that case disability policies need to address these stereotypes.

It is still the case that the needs and perspectives of women with disabilities are often not reflected neither in national gender nor in disability mechanisms. These mechanisms will need to move beyond working in silos and acknowledge the intersection between gender and disability.

Despite these findings, it also shown in this section that the gaps between women with disabilities and others vary from country to country, and some countries have managed to reduce gaps. Several countries have implemented measures promoting the inclusion of women and girls with disabilities and these good practices need to be scaled up in other countries. To fully achieve gender equality and empower all women and girls with disabilities, the following actions should be considered:

- 1) **Address the needs and perspectives of women and girls with disabilities in national disability strategies or action plans, as well as in national gender strategies and action plans.** Adopt a national disability strategy or a national disability action plan that is well-funded, has benchmark indicators, and pays due attention to the inter-sectoral dimension concerning women and girls with disabilities. Include also this dimension in national gender strategies and action plans.
- 2) **Develop policies and programmes focused on women and girls with disabilities aiming at full and equal participation in society.** Moreover, engage women and girls with disabilities in the development and evaluation processes of policies and programmes. Develop programs aimed at combating violence, especially sexual violence, against them.
- 3) **Support the empowerment of women and girls with disabilities to participate equally in society and to reduce gender gaps in economic, social and political participation.** Invest in education for women and girls with disabilities and support their transition from school to work through training. Education and training must be provided in accessible formats. Engage with employers to bring awareness of the value added of a diverse workforce including women and girls with disabilities.
- 4) **Raise-awareness on the needs of women and girls with disabilities and eliminate stigma and discrimination against them.** Provide disability training among organizations and personnel working on gender equality and launch public campaigns to combat negative stereotypes associated with disability and gender.
- 5) **Enhance the collection, dissemination and analysis of data on women and girls with disabilities and disaggregate and disseminate data by sex, age and disability** for effective policy development, implementation and monitoring of gender equality. Enhance capacity of national statistical offices to collect and disseminate these data. Promote evidence-based analyses to identify the barriers experienced by women and girls with disabilities, specifically if these are attitudinal barriers against disability, gender or both. Use the data and the studies to inform and guide policy making.

F. Ensure availability of water and sanitation for persons with disabilities (SDG 6)

This section addresses the achievement of SDG 6, i.e. the availability of water and sanitation, for persons with disabilities. Persons with disabilities face more difficulties in accessing adequate water, sanitation and hygiene (WASH) facilities than those without disabilities. This is due to a lack of household access, often resulting from insufficient financial resources, as well as lack of access in public environments. Barriers facing persons with disabilities in relation to water and sanitation include environmental barriers, such as lack of accessibility of the facilities.³⁵² However, barriers faced by persons with disabilities extend beyond issues of accessibility. Persons with disabilities often face stigma and discrimination from others when using both household and public facilities, such as misconceptions that persons with disabilities could contaminate water sources or they would make the latrines dirty. Persons with certain types of disabilities may also need to take a longer time to use the facilities – a stigmatising experience when using communal latrines. Persons with disabilities may also experience lack of dignity if they are dependent on family members to assist them in using inaccessible water and sanitation facilities. Lack of access to water and sanitation facilities outside the home has a negative impact on other areas of development. Children with disabilities are often prevented from attending schools due to a lack of accessible toilets. Lack of accessible toilets is also a barrier to persons with disabilities seeking jobs and health services.

The section lists major international normative frameworks on disability, water and sanitation and presents an overview of the availability and accessibility of water and sanitation for persons with disabilities. The section also identifies good practices and offers recommendations for improving the current situation of persons with disabilities regarding access to water and sanitation.

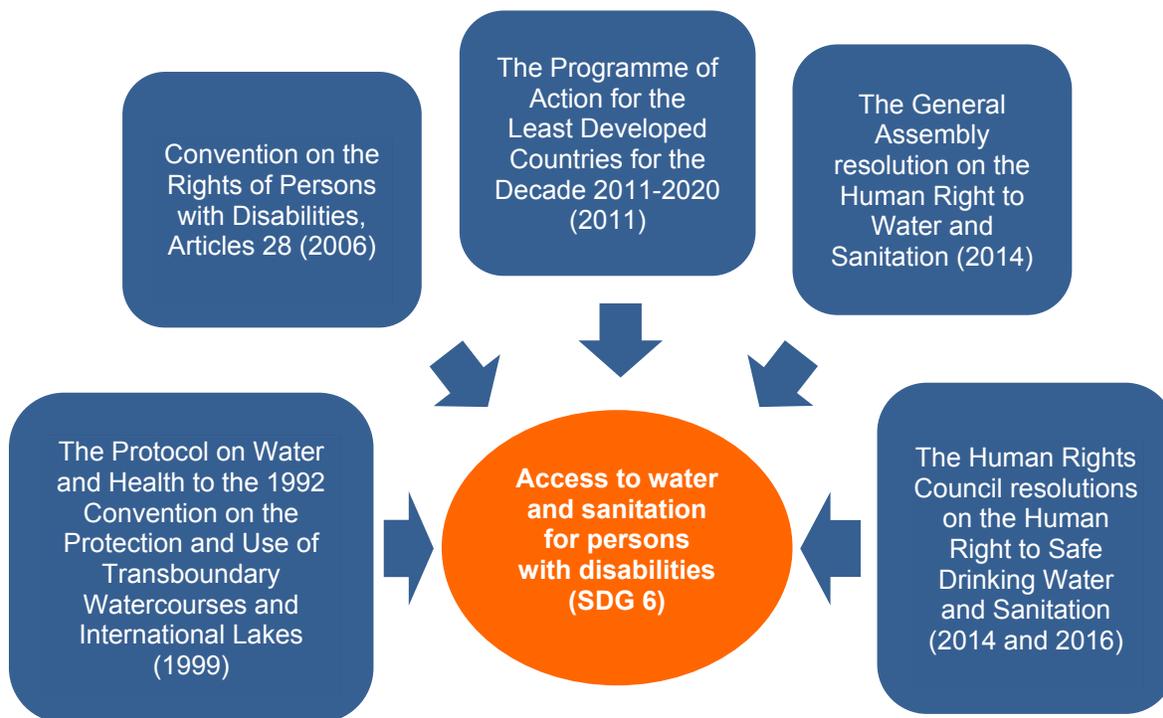
International normative frameworks on WASH and disability

The SDG 6 targets 6.1 and 6.2 indirectly include persons with disabilities in their respective calls to: “by 2030, achieve universal and equitable access to safe and affordable drinking water *for all*” and “by 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and *those in vulnerable situations*”. These are in line with Article 28 of CRPD which stipulates that State parties need to ensure equal access to clean water services for persons with disabilities. The article further calls for affordable services with access to devices and other assistance for disability-related needs. Article 4 on general obligations focus on aspects particularly relevant for access to water and sanitation, detailing in paragraph 1(c), the responsibility of State Parties to take appropriate measures to modify or abolish customs or practices that constitute discrimination against persons with disabilities; and in paragraph 1(f) to promote universal design in the development of standards and guidelines. According to Article 9, State Parties have responsibility to: promulgate, monitor and implement minimum standards and guidelines for the accessibility of WASH facilities and services open or

provided to the public (paragraphs 2(a)), to regulate the private sector to ensure that private entities offering WASH facilities and services take into account all aspects of accessibility for persons with disabilities.

Other frameworks focus on providing access to water and sanitation for persons with disabilities. For example, the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes (1999) stresses the need to ensure equitable access to water for people who are disadvantaged and the socially excluded.³⁵³ The Human Rights Council resolution on the Human Right to Safe Drinking Water and Sanitation (2014) notes the CRPD and highlights the importance of universal access to drinking water and sanitation, with particular attention to people who are in vulnerable situations.³⁵⁴ The General Assembly resolution on the Human Right to Water and Sanitation (2014) recognizes the CRPD and calls for providing safe drinking water and sanitation for all without discrimination, including persons with disabilities.³⁵⁵ Equal access to water and sanitation for persons with disabilities is also emphasized in the context of Least Developed Countries: the Programme of Action for the Least Developed Countries for the Decade 2011-2020 makes specific references to access to water and sanitation services and the equal rights of persons with disabilities.³⁵⁶ Furthermore, a 2016 United Nations Human Rights Council resolution stressed the need to reduce inequalities, in a comprehensive manner, on the ground of disability amongst others, in access to water and sanitation through enhancing collaboration among the water, sanitation and hygiene sector and other sectors including education, employment and health sectors.³⁵⁷ Although the major international frameworks recognize equal access to water and sanitation for persons with disabilities, the critical role of assistive technology on water and sanitation, including, for example, accessible handles for water pumps or toilets in making water and sanitation more accessible for persons with disabilities has been less addressed.

Figure II.60. International normative frameworks relevant for the achievement of SDG 6 for persons with disabilities.

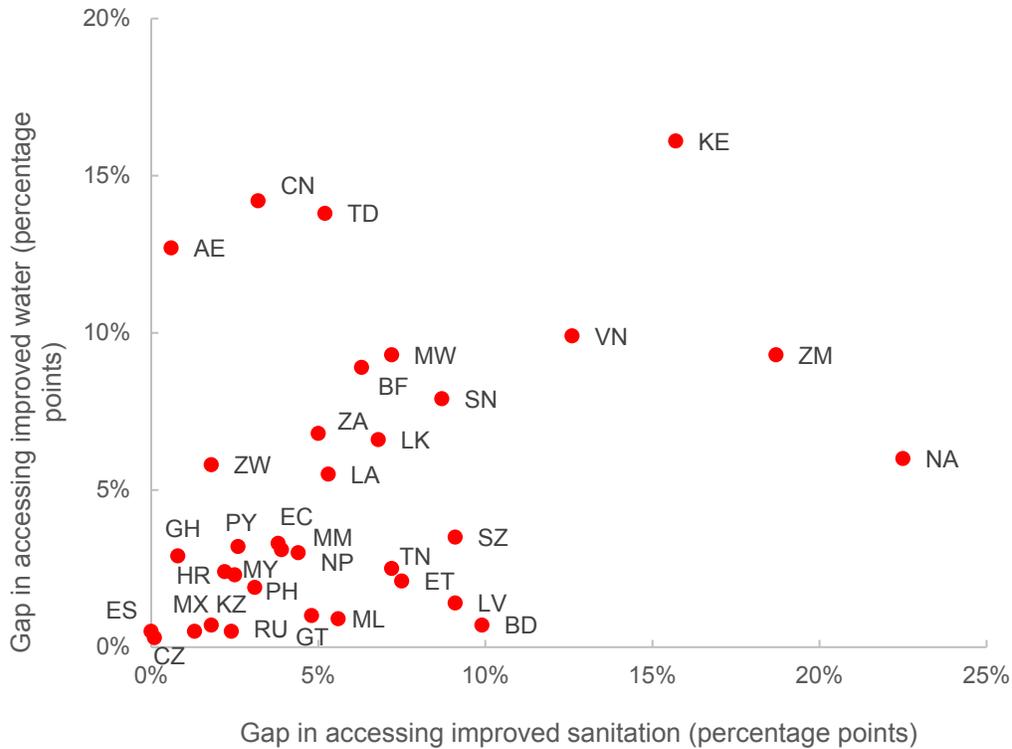


The situation of persons with disabilities: access to water and sanitation

Persons with disabilities are less likely to live in households with access to adequate water and sanitation

Access to both adequate water and adequate sanitation remains a challenge for many persons with disabilities. Data from 34 countries shows that persons with disabilities are more likely than persons without disabilities to live in households without access to adequate water and sanitation (Figure II.61). In some countries, the gaps reach more than 10 percentage points. Moreover, in countries where the gap is wider for access to an improved water source,³⁵⁸ it also tends to be wider for access to an improved sanitation facility.³⁵⁹ Household poverty, which is more prevalent among households with persons with disabilities, is likely to play a role in this gap.

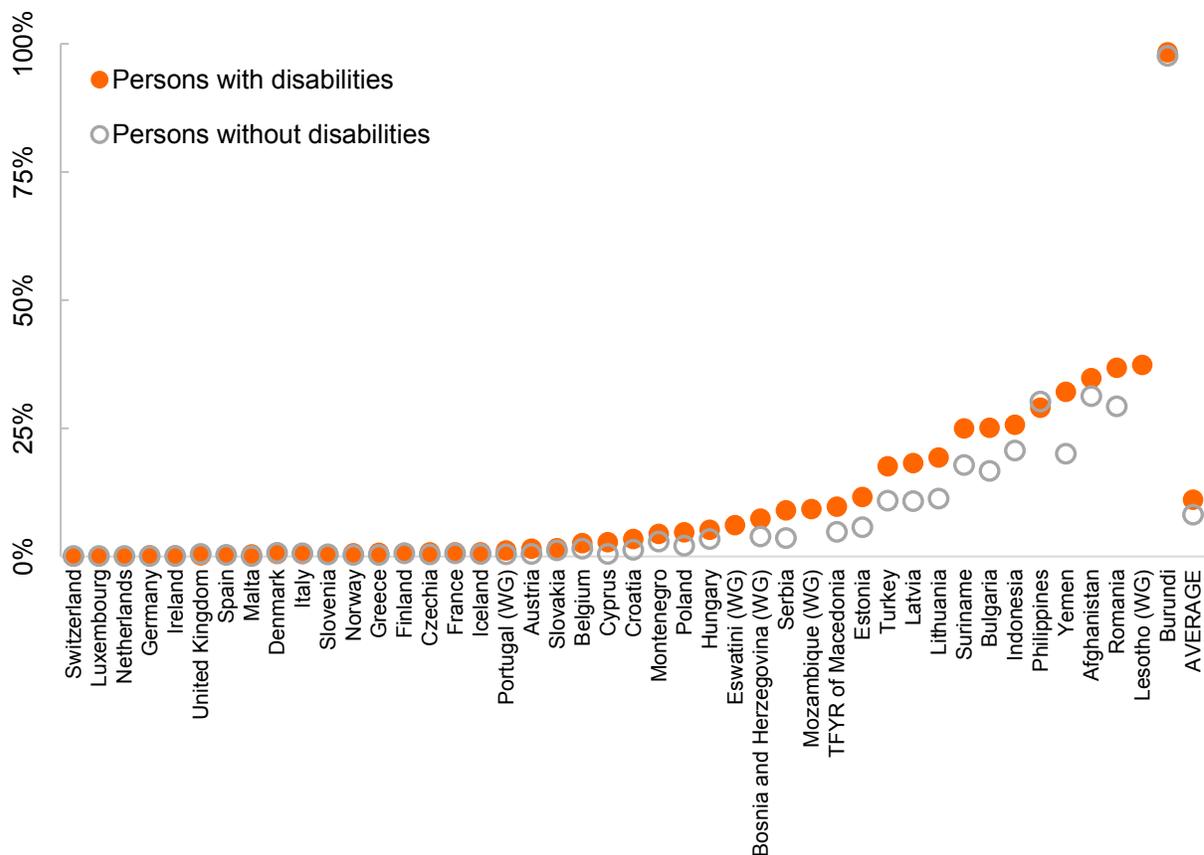
Figure II.61. Difference between the percentage of persons without and with disabilities^{360,361} in access to improved sanitation versus improved water, in 34 countries, 2002-2004.



Note: The list of country codes is AE: United Arab Emirates; BD: Bangladesh; BF: Burkina; CN: China; CZ: Czechia; EC: Ecuador; ES: Spain; ET: Ethiopia; GH: Ghana; GT: Guatemala; HR: Croatia; KE: Kenya; KZ: Kazakhstan; LA: Lao; LK: Sri Lanka; LV: Latvia; ML: Mali; MM: Myanmar; MW: Malawi; MX: Mexico; MY: Malaysia; NA: Namibia; NP: Nepal; PH: Philippines; PY: Paraguay; RU: Russia; SN: Senegal; SZ: Eswatini; TD: Chad; TN: Tunisia; VN: Vietnam; ZA: South Africa; ZM: Zambia; ZW: Zimbabwe.

Source: World Health Surveys, 2002-2004.³⁶²

Figure II.62. Percentage of persons without toilet in their dwelling, by disability status, in 44 countries, around 2014.



Note: Data not available for persons without disabilities for Lesotho, Mozambique and Eswatini. (WG) identifies countries with data collected using the Washington Group short set of questions.

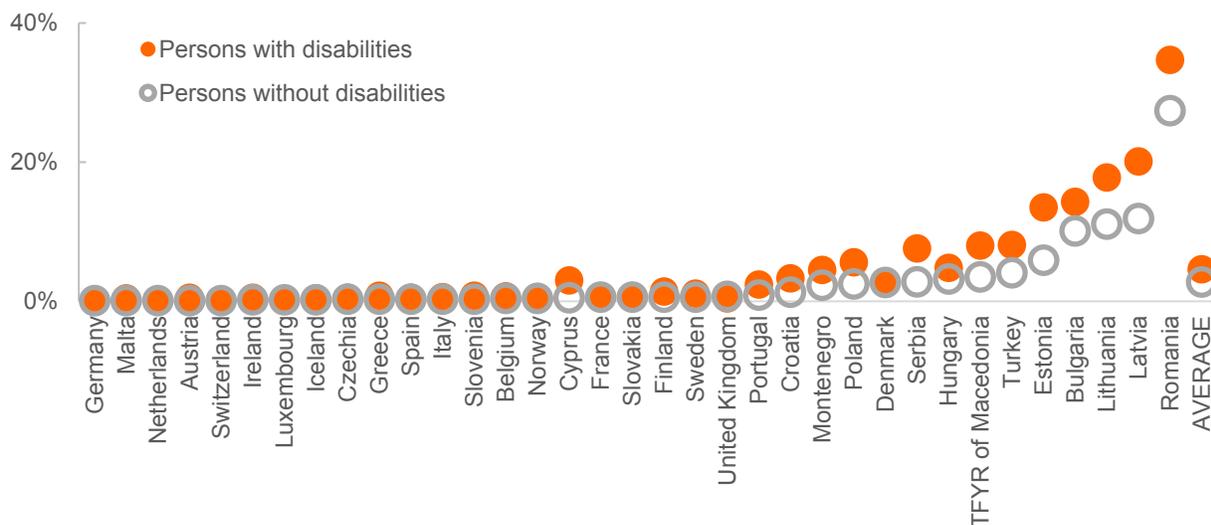
Source: Eurostat,^{81, 363} SINTEF⁹ and UNSD.

Persons with disabilities are less likely to live in households with hygiene and sanitation facilities on the premises

In 33 out of 44 countries, the percentage of persons residing in homes without an indoor toilet is higher for persons with disabilities than for person without disabilities (Figure II.62). In 10 of these countries, the gap among the two groups exceeds 5 percentage points. A distant, shared bathroom can pose additional difficulties for persons with disabilities, who may experience difficulties, for example, in mobility, locating the bathroom, in waiting in line. Persons with disabilities in developing countries are more often confronted with this challenge, with some countries reporting more than 25% of persons with disabilities not having an indoor toilet in their dwelling.

Similarly, it is more common for persons with disabilities to not have a bath or shower in their home. Data from 34 European countries and Turkey indicate that the average percentage of persons with disabilities with no bath or shower in their dwelling was higher (4.5%) in comparison to persons without disabilities (2.8%). In five of these countries more than 10% of persons with disabilities live in a dwelling with no bath and shower; in two countries this figure is above 20% (Figure II.63). For both toilets and bath/shower, the gaps between persons with and without disabilities is wider in countries where the overall lack of these facilities in dwellings is higher. This disadvantage is expected to be more extreme in other geographic regions, such as sub-Saharan Africa or Southeast Asia.

Figure II.63. Persons with no bath or shower in their dwelling aged 16 and over, by disability status³⁶⁴, in 35 countries, around 2016.³⁶⁵

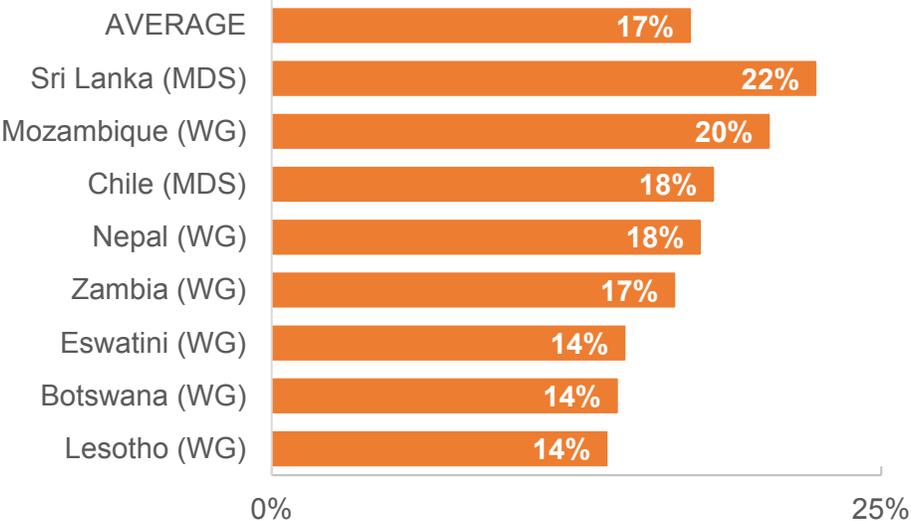


Source: Eurostat.⁸¹

One in five persons with disabilities reports that the toilet at home is hindering or not accessible

In many countries, use of inclusive design and implementation of accessibility measures are increasingly common. However, for persons with disabilities, particularly those living in developing countries, barriers to accessing water, sanitation and hygiene persist.³⁶⁶ Frequently mentioned structural barriers include lack of support bars in latrines for people who have difficulties holding themselves in a sitting or squatting position, or accessible sinks and washing points.^{367,368.}

Figure II.64. Percentage of persons with disabilities who report that their toilet³⁶⁹ at home is hindering or not accessible, in 8 countries, around 2013.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions. (MDS) identifies countries with data collected using the Model Disability Survey.

Source: SINTEF^{9,370} and WHO.¹⁰⁷

Among eight developing countries, 17 per cent of persons with disabilities reported that their toilet at home was hindering or not accessible (Figure II.64). For example, in Chile and Sri Lanka, approximately one out of five persons with a severe disability considered the toilet in their dwelling hindering or very hindering. In another 6 developing countries, 14 to 20% of persons with disabilities reported that their toilet at home was not accessible. Crowd-sourced data on more than 45,000 public toilets worldwide, mostly in developed countries, found that 69% were accessible for wheelchair users, but the degree of accessibility varies across countries. In Australia, for instance, a large number of public toilets have been assessed as accessible for wheelchair users (Figure II.65). Crowd-sourced data in developing countries is scarce, but the data available suggests that the majority of public toilets are not accessible for wheelchair users, as illustrated in Figure II.66 in the south region of Malawi. Lack of accessible public toilets in outdoor settings can prevent persons with disabilities from participating in society. This remains a key problem in schools, which often do not have accessible toilet (Box 3).

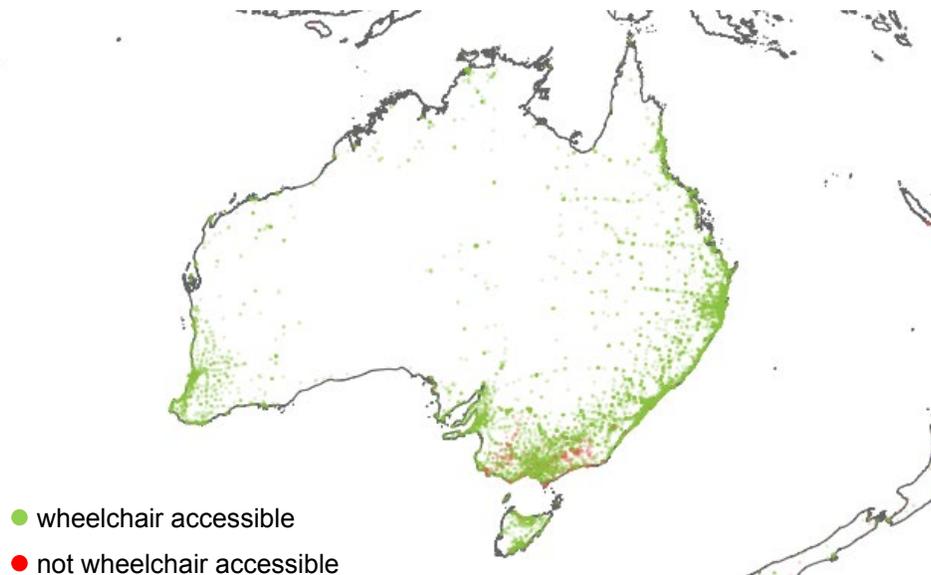
Because of lack of accessibility, distant facilities and negative attitudes, persons with disabilities may face serious challenges in toileting. These barriers prevent persons with disabilities from being able to independently collect water for themselves. For example, the water sources may be too distant, or the well

walls and water taps too high. There may be nowhere to rest the water container whilst filling it, or there may be nothing to hold on to for balance to avoid falling into a well or pond. Toilets with steps or raised above ground are often inaccessible to persons with physical impairments, washroom doors can be difficult to manipulate, and latrines are often too small to enable people with a wheelchair or crutches to enter and close the door behind them. Floors can be too slippery for people with walking or balancing impairments. If latrines are not accessible, persons with disabilities may be obliged to recur to open defecation, increasing the danger of accidents, rape and other adverse safety and health issues.

Data from three developing countries indicates that persons with severe disabilities most frequently report issues or extreme problems with toileting (

Figure II.68). The percentage of persons reporting significant problems is varied, ranging from 9% in Chile, 16% in Sri Lanka and 28% in two districts in Cameroon. In these countries, the lower the GDP per capita, the higher the percentage of persons with disabilities reporting problems with toileting, suggesting that lack of financial resources plays a role in hindering adequate access to water and sanitation for persons with disabilities.

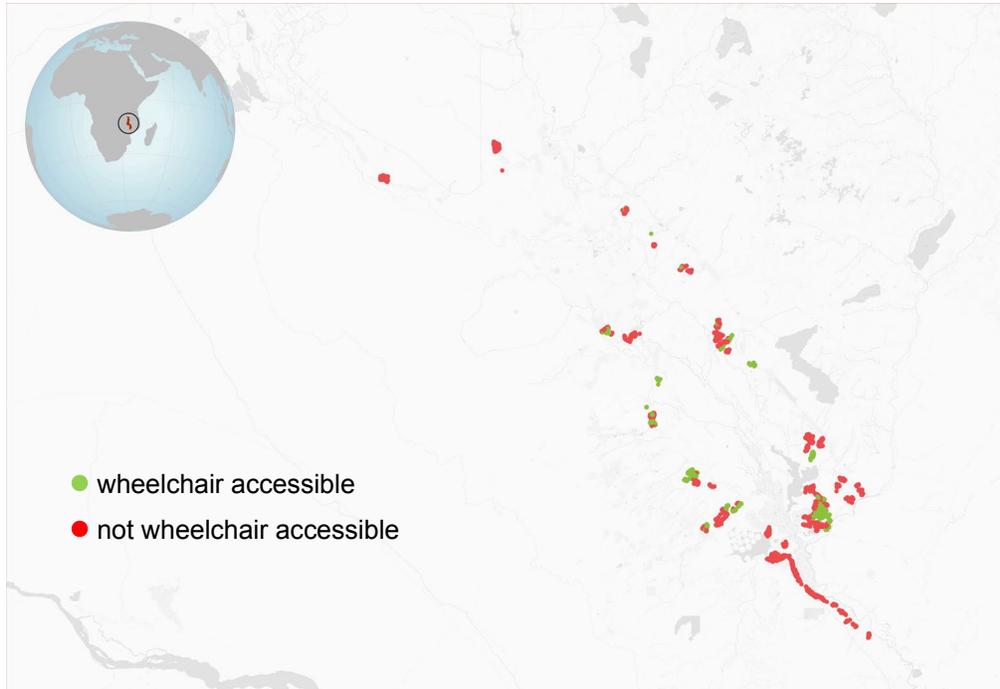
Figure II.65. Accessibility of public toilets for wheelchair users, in Australia, 2017 (crowd-sourced data).



Note: The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

Source: Sozialhelden.³⁷¹

Figure II.66. Accessibility of public toilets for wheelchair users, in the south region of Malawi, 2017 (crowd-sourced data).



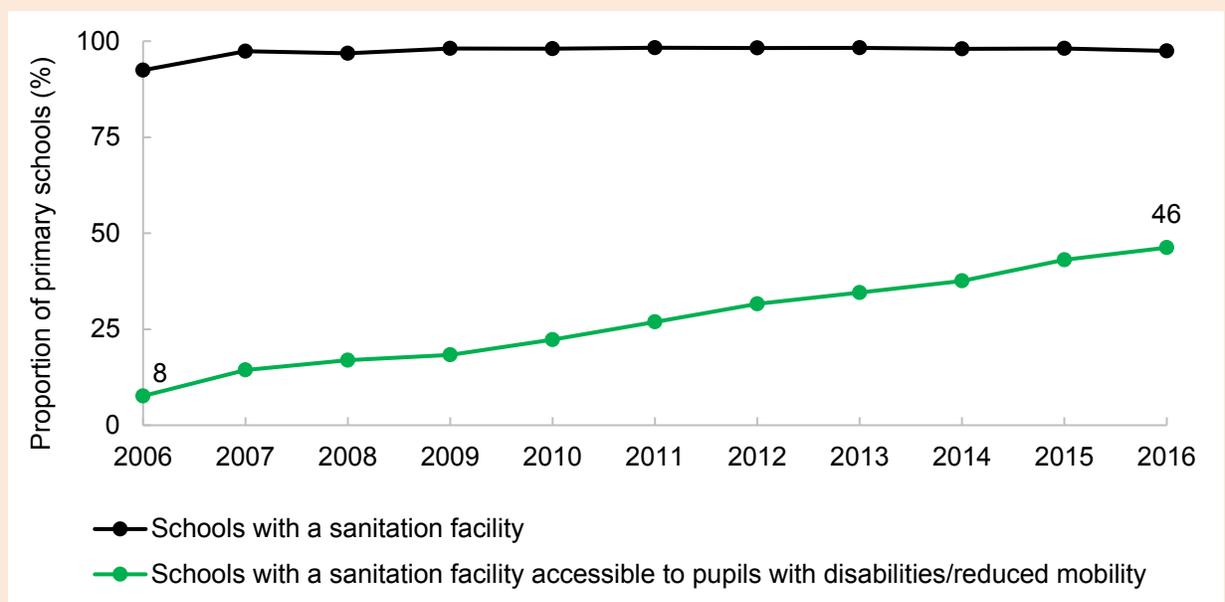
Note: The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

Source: Sozialhenden.³⁷²

Box 3. Accessible toilets at schools

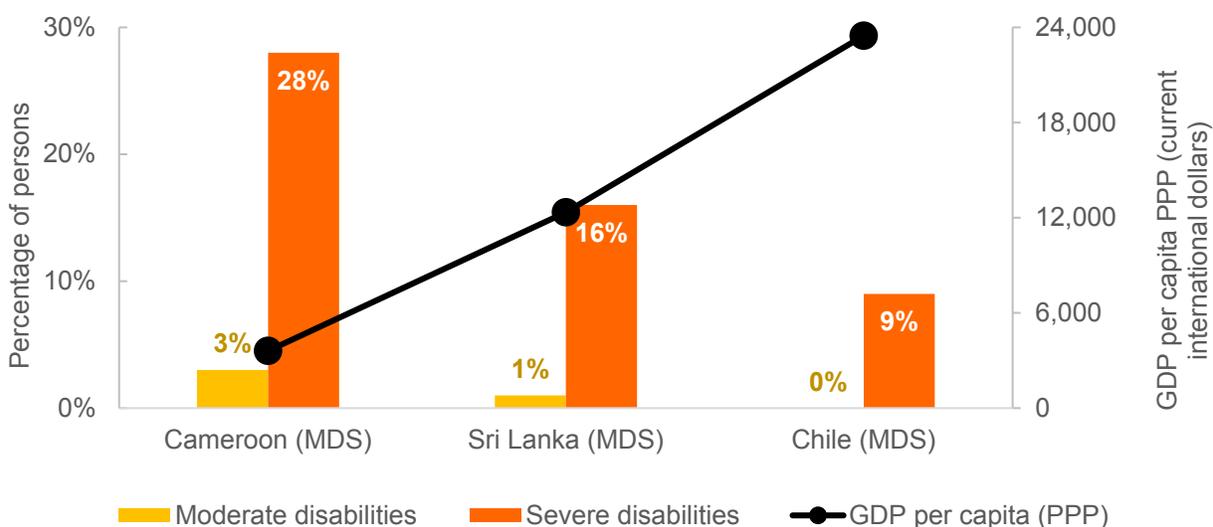
The availability of adequate, accessible toilets in settings outside the home is key to ensuring persons with disabilities can fully participate in education. Several countries have already collected detailed information about facilities at school, including whether sanitation facilities are on the school premises and whether these are accessible to pupils with disabilities. A good example is Brazil, where the yearly data on accessible toilets have been collected through the Censo da Educação Básica since 2006 (Figure II.67). Data from the latest round show that most primary schools have a toilet within the building (97%) but, despite considerable progress since 2006, less than half (46%) had a sanitation facility that was accessible to pupils with disabilities or reduced mobility. This is however a considerable improvement since 2006 when only 8% of primary schools had an accessible sanitation facility.

Figure II.67: Proportion of primary schools with any sanitation facility and a sanitation facility accessible for people with reduced mobility, in Brazil, from 2006 to 2016.



Source: WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP).³⁷³

Figure II.68. Percentage of persons aged 17 and over reporting a lot of or extreme problems with toileting, by disability status, versus GDP per capita, 2015-2016.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

Source: WHO³⁷⁴ and World Bank.³⁷⁵

Current practices on WASH and disability

Efforts have been made by various actors, including governments and international organisations, to mainstream disability in water sanitation and hygiene (WASH) programmes, including by 1) addressing discrimination and stigma when providing WASH services; 2) raising awareness and building capacity about the rights and specific needs of persons with disabilities when planning, implementing, monitoring and evaluating WASH programmes; 3) mandating minimum accessibility standards and considering disability in the design of WASH interventions; and, 4) designing and building WASH facilities according to the principles of universal design.

Twin-track approaches to disability inclusion in WASH with both disability-inclusive interventions (including providing WASH facilities according to universal design principles and ensuring WASH indicators explicitly address disability), and disability-targeted interventions (such as provision of assistive devices for persons with disabilities, and development and promotion of innovative access solutions for people with disabilities) are increasingly being adopted.^{376, 377} There are a growing number of programmes implemented in developing countries aimed to increase access to improved water and sanitation facilities and improved hygiene behaviours among low-income rural and peri-urban populations, including persons with

disabilities.^{378,379} In Indonesia, for example, the disability-inclusive approach has included in the national rural water supply and sanitation project' operations since 2016, providing disability-inclusive development trainings for government officials and WASH facilitators, and adopting design specifications for accessible school toilets and other accessible WASH facilities.³⁸⁰ In Zimbabwe, a pilot of community grants initiatives has been implemented to support informal community groups to ensure that WASH services would be available to all, particularly persons with disabilities, leading to improved access to water supply and disability-friendly sanitation facilities and services in over 14 small towns.^{381,382} In some countries, to address the stigma and concerns of persons with disabilities in accessing WASH services, initiatives have also been put in place to engage persons with disabilities, especially women and girls with disabilities, in the local communities so that their voices and concerns can be included in design, planning, implementing and monitoring.^{383,384,385}

The increased use of accessible facilities, such as accessible handles for water pumps or toilets, installing ramps and handrails, and widening doors that are designed for persons with disabilities is indeed helping making WASH accessible. For instance, in Mali, a communal well in a village was redesigned, in consultation with persons with disabilities, to include a high wall to protect persons who are blind from falling and a physical support was installed for lifting water. One section of the wall was lowered and a concrete ramp was developed for wheelchair users.^{386,386} In Nepal, moveable toilet seats were provided to rural households that had latrines, which helped persons with disabilities having leg and/or back problems and reduced the need to sit or crawl on a wet latrine floor.³⁸⁷

Furthermore, community-based rehabilitation (CBR) organizations have also played an important role in promoting accessible and inclusive WASH, through their work in capacity-building of local communities and families to address the needs of persons with disabilities. In India, for example, CBR approaches for inclusive WASH have been used, leveraging existing community networks and self-help groups to reach out to persons with disabilities as well as to raise awareness about good WASH practices in local communities.³⁸⁸ Some organizations have focused on compiling and sharing good practices that benefit persons with disabilities within and beyond mainstream sanitation approaches, such as community-led total sanitation (CLTS) for advancing the promotion of accessible and inclusive WASH for persons with disabilities.^{389,390}

Conclusions and the way forward

Available data indicates that persons with disabilities are less likely to have access to improved water and sanitation, less likely to enjoy hygiene and sanitation facilities in their dwelling, are often confronted with non-accessible facilities which they find hindering and may face stigma and discrimination when using WASH facilities. This can have a severe impact on the health, dignity and quality of life of persons with disabilities. In countries where overall access to adequate water and sanitation is lower, the gaps between persons with and without disabilities are wider. In such countries, in working to ensure access, the focus should be twofold: 1) simultaneously expanding access to water and sanitation, and 2) closing the disability gap. SDG 6 has created an unprecedented opportunity to simultaneously address both factors and realize the right to safe water and sanitation for persons with disabilities.

To achieve SDG 6 for persons with disabilities, it is imperative to focus on programs that target relevant challenges in access to WASH through various steps:

- 1) **Involve all stakeholders, especially persons with disabilities.** Governments have the lead role in designing and implementing plans to progressively give access to safe water and sanitation to all, including persons with disabilities. In low resource settings, civil society organizations often play a critical role in supporting government efforts in WASH. To ensure access of persons with disabilities to WASH, it is critical that Government, civil society and other relevant stakeholders ensure inclusion of persons with disabilities and their representative organizations in all stages of decision making and in the carrying out of programmes and advocacy efforts.
- 2) **Invest in and allocate financial resources/budget to accessible WASH in households and in settings outside the home, prioritizing schools, workplaces, health facilities and communal WASH facilities.** Ensuring a budget allocation for accessibility of water and sanitation facilities and develop and provide schemes/packages to support families with additional costs related to accessible water and sanitation facilities. This investment should be informed by regular monitoring of the availability and accessibility of adequate water and sanitation for persons with disabilities in households as well as in institutional settings, such as health care facilities and schools.
- 3) **Adopt a twin-track approach: mainstream disability in WASH policy and programmes and develop disability specific WASH programmes.** The voices and concerns of persons with disabilities should be reflected in the development, resourcing, implementation, monitoring and evaluation of all WASH policies and programmes.³⁹¹ Monitoring will be essential to assess the effectiveness the policies in place, as well as the extent to which they've been implemented, and to help identify any policy modifications that may be necessary to guarantee access to WASH for persons with disabilities. .
- 4) **Share information and build capacity about low-cost inclusive interventions to scale up good practices.** There is a wealth of knowledge regarding how to make WASH accessible for persons with

disabilities. However, existing expertise and good practices are not being sufficiently utilized or replicated.^{392,393,394} There are low cost inclusive adaptations and universal design solutions to facilities including toilets, water points, water carriers, bathing places and handwashing facilities, which can be implemented by households as well as by governments. Mechanisms to share information, in accessible ways, on inclusive practices, either online or through in person training of WASH professionals, can help in promoting and scaling such approaches.

5) **Raise awareness and end discrimination and stigma.** Governments should invest in measures to raise awareness and combat discrimination and stigma. Organizations and personnel working on WASH should receive and provide training on disability and accessibility. Negative stereotypes associated with disability and WASH may be further combatted through public information campaigns. The capacity of countries to design, implement and monitor these campaigns must also be strengthened.

6) **Monitor progress through the collection of individual data.** As detailed in the present chapter, access to water and sanitation at the household level does not always translate into access for household members with disabilities. To assess access to WASH within a household, those carrying out surveys should receive appropriate training on effective approaches to collecting information regarding disability within households.³⁹⁵

7) **Disaggregate data on WASH access by type of disability, as well as by age and gender.** To effectively and most appropriately address barriers to WASH access by persons with disabilities, data should be disaggregated by type of disability, as well as by age and gender to reflect the multiple challenges faced by persons with disabilities to accessing water and sanitation services and using them with dignity and safety.

8) **Collect, analyse and disseminate census and survey data on WASH access for persons with disabilities to inform inclusive policies.** Household surveys are a main source of data but, additionally, in several countries, the national census also collects information about persons with disabilities, including their access to water and sanitation services.

9) **Explore crowd-sourcing applications to obtain bottom-up information on the accessibility of water and sanitation facilities for persons with disabilities to inform accessibility policies.** Several applications already allow users to publicly review the accessibility of facilities anywhere the world. Current data covers mainly developed countries and efforts should therefore be made to expand the use of such applications in developing countries so that their benefits may be enjoyed more broadly. Information gathered by crowd-sourcing applications further reflects the experience of the users and can be helpful to inform national accessibility policies.

10) **Mainstream disability in international fora and global mechanisms working on WASH.** Disability is still often left out from international meetings, global mechanisms, international development

programs and major international publications working on WASH. Disability should be consistently addressed in order to trigger global action to close the WASH gap for persons with disabilities.

G. Ensuring access to energy for persons with disabilities (SDG 7)

The energy-disability nexus must be addressed to achieve the SDG 7 ‘Ensure access to affordable, reliable, sustainable and modern energy for all’, particularly SDG target 7.1 which calls for universal access to energy. Four critical issues need to be considered when implementing SDG 7 for persons with disabilities: (i) access to energy for development; (ii) access to electricity to charge or operate assistive technology; (iii) access to modern forms of energy which are less polluting for the households where persons with disabilities stay for longer periods of time; and (iv) affordable energy as many persons with disabilities live in low-income households.

Access to energy means provision of modern energy services to everyone around the world. These services are defined as household access to electricity and clean cooking facilities.³⁹⁶ Energy is needed for the provision of clean water, sanitation, adequate shelter, health care and for economic development and social progress – all of which can improve the lives of persons with disabilities. But access to energy is even more vital for persons with disabilities, many of whom require electricity to operate assistive technology for independent living. Moreover, clean and modern forms of energy can also bring benefits to many persons with disabilities worldwide because they may spend extended periods at home due to mobility challenges or because more time is required for selfcare at home, or because they are kept hidden due to stigma or shame, and may thus suffer higher exposure to indoor pollution caused by the use of solid fuels for cooking or lighting. Longer periods at home may also lead to higher electricity consumption, which results in higher energy bills. Access to reliable, affordable and clean energy is therefore crucial for persons with disabilities.

Yet, the unique needs of persons with disabilities in accessing sustainable energy are still overlooked in the global discourse on energy and development. This section addresses this gap. First, it presents an overview of current international normative frameworks on access to energy. Second, it presents evidence on the situation of persons with disabilities regarding access to energy and identifies good practices to close current gaps in access. The section concludes with recommendations for achieving SDG 7 for persons with disabilities.

International normative frameworks on disability and access to energy

Access to energy has long been discussed in the context of sustainable development and well-being of individuals, but particular disadvantaged groups such as persons with disabilities have been invisible in the discourse. This was the case, for example, in the World Commission on Environment and Development’s first report “Our Common Future”, also known as the Brundtland Report (1987), which recognized energy as a necessary means for daily survival.³⁹⁷ Similarly, the outcome document of the 2002 World Summit on Sustainable Development, the Johannesburg Declaration on Sustainable Development, called for a speedy increase in access to energy.³⁹⁸ And the Plan of Implementation of the World Summit on Sustainable

Development^{399 400} outlined the actions to improve access to reliable, affordable, economically viable, socially acceptable and environmentally sound energy services.⁴⁰¹ None of these documents made reference to persons with disabilities. The call for energy access *for all*, which implicitly includes persons with disabilities, came ten years later in 2012, when the outcome document of the United Nations Conference on Sustainable Development or Rio+20, “The Future We Want”, recognized the critical role that energy plays in the development process.⁴⁰² In the same year, the United Nations General Assembly adopted a resolution on promotion of new and renewable sources of energy and declared 2014-2024 the United Nations Decade of Sustainable Energy for All.⁴⁰³

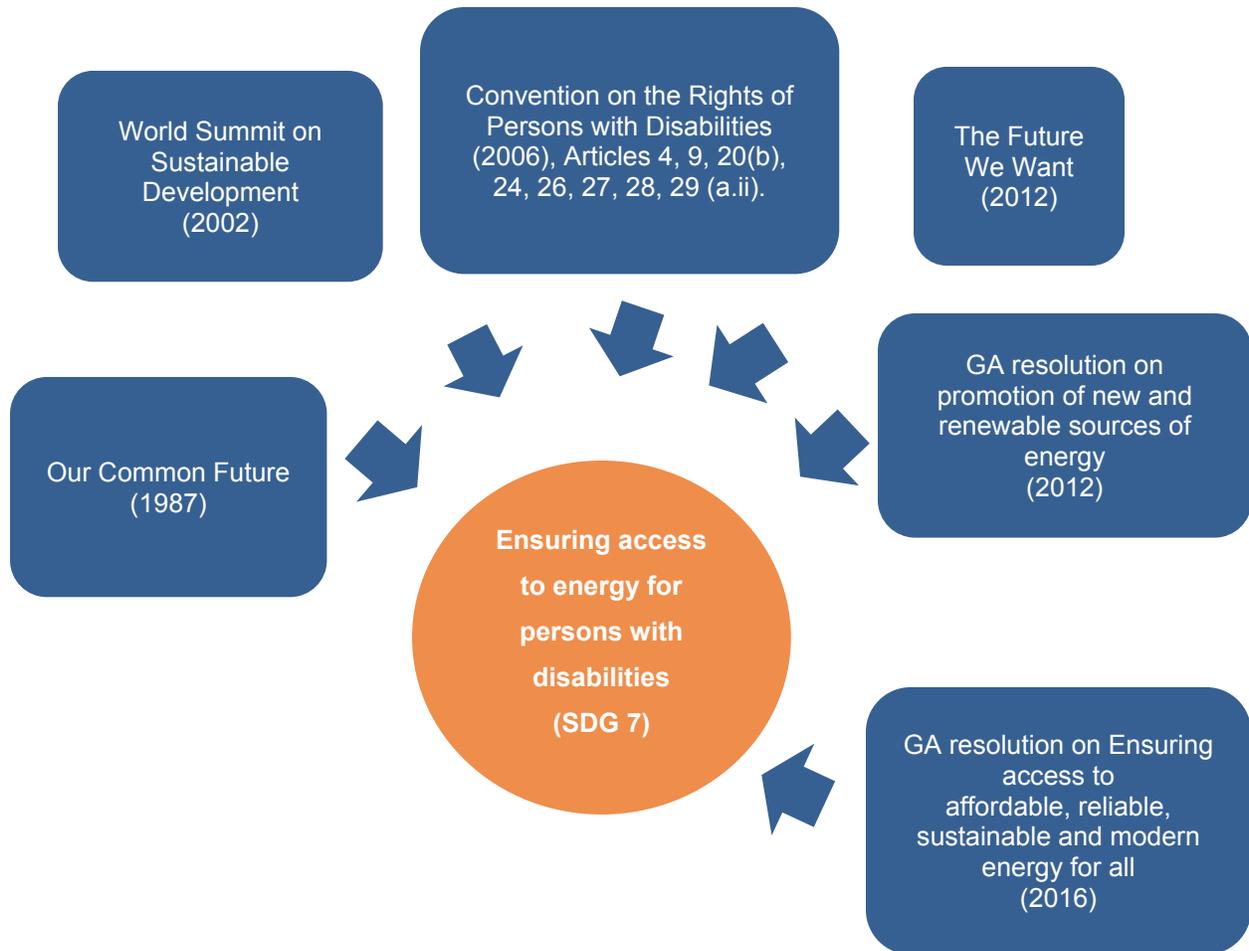
The critical link between energy and the well-being of persons with disabilities, has also been invisible in the major international frameworks on disability even though energy may be essential to their implementation. For instance, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)⁴⁰⁴ and the World Program of Action Concerning Disabled Persons (1982)⁴⁰⁵ address the need of persons with disabilities to access technologies that would require electricity. Similarly, the Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, provides a powerful base for the promotion of access to sustainable energy because the implementation of many of its articles will require providing access to energy for persons with disabilities. For example, the CRPD calls on States Parties to promote the availability, knowledge and use of assistive products, many of which require electricity to operate (Article 26) and recognizes the importance of access to information and communication technologies (Articles 4 and 9). Moreover, electricity-run assistive technologies can facilitate personal mobility (Article 20(b)), effective participation in education (Article 24) and employment (Article 27), habilitation and rehabilitation services (Article 26), voting (Article 29(a)(ii)), and access to clean water services (Article 28), among others.

The 2030 Agenda for Sustainable Development, the guiding global development framework, calls in its Goal 7 for ‘access to affordable, reliable sustainable and modern energy for all’. The aspect of affordability is critical for persons with disabilities who tend to have lower incomes than their peers without disabilities. The 2030 Agenda, with its core commitment to “leave no one behind”, brings attention to the importance of monitoring and follow-up on progress for persons with disabilities to ensure that they also fully benefit from this framework. More recently, the General Assembly adopted a resolution on ensuring access to affordable, reliable, sustainable and modern energy for all because such services are an integral part of social inclusion, thus underscoring the important role of energy in achieving development that is inclusive of various social and often vulnerable groups, including persons with disabilities.⁴⁰⁶

The negative impact on persons with disabilities of exposure to harmful pollution from traditional sources of energy could be addressed through progress towards SDG target 7.1, “By 2030, ensure universal access to affordable, reliable and modern energy services”. Other SDG 7 targets call for promoting investment in clean energy technology (SDG 7.a) and for expanding infrastructure and upgrade technology for supplying

modern and sustainable energy services for all in developing countries (SDG 7.b). These targets could accelerate the access by persons with disabilities to cleaner forms of energy and avoid the harmful exposure to pollution from traditional forms of energy.

Figure II.69. International normative frameworks relevant to achieving SDG 7 for persons with disabilities.



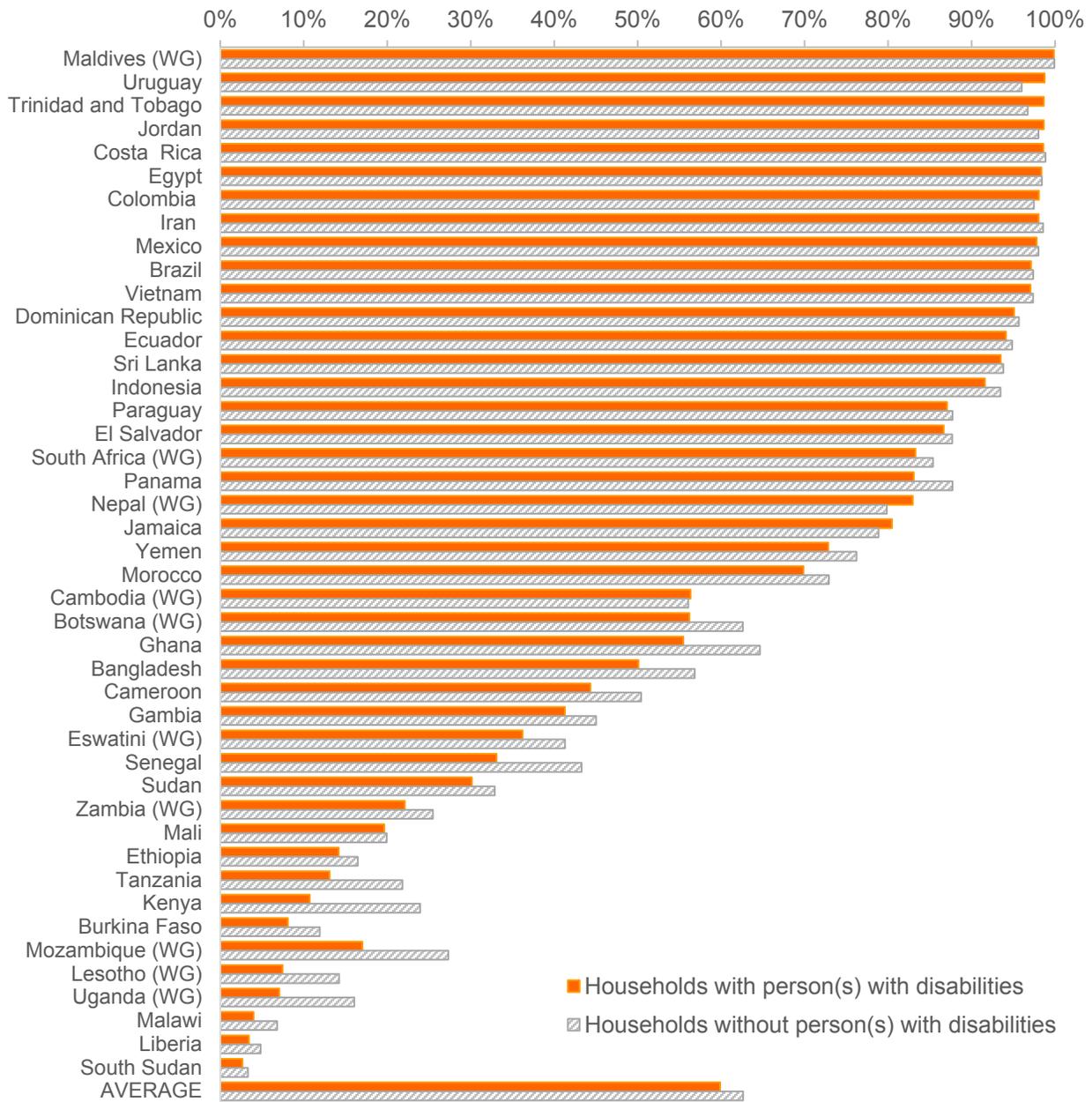
Situation of persons with disabilities: access to energy

Energy poverty,⁴⁰⁷ or lack of access to electricity and the reliance on the traditional use of biomass for cooking, is more prevalent among households with persons with disabilities. In particular, lack of access to electricity poses specific challenges to persons with disabilities who may require electricity-run assistive technology to live independently and to participate equally in society. This is especially challenging in low income countries worldwide, where access to electricity is low, with only 28% of the population having access.⁴⁰⁷ In Sub-Saharan Africa, in 2014, only 37% of the general population had access to electricity, with this figure coming down to 17% for those living in rural areas. Reduced access for those living in rural areas was also seen in the Pacific region, where 83% of the population had access to electricity, with this figure coming down to 44% for rural populations.⁴⁰⁷ Low electricity access is also a major challenge for displaced persons in camps, including those with disabilities. In 2014, seven million displaced people in camps had access to electricity for less than four hours a day.⁴⁰⁸

Persons with disabilities and their households tend to have lower access to electricity and heating

In many countries, households with persons with disabilities are less likely to have access to electricity than those without persons with disabilities. Figure II.70 shows that, between 2001-2015, in 37 out of 44 countries, households with persons with disabilities had lower access to electricity than households without persons with disabilities. This may be due, in part, to lower income in households with persons with disabilities as a consequence of limited employment opportunities for persons with disabilities and/or additional costs due to disability. In 17 of these countries, fewer than 50% of households with persons with disabilities had access to electricity.

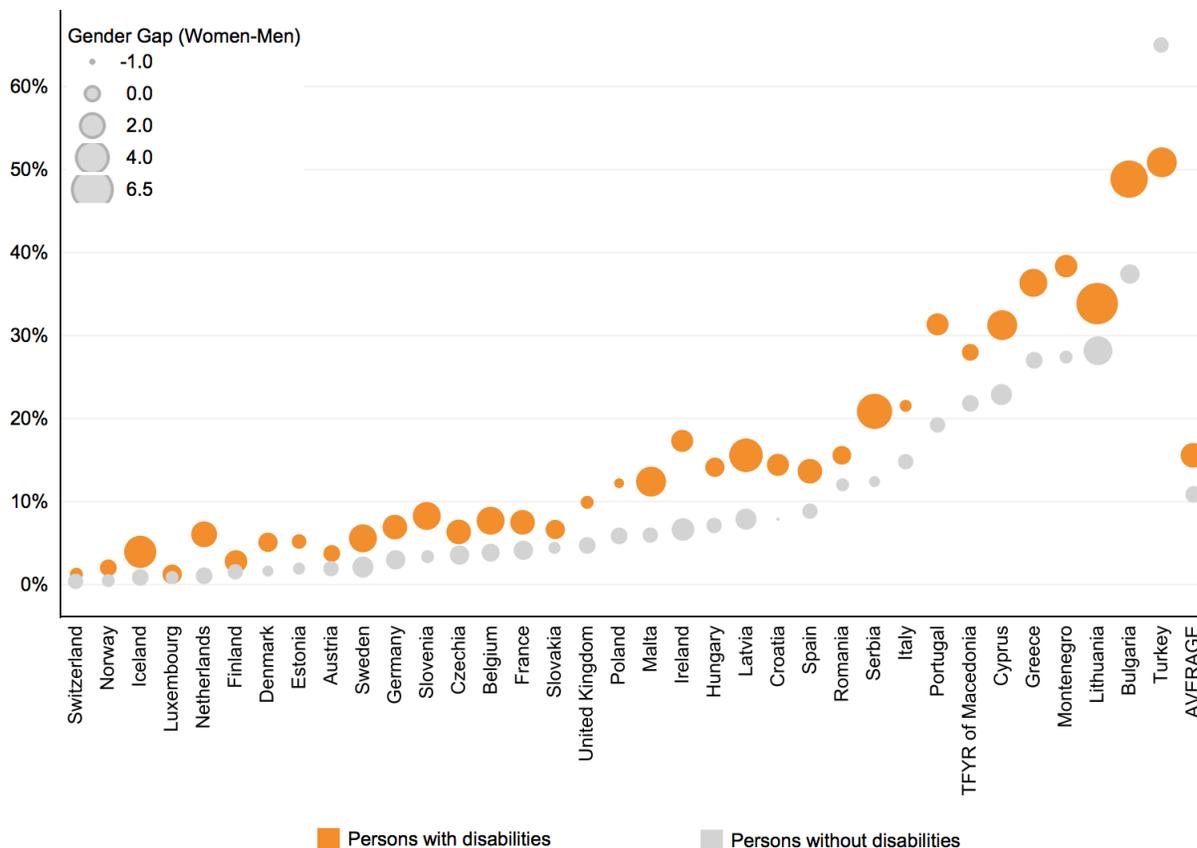
Figure II.70. Percentage of households, with and without persons with disabilities, with access to electricity,⁴⁰⁹ in 44 countries, 2001-2015.⁴¹⁰



Note: (MDS) identifies countries with data collected using the WHO Model Disability Survey. (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: ICF International,⁴¹¹ Minnesota Population Center,⁴¹² SINTEF⁹ and WHO.¹⁰⁷

Figure II.71. Gender gap (women minus men) and percentage of persons unable to keep home adequately warm for persons aged 16 and over with and without disabilities, in 35 countries, in 2016.⁴¹³



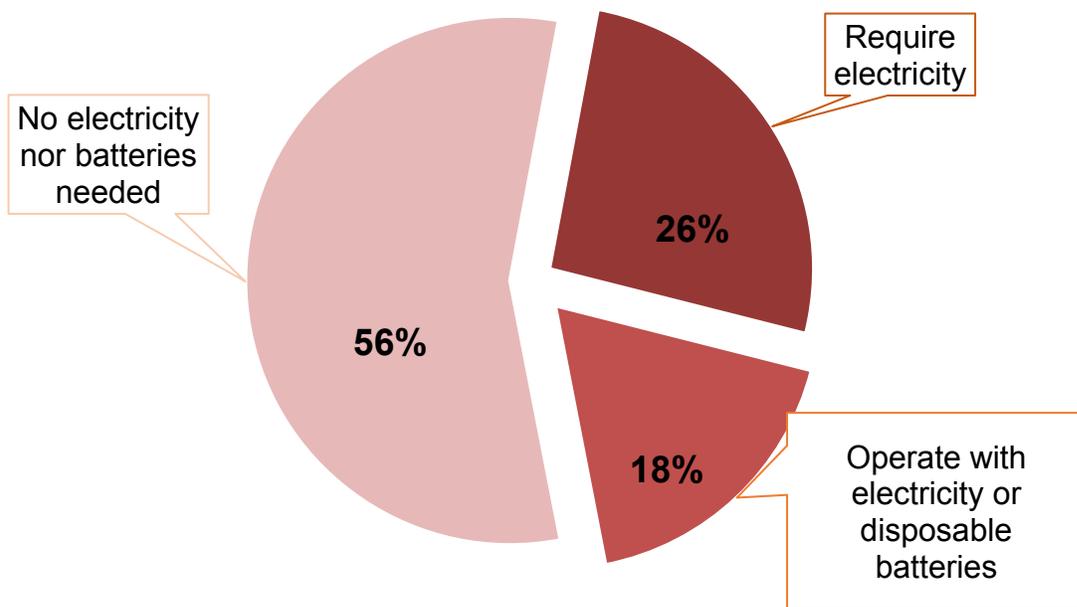
Source: Eurostat.⁸¹

In European countries, persons with disabilities are less likely to be able to keep their home adequately warm than persons without disabilities (Figure II.71). On average, 32% of persons with disabilities are unable to keep home adequately warm compared to 26% of persons without disabilities. While there is not much difference between the percentages of women and men without disabilities who are unable to keep their homes adequately warm (average gender gap less than half a percent point), the gender gap is wider among persons with disabilities, reaching up to 6.5 percentage points difference in some countries (average gender gap is 2.5 percentage points). Among persons with disabilities, more women in 30 out of 35 countries are unable to keep their homes warm as compared to men.

Persons with disabilities have more difficulties in paying for energy bills because of higher energy needs and reduced income

Persons with disabilities are likely to have higher energy needs.^{414, 415} Many spend longer periods of time in their households due to barriers faced in external environments, such as lack of accessible transportation and public spaces and/or discrimination, amongst others. Longer periods at home may lead to higher household electricity expenses.⁴¹⁶ Persons with disabilities may also require electricity-dependent assistive technology,⁴¹⁷ such as electric wheelchairs, braille displays, hearing aids, and fall detectors, which result in an increased energy consumption.⁴¹⁸ Studies in the United Kingdom showed that annual energy bills of families with persons with disabilities are about 50% higher than those without persons with disabilities.⁴¹⁹ Compared to households without persons with disabilities, the study found that the electricity bills are 39% higher for a household with older person with arthritis ; 50% higher for a single parent with two children with disabilities; and 55% higher for a household with a person with disability.⁴²⁰

Figure II. 72. Energy requirements of WHO Priority Assistive Products List.



Source: Authors' elaboration based on Priority Assistive Products List (WHO, 2016).

The increased need for electricity to operate assistive products is confirmed in the Priority Assistive Products List (see section on Assistive Technology),⁴²¹ released by the World Health Organization in 2016, which includes 50 priority assistive products selected on the basis of widespread need and impact on a person's life (Figure II. 72). More than a quarter of these products need electricity to operate, for example, electrically powered wheelchairs, gesture to voice technology, personal digital assistants, screen readers

and others; and 18% of them require either electricity or disposable batteries – including hearing aids, deafblind communicators and digital hand-held magnifiers, among others. Without access to affordable electricity and disposable batteries, persons with disabilities will not be able to operate 22 of the priority assistive products.

The burden of higher energy needs is made heavier by the reduced capacity of persons with disabilities to pay for energy bills. Persons with disabilities typically face additional costs due to disabilities and are more likely to be living in lower income households and less likely to be employed (see sections on SDGs 1 and 2 and SDG 8), leaving fewer financial resources to pay for energy bills. In 2011 in the United Kingdom, 22% of households with persons with disabilities spend more than 10% of their income on heating compared to only 14% of households without persons with disabilities; 14% of households with persons with disabilities would fall under the official poverty line after paying heating bills as compared to 10% of households without persons with disabilities.⁴²² This percentage varied based on type of disability from 12% to 18%, with households with persons with mental disabilities being mostly affected.⁴²³ Inability to afford adequate heating has also been linked to detrimental impacts in the physical and mental health of persons with disabilities due to cold room temperature and a concern of high bills. Some existing health conditions could be exacerbated by lack of heating.⁴²⁴

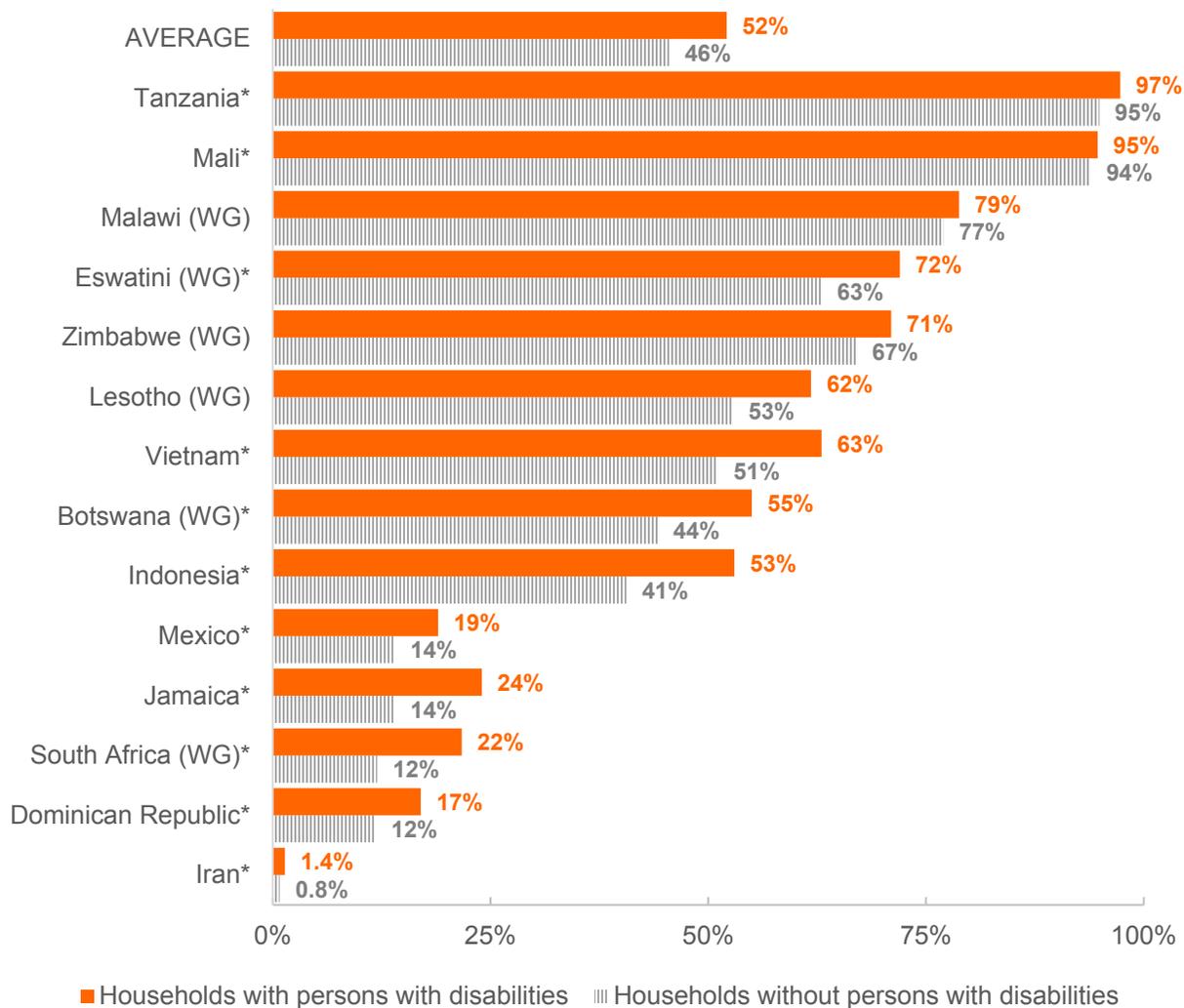
Persons with disabilities are more exposed to detrimental air pollution resulting from the use of traditional forms of energy

In developing countries, traditional fuels such as biomass and coal are often used as a main source for cooking and heating. Indoor pollution causes health problems, particularly to respiratory issues.⁴²⁵ Household air pollution is responsible for an estimated 4.3 million premature deaths per year worldwide, with high prevalence in countries with a high reliance on biomass and coal for cooking.⁴²⁶ Such inefficient cooking fuels and technologies like wood, crop wastes, charcoal, coal and dung are used in open fires and leaky stoves and produce household air pollution with a range of health-damaging pollutants, including small soot particles that penetrate deep into the lungs. In poorly ventilated dwellings, indoor smoke can be 100 times higher than acceptable levels for fine particles.⁴²⁷ Exposure can be particularly high among persons with disabilities who, due to stigma or lack of mobility, are likely to spend longer time indoors than persons without disabilities.

Household air pollution may especially be a problem in sub-Saharan Africa and Southeast Asia, where in 2013 more than half of the populations still used solid fuels for cooking and heating. Even in the Americas and Europe, the regions where use of solid fuels is the lowest, the population using solid fuels is still significant, 25% in Americas and 23% in Europe.⁴²⁸ Furthermore, available data from 14 developing countries, around 2010, shows that in all countries a higher proportion of households with persons with

disabilities than without persons with disabilities cooks with wood or coal (Figure II.73). On average, 53% of households with persons with disabilities versus 46% of households without persons with disabilities use these traditional forms of energy for cooking. The percentages of households with persons with disabilities which cooks with wood and coal vary from 1.4% in Iran to 97% in Tanzania. Households with persons with disabilities in rural areas are particularly affected, as the wood and coal are used for cooking in 66% of these households compared to only 32% of households with persons with disabilities in urban areas, on average (Figure II.74). In all these countries, the proportion of households with persons with disabilities cooking with coal and wood is higher in rural areas than in urban areas. Displaced persons with disabilities living in camps are also mostly affected, as almost all energy used for cooking in these camps comes from charcoal and firewood.⁴²⁹

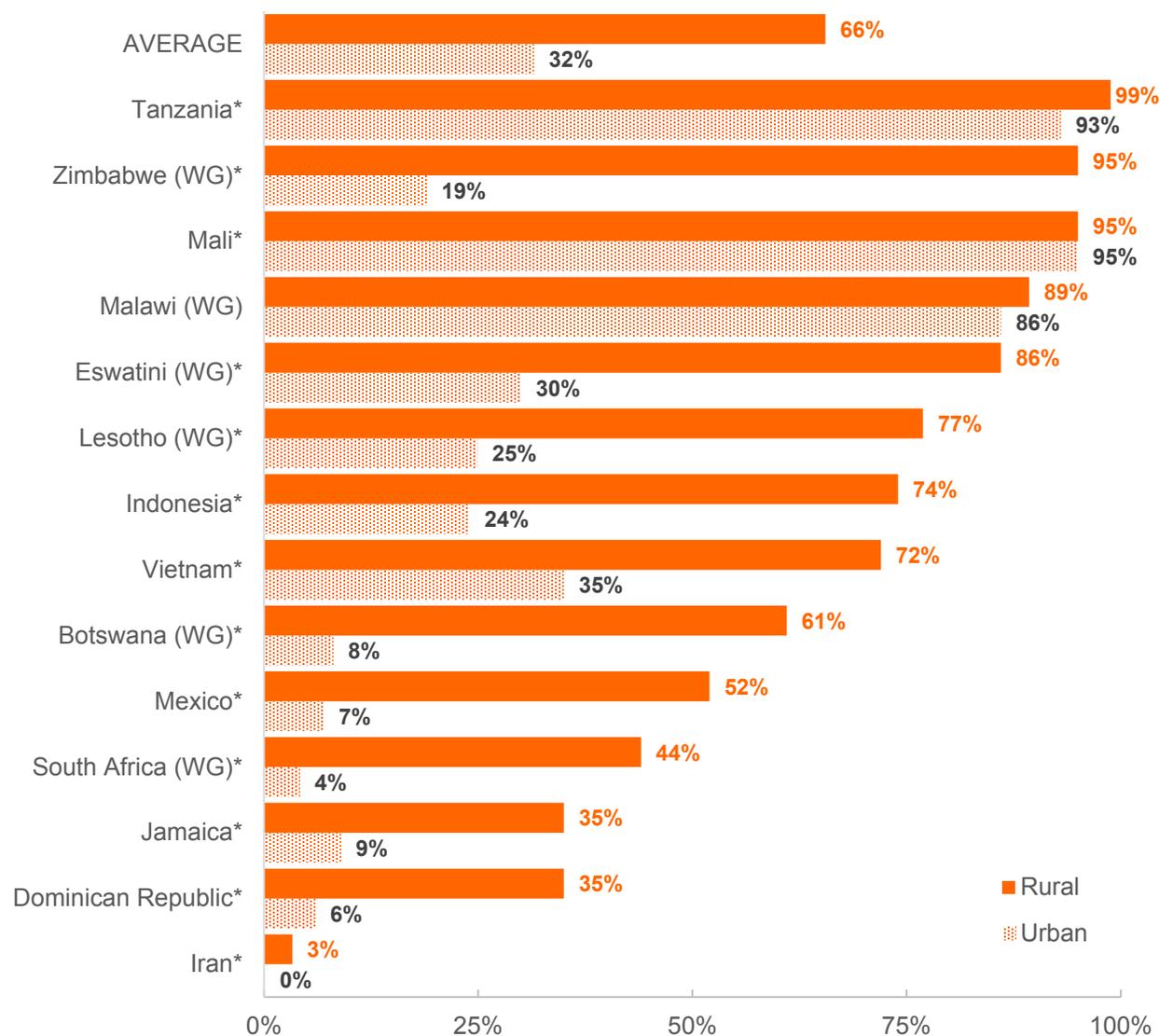
Figure II.73. Percentage of households with and without persons with disabilities cooking with wood or coal, in 14 countries, around 2010.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions. An asterisk (*) indicates that the difference between households with and without persons with disabilities is statistically significant at the 5% level.

Source: IPUMS.^{231,430}

Figure II.74. Percentage of households with persons with disabilities cooking with wood or coal, by location of household, in 14 countries, around 2010.



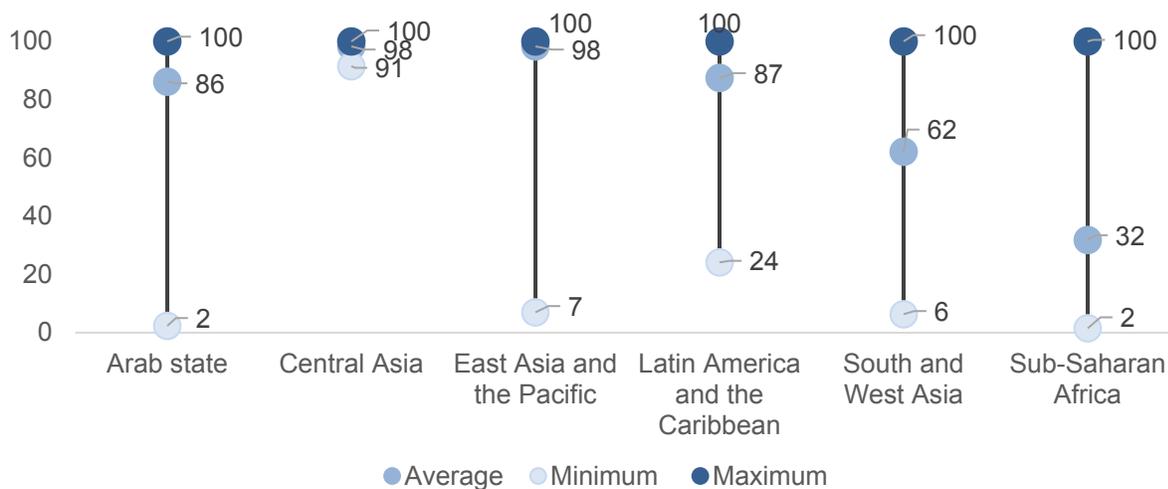
Note: An asterisk (*) indicates that the difference between households with and without persons with disabilities is statistically significant at 5% level.

Source: IPUMS.²³¹⁴³¹

Lack of electricity in schools prevents students with disabilities from accessing technology that would enhance inclusive education

Information and communication technologies (ICTs) have been designated as one of the most effective ways to advance inclusive education for persons with disabilities.⁴³² ICTs can be helpful in enhancing access by persons with disabilities to educational tools, in improving communication with teachers and schoolmates and in providing teachers with knowledge and tools to teach students with disabilities. Assistive ICTs also give students with disabilities the capacity to construct their own learning experiences. Due to their versatility and ability to be tailored to user needs, ICTs play a vital role in enhancing inclusive education and in enabling differentiated instruction and personalised learning. ICTs that can be used in schools to enhance the participation and inclusion of persons with disabilities include accessible education materials online, digital to Braille technologies, DAISY books, dyslexia formatted, text magnifiers, videos with captioning, audio formats, video in sign language, websites which can be made accessible by allowing for changes in font type and size; and digital documents which can be read with screen readers. Operating ICTs and assistive technology, however, requires access to electricity,⁴³³ which many schools particularly in developing countries, still lack. In 2012, on average, only 66% of primary schools in developing countries had access to electricity. In 35 out of 102 developing countries, less than 50% of primary schools had electricity (Figure II.75). Primary schools in sub-Saharan Africa had the lowest level of access with an average of 32%. In other regions, average percentages are higher, but in South and West Asia, in Latin America and the Caribbean and in Arab countries, there are countries where less than 10% of the schools have access to electricity. On the other hand, primary schools in 28 countries had 100% access to electricity. The Central Asia region has the highest level of access to electricity in primary schools, with an average of 98%.⁴³⁴

Figure II.75. Minimum, average and maximum values of national percentages of primary schools with electricity, by region, in 2012.



Note: Estimates based on 102 countries.

Source: UNESCO Institute of Statistics (2016).⁴³⁵

Lack of access to electricity in health-care facilities prevents the use of technology needed to assist persons with disabilities

Access to health-care services is essential for persons with disabilities who report seeking more medical attention than persons without disabilities.⁴³⁶ Energy plays a vital role in the quality of health-care services which may depend on electricity-run medical equipment.⁴³⁷ In addition, lack of electricity may prevent medical services from using assistive devices and technology essential for communication and independent participation of persons with disabilities. This, in turn, may contribute to the observed higher unmet need for medical care for persons with disabilities (see section on SDG 3). This is particularly a challenge in regions where electricity is not widely available in health facilities. Available data show that in sub-Saharan African countries on average 26% of health facilities had no access to electricity and only 28% of health facilities had reliable electricity.⁴³⁸

Current practices on energy and disability

Social welfare programmes have been established in many countries to provide financial support for persons with disabilities (see chapter on SDG 1.3). While the benefits provided in each country vary, financial assistance can contribute to improved energy access for persons with disabilities. Depending on whether the benefits consider the additional energy costs faced by persons with disabilities, they may be or not be enough to help with energy bills.⁴³⁹ Social welfare programs specifically directed at supporting the energy bills of persons with disabilities have been established in a few countries. In some countries, persons with disabilities with low incomes can also access low income social protection programs to receive support for their energy needs (see Box 4).

Box 4. Energy assistance programs accessible for persons with disabilities

The Cold Weather Payment⁴⁴⁰ and the Warm Home Discount Scheme for households with low-income⁴⁴¹ are both available to persons with disabilities in the United Kingdom to support payments for electricity to adjust room temperature in winter and summer. The Cold Weather Payment allows beneficiaries, including low-income households and those with persons and children with disabilities, to receive additional financial assistance when temperatures are at or below zero degrees Celsius for seven consecutive days in fall and winter months.⁴⁴² The Warm Home Discount Scheme provides a one-off per winter discount on the electricity bill of eligible low income households.⁴⁴³ Relatedly, the United Kingdom's Winter Fuel Payment enables older persons to get certain amount of money to help paying heating bills.⁴⁴⁴ In the United States, the Low Income Home Energy Assistance Program (LIHEAP), a federal programme distributed to and managed by each state, assists low-income households including those with persons with disabilities, to pay electricity bills for cooling and heating in residential dwellings, and to accommodate home energy needs in emergency situations such as extreme weather conditions. It further provides assistance with low-cost energy-related home repairs.⁴⁴⁵

Other positive national initiatives include legislation ensuring the inclusion of persons with disabilities in national energy bodies dealing with energy distribution and disputes. Kenya's Energy Bill (2015) stipulates that equal opportunities for persons with disabilities should be ensured in selecting, nominating, approving or appointing the members of the Energy and Petroleum Tribunal, a body composed of experts to determine energy disputes and appeals.⁴⁴⁶ In Germany, the payment services helpline of the E.ON, a utility company in Essen assists consumers having difficulty paying their utility bills to enhance their understanding on utility services and also provides easy-to-understand and accessible documents. Their services benefitted persons with intellectual disabilities in particular, contributing to 93% reduction of cases on energy shut down due to lack of payment.⁴⁴⁷ Other initiatives include targeting persons with disabilities in programs to enhance access to clean energy. For instance, in Dadaab refugee camp in Kenya, a settlement of more than 350,000 refugees, energy efficient stoves were disseminated, with the beneficiaries being selected by focusing on persons with disabilities and other vulnerable groups.⁴⁴⁸

One difficulty in developing effective policies to address the energy needs of persons with disabilities is that, at the national level, those government bodies with mandates relating to disability, assistive technology and on energy are almost always different. Disability tends to be under the responsibility of a ministry or a department of health or social welfare, while assistive technology tends to be under the mandate of the ministry of health, and energy issues fall under the mandate of a ministry or a department of energy. For example, in the U.K., programmes related to disability falls under two departments. The Minister of State for Disabled People sits under the Department for Work and Pensions, which provides Disability Living Allowance and social protection schemes that support the energy needs of citizens including persons with disabilities (see Box 4).⁴⁴⁹ The Department of Health and Social Care also provides services to persons

with disabilities in the areas of education and health including assistive technology.^{450 451} For the area of energy, the Department for Business, Energy & Industrial Strategy is in charge of securing energy supplies.⁴⁵²

UN entities have a number of activities underway designed to scale up the efforts to advance universal access to affordable, reliable and sustainable energy,⁴⁵³ but they typically do not include special measures for persons with disabilities. An exception is the UN Refugee Agency (UNHCR) Global Strategy For Safe Access to Fuel and Energy (SAFE) 2014-2018 which considers special measures to include and provide access to persons with disabilities in the integration of energy needs into emergency planning.⁴⁵⁴

Conclusions and the way forward

Many persons with disabilities live without access to electricity, thus compromising their capability to operate the necessary assistive technology for independent living and ultimately their participation in society. Moreover, fuel and energy poverty are experienced particularly by persons with disabilities, who tend to have less access to adequate heating and reliable access to modern forms of energy. Despite the interlinkage between energy and disability, this nexus has been absent from international normative frameworks on disability and on energy and is rarely addressed in national policy. This gap in policy and programmes must be addressed to achieve the goal of energy for all.

The 2030 Agenda for Sustainable Development through its Goal 7 and the principle of leaving no one behind has provided a powerful platform for Governments, UN agencies, civil society organizations and the private sector to galvanize momentum to promote sustainable energy for persons with disabilities in the upcoming years. As an immediate action, it is crucial to conduct more studies on disability and energy. Few studies exist on fuel poverty and disability and on the energy needs of persons with disabilities. More research will be needed to cover those gaps. National data collection activities can provide relevant information and comparable studies and evidence on energy consumption and access to energy between persons with disabilities and persons without disabilities may also help fill-in the gaps. Suggested immediate actions are outlined below:

- a. Produce a global mapping of the energy-disability situation, on existing policies, programmes and data;
- b. Undertake capacity building seminars/workshops to look into country-specific needs and to share good practices and lessons learnt at national, regional, and global levels;
- c. Develop a database of available information and disaggregated data on disability and energy;
- d. Undertake cost benefits analysis to understand and to present the co-benefits of providing access to modern energy to persons with disabilities;

e. Present a set of concrete recommendations on how to fill-in the gap in energy access between persons with and without disabilities at, *inter alia*, high-level and international conferences on energy including the preparatory meetings of the High-level Political Forum on Sustainable Development.

f. Form a multi-disciplinary multi-stakeholder task force, including policy makers and experts on energy and on disability as well as persons with disabilities and their representative organizations, to undertake the above activities.

Based on the study above, the following eight steps could contribute to address the unique energy needs and implement SDG 7 for persons with disabilities by 2030:

1) **Take into consideration the extra energy costs which persons with disabilities are faced with and co-benefits of providing access to energy for persons with disabilities in determining social protection measures.** Persons with disabilities tend to have higher energy consumption and higher energy bills. Electricity-run assistive technology, which many persons with disabilities need to live independently, may increase energy consumption. Social welfare programmes can play a crucial role in providing financial support for persons with disabilities to access the energy they need.⁴⁵⁵

2) **Include special measures for persons with disabilities in energy programs.** Initiatives and programmes launched by countries, international organizations, civil society and the private sector aiming at expanding access to energy should include targeted actions for persons with disabilities to ensure they also benefit from these initiatives and are not left behind. These special measures should also pay attention to the energy needs of persons with disabilities to secure their access to affordable and reliable energy.

3) **Close the gap in energy access between persons with and without disabilities.** This will require a focus on countries with low electricity access, because in these countries the gap between households with and without persons with disabilities tends to be wider. Rural areas also tend to have lower access to electricity and may require special measures.

4) **Prioritize electricity access for persons with disabilities who require electricity-dependent assistive technology for independent living and for participation in society.** Electricity services should reach out to persons with disabilities who require electricity-run assistive technology. In the absence of household electricity, charging at public facilities or off-grid systems,⁴⁵⁶ like solar power off-grid systems, could be considered. These alternatives should be particularly considered for persons with disabilities living in rural and remote areas where power lines are not always available.

5) **Reduce use of solid fuels and promote modern forms of energy in households of persons with disabilities.** Initiatives and programmes to reduce use of solid fuels should emphasize reaching households with persons with disabilities, making sure to reach households with persons with disabilities as a priority. Energy efficient stoves using modern forms of energy in particular would save persons with

disabilities who spend longer periods at home from indoor pollution due to traditional cooking and from exposure to violence particularly for women and girls with disabilities who may collect firewood.

6) **Promote electricity in schools to enhance opportunities for students with disabilities to participate equally in educational systems.** Access to electricity in schools is a prerequisite for effective participation for many persons with disabilities particularly those who rely on assistive technology. For many persons with disabilities, this technology can enhance their access to educational tools, and can improve their communication with teachers and schoolmates.

7) **Include persons with disabilities in national governing bodies working on energy access.** Inclusion of persons with disabilities in these bodies, including, for example, national energy committees, energy advisory boards and energy dispute tribunals, could play a vital role in addressing the unique energy needs of person with disabilities in the implementation of energy policies.⁴⁵⁷ Persons with disabilities must be engaged in decision-making process to ensure that their needs are adequately addressed in the policies.

8) **Raise awareness within ministries and promote inter-ministerial coordination to address fuel and energy poverty among persons with disabilities.** At the national level, those bodies with mandates relating to disability, assistive technology and on energy are usually different. But, these three areas are interlinked and more inter-ministerial coordination will be needed to address this nexus. Discussions on energy and fuel poverty of persons with disabilities will need to be linked to discourses around assistive technology, and vice-versa, because being energy poor impacts on the use of assistive technology, which in turn impacts on the independent living of persons with disabilities and their enjoyment of human rights.

H. Full and productive employment and decent work for persons with disabilities (SDG 8)

This section reflects on the achievement of SDG 8 for persons with disabilities. SDG 8 calls for promoting sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. The section presents international normative frameworks covering employment issues for persons with disabilities, provides an overview of the status of participation of persons with disabilities in the workforce, lists measures taken by countries to increase job opportunities for persons with disabilities and concludes with a conclusion and recommendations.

Decent work and employment are essential for the well-being and dignity of all, including persons with disabilities. Being able to work has a positive impact on social inclusion and quality of life. Quality employment is also essential for the economic empowerment and thus for the independent living of persons

with disabilities. Employment and decent work are the most effective means to break the vicious cycle of poverty and marginalization in which persons with disabilities may fall. The professional potential of persons with disabilities often remains untapped due to misconceptions about their working capacity, negative societal attitudes and non-accessible workplaces, vocational skills centres and job services.

International framework on disability and employment

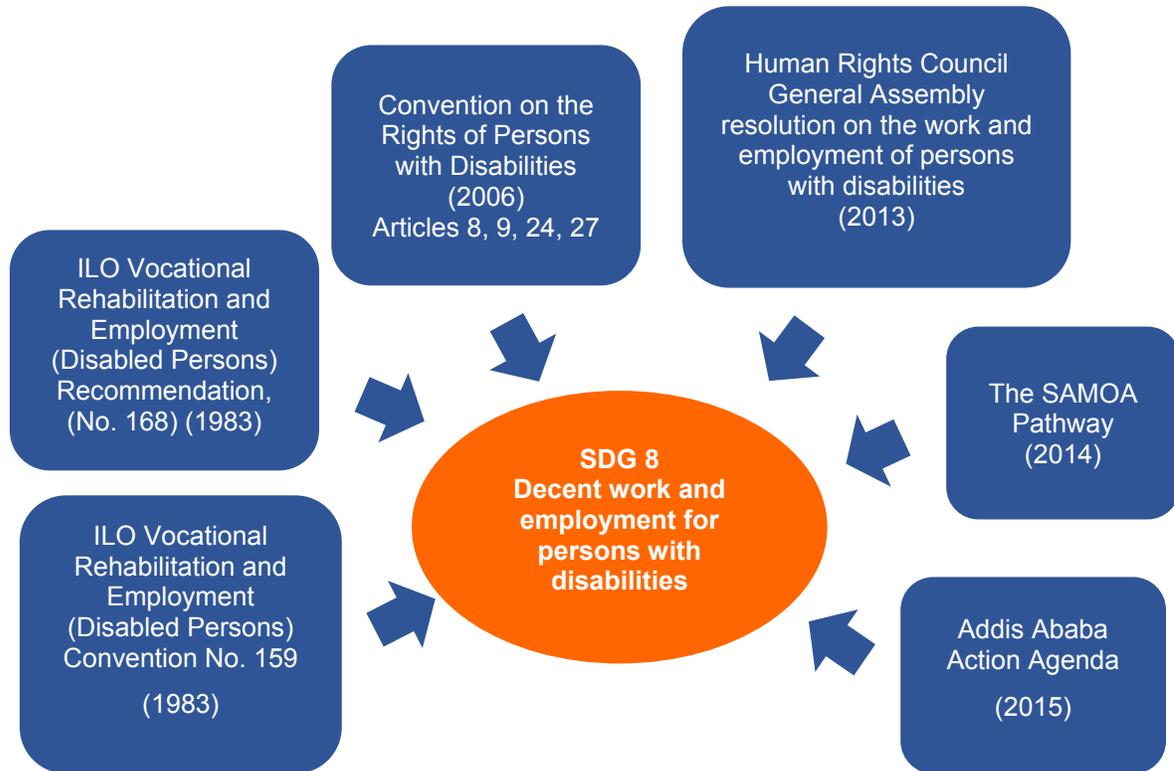
Several recently adopted instruments directly address persons with disabilities' right to work (Figure II.76). This right is explicitly enshrined in Article 27 of the CRPD, which focuses on work and employment. SDG 8, "Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all" explicitly refers to persons with disabilities in its target 8.5 which aims to, by 2030, achieve full and productive employment and decent work for all women and men, including for persons with disabilities, and equal pay for work of equal value. In 2013, the Human Rights Council's General Assembly adopted a resolution focused on employment and persons with disabilities, the Work and Employment of Persons with Disabilities (2013), which calls on States Parties to ensure that persons with disabilities can fully enjoy the right to work on an equal basis with others, and requests to take measures to do so by prohibiting discrimination, increasing employment, promote entrepreneurship, eliminating barriers that hinder job seekers from accessing the workplace, ensuring reasonable accommodation, amongst others.⁴⁵⁸ Equality of opportunity and equality between men and women with disabilities are principles that are also present in the ILO Convention No. 159. The ILO Convention No. 159, accompanied by the ILO Vocational Rehabilitation and Employment (Disabled persons) Recommendation, 1983 (No. 168), requires that member States formulate, implement and periodically review a national policy on vocational rehabilitation and employment of persons with disabilities.

The Addis Ababa Action Agenda and the international framework on Small Island Developing States (SIDS) address the equal employment opportunities for persons with disabilities. The Addis Ababa Action Agenda encourages the full and equal participation of women and men, including persons with disabilities, in the formal labour market.⁴⁵⁹ The Small Island Developing States Accelerated Modalities of Action (SAMOA) Pathway highlights the high rates of unemployment amongst persons with disabilities⁴⁶⁰ and calls for development of entrepreneurial and vocational skills for persons with disabilities and their inclusive and sustainable industry.⁴⁶¹ Given that the tourism sector represents a major economic pillar for many SIDS, the SAMOA Pathway stresses the enhancement of employment opportunities for persons with disabilities in the sustainable tourism sector.⁴⁶²

Both the CRPD and the SDGs recognize the importance of education for work and employment opportunities, including vocational and continuing training. Article 27 of CRPD calls for taking steps to "enable persons with disabilities to have effective access to general technical and vocational guidance

programmes, placement services and vocational and continuing training” and the need to create inclusive educational systems (Article 24). This in line with SDG 4 on education which calls for ensuring “inclusive and equitable quality education and promote lifelong learning opportunities for all” and particularly with SDG target 4.5 which emphasizes the importance of equal access to all levels of education and vocation training for persons with disabilities. Furthermore, the CRPD contains other provisions relevant for employment, such as awareness raising on the capabilities of persons with disabilities (Article 8) and increased accessibility of the physical environment, transport, information and communication (Article 9), all of which will optimize opportunities for persons with disabilities to participate in the labour market.

Figure II.76. International normative frameworks relevant for the achievement of SDG 8 for persons with disabilities



The situation of persons with disabilities in employment

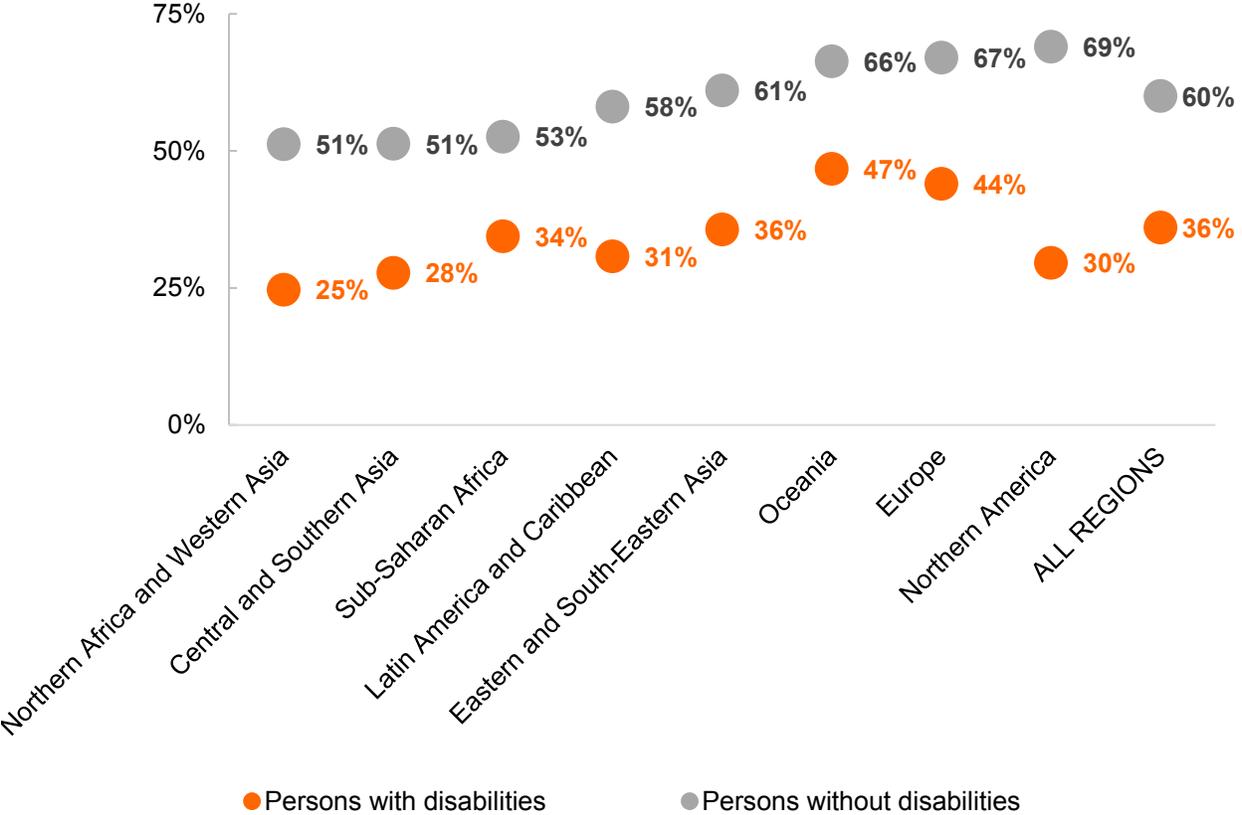
Persons with disabilities, particularly women with disabilities, are less likely to be employed than persons without disabilities

Lower rates of employment have been persistently observed for persons with disabilities. Across eight geographical regions, the employment to population ratio (EPR) for persons with disabilities aged 15 years and older is 36% on average, whereas the EPR for persons without disabilities is 60% (

Figure II.77). EPR among persons with disabilities varies from 25% in Northern Africa and Western Asia to 47% in Oceania. These regional averages are based on data from 91 countries and territories, and at the national level EPRs vary more widely from 7% to 69%.^{463,464,465,466,467,468} The employment gap is observed in all regions of the world (

Figure II.77) and varies between 18 percentage points in sub-Saharan Africa to 39 percentage points in Northern America. Gender gaps in access to employment are discussed in the section on SDG 5, showing that, in all regions, women with disabilities are less likely to be employed than men with disabilities, than persons without disabilities.

Figure II.77. Employment to population ratios for persons aged 15 years and over, by disability status, by geographical region, in 2006-2016.



Note: Based on data from 91 countries and territories. For some countries, data are for the age group 15 to 64.

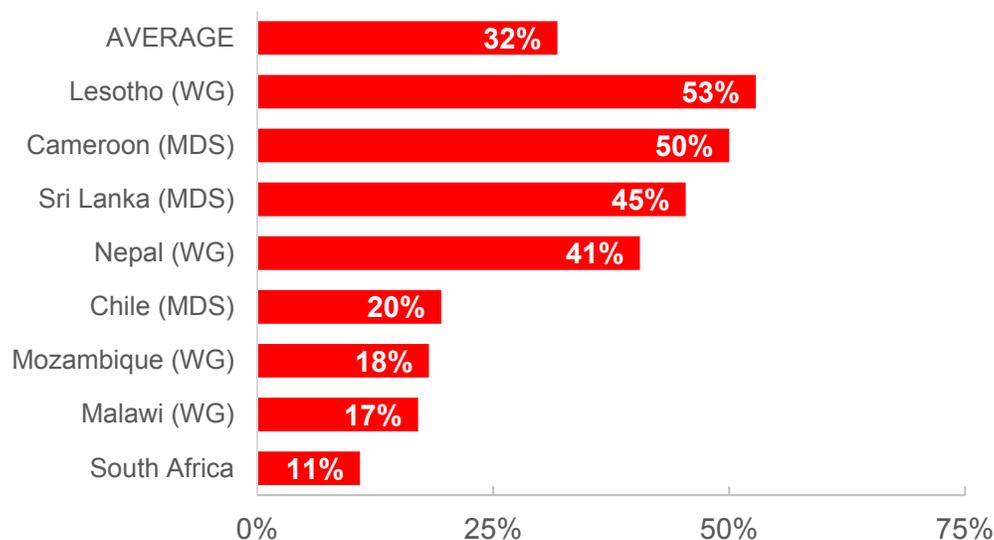
Source: ESCAP,⁴¹ ESCWA,²⁴¹ Eurostat,⁸¹ ILO⁴⁶⁹, IPUMS²³¹ and SINTEF.⁹

Since disability prevalence tends to increase with age and EPRs tend to be lower for older age groups, all factors equal one would expect EPRs to be lower for persons with disabilities aged 15 and over. However, the gap between persons with and without disabilities in employment is not only due to differences in demographic characteristics. Although the lower education levels often achieved by persons with disabilities impact access to employment, other factors also appear to play a significant role in limiting job

opportunities. These include discrimination, stigma, negative attitudes, lack of accessible transportation to get to work, and inaccessible workplaces with limited availability of accommodations for persons with disabilities.⁴⁷⁰ For example, in eight developing countries, an average of 32% of persons with disabilities reported that their workplace is hindering or not accessible (

Figure II.78). In many countries, laws regulating labour still miss protections against discrimination on the ground of disability (see section on SDG 10). Due to these obstacles, many persons with disabilities who are capable to work are not able to secure a job and remain an underutilized segment in the labour force.⁴⁷¹

Figure II.78. Percentage of persons with disabilities who report that their workplace is hindering or not accessible, in 8 countries, around 2013.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions; (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon and South Africa were collected in selected regions and are not nationally representative.

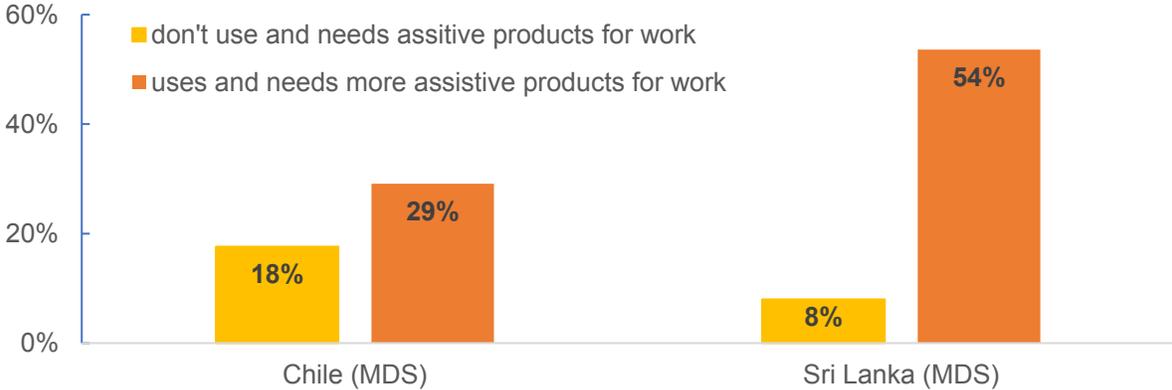
Source: WHO¹⁰⁷ and SINTEF.⁹

Reasonable accommodation, including assistive technology, is often missing at the workplace

Reasonable accommodations are necessary and appropriate modification and adjustments, not imposing a disproportionate or undue burden, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.⁴⁷² Reasonable accommodations used at workplaces vary from no-tech solutions which cost little or no money (like additional preparation time for an individual, or implementing a color-coded filing system), to accommodations that are

technologically simple or unsophisticated (e.g. replacing a door knob with an accessible door handle or providing a magnifier) to accommodations that use advanced or sophisticated assistive technology (such as use of screen reading software with synthesized speech). Advanced assistive technology is often costly and less available. In Chile and Sri Lanka, 8 to 18% of adults with disabilities do not use but would need assistive products for work, and 29 to 54% already use but would need more assistive products for work (Figure II.79). In some countries, employers can seek financial support for reasonable accommodation from a state fund or a charity fund.⁴⁷³

Figure II.79. Percentage of persons with disabilities who need assistive products at work, in Chile and Sri Lanka, 2015.



Note: (MDS) identifies countries with data collected using the Model Disability Survey.

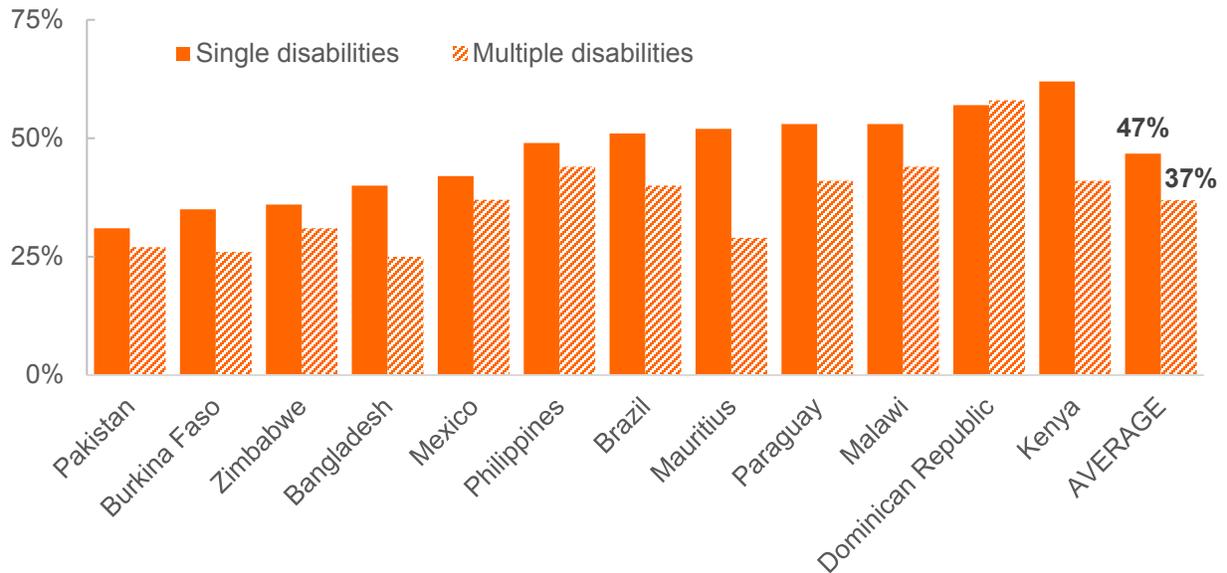
Source: WHO.¹⁰⁷

Persons with multiple, very severe, mental or intellectual disabilities, are less likely to be employed

Employment to population ratios for persons with multiple disabilities tend to be lower than those for persons with single disabilities. Data collected in 12 countries between 2002 and 2004 found that in all but one country the employment to population ratio of persons with multiple disabilities was lower than that for persons with a single disabilities (

Figure II.80). Among these countries, on average, 37% of persons with multiple disabilities and 47% of persons with a single disability are employed.

Figure II.80. Employment to populations for persons aged 18 to 60, by disability status, 2002-2004.



Source: Mizunoya, S. and Mitra, S. (2013) using data from the World Health Surveys 2002-2004.⁴⁷⁴

Persons with distinct types and degrees of severity of disabilities may be impacted differently by inaccessibility and other obstacles in employment. For instance, in Brazil, persons with more severe motor disabilities are less likely to be employed than persons with less severe motor disabilities.⁴⁷⁵

Available data shows that persons with mental disabilities are twice less likely to be employed as persons with other types of disabilities (

Figure II.112).

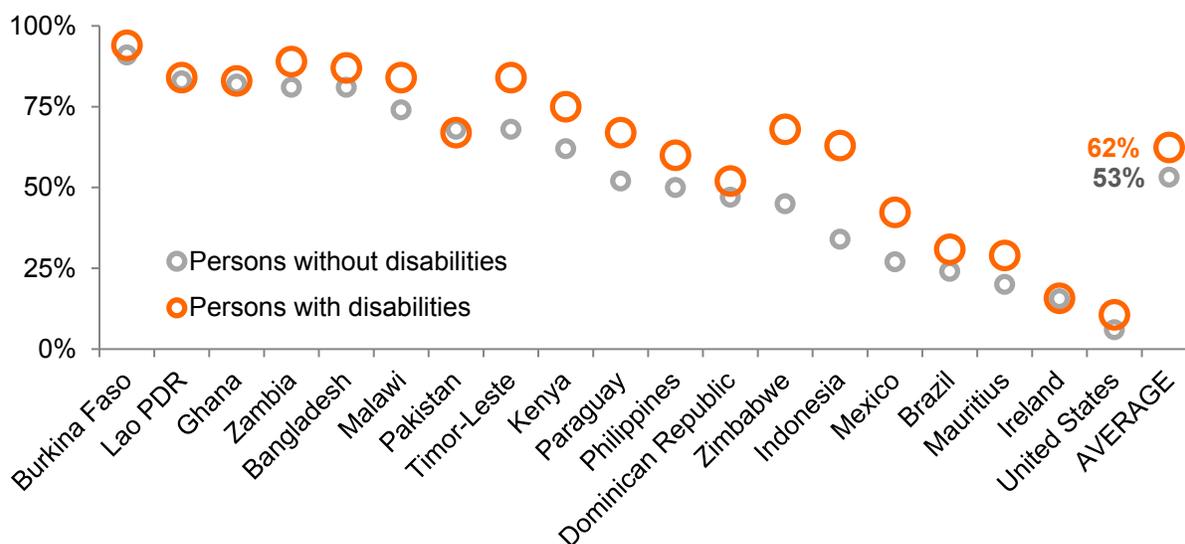
Persons with disabilities are more likely to be in vulnerable employment⁴⁷⁶

Even where persons with disabilities are employed, they may disproportionately face precarious situations in comparison to the general population. In most countries, for example, persons with disabilities are more likely to be employed in the informal sector and to be self-employed. For example, in Mongolia, persons with disabilities are four times more likely than persons without disabilities to be engaged in the informal sector.⁴⁷⁷ Regarding self-employment, persons with disabilities are also more likely to be self-employed. Among 19 countries, on average 62% of persons with disabilities versus 53% of persons without disabilities are self-employed (

Figure II.81). Within this sample of countries, the gap between persons with and without disabilities is wider for developing countries than for developed countries. In 13 of these countries, self-employment rates for

persons with disabilities are 5 percentage points higher than for persons without disabilities. The gaps are higher in Indonesia, in 2010, where over 63% of people with mild disabilities who are working are self-employed, compared to 34% of persons without disabilities. Many persons with disabilities who are self-employed work for their family. In Timor-Leste, 21% of employed persons with disabilities are family workers.⁴⁷⁸ In developed countries, evidence from Ireland and the United States suggests that the gaps are narrower. In Ireland, the self-employment rate for persons with and without disabilities is the same, while in the United States the self-employment rate is 5 percentage points higher for persons with disabilities.

Figure II.81. Percentage of employed persons with disabilities who are self-employed, by disability status, 2002-2017.⁴⁷⁹



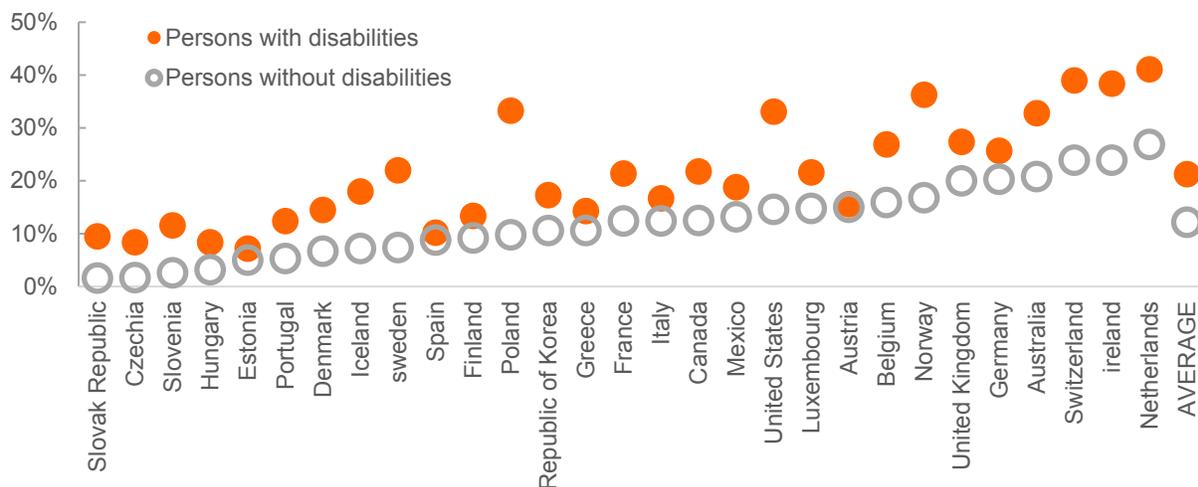
Source: IPUMS,²³¹ U.S. Bureau of Labour Statistics, Mizonoya and Mitra (2013),⁴⁸⁰ UNESCAP (2015).⁴¹

Also, persons with disabilities are probably less likely to be covered by collective bargaining agreements and thus have fewer protections at work because they are more likely to be self-employed or in the informal sector.

When in employment, persons with disabilities are more likely to be in part-time jobs. A 2010 study in 29 countries showed that in all of them the percentage of part-time employees among employed persons with disabilities was higher than for persons without disabilities in all countries (Figure II.82). A study in Nepal showed however that, for persons with disabilities, higher levels of job satisfaction are associated with full-time work.⁴⁸¹ Often persons with disabilities are limited to part-time employment because the full-time employment does not give them the proper time to prepare for work, time to travel to and from work due to

lack of accessible transportation (see section on SDG 11), and to deal with disability-related services that they may need.⁴⁸² When given the necessary accommodations, persons with disabilities are able to engage in full time work.

Figure II.82. Share of part-time employment in total employment, by disability status, in 29 countries, 2003-2008.



Source: OECD (2010).⁴⁸³

Persons with disabilities tend to earn lower wages

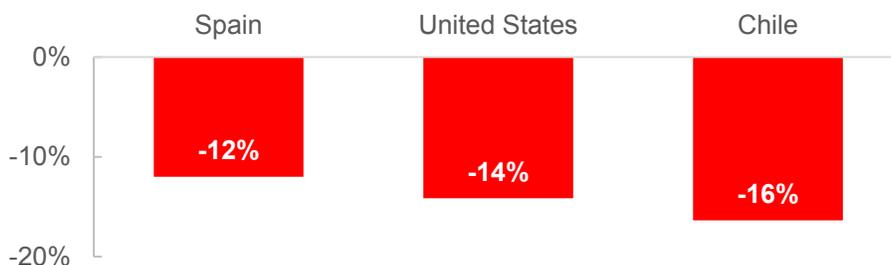
Employed persons with disabilities tend to earn lower wages than persons without disabilities.⁴⁸⁴ This may be in part because persons with disabilities are disproportionately self-employed, and the self-employed earn less, and because persons with disabilities more often have irregular employment.⁴⁸⁵

Wage gaps wider than 10% have been reported (Figure II.83). In Spain, a person with disabilities earns on average 12% less per hour than a person without disabilities. Similar analysis in the United States reveals that the median earnings of working-age persons with disabilities who worked full-time and a full-year in 2012 were 14% lower than those of persons without disabilities. In Chile, in 2013, the average income from the main job of a person with disabilities 15 years or older was 16% lower than the average employment income of a person without disabilities. Persons with some types of disabilities experience even wider gaps. In the United States, persons with cognitive disabilities earned 29% less than persons without disabilities;⁴⁸⁷ in Spain, persons with intellectual disabilities earned 49% less than persons without disabilities.⁴⁸⁶

Among persons with disabilities, those living in rural areas and women tend to receive the lowest salaries. In Peru, in 2012, 61% of persons with disabilities living in rural areas versus 36% in urban areas received

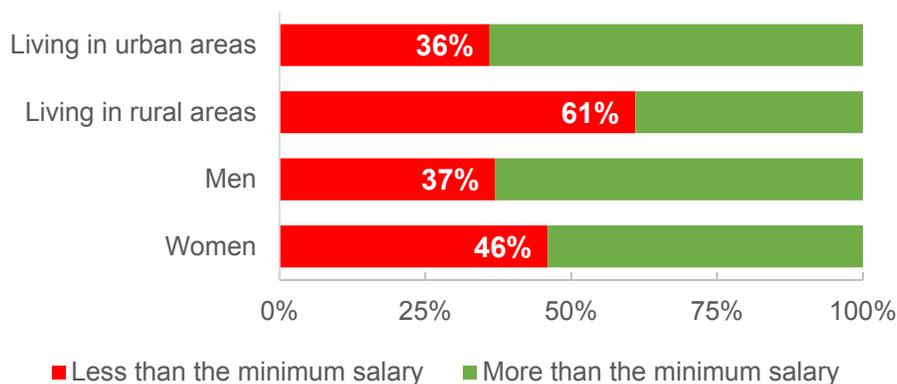
less than the minimum salary; and 46% of women versus 37% of men with disabilities received less than the minimum salary (Figure II.84). In Spain, women with disabilities earned 16% less than men with disabilities.⁴⁸⁶

Figure II.83. Wage gap between persons with and without disabilities (persons with disabilities minus persons without disabilities), 2012-2013.



Source: National Statistical Institute of Spain,⁴⁸⁶ Erickson et al (2014)⁴⁸⁷ and Ministry of Social development of Chile.⁴⁸⁸

Figure II.84. Percentage of employed persons with disabilities (employees, employers and own-account workers) receiving less and more than the minimum salary, by sex and area of residence, in Peru in 2012.



Source: National Statistical Institute of Peru.⁴⁸⁹

Current practices on disability and employment

In all regions, countries are making efforts to harmonize national legislative and policy frameworks with the CRPD, including by seeking to domesticate provisions regarding the right of persons with disabilities to work and employment. Many relevant national initiatives focus on promoting inclusive employment, including through anti-discriminatory legislation, inclusive job services in both the public and private sectors,

promoting inclusive education and training, and adopting social protection schemes which encourage work. Although countries often focus both on targeted programmes and disability mainstreaming, there has been a move towards the latter, and therefore towards inclusion of persons with disabilities in mainstream programmes and services.

National practices on promoting inclusive employment

Many countries have been implementing or strengthening their disability-specific anti-discrimination legislation and policies in the areas of employment. For example, 22 UN member states have provisions in their constitutions explicitly guaranteeing the right to work to persons with disabilities or prohibiting employment discriminations against persons with disabilities.⁴⁹⁰ Figure II.104 shows that more than 60% of countries have included disability-specific provisions prohibiting discrimination practices and guaranteeing equal pay in the laws regulating labour. Some countries have developed national employment policies (NEP)⁴⁹¹ that include provisions for ensuring the right of persons with disabilities to equal employment opportunities. Examples can be found in the NEPs of Liberia, Sri Lanka, Ethiopia and Seychelles.⁴⁹²

Despite such positive examples, legislation seeking to ensure equal access to employment is not always sufficiently comprehensive to address all obstacles. For example, relevant legislation often does not include provisions for reasonable accommodation, although a number of countries - like the United Kingdom⁴⁹³ and the United States⁴⁹⁴ - have already considered such provisions. Even in countries where denial of reasonable accommodations is legally considered an act of discrimination, insufficient guidance is often given by States to employers, workers with disabilities and other relevant stakeholders on how reasonable accommodation should be provided in the workplace. In some instances, anti-discrimination legislation may lack adequate enforcement mechanisms, which can undermine the legislation's effectiveness.

Many countries have also mainstreamed disability into their public employment services (PES), which can include job search and placement support, provision of relevant labour market information, and career guidance and training. Mainstreaming disability in these services can include facilitating job matching between companies and job seekers with disabilities. This, in turn, requires reducing disability-based bias in recruitment practices of employers, and provision of financial and technical assistance for making adjustments to the workplace. Countries that have started to explicitly take disability into account in their public employment services include India, Ivory Coast, Mexico, Peru, Philippines and Vietnam.⁴⁹⁵

Public employment programmes have been used as an additional policy instrument with which to tackle the challenge of unemployment and underemployment of persons with disabilities. Such programmes can become more inclusive of persons with disabilities by including provisions for increasing the accessibility of the built environment, transport, information and communication; for providing reasonable accommodation, if needed; and building the disability awareness of programme staff, managers and co-workers.

One example of a public employment program with measures to effectively include persons with disabilities is provided by India.⁴⁹⁶ Through this programme, which guarantees 100 days of wage employment in a financial year to every household, state governments in India have to provide work that takes into account disability-related needs of persons with disabilities. For instance, efforts are made to ensure that persons with disabilities are provided work opportunities close to their place of residence, so that they do not need to travel long distances to the workplace. Moreover, it is ensured that persons with disabilities are paid wages equal to persons without disabilities. This public employment programme also seeks to ensure a stigma-free environment at the workplace, so that workers with disabilities are not looked down upon or face any form of discrimination. In 2015-16, about half of the 130,420 persons with disabilities registered under this programme engaged in work under the scheme.⁴⁹⁷

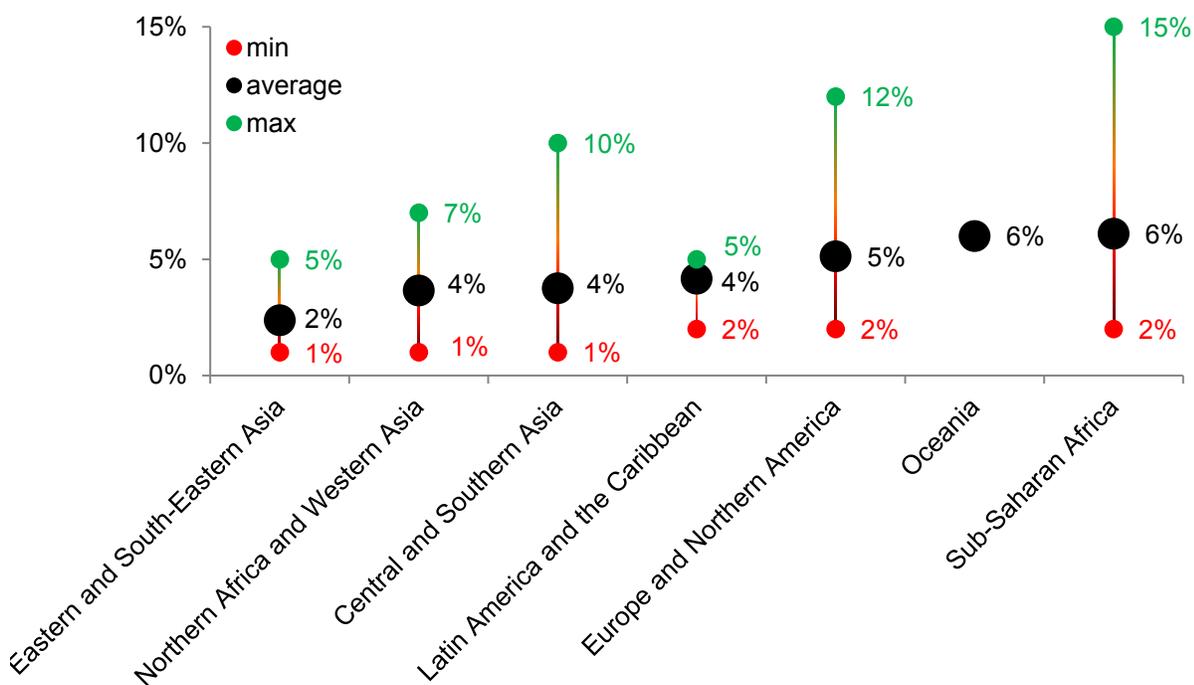
In addition to designing and implementing laws, policies, services and programmes to promote the employment of persons with disabilities, the public sector has also played a role as an employer of persons with disabilities. For instance, New Zealand has implemented a range of initiatives to promote the employment of persons with disabilities in the public sector, including providing guidance on disability inclusion for leaders, managers and human resources professionals in the public sector.

One of the frequent affirmative action measures used by countries to promote employment of persons with disabilities are quota systems, which establish an obligation for employers to fill a certain percentage of their total jobs with employees with disabilities. National quota systems currently in place apply to employers in either the public or private sector or to both. In some countries, quotas are only applied to employers of a certain size, and different quota levels, typically range from 1 to 15% (Figure II.85), are often used for the public and for the private sector. Eastern and South-Eastern Asia have the lowest regional quota levels; and sub-Saharan Africa the highest.

As there have been no thorough evaluations of quotas, it is difficult to assess their role in including persons with disabilities in the labour market.⁴⁹⁸ Countries with quotas between 1 and 4% show a wide range of EPR gaps between persons with and without disabilities; countries with quotas between 5 to 9% have the lowest EPR gaps and the few countries with more than 10% quota levels have currently wide gaps (

Figure II.86). This wide variability is likely due to variation across countries in the degree of enforcement of quota levels as well as to the existence, or absence, of additional instruments to complement the shortcomings of quota systems. The most effective quota systems include the payment of a levy by the non-complying company for every designated position not held by a person with disabilities. Such levies typically contribute to a special fund which is used to finance measures promoting the employment of persons with disabilities. Quota systems are of little relevance in low income countries, where the vast majority of people work in the informal economy. Also, often employers prefer to pay the sanction or include persons with disabilities in their payroll but do not expect them to come to work.⁴⁹⁹

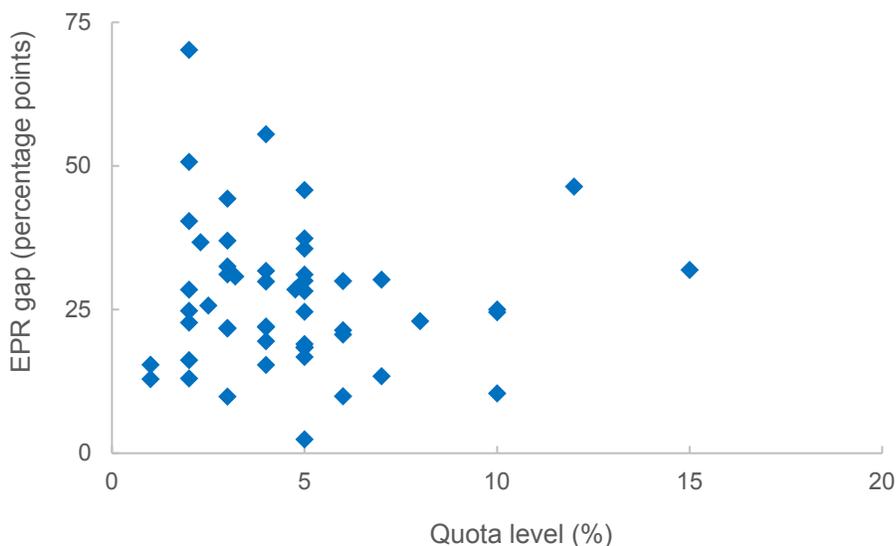
Figure II.85. Minimum, average and maximum employment quotas for persons with disabilities, by region.



Note: Based on information from 100 countries. Value for Oceania based on one country.

Source: ILO and UNDESA.

Figure II.86. Employment quotas for persons with disabilities versus employment-to-population (EPR) ratio gap (persons without disabilities minus persons with disabilities), around 2010.



Source: For sources of data, see figures 2 and 9.⁵⁰⁰

The public sector has also encouraged the creation of decent work for persons with disabilities by including disability-related provisions in public procurement policies. For instance, under the Preferential Procurement Policy Framework of South Africa, enterprises are awarded contracts based on a preferential points system which features disability inclusion as one of the areas that positively impact the company’s overall rating vis-à-vis the public sector. The United States has a similar system requiring all federal contractors to pursue the goal of a workforce in which at least 7 percent of workers have disabilities.⁵⁰¹ In the Philippines, public institutions and local governments are required to procure at least 10% of goods and services from cooperatives and organizations of persons with disabilities, where possible and applicable.

There are also promising initiatives to support entrepreneurship among persons with disabilities, particularly by removing discriminatory practices and improving access to financial services. A persistent barrier in this area has been the false assumption that persons with disabilities represent a higher-risk group. In fact, persons with disabilities have similar payback rates on their loans as persons without disabilities.⁵⁰² In Uganda, the Association of Microfinance Institutions has taken measures to create equal opportunities for persons with disabilities to access their financial services, with particular focus on sensitizing its staff on disability rights.⁵⁰³ A major banking group in Austria offers customer services in sign language through online video calls.⁵⁰⁴

Many persons acquire their impairment while they are in employment. However, in some countries, there are no policies or programmes in place to support job retention or return to work, in such instances,

particularly if the employee has had to leave work for some time.⁵⁰⁵ Evidence shows that the longer an absence from work, the more difficult it is to bring a person back into the labour market. But national initiatives have been taken to counter this trend and support the retention or return to work of persons who acquired their impairment while they were in employment. The Return to Work programme of the Malaysian Social Security organization is an example of a good practice in this area. The efforts in Malaysia focus initially on getting the person with disabilities back to the company where she/he was working before (same job or, if the same job is no longer an option, a similar job). If this is not possible, efforts are made to employ the returning worker at another company and, only if this has not worked out, the focus is on providing self-employment opportunities. Ensuring job retention and return to work for persons with mental health conditions and persons with psychosocial disabilities is particularly challenging, as issues of stigma related to mental health still persist.⁵⁰⁶ Public policies to address this issue include individual placement and support (IPS), which has some common elements with supported employment and is used particularly for persons with psychosocial disabilities.

Persons with disabilities sometimes require additional support to be able to find, secure and retain a job. Supported employment⁵⁰⁷ has proved to be an effective methodology. Supported employment may consist of on-the-job training provided by an externally funded job coach who accompanies the employee with a disability during the initial period of the employee's new job. The support is gradually phased out, but the organization providing this support remains available to intervene, if needed. Supported employment is particularly effective for people with intellectual and psychosocial disabilities; however, it is not limited to these groups.⁵⁰⁸

Another approach involves making an initial, substantial investment in helping an individual to become established in a competitive job, without an expectation of continued support thereafter. The focus is on providing the individual with introductory work opportunities—visiting employers, job-shadowing, subsidized internships, temporary or part-time jobs, etc.—with technical assistance provided by a counsellor. The approach helps the individual understand what work requires, exposes them to jobs that may be of interest to them, and helps employers understand how they use the individual's work capacity. Project SEARCH is a prominent example of this approach in the United States.⁵⁰⁹

Sheltered employment has historically played a relevant role, usually for persons with disabilities who face particular challenges entering the mainstream labour market. Sheltered employment, mostly found in developed countries, varies significantly among and within countries. It includes workshops or companies in which workers with disabilities have standard labour contracts and wages according to the sector in which they operate. Sheltered employment can also include workshops in which persons with disabilities do not have labour contracts, but receive disability benefits from the State and minimal pocket money from the workshop, based on their production. The transition into the “open” labour market - the goal that most sheltered workshops are supposed to promote has generally not been achieved.

One of the main challenges for persons with disabilities in finding jobs, particularly in developing countries, has been the lack of involvement of the private sector. A successful initiative to address this challenge is the ILO Global Business and Disability Network (ILO GBDN) which provides a platform for global and local companies to exchange practices on the inclusion of employees with disabilities. This initiative draws on the advantages for business of employing persons with disabilities, by highlighting the talents and skills workers with disabilities bring to the company, thereby contributing to a diverse workforce that is better prepared to respond to the diverse needs of the globalised economy. A small but increasing interest of the private sector in the employment of persons with disabilities exists in developing countries, demonstrated by the establishment of national employer-led initiatives on disability inclusion in countries including Bangladesh, Indonesia, Peru and Zambia, among others. These initiatives are particularly important as they challenge the widely held view that the only opportunity for persons with disabilities in developing countries to obtain a livelihood is through self-employment in the informal economy.

National practices on ensuring full inclusion in technical vocational education and training

Many countries have been working to adopt or strengthen existing disability-specific anti-discrimination legislation that includes provisions relating to vocational education and training. Many have also established initiatives to promote inclusive Technical Vocational Education and Training (TVET). Some countries, including Bangladesh⁵¹⁰, Malaysia, Australia, India, Canada, Ethiopia⁵¹¹, have introduced general or disability-specific laws, policies or strategies that promote the inclusion of persons with disabilities in mainstream TVET systems and programmes. In addition, countries including Ethiopia, Brazil, South Africa, Egypt and Indonesia have taken steps to create more disability inclusive apprenticeship schemes, such as workplace programmes and hands-on learning open also to persons with disabilities at a company combining on-the-job-training with complementary school-based training for a full occupation, craft or trade.⁵¹² In Mozambique, support has been provided for young persons with disabilities to access technical and vocational training by removing physical barriers in accommodations and training centres, for example, by developing accessible lavatories and installing lower door locks and light switchers.⁵¹³ National initiatives that include youth with disabilities in programs offering comprehensive education, job training and job placement services to economically disadvantaged youth have been found to be especially effective in improving the work outcomes for youth with disabilities.⁵¹⁴

National practices on social protection to encourage work among persons with disabilities

In countries that provide disability benefits, eligibility is often tied to the inability to work, providing a potential disincentive to look for employment. Awarding benefits based on inability to work reduces employment of persons with disabilities and undermines support for work from service providers, other public programs, employers, family and friends. The result is that persons with disabilities are less productive than they

otherwise might be and more frequently are excluded not only from employment but also from other aspects of society. This approach has been cited as a major impediment to the success of other efforts to improve employment outcomes,⁵¹⁵ including establishment of the right to work and investments in education, training and employment services. Yet this approach to determining eligibility remains common in developed countries, at least in part because of fears that other approaches will result in rapid growth of program costs, as those working despite their disabilities would become eligible for benefits. A few countries, such as the United Kingdom, have disability allowance schemes, designed to pay for the extra costs associated with having a disability, without considering employment or earnings, but these are small relative to programs awarding benefits on the basis of inability to work. In recent years, a few OECD countries have addressed this issue by putting greater emphasis on improving support for workforce retention before workers become dependent on social protection. This promotes greater inclusion of persons with disabilities and helping workers stay in the labour force appears to be less costly than providing benefits on the basis of inability to work.

Conclusions and the way forward

Many persons with disabilities, particularly women with disabilities and those with very severe disabilities, face difficulties in participating in the labour market. Gaps remain in the employment of persons with disabilities in the mainstream labour market and those who are employed are more likely to be in vulnerable employment and to earn lower wages compared to persons without disabilities. Many countries have taken initiatives to address these issues, through anti-discrimination legislation and quota systems, as well as by developing disability-inclusive national employment policies, technical vocational education and training, public employment services and programmes, public procurement, entrepreneurship support services, and social protection schemes for persons with disabilities which are compatible with work.

To address the current employment gaps and realize SDG 8 for persons with disabilities, the following steps could contribute to address current challenges:

- 1) **States should ensure that national legislation protects persons with disabilities from discrimination on the basis of disability in all matters of employment and that it includes the denial of reasonable accommodation as a form of discrimination.** Reasonable accommodation in most cases does not incur costs or incur just a minimal cost.⁵¹⁶ It is important that States improve and standardize the support available for providing reasonable accommodation in the workplace.⁵¹⁷
- 2) **The public sector should lead by example by hiring persons with disabilities** and take affirmative actions to promote their initial employment and career development. This will expand the opportunities for persons with disabilities to work, create a model for other employers and increase the legitimacy and credibility of the public sector in terms of representing the whole population it is supposed to serve.

- 3) **Public procurement policies and systems should include provisions that encourage the employment of persons with disabilities**, including by setting a clear goal on the proportion of procurement of services and products provided by persons with disabilities.
- 4) **States should ensure that public employment services are inclusive of persons with disabilities**, including through managing disability-disaggregated data, reducing disability-based bias in recruitment practices of employers and providing financial and technical assistance in making adjustments to the workplace. Staff of PES who interact with clients with disabilities need to be sensitised about disability issues and disability-specific needs and should be enabled to read, interpret and develop labour market data in an efficient and effective manner and communicate it in a comprehensible way to job seekers with disabilities. Where disability-specific placement services exist, these should be well coordinated with the PES.
- 5) **Where employment quota legislation exists in the public and/or private sectors, the State should ensure its implementation with an effective evaluation system throughout the career development of employees with disabilities.** Quota systems should complement anti-discrimination legislation that ensure equal working condition for persons with disabilities after being hired. On one hand, quota systems are more effective in getting persons with disabilities into the labour market, but do not require employers to ensure equal opportunities for the career development of employees with disabilities. On the other hand, anti-discrimination legislation is less effective to facilitate the entry into the labour market, but it can be very effective in guaranteeing equal working conditions for workers with disabilities.
- 6) **Mainstream entrepreneurship development training and microfinance systems should include persons with disabilities** by, *inter alia*, combatting stereotypes about persons with disabilities' entrepreneurial and financial abilities and facilitating access of current and potential entrepreneurs with disabilities to credit and financial services. To mainstream entrepreneurship development training, a first step could be ensuring that the trainings provide reasonable accommodation and when the courses are announced they refer to entrepreneurs with disabilities as welcomed participants.
- 7) **States should have policies in place that facilitate job retention and return to work for persons who acquire a disability, including for persons with mental health conditions**, with the provision of disability benefits that are compatible with full or part time work. Programs designed to support the entry or re-entry into the labour market should ensure full inclusion. The International Social Security Association (ISSA) guidelines on job retention and return to work provide useful guidance on the different measures that need to be in place for this to happen.⁵⁰⁵
- 8) **States should support persons with disabilities in sheltered employment to benefit and enter the mainstream labour market.** While sheltered workshops have played a vital role in the employment

of persons with disabilities, there is a need to move towards a more inclusive model and improve the number of employees with disabilities that participate in the mainstream labour market. In addition, the reference to “all forms of employment” in paragraph 1 (a) of Article 27 of CRPD ensures that persons with disabilities working in sheltered companies or workshops should also be protected from discrimination in all the matters covered by the article.

- 9) **States should pay particular attention to encouraging employment of persons with disabilities in the private sector**, both working on the demand side, supporting initiatives that will increase disability confidence among employers, as well as the supply side, ensuring better access of persons with disabilities to education and vocational training, and by facilitating job placement services. Private sector involvement will need to be supported by Governments through improvements in legislation, policies and services, particularly those related to skills development and adequate placement services.
- 10) **Mainstream Technical Vocational Education and Training (TVET) systems and programmes and other skills development systems should have provisions to include persons with disabilities**, for example, through building capacities of TVET staff's in training persons with disabilities, increasing the physical accessibility of TVET centres with a provision of reasonable accommodation, and conducting adaptations of entry criteria, teaching methods and materials as well as evaluation methods that consider disability. Women with disabilities should receive particular attention. In-house and online training can also increase the participation of persons with disabilities. Mainstream workplace-learning, particularly apprenticeships should be made inclusive of persons with disabilities. For instance, all federal and state employment and training services should be accessible to those with disabilities.
- 11) When designing and implementing social protection systems, **States should consider a flexible combination of income security and disability-related support** in a complementary way to promote the economic empowerment of persons with disabilities. Social protection systems can play a critical role in laying the foundation for many persons with disabilities to enter and/or stay in employment. By ensuring that persons with disabilities have income security, that their disability-related needs and extra costs are met and that they have effective access to health care services, these systems can significantly promote the participation of persons with disabilities in the open labour market and in society at large.
- 12) **Build robust evaluation plans for the implementation of the programmes to improve the employment of persons with disabilities.** The development, implementation and evaluation of national employment policies should include a rights-based disability perspective, including measures that effectively promote the employment of persons with disabilities as well as a meaningful involvement of organisations of persons with disabilities at all stages. Disability-disaggregated indicators need to be included in the action plans for the implementation of policies to ensure that monitoring and evaluation effectively takes disability issues into account.

13) **States should ensure that a database of available information and disaggregated data on disability and employment is developed and available in an accessible format.** When reporting on the disability employment gap, it is important to go beyond the percentage of persons with disabilities in employment to also include breakdowns by status in employment, hours worked, and earnings to provide a fuller picture of the differences in employment between people with and without disabilities. Comparisons of employment profiles of persons with and without disabilities should also include disaggregation by other significant demographic, social and economic characteristics (such as gender, age, ethnicity, economic activity, occupation and level of education, amongst others), because of the interactive aspects of these characteristics with the impact of disability. Disaggregation should take a due regard to the need for confidentiality and statistical significance.

I. Increase access to ICT for persons with disabilities (SDG 9.c)

This section will address access to ICTs as it relates to persons with disabilities, beginning by presenting the international normative framework in this area. An overview of global ICTs access and usage among persons with disabilities is presented. The section also illuminates national initiatives and ends with recommendations to improve access to ICT among persons with disabilities.

The reach and power of information and communication technology (ICT)⁵¹⁸ has grown tremendously in recent decades. In today's digital age, ICT plays a central role in nearly all aspects of life. ICTs affect how people work, play, vote, and interact. For persons with disabilities, ICTs can in addition represent a powerful opportunity to improve quality of life, enhance inclusion and social engagement and make independent living possible: "For most people, technology makes things easier. For persons with disabilities, technology makes things possible".⁵¹⁹ Definitely, ICTs can offer persons with disabilities opportunities for education, work, leisure, and social interaction, political participation as well as act as sources of access to public services and information. Online access to public services, e-learning materials which can be adapted to the needs of students with disabilities, text to voice devices, among others, are indeed giving persons with disabilities the ability to further engage in society.

Therefore, and with information and communication moving increasingly online, digital technologies present an unprecedented opportunity for the inclusion of persons with disabilities. At the same time, they also present a major risk of leaving persons with disabilities further behind, in cases where these technologies, products, content and services are not created with accessibility in mind. Increasingly, digital inclusion – i.e. the ability of all persons, including persons with disabilities, to access and use information and communication technologies – and ICT accessibility must be seen as a critical element for ensuring inclusion and the achievement of other SDGs for persons with disabilities.

International normative framework on disability and ICT

SDG target 9.c commits to significantly increase access to ICT and to provide *universal* and affordable access to the Internet in least developed countries by 2020. This represents a crucial target in the development of digital inclusion, and in particular for persons with disabilities. Current international normative frameworks which include provisions on ICT and persons with disabilities focus mainly on affordable and equitable access, on removing barriers in access to ICT for persons with disabilities and in promoting ICTs that respond to the needs of persons with disabilities (Figure II.87).

A key framework in this regard is the CRPD, which recognizes the critical role that information and communication plays in ensuring that persons with disabilities fully enjoy human rights and fundamental freedoms (preamble (v)). CRPD calls also for promoting research and development and enhancing the availability and use of new technologies, including information and communication technologies (Article 4

(g)). In addition, Article 9 is dedicated to accessibility and stipulates that States Parties should take appropriate measures to ensure to persons with disabilities have access, on an equal basis with others, to information and communications, including information and communications technologies and systems. To ensure this access to ICT, Article 9 further calls for removing barriers to information, communication and other services including electronic services and emergency services and to promote the design, development, production and distribution of accessible ICT at an early stage. Article 21 urges private entities and the mass media which provide services and information through the Internet to make these accessible to persons with disabilities. ICT also plays a key role in meaningful habilitation and rehabilitation, and Article 26 calls on State Parties to promote the availability, knowledge and use of assistive technologies used in this regard.

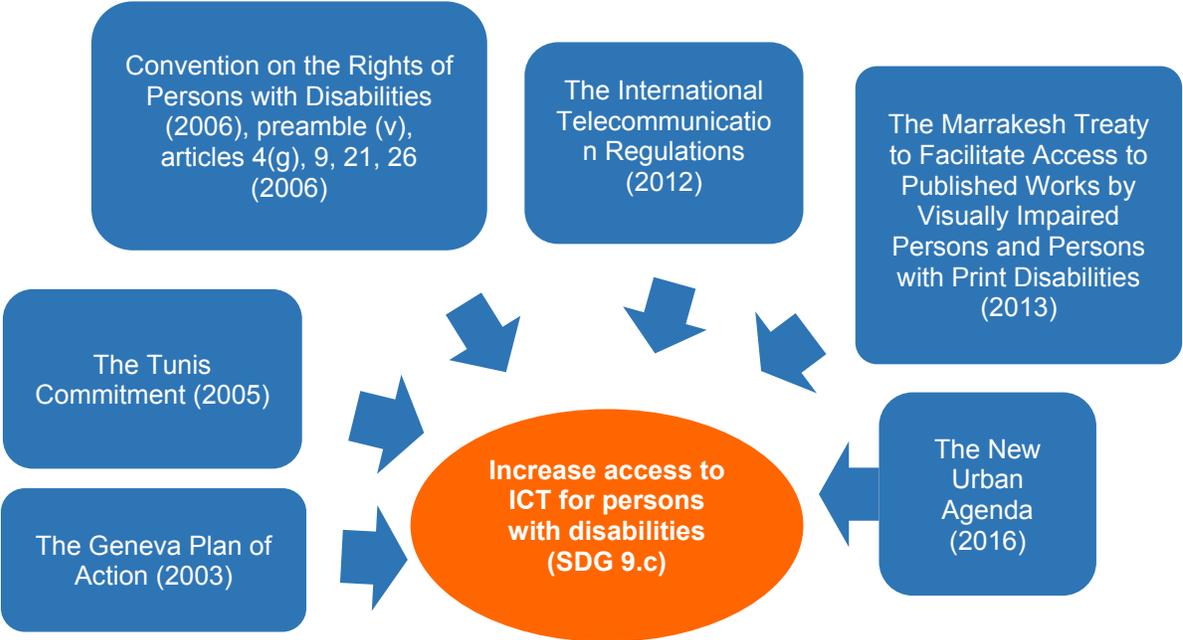
The International Telecommunication Regulations (2012), one of the major international frameworks focusing on information and communications, specifically calls on Member States to promote access for persons with disabilities to international telecommunication services.⁵²⁰ In addition, an outcome document of the World Summit on the Information Society (WSIS), the Geneva Plan of Action (2003), calls for full inclusion of persons with disabilities in the information society and encourages the design and production of information and communication technology (ICT) equipment and services that meets the needs of persons with disabilities and promotes the development of technologies, including assistive technologies, in line with the Universal Design Principle.⁵²¹ It also addresses the need of nurturing local capacity for the creation and distribution of software in the local context for the population, including persons with disabilities.⁵²² Another WSIS outcome document, the Tunis Commitment (2005), also stressed that the needs of persons with disabilities should be taken into account in providing equitable and affordable access to ICTs.⁵²³ Furthermore, the World Summit on the Information Society (WSIS)+10 Review and Strategic Directions for Building Inclusive Knowledge Societies for Persons with Disabilities (2013) states that for ICT to be accessible, people with disabilities need to be able to 'perceive output information, understand it and act upon it'.⁵²⁴

Other international frameworks which stress the importance of ensuring access to ICTs for persons with disabilities, include the New Urban Agenda (2016) which calls for facilitating access for persons with disabilities, on an equal basis with others, to ICTs and systems.⁵²⁵ It also commits to promote the development of national information and communications technology policies and e-government strategies to make ICT accessible to the public, including persons with disabilities.⁵²⁶

In addition, several international normative frameworks have recognized the importance of international cooperation in expanding access to ICTs. This is particularly relevant for persons with disabilities for whom state-of-the-art ICTs can make a crucial difference with regards to their independent living. CRPD Article 32 highlights the importance of international cooperation in the facilitation of access to and sharing of accessible and assistive technologies, some of which are ICTs. In the same vein, SDG 17.8 commits to

fully operationalize the technology bank and science, technology and innovation capacity-building mechanism for least developed countries and enhance the use of enabling technology, particularly ICT.

Figure II.87. International normative frameworks, and examples of regional frameworks, relevant for the achievement of SDG 9.c for persons with disabilities.



Box 5. Regional normative frameworks on ICT and disability

Normative frameworks on ICT established at the regional levels have also reflected the needs and perspectives of persons with disabilities. The European Union Digital Agenda (2010) emphasizes the importance of accessibility of websites and online services, and calls for addressing the challenges of accessibility and usability of persons with disabilities by helping them participate in digital society including by training. In this Digital Agenda, the European Commission commits to systematically evaluate accessibility in revisions of legislation, following the CRPD.⁵²⁷ Relatedly, the European Accessibility Act (2015) seeks to improve the functioning of the internal market for accessible products and services through eliminating obstacles caused by divergent legislation in order to facilitate accessibility of persons with disabilities.⁵²⁸ The directive of the European Union on “the accessibility of the websites and mobile applications of public sector bodies” (2016) aims to improve the accessibility of public sector websites and mobile applications, particularly for persons with disabilities.⁵²⁹

In the Americas, the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (CIADDIS) was adopted in 1999 to advance the rights and fundamental freedoms for persons with disabilities. While this instrument does not specifically mention access to information and communication technologies, there are directives that promote States Parties to eliminate discrimination against persons with disabilities including by providing accessible communications.⁵³⁰ Within the framework of the Organization of American States (OAS), the Program of Action for the Decade of the Americas for Persons with Disabilities (2006-2016) calls for elimination of communication and information barriers in all communications media and public services to improve access for persons with disabilities (5.f) and designing and executing education programs by using new information and communication technologies (3.f).⁵³¹

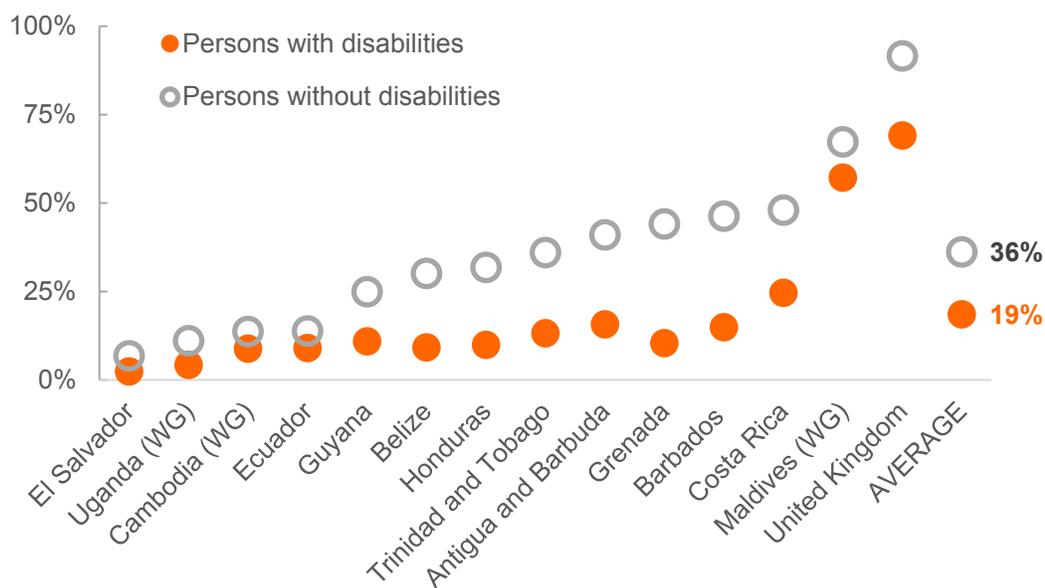
The Action Plan for the Information Society in LAC (eLAC2015) adopted in 2013 recognizes ICT are tools for economic development and social inclusion. Its Goal 6 commits to promote ICT access and use by persons with disabilities with emphasis on the development of application that considers standards and criteria on inclusion and accessibility.⁵³² The Digital Agenda for Latin America and the Caribbean (eLAC2018) adopted in 2015, complements the eLAC2015, with an emphasis on achieving universal access to digital services and content production including vulnerable groups, which implicitly includes persons with disabilities (Objective 1). The eLAC2018 also ensures ICT access for vulnerable groups to improve their social, educational, cultural and economic integration (Objective 18).⁵³³

The situation of persons with disabilities: access to ICT

Access to and use of Internet

Internet websites have been ranked as one of the most important ICTs for persons with disabilities for healthcare, education, employment, access to government services and participation in political and public life.^{534,535} However, significant gaps are observed between persons with and without disabilities in the use of Internet, with persons with disabilities reporting lower usage. Among 14 countries, around 2011, the average gap was 18 percentage points, with some countries reaching gaps as high as 30 percentage points (Figure II.88). On average, in these countries, 19% of persons with disabilities use the Internet versus 36% of persons without disabilities. In all 14 countries, compared to persons without disabilities, the percentage of persons with disabilities using the Internet is lower. Countries with overall higher Internet usage tend to have higher gaps between persons with and without disabilities in Internet use.

Figure II.88. Percentage of persons who use Internet, by disability status, in 14 countries, around 2011.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: ECLAC,⁵³⁶ UK Office for National Statistics⁵³⁷ and UNDESA (on the basis of data from DHS⁵³⁸).

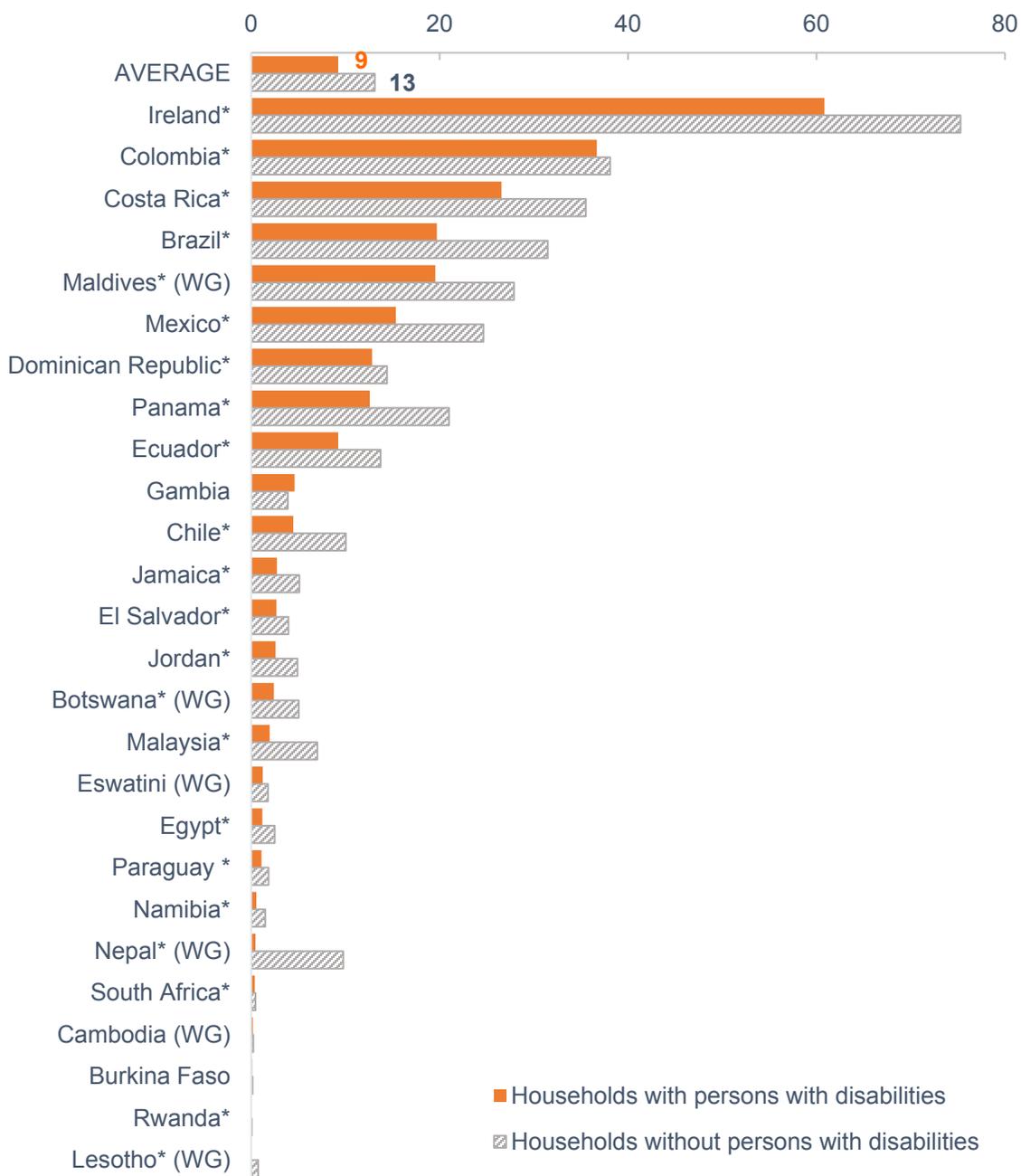
Households with persons with disabilities tend also to have lower Internet access (Figure II.89). Among 26 countries, 9% of households with persons with disabilities versus 13% of households without disabilities have access to Internet. In 9 of these countries, the gap is above 5 percentage points.

The gap between access to Internet at home and use of Internet varies with age. For instance, in 11 Latin American and Caribbean countries, a higher percentage of younger persons with disabilities, especially those under the age of 40, use Internet than have Internet access in the home, whereas for adults aged 40 and above with disabilities it is more common to have access in the home than report Internet use (Figure II.90). These patterns suggest that for the younger generation of persons with disabilities use of Internet is not constrained by not having connectivity at home, which may reflect the rising popularity of smart phones and other portable devices that have Internet connectivity, or the use of Internet in public places by younger generations.⁵³⁹ For older adults with disabilities, having Internet access does not equate with Internet use. The age differences are much more pronounced for use than access. This can be due to the fact that access may be related to the household income level, whereas use of Internet and ICT more generally are marked by an age digital divide.

Several reasons may explain the lower use of Internet among persons with disabilities, with unaffordability of Internet, unaffordability and inaccessibility of the devices on which to access Internet (e.g. computers or smartphones) and lower ICT skills among persons with disabilities, all possibly playing a significant role. Indeed, persons with disabilities have lower employment rates and lower incomes (see section on SDG 8), and may have extra costs related to disability, making it more likely that the costs of Internet subscriptions and electronic devices will be prohibitive for them. For instance, data available for three sub-Saharan countries indicates that 15 per cent of households without persons with disabilities but only 8 per cent of households with persons with disabilities are able to afford Internet costs (

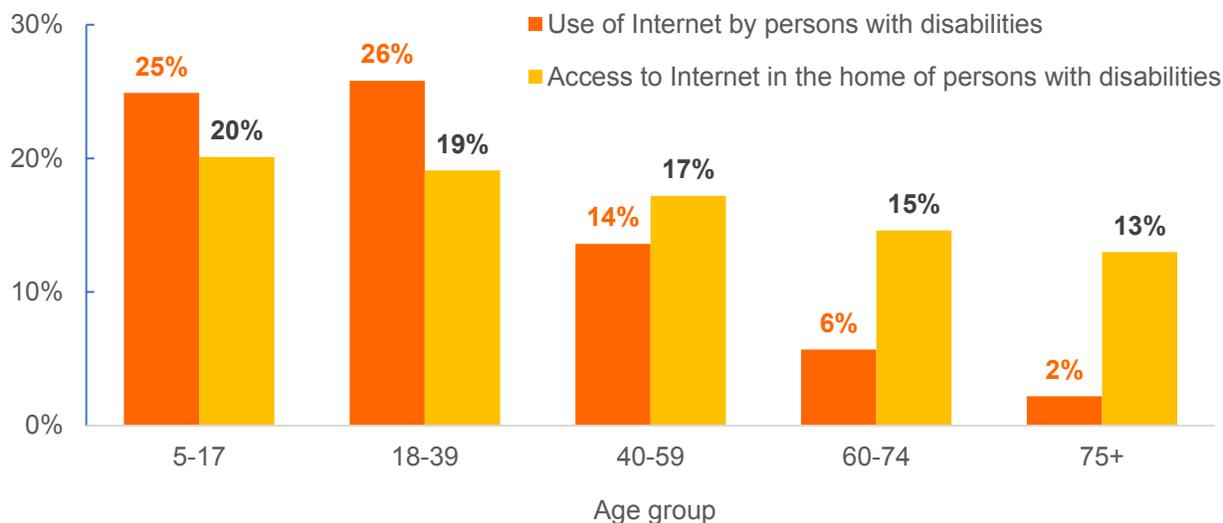
Figure II.91).⁵⁴⁰ Households with persons with disabilities are also less likely to have a computer (11% of households with versus 16% of households without persons with disabilities).^{6, 541, 542, 543}

Figure II.89. Percentage of households, with and without one or more persons with disabilities, that have Internet access, in 26 countries, in 2000-2016.



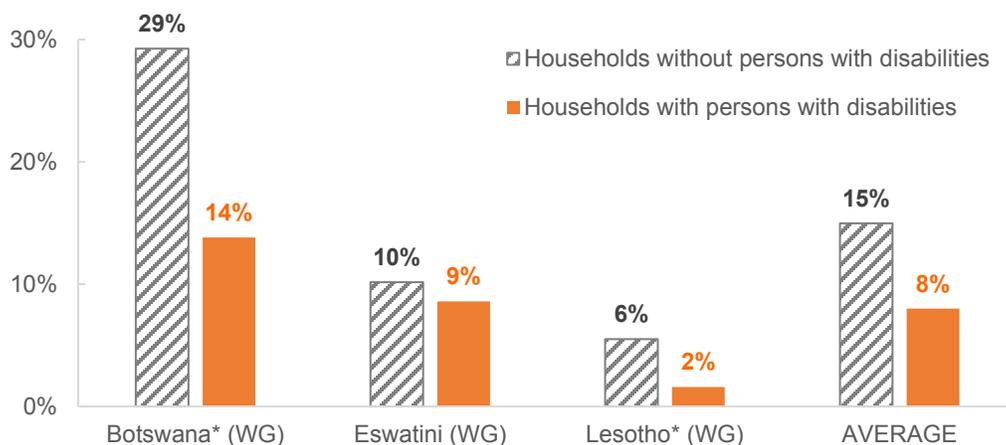
Note: (WG) identifies countries with data collected using the Washington Group short set of questions. An asterisk (*) indicates that the difference between households with and without persons with disabilities is statistically significant at 5% level. Data from South Africa was collected in selected regions of the country and is not nationally representative. Source: DHS⁵⁴⁴, IPUMS²³¹ and SINTEF.⁹

Figure II.90. Average percentage of persons with disabilities using and having access at home to the Internet, by age, in 11 countries in Latin America and the Caribbean, around 2010.



Source: United Nations Economic Commission for Latin America and the Caribbean.⁵⁴⁵

Figure II.91. Percentage of households with and without persons with disabilities which can afford Internet costs, in 3 countries, around 2013.

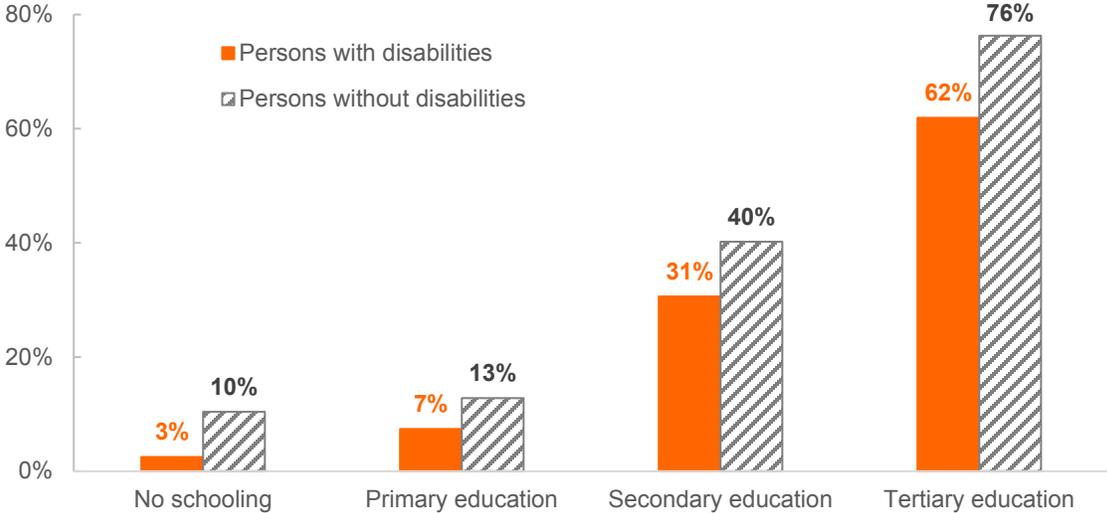


Note: (WG) identifies countries with data collected using the Washington Group short set of questions. An asterisk indicates the difference between households with and without disabilities is statistically significant at 5% level.

Source: SINTEF.^{9,546}

In addition, persons with disabilities are less likely to receive an education (see section on SDG 4) and are thus more likely to have lower levels of digital literacy. And, even with similar levels of education, they may face additional barriers using Internet. For example, around 2010, in 11 countries in Latin America and the Caribbean, persons with disabilities were less likely to use the Internet than persons without disabilities with identical education levels (Figure II.92). Although the use of Internet increased with the level of education for both persons with and without disabilities, the gaps between the two ranged from 6 percentage points in primary education to 14 percentage points in tertiary education.

Figure II.92. Average percentage of persons using Internet, by age, in 11 countries in Latin America and the Caribbean, around 2010.



Source: United Nations Economic Commission for Latin America and the Caribbean.⁵⁴⁷

Even where digital education, ICTs, and Internet connections are all available, the electronic devices often remain inaccessible unless special assistive technologies are also provided. For example, persons with physical disabilities may not be able to operate the standard devices used for navigating the Internet (mouse, keyboard, screen), and may need alternate devices suited to their needs. Persons with visual, reading, cognitive, or other disabilities may encounter barriers with inaccessible digital content (e.g. webpages and documents), and may require more accessible formatting or assistive software. In addition, shops selling electronics are not always accessible for persons with disabilities. Crowd-sourced reports on 6,015 electronic shops worldwide, mostly from developed countries, indicated that 43% were not accessible for persons using wheelchairs.⁵⁴⁸

Access to and usage of mobile phone

Mobiles phones can have a high impact on independent living of persons with disabilities.⁵⁴⁹ But, similar to Internet ownership, households with persons with disabilities are less likely to own a mobile phone (Figure II.93). Among 36 countries, 53% of households with persons with disabilities, compared to 60% of households without persons with disabilities, own a mobile phone. In 11 countries, the gap is larger than 10 percentage points. Gaps tend to be wider in countries with lower coverage.

Even if a mobile phone exists at home, persons with disabilities may not be able to use it. And individual ownership of mobile phone is likely to be lower for persons with disabilities. For instance, in Uganda, in 2016, persons with disabilities were less likely to own a mobile phone (Figure II.94). Women with disabilities were the least likely to own one, only 42% as compared to 46% of women without disabilities, 52% of men with disabilities and 66% of men without disabilities. Likewise, the percentage of women with disabilities who used a mobile phone for financial transactions was only 26%, whereas 34% of women without disabilities and 48% of men without disabilities did so.

Use of TV and radio

In 4 developing countries, use of radio and TV tends to be lower among persons with disabilities (Figure II.95), but the gaps between persons with and without disabilities are narrower than those observed for Internet. On average, 74% of persons with disabilities while 78% of persons without disabilities use radio; and 72% of persons with disabilities while 65% of persons without disabilities use TV.

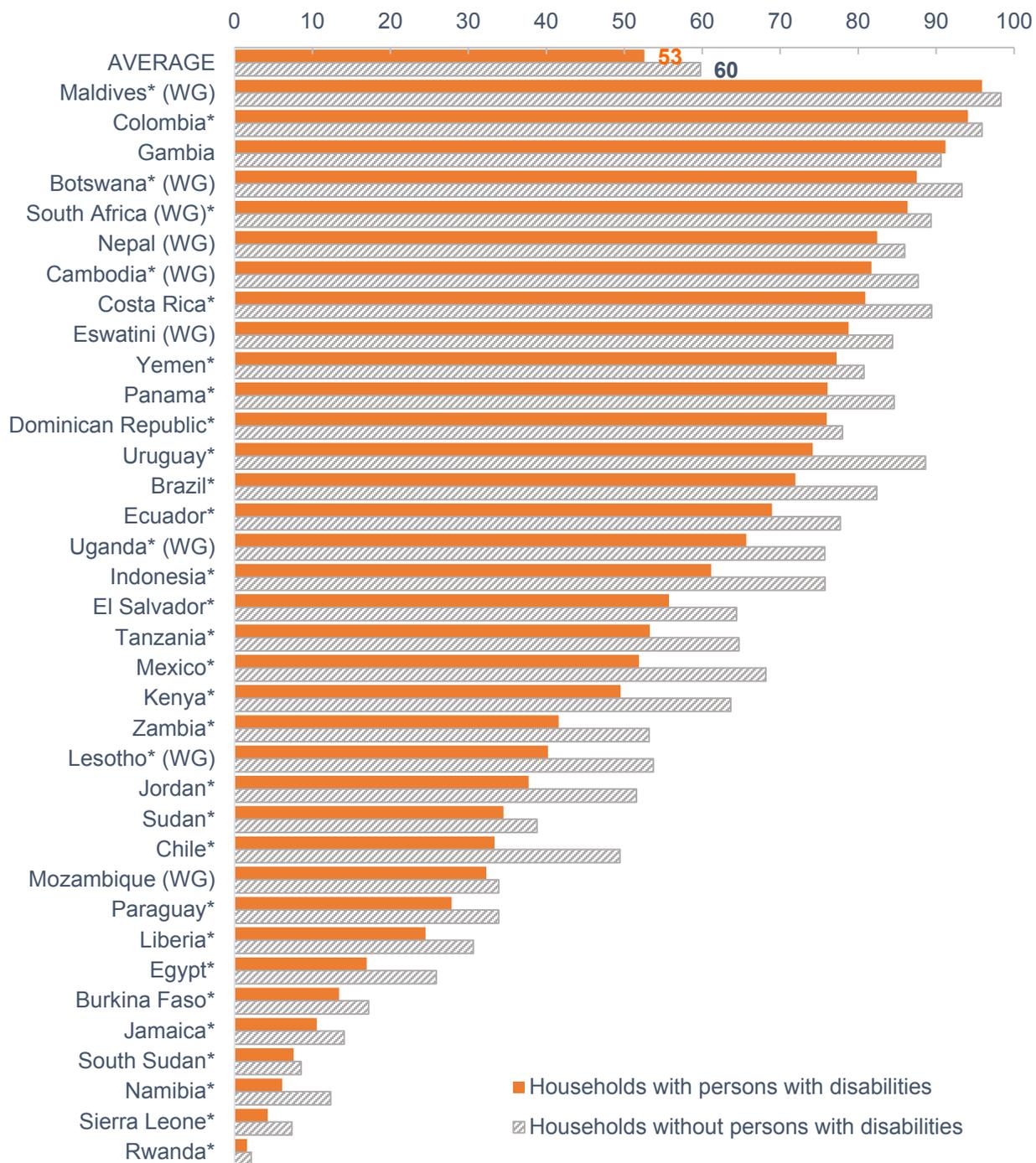
Affordability of ICT

Persons with disabilities and their households have more difficulties affording ICTs (Figure II.90, Figure II.96 and

Figure II.97). For instance, in three countries in sub-Saharan Africa, around 2012, on average only 37% of households with persons with disabilities could afford a TV, 61% could afford a radio and 67% a mobile phone (Figure II.96). In all three countries and for all ICTs, the ability of households with persons with disabilities to afford ICTs was lower as compared to households without persons with disabilities. In Turkey, in 2007, only 53% of persons with disabilities could afford a computer, and 82% could afford a telephone). In 34 countries in Europe (

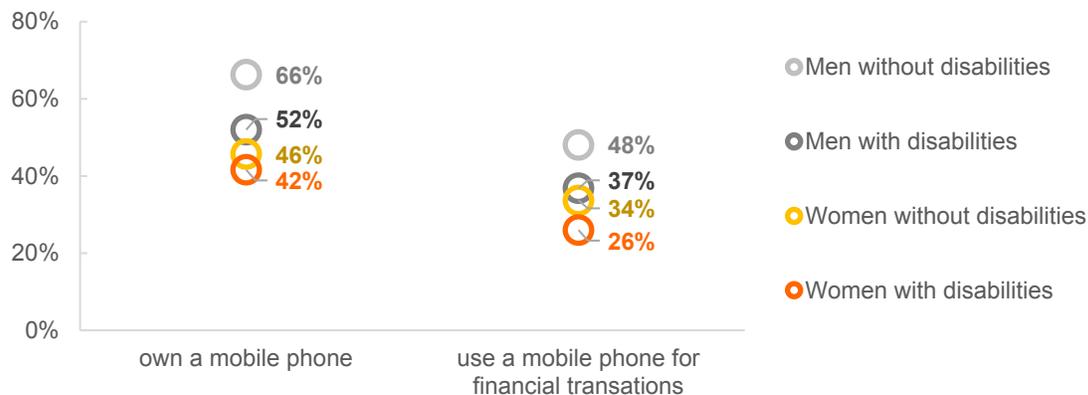
Figure II.97), the percentage of persons who can afford a computer is slightly higher among persons without disabilities (95%) than among persons with disabilities (91%). In these countries, the percentage of persons who can afford a telephone and a TV is about the same among persons with and without disabilities (99%).

Figure II.93. Percentage of households, with and without persons with disabilities, that own a mobile phone, in 36 countries, in 2001-2016.



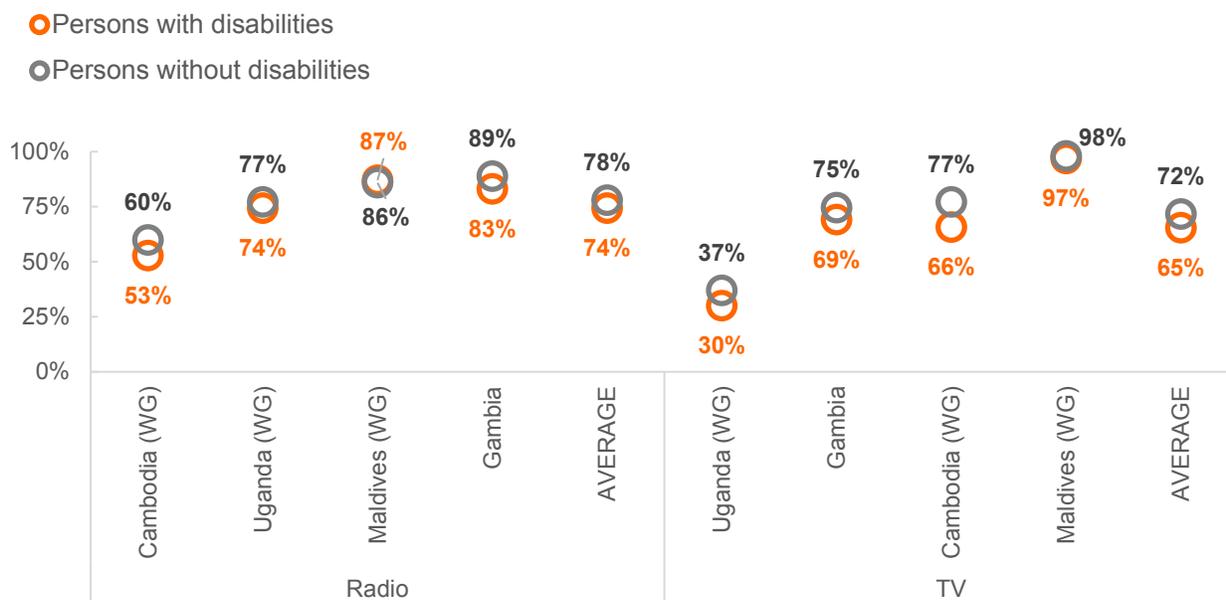
Note: (WG) identifies countries with data collected using the Washington Group short set of questions. An asterisk (*) indicates statistical significance. Source: DHS⁶, IPUMS²³¹ and SINTEF.⁹

Figure II.94. Percentage of persons who own a mobile phone and who use a mobile phone for financial transactions, by disability status and gender, in Uganda (WG), in 2016.



Source: Uganda DHS 2016 report.⁶

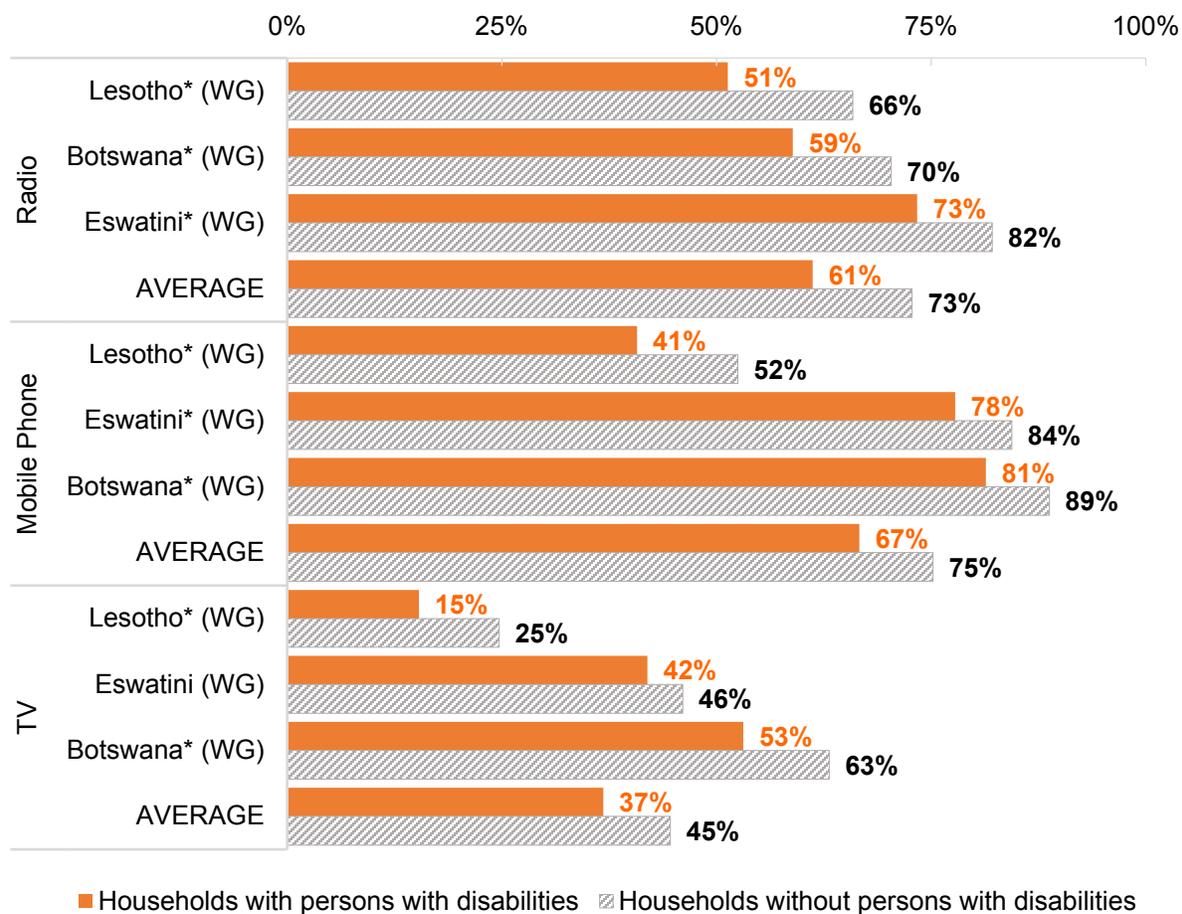
Figure II.95. Percentage of persons who use radio and TV, by disability status, in 4 countries, in 2008-2016.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: DHS.⁶

Figure II.96. Percentage of households with and without persons with disabilities which cannot afford radio, mobile phone or TV, in 3 countries, around 2012.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: SINTEF.⁹

Figure II.97. Percentage of persons aged 16 and over who can afford a computer, telephone and TV, and gender gap, by disability status, in 35 countries, in 2016.



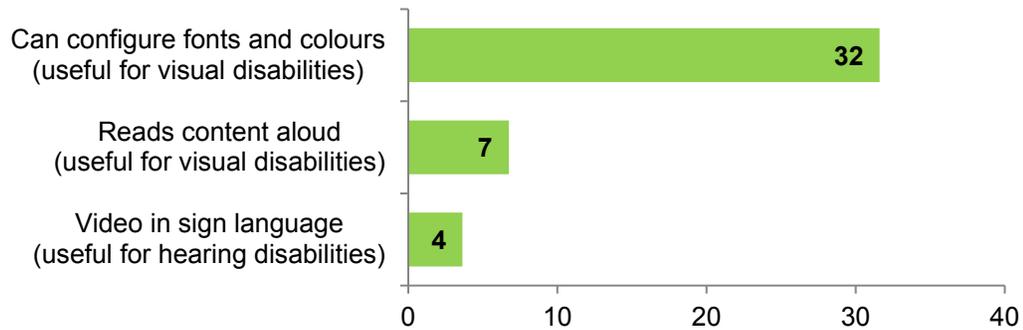
Source: Eurostat.⁸¹

Accessibility of ICTs

A growing number of mainstream, everyday ICT such as mobile devices and desktop computers increasingly offer functionalities that facilitate communication and information access for persons with disabilities. Features such as text-to-speech and voice recognition, ability to change contrast and colour schemes, touch and gesture input, and screen magnification, which in the past required specialized standalone software and hardware, are embedded within off-the-shelf ICT devices. These features enable persons with disabilities to receive information and content in the format that they can perceive and prefer. For example, a person with visual impairments can use speech-to-text functionality or software to read a website, a person with hearing impairments can use SMS or instant text messaging to communicate, and

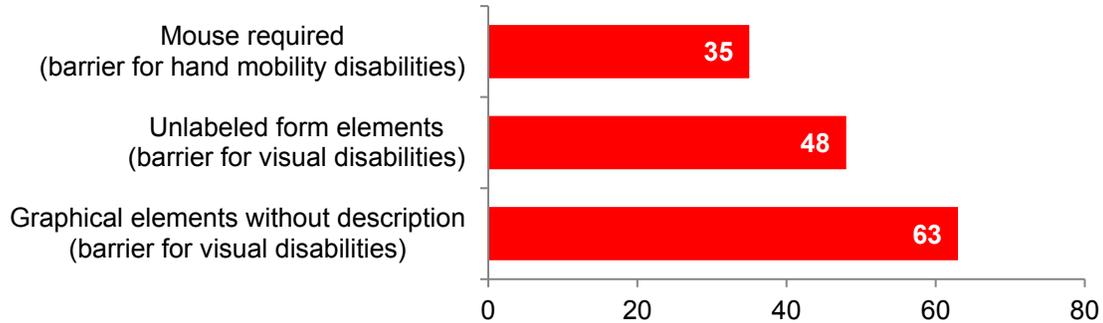
a person with mobility impairments can use voice recognition to operate and navigate their digital device.

Figure II.98. Percentage of countries with online national portals offering features which promote accessibility, in 193 countries, 2012.



Source: 2012 UN E-Government Survey.⁵⁵⁰

Figure II.99. Percentage of countries with accessibility barriers in their online national portals, in 193 countries, in 2012.



Source: 2012 UN E-Government Survey.⁵⁵⁰

Another key technological, social and economic trend in recent years is the inclusion of accessibility features in mainstream technologies, which reduces the need for costlier specialized assistive technologies. For instance, some web pages use bigger fonts or particular colour combinations which are easier for the visually impaired. Similarly, captions in audio or video content on web pages are useful for the hearing impaired. Some websites also include special features for persons with motor impairments so that they can navigate the sites without a pointing device.

But the large majority of websites lack features which promote accessibility and include features inaccessible for persons with disabilities. This includes governmental websites (

Figure II.98 and Figure II.99). Among governmental portals of the 193 UN Member States, the fonts and colours in the portals can be reconfigured in only 32% of countries (a feature helpful for those with visual disabilities);⁵⁵¹ the website content can be read aloud (a feature helpful for those with severe visual difficulties) in portals of a mere 7% of countries. Only 4% of governmental websites include video in sign language, which makes information and a website accessible for persons with hearing difficulties. Moreover, people with disabilities will encounter additional barriers in many national portals: in 35% of countries the national portals included features that can only be used with a mouse, which poses difficulties for persons with hand mobility disabilities; in 48% of countries form elements⁵⁵² were not labelled and in as many as 63% of countries graphical elements were lacking descriptive text, all of which create difficulties for persons with visual disabilities. Although more recent data on all these features are not available, it is known that there has been progress on the number of governmental websites that allow for changes in font type and size, a feature which is useful for persons with visual disabilities. While in 2012, 31% of countries allowed for flexible font size and type, this percentage has increased to 40% in 2014.⁵⁵³

Enhanced accessibility of mobile phones and services has remained a relatively underdeveloped segment of the ICT market, yet the technology supporting accessibility is becoming more developed with a growing number of accessibility applications for smartphones (Table II. 3). Some applications, like screen readers, do make the tool accessible; others, like GPS, can increase the accessibility for persons with disabilities in their physical environment. Although many features and applications are available free of charge, affordability remains a major issue, especially for smartphones.⁵⁵⁴ Screen readers and text-to-speech applications cost several hundred US dollars on some mobile platforms.⁵⁵⁵ Another issue limiting usage of accessibility features and applications is language, as they tend not to be available in local languages. For instance, in India, there are 22 official languages yet the applications only exist in Hindi. Other countries where many languages are used, such as several African countries, suffer from a similar situation.

Table II. 3. Mobile phone and platform features which enhance accessibility

Mobile phone and platform features	Enhances accessibility for persons with:
Screen readers (into speech or Braille), tactile markers ⁵⁵⁶ , audible feedback on pressed buttons, adjustable font sizes, audible cues, adjustable brightness/contrast, screen magnifiers, digital access to “talking” books, GPS	Visual disabilities
Visual and vibrating alerts, relay services, ⁵⁵⁷ hearing aid compatible device, volume adjustment, SMS text messaging, SMS-based emergency service, mono audio ⁵⁵⁸ , captioning of videos	Hearing disabilities
Voice recognition, auto text ⁵⁵⁹ , head movement recognition ⁵⁶⁰	Arms/hands/fingers mobility disabilities
Predictive texting, speech recognition, text-to-speech, built-in calculator, schedule reminders, large and simple display screens	Cognitive disabilities

Source: Author’s elaboration on the basis of information from International Telecommunication Union and G3ict (2012)⁵⁶¹ and Sesame.⁵⁶⁰

Current practices on disability and ICT

At the country level, laws, policies and programmes have been progressively introduced to enhance access to ICT for persons with disabilities.⁵⁶² Most of these initiatives have been focusing on providing access on an equal basis with others and improving accessibility of ICT. Some countries focus on improving ICT skills through training of persons with disabilities, sometimes focusing on youth.^{563,564,565, 566}

On legislation promoting accessibility of information and communication technologies, for instance, in Latin America and the Caribbean, ICT and persons with disabilities are mentioned under the general disability law in 13 countries and territories,⁵⁶⁷ and are a provision of the general telecommunication law in 6 countries.^{568,569}

Standards and guidelines have been created for accessible websites, documents, and other digital media. One of the most universally recognized and widely used is the Web Content Accessibility Guidelines (WCAG) 2.0 that aims to provide a single shared standard for web content accessibility that meets wide range of users including those with disabilities (Box 6.).⁵⁷⁰ Many national governments have adopted WCAG into their basic web accessibility standards, and in some cases, the WCAG have even been written into the law.^{571,572,573,574,575} Capacity building on web accessibility for web designers and programmers is

crucial in encouraging the development of accessible web sites and was provided in some countries.^{576,577} Disseminating information on accessibility guidelines for ICTs has been another way to raise awareness and promote accessibility.⁵⁷⁸

Box 6. Web Content Accessibility Guidelines (WCAG) 2.0

The WCAG 2.0 guidelines⁵⁷⁹, also known as the ISO/IEC 40500:2012 standards, provide guidance on making web content more accessible to persons with disabilities. Its four principles offer the means to making the web more accessible:

- 1) Perceivable – information to be presented in a way that users can perceive them
- 2) Operable⁵⁸⁰ – interface and navigation to be operable
- 3) Understandable – operation of user interface to be understandable
- 4) Robust - content to be interpreted reliably by a variety of users, and a range of assistive technologies

Other guidelines and standards exist for a variety of technologies. The Guidelines for Accessible Information cover many forms of digital media, including video, audio, text, and images.⁵⁸¹ The International Organisation for Standardization (ISO) published accessibility standards for a variety of ICTs, including standards for hardware devices like keyboards and screens,⁵⁸² standards for software,⁵⁸³ and standards for accessible PDF documents.⁵⁸⁴ The EPUB3 accessibility guidelines were also developed for eBooks.⁵⁸⁵ Many countries have standards for closed captioning in television and digital video broadcasting, such as China,⁵⁸⁶ European countries,⁵⁸⁷ Japan,⁵⁸⁸ and the United States.⁵⁸⁹ In addition, the Telecommunications Accessibility Guidelines for Older Persons and Persons with Disabilities and the recommendation on Audio-based Network Navigation System for Persons with Vision Impairment that meet the needs of persons with visual impairments have been developed by the International Telecommunication Union's Telecommunication Standardization Sector (ITU-T).^{590,591}

Countries have also been adopting accessibility requirements in public procurement thus influencing accessibility in government services and promoting overall ICT accessibility through ripple effects in the broader consumer market.^{592,593,594} Policies have also been established requiring telecommunications service providers, public sector organizations, including government owned banks, public accommodation and commercial facilities and producers and distributors of digital media to provide accessible services.⁵⁹⁵

Increasingly, online content has been more accessible to persons with disabilities through online videos with captioning;^{596,597,598} and national news agencies have developed news services in easy language accessible to persons with intellectual disabilities.^{599,600} TV broadcasters have been offering television programmes with described video and closed captioning, as well as audio services of some programmes;⁶⁰¹

and sign language interpretation videos have been made of national radio programming.⁶⁰² Countries have also established funds that support accessibility of broadcasting content.⁶⁰³

National and international funding mechanisms have been playing a significant role in promoting the development of ICTs for persons with disabilities. For instance, funds have been established to promote open-source accessible digital e-reader (textbook) for children of primary schools in Kenya and a mobile application to help children with speech impairments to communicate in India;⁶⁰⁴ to disseminate examples of best practices for accessibility and raising awareness through mainstreaming of ICT accessibility standards;^{605,606} and to support the distribution specialized equipment to persons with disabilities of low-income to be able to access ICT.⁶⁰⁷

Conclusions and the way forward

Digital technologies have been spreading, but not all persons with disabilities have been able to partake of the benefits of using ICTs and digital gaps remain between persons with and without disabilities. In some countries, the gap between persons with and without disabilities reaches 30 percentage points for internet use, 10 percentage points in access to internet in the household, 5 percentage points in radio and TV use. This digital gap persists because many technologies are not accessible nor affordable for persons with disabilities. More than 60% of national online portals are not accessible for persons with disabilities. Regarding affordability, limited data suggests that in developing countries households with persons with disabilities are twice less likely to afford internet costs, and slightly less likely to be able to afford radio, TV and a mobile phone.

Yet, access to ICTs is recognized as crucial for the independent living and inclusion of persons with disabilities and is thus imperative for achieving all SDGs. The evidence above suggests that access to education is crucial to increase access to ICTs among persons with disabilities. Moreover, there are a number of initiatives, projects, and organisations worldwide carrying out innovative practices in enhancing access to ICTs for persons with disabilities, the majority of which are based in developed countries. Many developing countries lack basic ICT infrastructure for persons with disabilities. Considering the vast potential of Internet technology to improve the lives of persons with disabilities and to contribute to the realization of various SDGs for persons with disabilities, wider Internet access should be considered priority.

Looking forward, the following recommendations offer guidance on how to strengthen the ICT ecosystem to ensure inclusion and accessibility for persons with disabilities:

1) Raise awareness and enhance knowledge of ICT accessibility. Improving public awareness of the barriers and solutions presented by ICTs for persons with disabilities will be crucial to successfully increase ICT access and use among persons with disabilities. In particular, key stakeholders such as governments and decision makers, educators, statisticians, non-governmental organizations particularly organisations of

persons with disabilities, and ICT industries in the public and private sectors must be alerted to the vast potential of, and urgent need for, accessible ICTs to improve the quality of life and inclusion among persons with disabilities. Methods to achieve this could include the development of academic programs and training programs highlighting ICT accessibility and universal design.

2) Involve persons with disabilities directly. In order to properly understand the variety of needs and abilities that ICTs can address, as well as necessary accessibility requirements, persons with disabilities must be involved at every stage of ICT development. One of the most effective ways to do this is to work together with organisations of persons with disabilities, particularly those which have expertise in the field of ICT accessibility and connect them with ICT businesses for their input and insights.

3) Promote the principles of Universal Design in the mainstream ICT industry and the public sector. Implementing Universal Design principles is more inclusive, affordable, and often simpler than developing specialized software or hardware for persons with disabilities. Good ICT examples of universal design already developed can be scaled up. The benefits of exercising Universal Design extend not only to persons with disabilities, but also to companies by opening new market opportunities for vendors.

4) Adopt national accessibility policies and regulations. ICT accessibility policies and regulations build a foundation for implementing ICT accessibility in different areas and can promote accessibility of the virtual environments. Setting national standards and regulations facilitates the implementation of ICT accessibility because the actors involved in the production of ICTs will know what is expected.

5) Create dedicated focal points in relevant ministries/departments dealing with ICT Accessibility to coordinate and encourage ICT accessibility in line with CRPD provisions, including through relevant policies and incentives to regulate all actors in the ICT industry and market and in public procurement. A dedicated focal points can also oversee the development of policies and directives and, in collaboration with other national bodies, be responsible for monitoring national progress towards ICT accessibility, organizing public campaigns, and coordinating data collection activities.

6) Provide affordable Internet access for persons with disabilities. Introduce programs, policies or regulations that facilitate free or reduced-rate Internet access for persons with disabilities, particularly those in lower income brackets. This could be in the form of either a monetary social benefit for persons with disabilities, or non-monetary benefits such as free or subsidized mobile devices and Internet subscriptions. Mobile Internet access, in particular, should be prioritized, given that mobile network coverage is globally higher than broadband penetration, and is expected to increase further, especially in developing countries. Alternatively, community resource centres could be established, where persons with disabilities can have facilitated access to Internet. Affordable Internet access is a crucial element of digital inclusion, as it can provide job opportunities, access to information and education materials, access to services and social participation.

7) Provide funding mechanisms to support the development of open-source software. Open-source software offers many advantages. It can be acquired free of cost, and can be adjusted according to different user needs, languages, and cultural contexts. This will be particularly important in areas where financial resources are lower and commercially available software may not be affordable for persons with disabilities. Open source software is also an ideal way to address directly the needs of users with disabilities, because it gives programmers with disabilities a chance to directly fix inaccessible software themselves.

8) Involve all relevant stakeholders and increase funding to support universal design and low-cost ICTs for persons with disabilities. Many of the recommendations presented here involve multiple stakeholders – governments, the private sector, and non-governmental organisations all have potential roles to play. Overall, both involvement and funding in the area of ICT accessibility should be increased. The social responsibility departments of large corporations could also be an important part of this change by dedicating more resources to the issue of digital inclusion for persons with disabilities. Funding should be provided to support universal design, open-source software, and low-cost assistive ICTs worldwide, as many developing countries lack the financial resources to use specialized commercial solutions. International cooperation and capacity building in ICT accessibility should be promoted.

9) Develop and publish comparable data on access to and use of ICTs disaggregated by disability as well as on accessibility of ICTs. With the current lack of comparable statistics on access and use of ICT by disability status, as well as on accessibility of ICTs, it will be impossible to know to what extent the SDG 9.c is being met. There is an urgent need for reliable and comparable data and analysis in order to ensure accountability among Member States and other relevant actors. A systematic collection of data, a clear methodology for comparison, regular data evaluation, and a publicly available platform to showcase to interested parties are strongly recommended for a successful analysis of the state of the 2030 Agenda in terms of ICT access, use and accessibility.

J. Reducing inequality for persons with disabilities (SDG 10)

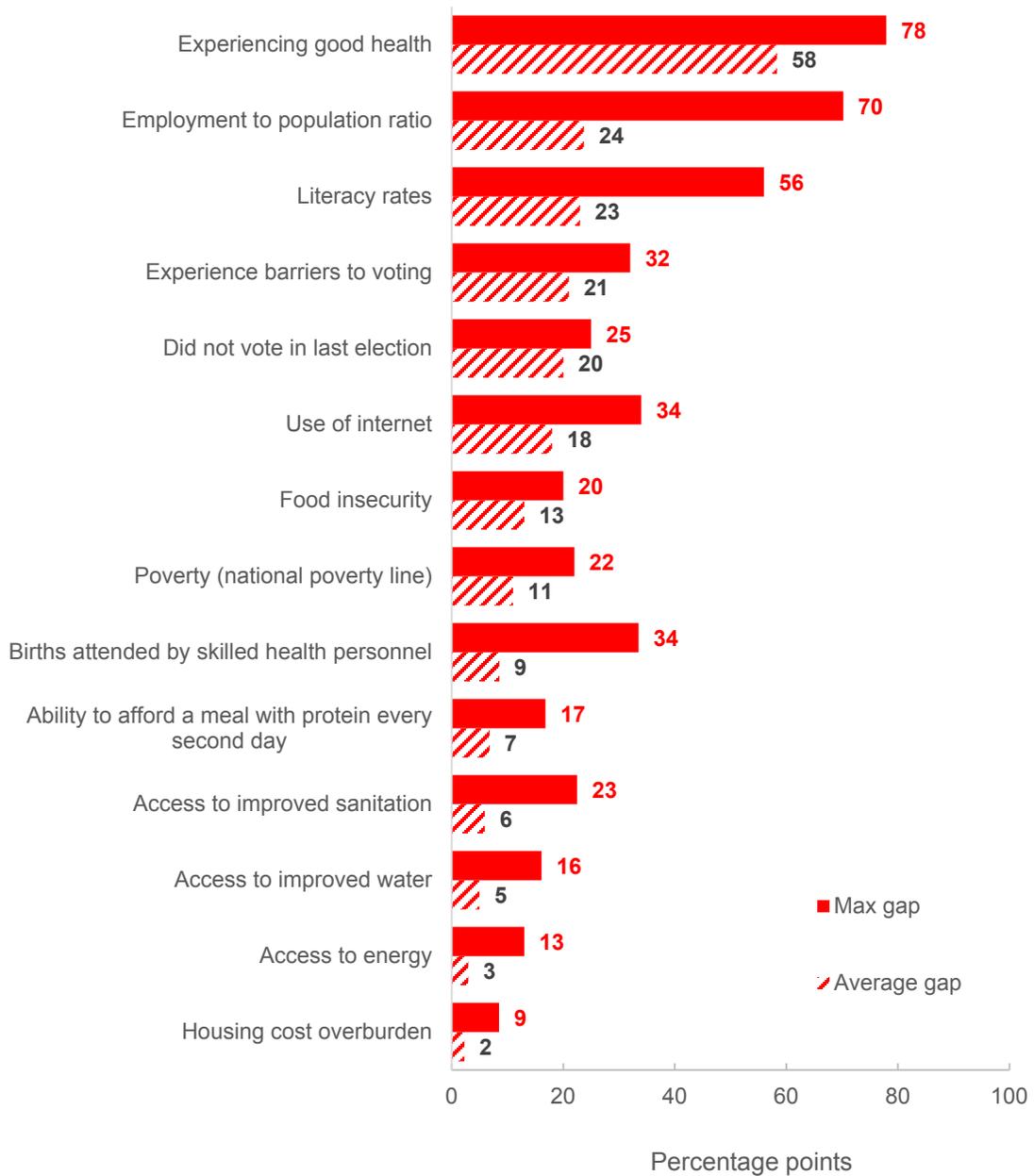
This section will discuss SDG 10, which calls for reducing inequalities within and among countries, from a disability perspective. It will focus particularly on SDG 10.2, which calls for the empowerment and promotion of social, economic and political inclusion of all, irrespective of disability and SDG target 10.3 which aims at the elimination of discriminatory laws, policies and practices concerning persons with disabilities. The section will first provide an overview of the gaps between persons with and without disabilities, in various areas of development covered by the SDGs. This overview is based on the evidence presented throughout this report. It will then discuss three factors that are crucial for promoting the social, economic and political inclusion of persons with disabilities and reducing the disability gap. These are: (i) combating discrimination; (ii) ensuring access to assistive technology; and (iii) deinstitutionalization. Accessibility of the physical and virtual environments is also a key factor and is discussed under the sections on SDG 11 (physical environment) and SDG 9.c (virtual environment).

When discussing inequalities, it is important to recognize that some groups of persons with disabilities are even at higher disadvantage than others due to multiple discrimination. In particular, higher inequalities of outcomes are typically observed for women with disabilities (see section on SDG 5), indigenous persons with disabilities and persons with intellectual and psychosocial disabilities. The section will illustrate in detail the situation of persons with psychosocial disabilities.

Overview of the gaps between persons with and without disabilities

Disability gaps vary from among countries and are wider in relation to certain areas (Figure II.100). On average, the wider gaps are observed in health status, employment, literacy, voting, use of internet, food insecurity and poverty. In these areas, the average gap is above 10 percentage points. Much larger gaps are observed in some countries: the gaps can reach more than 20 percentage points for income poverty, more than 30 percentage points for multidimensional poverty, more than 15 percentage points in ability to afford a meal with protein every second day, more than 70 percentage points in experiencing good health, more than 50 percentage points in literacy rates and 70 percentage points in employment to population ratios. Persons with disabilities are also at a disadvantage in accessing and affording basic and essential services. In countries where gaps are wider, the gaps reach more than 15 percentage points for access to improved water and more than 20 percentage points in access to improved sanitation, 9 percentage points in energy access in the household,⁶⁰⁸ more than 30 percentage points in the use of internet and more than 10 percentage points in housing cost overburden.⁶⁰⁹ In addition, persons with disabilities are more likely to be under-represented in decision-making process (see section on SDG 16) and in political participation. The gap between persons with and without disabilities who face barriers to voting or engaging in politics reaches more than 30 percentage points in some countries.⁶¹⁰

Figure II.100. Average and maximum gap between persons with and without disabilities (or households with and without persons with disabilities) for 14 selected indicators.⁶¹¹



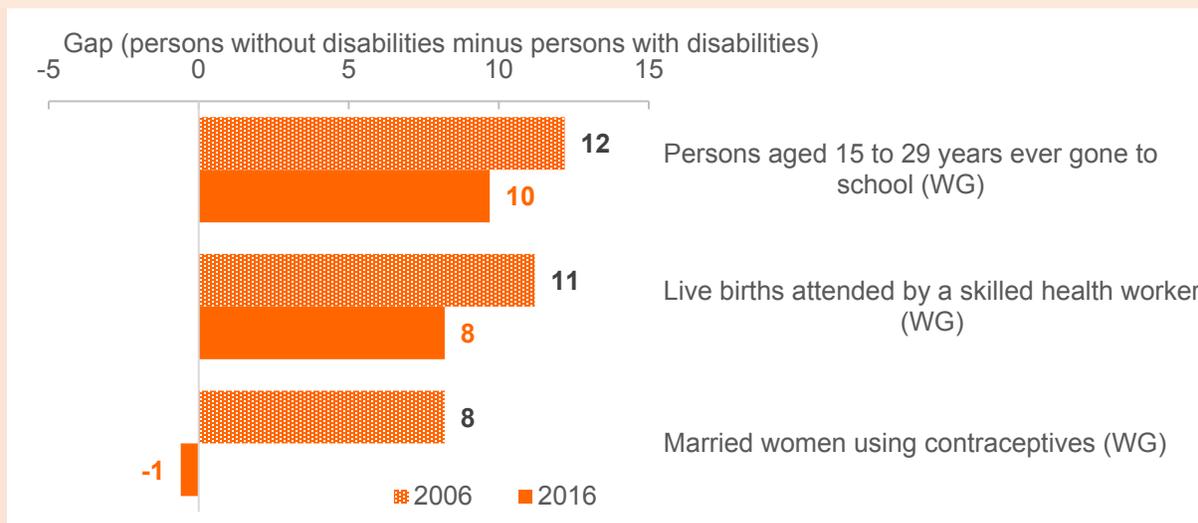
Source: DHS,⁶¹² ESCWA,²⁴¹ ESCAP,⁴¹ Eurostat,⁸¹ ILO, IPUMS,²³¹ SINTEF,⁹ UNDESA, UNESCO and WHO¹⁰⁷.

Box 7. In Uganda, the gap between persons with and without disabilities has been decreasing in a number of areas

Article 21 of the Constitution of Uganda bans discrimination based on disability, and the country was among the first to ratify the CRPD in 2008. Uganda also adopted national disability legislation and policies, including the National Council for Disability Act in 2003, the Persons with Disabilities Act and the National Policy on Disability in 2006. The country has also produced disability data to inform policy.⁶¹³ For instance, it was one of the first countries to include the Washington Group short set of questions in Demographic and Health Surveys.⁶¹⁴

Data from these surveys show that the gaps between persons with and without disabilities have been decreasing in a number of areas (Figure II. 101. Gaps between persons with and without disabilities, for 4 selected indicators, in 2006 and 2016, in Uganda. Figure II. 101). Between 2006 and 2016, these gaps decreased from 12 to 10 percentage points for the percentage of persons aged 15 to 29 ever gone to school and from 11 to 8 percentage points for the percentage of live births attended by a skilled health worker. An even larger reduction is seen among the percentage of married women using contraceptives, from an 8-percentage point difference to married women with and without disabilities showing similar rates of usage (1 percentage point difference). The reductions have occurred while progress was being made in all these areas for both persons with and without disabilities. Specifically, the percentage of live births attended by a skilled health worker doubled from 2006 to 2016 for births from mothers with disabilities, and the percentage of married women with disabilities using contraceptives doubled also. The percentage of young persons with disabilities ages 15 to 29 who ever attended school increased from 80% to 87% in the same period.

Figure II. 101. Gaps between persons with and without disabilities, for 4 selected indicators, in 2006 and 2016, in Uganda.



Source: DHS.⁶¹⁵

There is not enough data to assess trends in inequalities for persons with disabilities worldwide, but data available from Uganda shows progress from 2006 to 2016 in reducing these inequalities in areas related to education, health care and reproductive health after a number of positive legal changes in the country (Box 7).

This section will now continue by discussing three key factors to reduce inequalities for persons with disabilities.

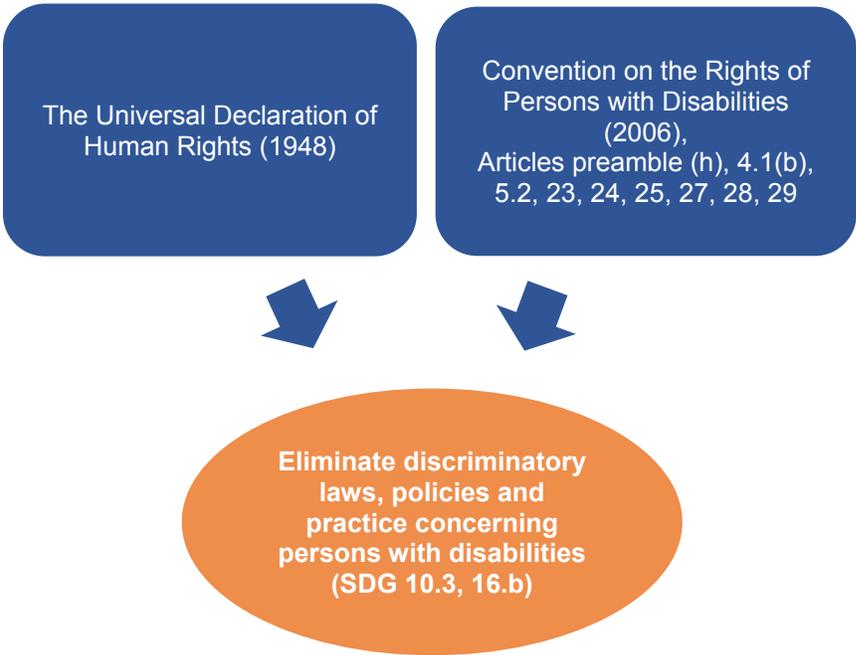
Eliminating discriminatory laws, policies and practices concerning persons with disabilities (SDGs 10.3, 16.b)

This part focuses on. discrimination against persons with disabilities, which remains a major barrier to the social, economic and political inclusion of persons with disabilities, to the reduction of inequalities between persons with and without disabilities and therefore the achievement of SDG 10. This section relates, in particular, to SDG targets 10.3 and 16.b which call for elimination of discriminatory laws, policies and practices, and discusses these targets from a disability perspective. It does so by elaborating the international normative frameworks calling for non-discrimination against persons with disabilities and by providing an overview of persistent discriminatory practices against persons with disabilities as well as initiatives to eliminate discriminatory clauses from national legislation. The section concludes with recommendations on the way forward based on current evidence.

International normative framework on non-discrimination

SDG 10.3 commits to ensuring equal opportunity and reducing inequality by, amongst others, eliminating discriminatory laws, policies and practices and to promoting appropriate legislation, policies and action in this regard. This is closely linked to SDG 16.b that calls for promoting and enforcing non-discriminatory laws and policies for sustainable development. The international effort to eliminate discrimination is rooted in the Universal Declaration of Human Rights (1948) which highlights that all are equal before the law, entitled to equal protection of the law, and have the right to equal pay for equal work without any discrimination (Articles 7 and 23).⁶¹⁶ The Convention on the Rights of Persons with Disabilities (CRPD) (2006) reaffirms this commitment and recognizes that discrimination against any person on the basis of disability⁶¹⁷ is a violation of inherent dignity and worth of the human person (preamble (h)). CRPD stipulates States Parties are to ensure the full realization of all human rights and fundamental freedoms for persons with disabilities without discrimination including by modifying or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities (Article 4.1(b)) and by prohibiting all discrimination on the basis of disability and guaranteeing equal and effective legal protection against discrimination on all grounds (Article 5.2). These approaches are closely linked to SDG 10.3. In addition, the CRPD calls for elimination of discrimination against persons with disabilities in areas of family (Article 23), education (Article 24), health (Article 25), work and employment (Article 27), living standard (Article 28), and political participation (Article 29).

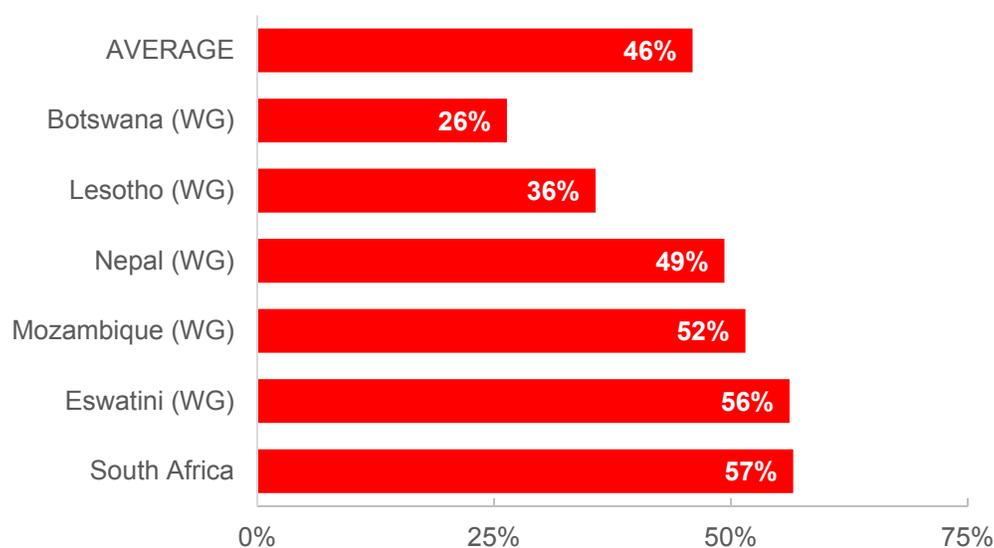
Figure II.102. The international normative frameworks relevant for the achievement of SDG 10.3 and 16.b for persons with disabilities.



Discrimination against persons with disabilities

Persons with disabilities face discrimination in many facets of life. There is research indicating that one of the main causes of discrimination is a lack of awareness about disabilities, disabling conditions, the needs and abilities of persons with disabilities.⁶¹⁸ Evidence from 6 countries from around 2011 indicates that on average 46% of persons with disabilities experienced some form of negative discrimination (Figure II.103). Many persons with disabilities also face discrimination in public services (Figure II.132).

Figure II.103. Percentage of persons with disabilities who have experienced discrimination, in 6 countries, around 2011.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF.^{9,619}

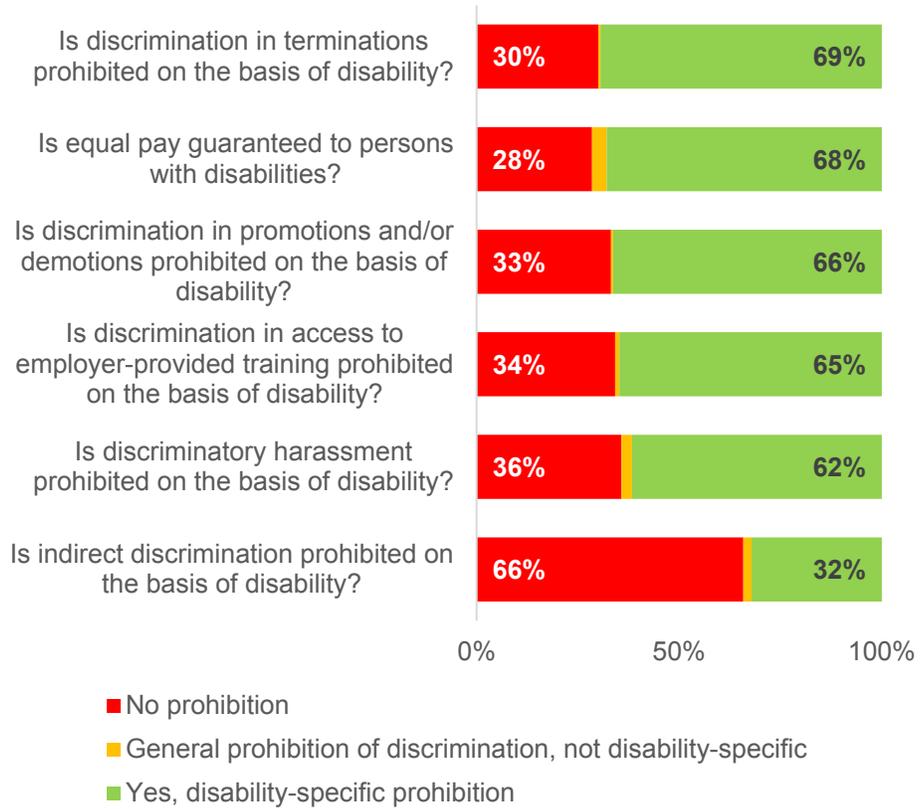
Overcoming discriminatory laws and policies for persons with disabilities

Progress has been made during the past decade since the adoption of the CRPD. For instance, national constitutions adopted after 2006, the year of adoption of CRPD, are more likely to explicitly guarantee the rights of persons with disabilities and omit any discriminatory clauses: 62% of constitutions included this guarantee as opposed to only 16% of constitutions adopted before 2006. However, among the 193 UN Member States, 2% still include discriminatory provisions: they guarantee equal rights but allow for exceptions if disability prevents a person from exercising his/her rights. In relation to health, 16% of the UN Member States explicitly guarantee health rights to persons with disabilities or free medical services broadly in their constitutions, and another 10% prohibits discrimination broadly. In the areas of education and employment, 27% clearly guarantee education rights and 19% guarantee work rights in their constitutions. However, several constitutions still include discriminatory provisions such as limiting the right to work to able-bodied persons.⁶²⁰

A number of countries still have laws discriminating against persons with disabilities, particularly in relation to the rights to marry, to legal capacity, to vote and to be elected for office. Only 36% of countries have no legal restrictions for persons with disabilities to marry, only 13% have no restrictions to vote, and only 9% have no restrictions to be elected for office and to enter into contract (see section on persons with psychosocial disabilities and section on SDG 16). But many countries have also advanced anti-discrimination protections for persons with disabilities. For instance, as of 2016, many UN Member States had included in their labour legislation protections prohibiting discrimination on the basis of disabilities: 69% in terminations, 66% in promotions or demotions and 65% in access to employer-provided training (

Figure II.104). Furthermore, 68% of UN Member States guarantee equal pay for persons with disabilities, 62% prohibit discriminatory harassment and 32% prohibit indirect discrimination on the basis of disability.

Figure II.104. Percentage of UN Member States that prohibit or not discrimination against persons with disabilities in the laws regulating labour, among 193 UN Member States, around 2016.



Note: Indirect discrimination indicates imposing unreasonable standards, criteria, or other requirements that may apply to all but disproportionately impact persons with disabilities in a negative way.

Source: World Policy Analysis Center.⁶²¹

Conclusions and the way forward

Discrimination is a major cause of exclusion of persons with disabilities and impedes persons with disabilities from pursuing equal participation in society. Some groups of persons with disabilities such as women with disabilities, indigenous persons with disabilities and persons with intellectual and psychosocial disabilities face multiple discrimination and are even more disadvantaged. Discriminatory laws still exist, especially in the areas regulating marriage, legal capacity, work and political participation, despite of progress made by many countries by adopting non-discriminatory laws and policies. To overcome discrimination against persons with disabilities, and eliminate discriminatory laws and policies, it will be crucial to:

- 1) **Review national laws and policies to identify and eliminate discriminatory provisions against persons with disabilities** and ensure their equal opportunities to participate politically, economically, and socially without discrimination. Guarantee the participation of persons with disabilities in the revision process to ensure that their needs and perspectives are considered.
- 2) **Raise awareness about persons with disabilities through public campaigns to combat negative stereotypes against them.** Engage persons with disabilities and organizations of persons with disabilities in the outreach activities. These campaigns should focus on bringing awareness among the population on the needs and abilities of persons with disabilities.
- 3) **Develop mechanisms for reporting on discrimination.** Approaches to developing such mechanisms include creation of a public service, where persons with disabilities can file or report incidences of discrimination faced, or carrying out of periodic surveys and collection of feedback from persons with disabilities regarding how anti-discriminatory laws are being implemented in practical term.

Reducing inequalities through enhanced access to assistive technology for persons with disabilities

This part focuses on access to assistive technology⁶²² for persons with disabilities, a precondition for reducing inequalities between persons with and without disabilities and therefore for achieving SDG 10. Assistive products include devices, equipment, instruments and software whose primary purpose is to maintain or improve an individual's functioning and independence, and thereby promote their well-being.⁶²³ They can enhance an individual's performance,⁶²⁴ and enable people to live healthy, productive, independent and dignified lives.⁶²⁵ The absence of effective assistive products can undermine the ability of persons with disabilities to fully participate in society.⁶²⁶ Enhancing access at an affordable cost is therefore fundamental if no one is to be left behind.⁶²⁷

The part presents the international normative framework on assistive technology and continues with an overview of unmet needs for assistive technology. This section also discusses current practices in countries as well as recommendations to enhance access to assistive technology.

International normative framework on assistive technology

Both the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) and the CRPD acknowledge the instrumental role of assistive technology in enabling persons with disabilities to enjoy and exercise their rights and freedoms on an equal footing to those without disabilities. Through Rule 4 of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993), assistive technology was introduced in international policies and States were obliged to ensure the development and supply of assistive products to assist persons with disabilities to increase their level of independence and to exercise their rights.⁶²⁸ With the adoption of the CRPD, assistive technology was further incorporated into the international policies framework, applying a more rights-specific approach in its specification regarding provision of assistive technology as a measure that States should take to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms.

Specific or general assistive technology measures are suggested in seven articles of the CRPD, namely, Article 4 on general obligations, Article 9 on accessibility, Article 20 on personal mobility, Article 21 on freedom of expression and opinion, and access to information, Article 26 on habilitation and rehabilitation, Article 29 on participation in political and public life, Article 32 on international cooperation. However, explicit assistive technology measures in the CRPD are not included in all relevant articles, such as health (Article 25) and work (Article 27), despite of significant benefits that persons with disabilities gain from using assistive technology.⁶²⁹ Moreover, assistive technology is not explicitly mentioned as a means to empower women and girls with disabilities (Article 6) and to live independently (Article 19), both of which are critical to achieving SDG target 10.2 on social, economic and political inclusion of all.

More recently, a resolution on improving access to assistive technology was adopted at the 71st World Health Assembly. The resolution urged member states to improve access to assistive technology through, amongst others, development of policies and programmes within universal health and/or social services coverage, training of human resources on assistive products, research and development on product designs, international and regional collaboration, and collection of population-based data on health and long-term care needs.^{630,631}

Figure II.105. International normative frameworks relevant so enhance access to assistive technology for persons with disabilities.



The situation of persons with disabilities regarding access to assistive technology

Assistive technology has positive functional, health and economic benefits. Assistive products can benefit people with functional limitations in mobility, hearing, seeing, communication and cognition.^{632, 633, 634} Moreover, they can benefit children with disabilities in their development and participation,⁶³⁵ as well as older people in their participation and independence.^{636,637} Assistive products can have positive socio-economic effects by improving users' access to education and increasing their educational achievement, and can support participation in work and maintenance of health.^{638, 639, 640, 641, 642} Moreover, empirical evidence clearly shows that the provision of assistive products can be cost-effective as it can reduce the needs and costs for other services, enable users to earn an income, or facilitate or reduce the need for

support provided by family members,^{643,644,645} who may then be able to use their time for work or other activities.

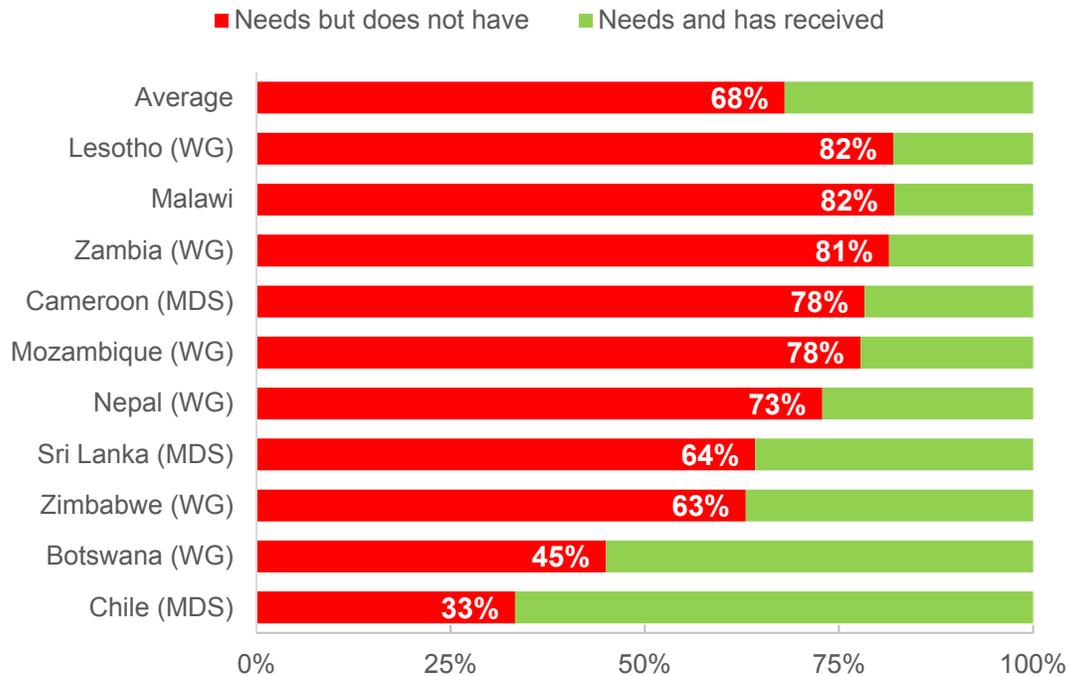
Needs for assistive products

Responsible planning of systems for the provision of assistive technology ought to be based on quantitative data on the needs for assistive products. However, reliable data on these needs is simply not available in many countries. Global estimates indicate that about 0.5% of a population need prosthetic or orthotic devices, about 1% need a wheelchair and about 3% need a hearing aid.^{646,647,648} In years following the adoption of the CRPD, it was estimated that only 5-15% of the population in need have access to assistive products,⁶⁴⁹ and that only 3% of those that would benefit from using a hearing aid have one.⁶⁵⁰

Due to factors such as age distribution and prevalence of various impairments, these needs may vary between countries as well as between regions within a country. In Sweden, the proportion of users of assistive products increased from 20% at age 70 to 90% at age 90.⁶⁵¹ In Chile and China, about 7-9% of school-aged children would benefit from using properly prescribed eyeglasses.^{652,653}

Available evidence from developing countries suggests there is a large unmet need for assistive devices. Among 10 countries, around 2013, the percentage of persons with disabilities who needed but did not have assistive devices was on average 68%, from 33% in Chile to 82% in Lesotho (Figure II.106).

Figure II.106. Percentage of persons with disabilities who need but do not have assistive devices (e.g. sign language interpreter, wheelchair, hearing/visual aids, Braille etc.), in 10 countries, around 2013.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions; (MDS) identifies countries with data produced using the Model Disability Survey. Data from Cameroon is from one selected district in the country and the should be interpreted with caution because it is based on 25 to 49 observations.

Source: SINTEF⁹ and WHO.¹⁰⁷

Barriers to accessing assistive technology

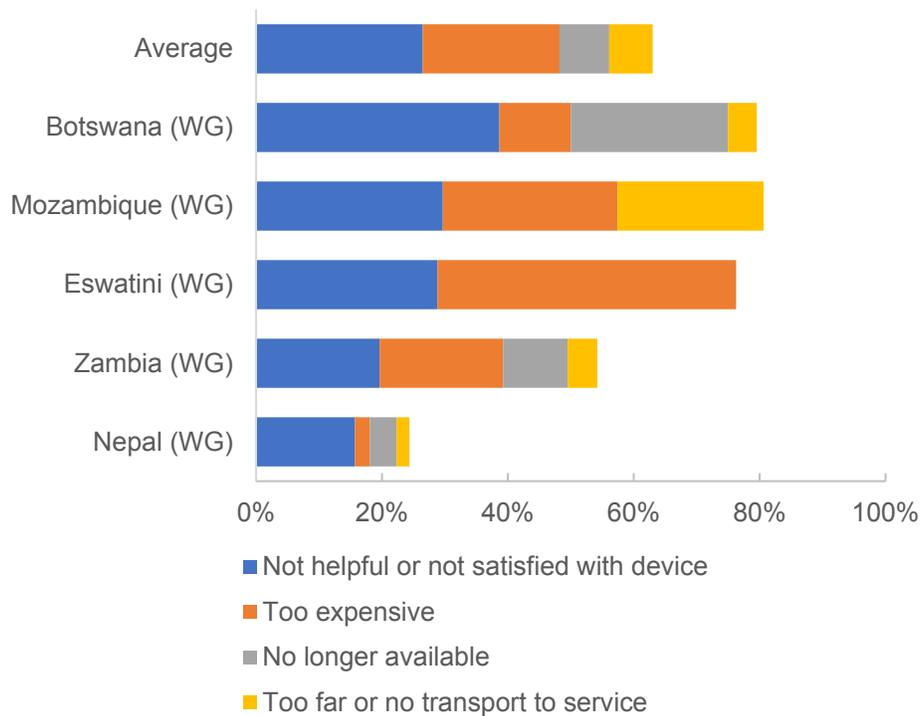
Major barriers in achieving universal assistive technology coverage include lack of awareness, governance, services, products, accessibility, human resources, affordability and economic resources.⁶⁵⁴ In many countries, persons with disabilities, their families and health-related personnel have limited knowledge about assistive products or where to get them. Moreover, policy- and decision-makers are often not aware about assistive technology and the possibilities they bring. In many countries, services are in short supply, often located far away from people in need of them. Similarly, the availability of safe and effective assistive products is limited in terms of quantity, as well as in terms of the range of types, models and sizes of the products. Lack of physical and cognitive accessibility of the transport system and the facilities where

services are provided raise additional barriers. Another common barrier to assistive technology provisioning is the lack of properly trained personnel, skilled in manufacturing or adapting products, or delivering services. Finally, high costs for assistive products and services and traveling costs constitute major barriers. Taxes and duties on assistive products, or materials and components for their production, add to the costs.

Data available from 5 countries on persons with disabilities who stopped using assistive devices (

Figure II.107) indicates that most often they stopped because the device was too expensive (22% on average) or not helpful for them (26% on average). The device no longer being available (8% on average) or the service to get it being too far (7% on average) were also identified as reason in these countries.

Figure II.107. Percentage of persons with disabilities who stopped using an assistive device, by reason for stopping, in 5 countries, around 2012.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions.
Source: SINTEF.⁹

Current practices on promoting access to assistive technology

In 2004-2005, among 114 countries, a large majority of the governments were involved in the provision of assistive products (91%), but about one third (36%) indicated that they did not pay or allocate financial

resources for the provision of assistive products. Regarding laws and policies, 59 of the responding countries (52%) had assistive technology related policies in place, and 57 (50%) had passed related national legislation.⁶⁵⁵

More recently, national policies and laws have increasingly promoted access to assistive technology for persons with disabilities through a provision of grants for assistive technology,⁶⁵⁶ free training on using and maintaining assistive devices,⁶⁵⁷ and enhancing access to information and communication technology (ICT) for persons with disabilities including through removal of barriers, obligating public and private sector to make their information and services accessible, and requiring an assistive technology centre to establish a fund to improve access to assistive products.⁶⁵⁸ Relatedly, a national plan on science, technology and innovation called for incentivizing the development of new technology and devices to enhance the quality of life and inclusion for persons with disabilities.⁶⁵⁹ In addition, assistive devices were disseminated to help persons with disabilities in the post-disaster processes in some areas.^{660,661}

National systems for the provision of assistive technology vary among countries, from centralized or standardized systems⁶⁶² to more decentralized or administered by local authorities.⁶⁶³ Some countries largely engage non-governmental organizations, rehabilitation and/or medical institutions in the provision of assistive products.⁶⁶⁴

Various initiatives have been taken to support countries in their efforts to improve the access to assistive products. For instance, a classification of a wide range of assistive products known as ISO 9999 was developed,⁶⁶⁵ and the Global Cooperation on Assistive Technology (GATE) initiative was launched in 2014 through partnerships among United Nations agencies, organizations of and for persons with disabilities, donor agencies, professional organizations, academia and industry. The GATE initiative led to the development of the first Priority Assistive Products List that included 50 priority assistive products.^{666,667, 668}

Assistive products have been found to be instrumental and effective in facilitating the achievement of all SDGs⁶⁶⁹. For instance, in relation to SDG 1 which calls for ending poverty, in Bangladesh, persons with hearing and mobility impairments using hearing aids and wheelchairs, respectively, were found to be less likely to be poor than those who could not access the assistive devices.⁶⁷⁰

Conclusions and the way forward

Assistive technology enables persons with disabilities to live independently and, to enhance productivity and plays a critical role in achieving the equalization of opportunities for persons with disabilities. The use of assistive products has a positive socioeconomic impact for persons with disabilities. A number of countries have strived to enhance access to assistive technology for persons with disabilities by integrating provision of assistive products into national plans and policies. Technology had been improving and new assistive technologies now can better support persons with disabilities. However, major barriers to access assistive products include high costs, lack of transport to services, lack of awareness of their potential, lack

of trained personnel in adapting products or delivering services, and limited policies in promoting accessible and affordable assistive technology.

Universal access to assistive products is essential to ensuring the social, economic and political participation of persons with disabilities. Underutilization of assistive technology can undermine equality for persons with disabilities. To promote accessible and affordable assistive technology for persons with disabilities, various actions need to be considered:

- 1) **States should formulate policies and laws to support the development, production, distribution and servicing of assistive products.** Provision of assistive technology should be incorporated into existing or new legislation, strategies and policies, including in the areas of education, employment, and health. It is also important to include assistive technology in disability strategies and plans of actions.
- 2) **States should ensure that assistive products are available and affordable for persons with disabilities** including through a provision of grants. Compensation schemes should be implemented, as appropriate, to meet extra expenses for assistive products. Barrier-free environments should be ensured for effective use of assistive products. Emergency and fragile settings can incorporate provisions of assistive technology into emergency preparedness and response plans and include assistive products as part of humanitarian supplies. In countries with established systems for the provision of assistive technology, the focus should be on improving efficiency and effectiveness, by expanding the coverage and improving relevance, quality and affordability, while other countries may focus on introducing and gradually expanding such systems, prioritizing cost-effective approaches.
- 3) **Incentivize research on and the development of assistive technology.** Provide financial incentives for research and development of assistive technology. Design assistive products and programs in close collaboration with persons with disabilities and their organizations. Estimating needs for assistive technology and mapping available human and financial resources are a prerequisite for planning equitable services. It is important that the needs of persons with all types of disabilities are considered, including those with physical, cognitive and sensory disabilities.
- 4) **Enhance capacities of persons with disabilities and their families, governmental officials, and service providers on assistive technology.** Ensure that persons with disabilities and their families obtain knowledge on available assistive products and schemes from which they can benefit. Train governmental officials and service providers on the need and availability of assistive technology to deliver high quality of services for persons with disabilities.
- 5) **Invest in the environment to optimize the benefits of assistive technology.** Although assistive products have the potential to improve quality of life and participation in society, success cannot be guaranteed. Accessibility of the environment is a precondition for using certain assistive products, for

example, ramps and wide doorways can enable effective use of a wheelchair.^{671,672} Measures should be taken to ensure that assistive products can be used effectively, such as hearing loops for hearing aid users.⁶⁷³ In addition to accessibility, assistive products need to meet the preferences and expectations of a user to be effective.⁶⁷⁴

6) **Monitor unmet needs for assistive technology to identify and fill the gaps.** Little research has been conducted on population-level needs for assistive products, policies, service provision models, implementation and cost-effectiveness. There is a need to monitoring progress in meeting these needs for assistive products and the barriers to access.

Promote inclusion of persons with disabilities through deinstitutionalization

Social, economic and political inclusion of persons with disabilities is hampered by placing persons with disabilities in institutions or special homes for persons with disabilities, where they remain excluded from society and deprived from liberty. Often, persons of disabilities living in institutions are not able to obtain an education, cannot exercise their right to vote and are not empowered to make their own decisions.

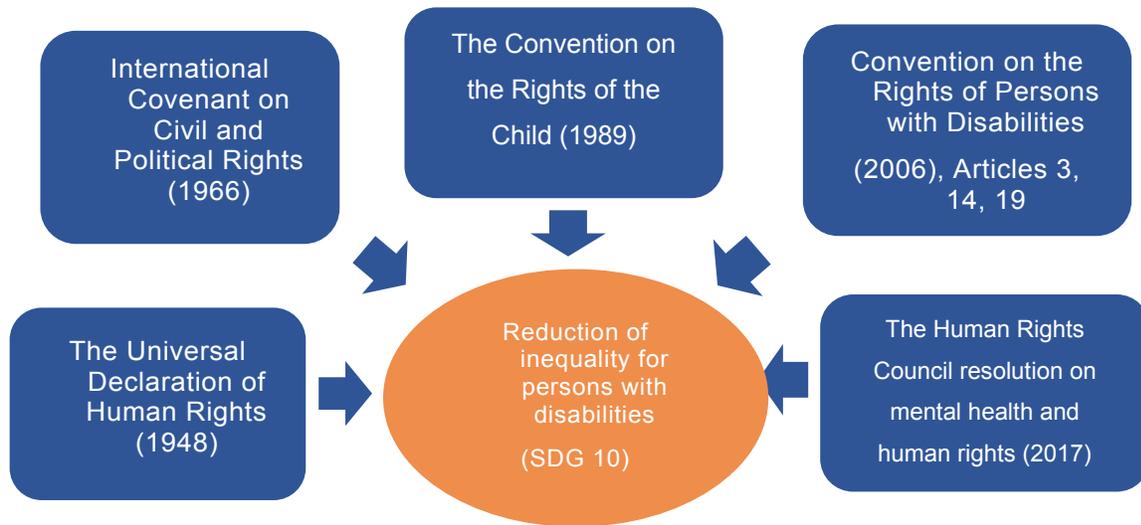
International normative frameworks

A number of international normative frameworks advises against the institutionalization of persons with disabilities. The Universal Declaration of Human Rights (1948)⁶⁷⁵ and International Covenant on Civil and Political Rights (1966)⁶⁷⁶ among other core International Human Rights Treaties, have established the norm that everyone has the right to liberty. The CRPD, in Article 14, specifies that States Parties should ensure that persons with disabilities, on an equal basis with others, enjoy the right to liberty, and that the existence of a disability shall in no case justify a deprivation of liberty. Article 19 further states that States Parties shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of the rights to living independently and being included in the community. A number of CRPD general principles are also particularly relevant to deinstitutionalization, such as respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of person (3(a)), full and effective participation and inclusion in society (Article 3(c)) and respect for difference and acceptance of persons with disabilities as part of human diversity and humanity. SDG 10, which calls for reducing inequality within and among countries, includes target 10.2 highlighting the empowerment and promotion of social, economic and political inclusion of all, irrespective of disability.

The Convention on the Rights of the Child (1989) also specifies the obligations of States Parties in its Article 23 in relation to children with disabilities, including to ensure dignity, promote self-reliance and facilitate the child's active participation in the community.⁶⁷⁷ The Human Rights Council resolution on mental health and human rights (2017), expressed concern that persons with mental health conditions or psychosocial

disabilities may be subject to social exclusion and segregation, unlawful or arbitrary institutionalization; and urged Member States to develop community-based, people-centred services and supports.⁶⁷⁸

Figure II.108. International normative frameworks relevant to achieving SDG 10 on reduction of inequality for persons with disabilities

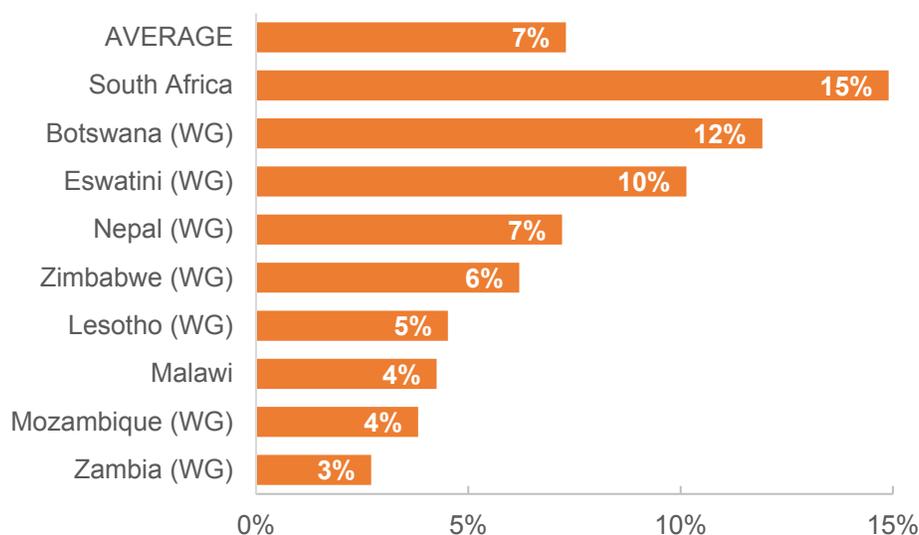


Persons with disabilities living in institutions: status and current practices

The institutionalization of persons with disabilities exists in many countries. Data from nine developing countries indicated that between 3 to 15% of persons with disabilities live in institutions or special homes for persons with disabilities (

Figure II.109). Rates of institutionalisation of children with disabilities also remain high in many countries, including increasingly in many low and middle-income countries. These children are often removed from their families at birth or immediately following a medical diagnosis, at times against the expressed wishes of the parents.⁶⁷⁹ In an assessment of alternative care in 21 countries, it was found that in 13 countries, disability was listed as the 'root cause' of a child being placed in alternative care⁶⁸⁰. In 2007, one third of children in alternative care in Eastern Europe were children with disabilities.⁶⁸¹ Children with disabilities in institutions tend to face a chronic deficit of physical and emotional attention and affection⁶⁸² and are 1.8 times more likely to be neglected and 2.8 times more likely to be emotionally neglected⁶⁸³. Many youth with disabilities are institutionalised during their adolescence as their families find it too difficult to manage with limited resources or are too old to care for a grown individual.⁶⁸⁴ In most countries, care for persons with mental and intellectual disabilities is still predominantly provided in institutions, but community-based mental health services have been shown to be effective, less costly and better at lessening social exclusion.^{685, 686} Some countries have made remarkable efforts to reduce the number of children in institutions. For example, in Serbia, the number of children in institutions declined by 63% between 2000 and 2011, whilst the number of children with disabilities declined by only 37%.⁶⁸⁷

Figure II.109. Percentage of persons with disabilities who have ever lived in an institution or special home for people with disabilities, in 9 countries, 2004-2015.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF.⁹

Conclusions and the way forward

Persons with disabilities, particularly children and youth with disabilities and persons with mental and intellectual disabilities, remain deprived of liberty and excluded from their communities and from society due to the institutionalization. They often do not have access to education, cannot vote and cannot participate socially, economically and politically in society. Persons with disabilities living in institutions should not be left behind. Achievement of SDG 10 will require deinstitutionalisation, and abolishment of coercive practices. To achieve this, efforts should:

- 1) **Review and eliminate policies and laws that allow forced institutionalization of persons with disabilities**, and those that deprive their liberty.
- 2) **Replace institutions by community-based services and support systems for families of persons with disabilities** to allow persons with disabilities to live where they like.
- 3) **Raise awareness at various levels**, including service providers at institutions, families and parent groups and policy makers. Public awareness and advocacy campaigns need to be targeted at changing mind-sets and social norms directed at persons with disabilities, especially children with disabilities and persons with intellectual disabilities, to promote community-based solutions.

Reducing inequalities for persons with mental impairments or psychosocial disabilities

In the context of SDG10, this part highlights the specific inequalities and discriminatory laws that must be addressed in relation to persons with mental impairments or psychosocial disabilities. They are subject to stigma and discrimination and to exclusion from participating in civil, cultural, economic, political and social life due to the perpetuation of laws that allow segregation, marginalization, discrimination and coercion of persons with mental impairments or psychosocial disabilities.

Various terms have been in use to refer to persons with psychosocial disabilities. The term *persons with psychosocial disabilities* has been used by the Committee on the Rights of Persons with Disabilities,⁶⁸⁸ but the term is used indistinguishably as *persons with mental impairments*, for example in the CRPD,⁶⁸⁹ or as *persons with mental health conditions or psychosocial disabilities*, like for instance in the Human Rights Council's resolution 32/18⁶⁹⁰. Mental health conditions include schizophrenia, bipolar disorder, depression, epilepsy, alcohol and drug use disorders, among others.⁶⁹¹ Throughout this section, the term *persons with psychosocial disabilities* will be used.

The section begins by describing relevant international normative frameworks, followed by an analysis of the situation of persons with psychosocial disabilities and a review of national laws and policies and good practices. Concluding remarks and recommendations are provided at the end of the section.

International normative framework on persons with psychosocial disabilities

All international normative frameworks which apply to persons with disabilities described throughout this report apply also to persons with psychosocial disabilities. The CRPD in particular clarifies that persons with disabilities include persons with mental impairments and all articles of CRPD are relevant for persons with psychosocial disabilities. One of the provisions that most disproportionately is violated for persons with psychosocial disabilities is the right to equal recognition before the law, reflected in Article 12 of the CRPD. This provision of the treaty ensures the right to make legally valid decisions to all persons with disabilities, including persons with psychosocial disabilities, at any given time.⁶⁹²

The UN Human Rights Council resolution adopted in 2016 focusing on mental health and human rights expressed concern that (i) “persons with mental health conditions or psychosocial disabilities, in particular persons using mental health services, may be subject to, inter alia, widespread discrimination, stigma, prejudice, violence, social exclusion and segregation, unlawful or arbitrary institutionalization, overmedicalization and treatment practices that fail to respect their autonomy, will and preferences”; and that (ii) “such practices may constitute or lead to violations and abuses of their human rights and fundamental freedoms, sometimes amounting to torture or other cruel, inhuman, or degrading treatment or punishment, and conscious that greater commitment is needed to address all the remaining challenges in this regard”.⁶⁹³ The resolution also reaffirms the obligation of States to ensure that policies and services

relating to mental health comply with international human rights norms; and recognizes the need for States to take active steps to fully integrate a human rights perspective into mental health and community services, particularly with a view to eliminating all forms of violence and discrimination within that context, and to promote the right of everyone to full inclusion and effective participation in society.

In 2013, a Comprehensive Mental Health Action Plan 2013-2020 has been adopted by the World Health Assembly. This Plan includes actions for the empowerment of persons with psychosocial disabilities to engage in mental health activities such as advocacy and policy development.⁶⁹⁴ The Sendai Framework for Disaster Risk Reduction (2015) specifically calls for the enhancement of recovery schemes that provide psychosocial support and mental health services. These services are fundamental for persons with psychosocial disabilities who need them.

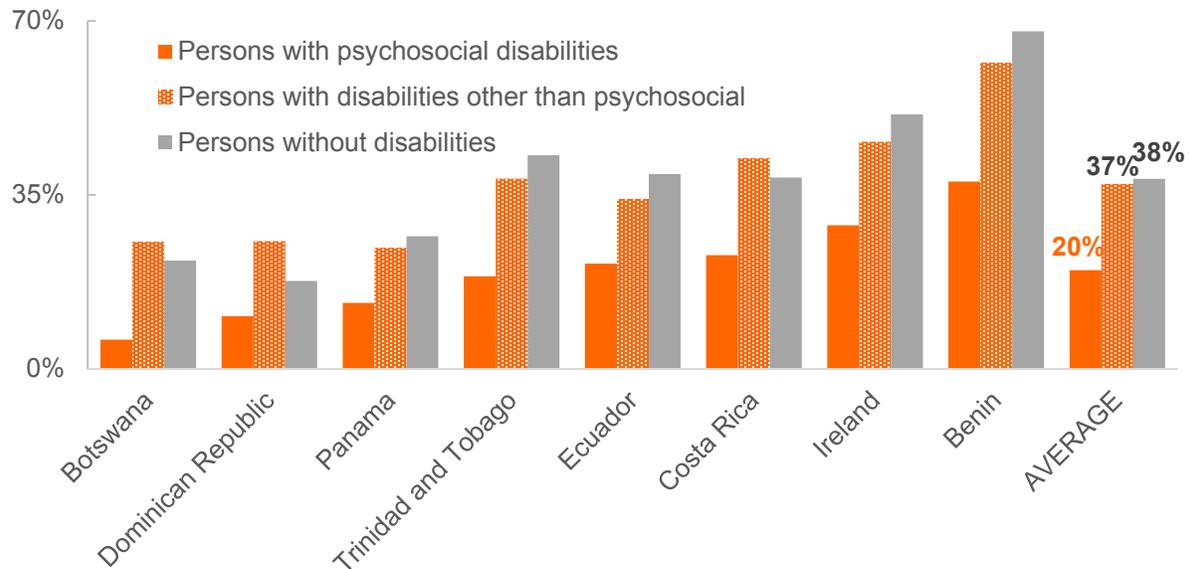
The situation of persons with psychosocial disabilities

Across the world, persons with psychosocial disabilities experience major violations to their rights, participation, legal capacity, dignity and inclusion, including institutionalization, abuses occurring in psychiatric hospitals, harmful and coercive treatment practices, as well as poor living conditions.^{695,696,697} The denial of the right to exercise legal capacity, enforced through guardianship, conservatorship, mental health and other legislation in countries, strips persons with psychosocial disabilities of the ability to make decisions and have control over their lives.

Violence, coercion and abuse against persons with psychosocial disabilities occur in both mental health services and in the wider community.⁶⁹⁸ One in four persons with psychosocial disabilities experiences physical or sexual violence in a given year, a much higher rate than experienced by the rest of the population.⁶⁹⁹ In the mental health care context, persons with psychosocial disabilities are often denied the right to make decisions concerning their treatment and care, resulting in forced institutionalisation and treatment and other abusive practices such as the use of seclusion and restraint, inappropriate and overuse of medications and electroconvulsive therapy without consent.^{700,701}

The denial of legal capacity also impacts on other aspects of people's lives, stripping them of critical civil and political rights such as the right to marry, to have children, to have legal representation, to defend their rights in court, and to vote or stand for public office.^{702,703} For instance, Figure II.110 shows the percentage of married persons with psychosocial disabilities, in 8 countries, around 2011. On average, only 20% of persons with psychosocial disabilities are married versus 37% of persons with other disabilities and 38% of persons without disabilities. In all these countries, persons with psychosocial disabilities are less likely to be married than others.

Figure II.110. Percentage of persons aged 18 and over who are married, by psychosocial disability and disability statuses, in 8 countries, around 2011.

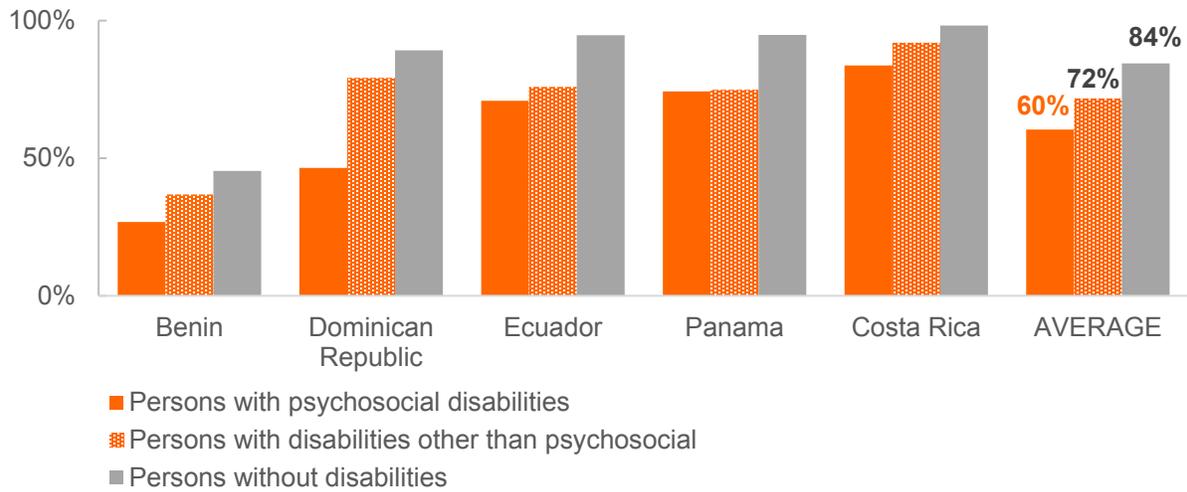


Source: IPUMS.²³¹

Access to education, employment and other income-generating opportunities are also denied to many persons with psychosocial disabilities.^{704,705} Rates of discrimination among individuals with a diagnosis of schizophrenia, for example, are high and consistent across countries of varying income levels.^{706,707,708,709} Available data indicates that persons with psychosocial disabilities tend to have lower literacy rates than the rest of the population (Figure II.111). Among 5 countries, on average, only 60% of persons with psychosocial disabilities are literate compared to 72% of persons with other types of disabilities and 84% of persons without disabilities. Furthermore, even more marked gaps are observed in access to the labour market (

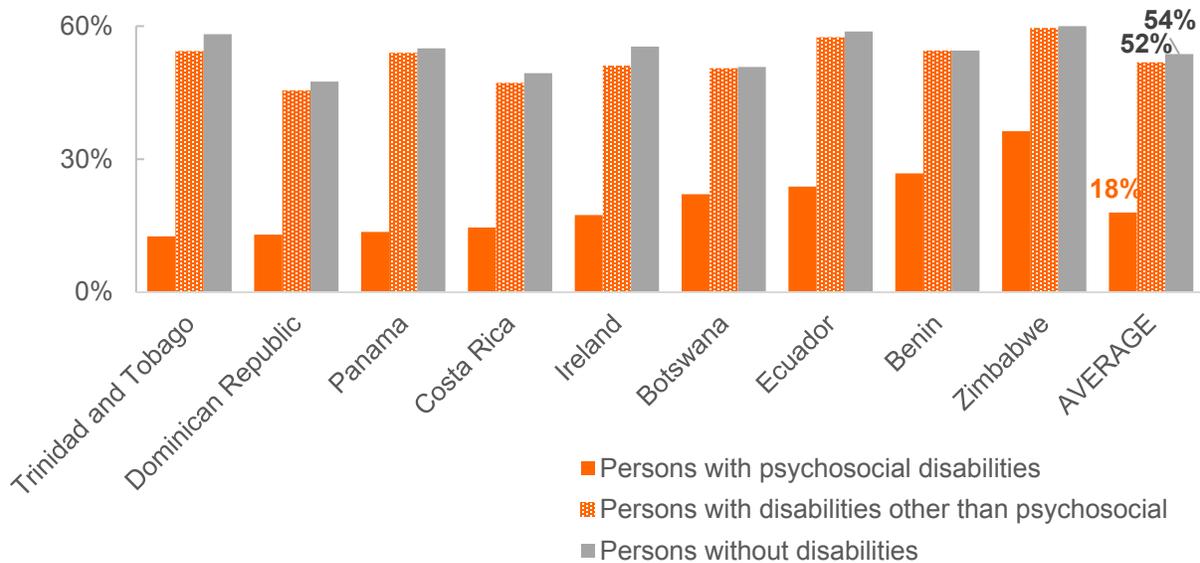
Figure II.112). Among 9 countries, on average, only 18% of persons with psychosocial disabilities are employed compared to 52% of persons with other types of disabilities and 54% of persons without disabilities. For persons with psychosocial disabilities, these percentages, also called employment to population ratios, vary from 13% in the Dominican Republic and Trinidad and Tobago to 36% in Zimbabwe. In all countries, the gaps in employment to population ratios between persons with psychosocial disabilities and persons with other types of disabilities are over 20 percentage points, reaching 40 percentage points and more in 2 countries.

Figure II.111. Percentage of persons aged 15 and over who are literate, by psychosocial disability and disability statuses, in 5 countries, around 2011.



Source: IPUMS.²³¹

Figure II.112. Percentage of persons aged 15 and over who are employed, by psychosocial disability and disability statuses, in 9 countries, around 2011.



Source: IPUMS.²³¹

Persons with psychosocial disabilities also lack access to housing and other social services and supports, as well as to appropriate health care. Evidence from three countries, around 2015, indicates that persons with psychosocial disabilities are more likely to find health facilities hindering or very hindering (

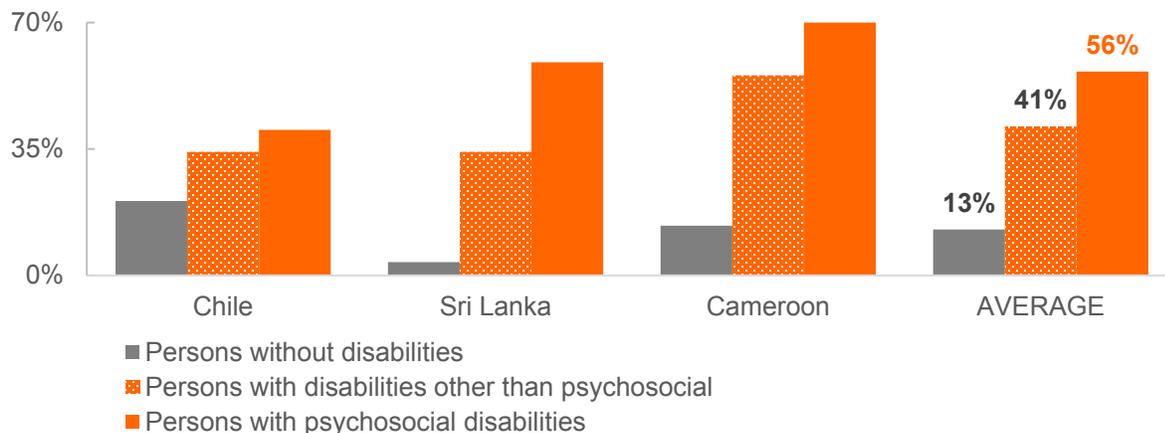
Figure II.113): on average, 56% of them whereas 41% of persons with other types of disabilities and 13% of persons without disabilities find these facilities hindering. These disparities hold in the three countries, with Chile having the lowest percentage of persons with psychosocial disabilities facing this challenge (40%).

Similarly, evidence from the same countries finds that persons with psychosocial disabilities are more likely to consider their overall health bad (Figure II.114): an average of 60% of persons with psychosocial disabilities, 47% of persons with disabilities other than psychosocial and 7% of persons without disabilities consider their overall health bad or very bad. Among these three countries, the lower the proportion of persons with psychosocial disabilities who find health facilities hindering, the lower the proportion who considers their overall health bad, suggesting that accommodating health facilities play a role in providing adequate health care. Persons with psychosocial disabilities die at younger ages than the rest of the population.

Regarding family and community activities, available evidence suggests that persons with psychosocial disabilities face more barriers in participating in them. For instance, in Sri Lanka, in 2015, a higher proportion of persons with psychosocial disabilities, compared to the rest of the population, reported challenges participating in selected family and community activities: 27% of them could not participate in family decisions, 39% of them found joining community activities problematic or very problematic, 59% found the places for socializing hindering and very hindering and 62% found shops, banks and the post office hindering or very hindering. (Figure II.115) In comparison, less than 3% of persons without disabilities reported any of these challenges. Persons with psychosocial disabilities also more likely to encounter these difficulties than persons with other types of disabilities: five times as likely to not be included in family decisions, almost two times as likely to find joining activities problematic and also two times as likely to find places for socializing, shops, banks and the post office hindering.

Without education and work opportunities, basic services and social support, many persons with psychosocial disabilities end up living on the streets, in psychiatric hospitals or in abject poverty.⁷¹⁰ A study in the United Kingdom showed that mortality of persons with severe mental health problems were twice as likely to die early as the general population.⁷¹¹

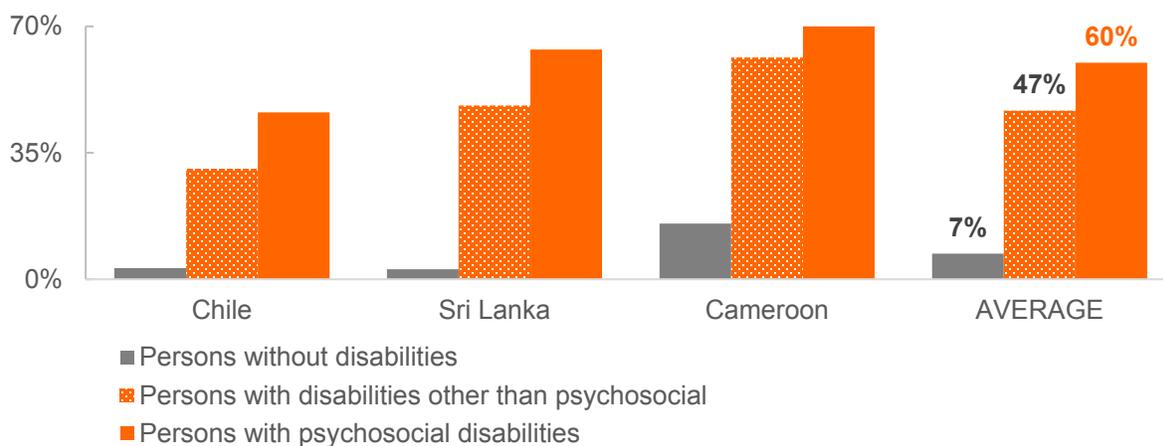
Figure II.113. Percentage of persons who find health facilities hindering or very hindering, by psychosocial disability and disability statuses, in 3 countries (MDS), around 2015.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions and is not nationally representative.

Source: WHO.¹⁰⁷

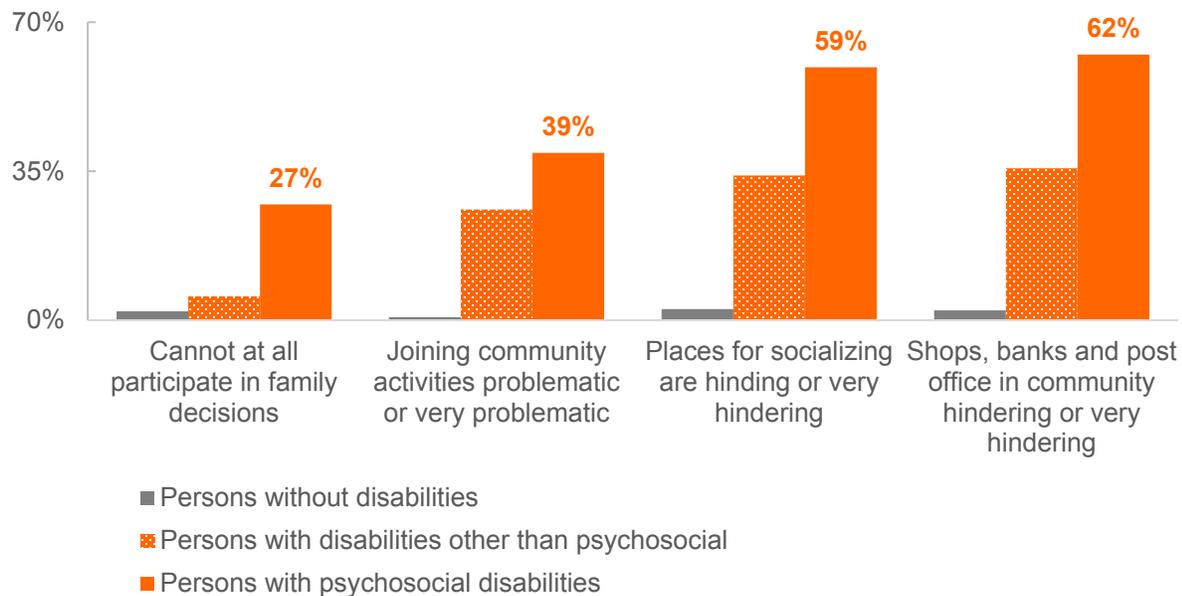
Figure II.114. Percentage of persons who consider their overall health bad or very bad, by psychosocial disability and disability statuses, in 3 countries (MDS), around 2015.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions and is not nationally representative.

Source: WHO.¹⁰⁷

Figure II.115. Percentage of persons who report challenges participating in selected family and community activities, by psychosocial disability and disability statuses, in Sri Lanka (MDS), in 2015.



Source: WHO.¹⁰⁷

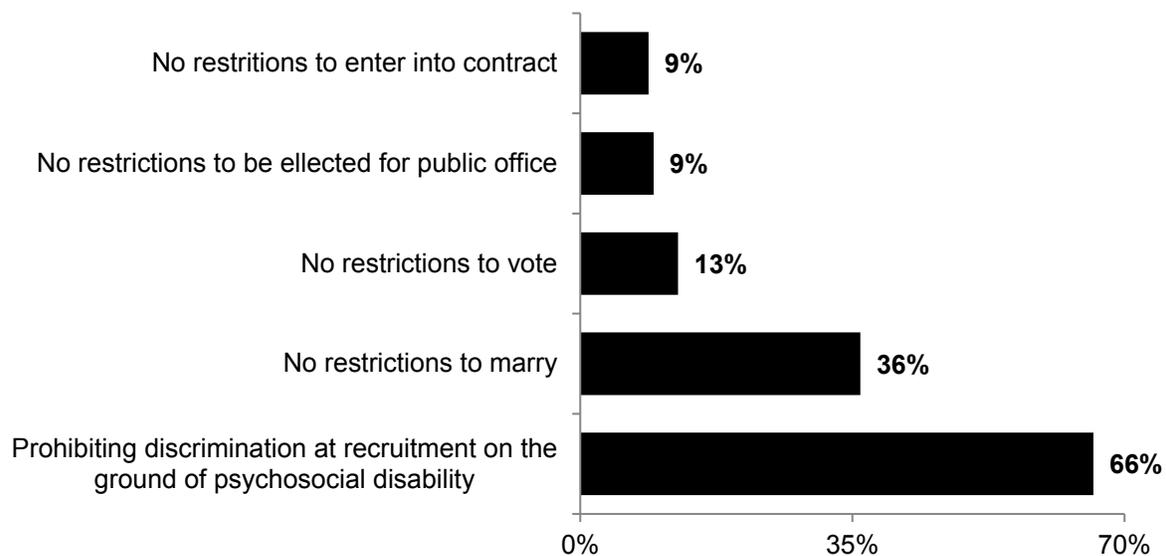
Current practices

National policies and laws specifically related to mental health and psychosocial disabilities have direct and significant impacts on the degree of inclusion and participation of persons with psychosocial disabilities in society. Although, historically, policies and laws related to disability have often neglected psychosocial disabilities, an increasing number of policies and legislation include them. As of 2014, among 168 countries, 21 countries had integrated plans for mental health in their general health or disability plans. Another 131 countries had developed mental health plans. Most of the policies related to mental health, either standalone or part of other general policies on health or disability, included a number of checklist items to reflect the needs of persons with psychosocial disabilities: 92% indicated their policies or plans promote transition towards community-based mental health services and 85% suggested their policies or plans pay explicit attention to respect for the human rights of persons with psychosocial disabilities.⁷¹² However, only 15% of the countries indicated that their mental policies or plans are implemented.⁷¹³

Legislation in a number of countries promotes the social, economic and political inclusion of persons with psychosocial disabilities on an equal basis with others (Figure II.116). But, many laws on employment, marriage, voting and property related rights still fail to address obligations for persons with psychosocial disabilities under the CRPD.^{714, 715, 716} Among 186 countries, 53% permit dismissal, suspension or

termination from work if a person has a psychosocial disability. However, this has been prohibited in 37% of these countries and discrimination on the ground of psychosocial disability at the time recruitment is prohibited in 66% of the countries.⁷¹⁷ Laws do not impose any restrictions on the eligibility of persons with psychosocial disabilities to enter into marriage only in 36% of 161 countries. The right to marry for persons with psychosocial disabilities is denied in the laws of 44% of the countries, while in 7% of them persons with psychosocial disabilities have to seek the opinion or permission from others to get married. In the remainder 13%, psychosocial disability is a permissible ground for voiding a marriage or divorce.⁷¹⁸ Restrictions on parental rights of persons with psychosocial disabilities are even more widespread.⁷¹⁹ Among 167 countries, only 13% have no legal restrictions on the right to vote by persons with psychosocial disabilities, while legal restrictions exist in the remainder 87%.⁷²⁰ Regarding the right to be elected for public office, even more countries have restrictions: among 161 countries, persons with psychosocial disabilities face legal restrictions in exercising this right in 91% of the countries. In more than half of these countries, the restriction targets specifically persons with psychosocial disabilities.⁷²¹ Only 16 out of 182 countries, i.e. 9%, impose no legal restrictions for persons with psychosocial disabilities to enter into contract.⁷²²

Figure II.116. Percentage of countries with legislation allowing persons with psychosocial disabilities to marry, to be recruited for work, to vote, to be elected for public office and to enter into contract, on an equal basis with others, around 2017.



Source: Nardodkat et al (2016),⁷²³ Bhugra et al (2016),⁷²⁴ Bhugra et al (2016a),⁷²⁵ Bhugra et al (2016b)⁷²⁶ and UNDESA.⁷²⁷

Similarly, the legislation in several countries still bars persons with psychosocial disabilities from fully making decisions regarding their own health care. For instance, in Commonwealth Member States⁷²⁸

Some countries have made progress through elimination of all forms of guardianship and curatorship for persons with disabilities, providing effective legal capacity for persons with psychosocial disabilities.⁷²⁹ At the global level, a tool focused on persons with psychosocial disabilities, the QualityRights Tool Kit, has been developed to build countries' capacity to assess and improve the quality of care and human rights conditions in mental health and social care services.⁷³⁰

Conclusions and the way forward

Persons with psychosocial disabilities in all countries continue to experience discrimination in laws and policies, healthcare settings and society in general, deepening their exclusion and marginalisation. Promoting the principles of the CRPD for persons with psychosocial disabilities requires a significant overhaul of mental health policies and laws in most countries. Laws and policies need to ensure that services are available, accessible, acceptable and of decent quality, and that they promote and uphold the rights of persons with psychosocial disabilities on an equal basis with others. And these laws and policies need to be enforced and implemented. In implementing Goal 10 of the SDGs, to reduce inequalities, development actors must specifically act to empower persons with psychosocial disabilities and take action to ensure their social, cultural, economic, civil and political inclusion. Achieving this will require constructive and coordinated multi-stakeholder efforts and collaboration at various levels, with the objective to:

- 1) **Review national policies and legislation to eliminate or amend that discriminate and deny the rights of persons with psychosocial disabilities** from participating in social, economic and political spheres. Engage persons with psychosocial disabilities and their organizations in the process of revisions where possible.
- 2) **End coercive practices, including institutionalisation and harmful and forced treatment, and establish a full range of services and support to enable persons with psychosocial disabilities to access quality mental healthcare services.** Harmful practices should be eliminated, including forced electroconvulsive treatment, solitary confinement, forced and over-medication, medication provided under misrepresented information, as well as physical and chemical restrains. These practices can be considered ill-treatment and amount to torture.^{731,732,733,734,735,736} Persons with psychosocial disabilities should not be forced to treatment on the ground of “medical necessity” or “best interest”, without free and informed consent of the person concerned.^{737,738}
- 3) **Establish policies and programmes targeted for persons with psychosocial disabilities to support their equal participation in society.** Persons with psychosocial disabilities should be engaged in any activities about them such as awareness-raising campaigns and policy development.

4) **Empower persons with psychosocial disabilities.** Support their participation in decision-making processes, to live independently and be included in the community and to exercise their right to liberty and legal capacity on an equal basis with others. In particular, promote informed consent to health care admission and treatment as well as participation.

K. Making cities and human settlements inclusive and sustainable for persons with disabilities (SDG 11)

SDG 11 focuses on safety and resilience of cities and human settlements. This section addresses the challenges and needs of persons with disabilities by providing the international normative frameworks pertaining to inclusive cities and human settlements and examines available national policies and good practices.

Apart from discussing the inclusiveness of cities and human settlements for persons with disabilities – in line with SDG 11, the section focuses in particular on four SDG 11 targets: (i) SDG 11.1, which calls for access for all to adequate, safe and affordable housing and basic services; (ii) SDG 11.3 which calls for inclusive urbanization; (iii) SDG target 11.2 which calls for providing by 2030 access to safe, affordable, accessible and sustainable transport systems for all, with special attention to the needs of inter alia persons with disabilities; and (iv) SDG target 11.7 which commits to providing by 2030 universal access to safe, inclusive and accessible, green and public spaces, in particular for persons with disabilities. The experience of persons with disabilities in urban and rural settings is also analysed in order to identify targeted actions to achieve SDG 11 in both settings.

Although safety of cities and human settlements is briefly discussed in this section, a more comprehensive discussion is provided in the section on SDG 16.1. The resilience aspect is discussed in the section on Disasters.

International normative frameworks on inclusive cities and human settlements

SDG 11 'Make cities and human settlements inclusive, safe, resilient and sustainable' has its origins in several key international treaties, including the freedom to choose one's residence as recognized in the International Covenant on Civil and Political Rights (ICCPR) (1966),⁷³⁹ and the right to an adequate standard of living, including the right to adequate housing in the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966).⁷⁴⁰ The need for freedom of movement, and freedom to choose one's residence is further supported through the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979),⁷⁴¹ and assistance to children with disabilities to promote their participation in the community is addressed in the Convention on the Rights of the Child (1989).⁷⁴²

The Convention on the Rights of Persons with Disabilities (CRPD) includes various provisions related to the issues covered by SDG 11, particularly on making cities and human settlements inclusive for persons with disabilities, by focusing on the needs and perspectives of persons with disabilities. Specifically, the Convention includes the right to live independently and in the community (Article 19), the right to adequate standard of living and social protection (Article 28). Elements of these rights include the right to choose their place of residence and with whom they live (Article 19 (a)).

Moreover, the New Urban Agenda (2016) addresses the right to adequate housing and standard of living, access to basic physical and social infrastructure including affordable serviced land, housing, and information and communication technologies, accessible public spaces and transport, and empowerment and participation for persons with disabilities.⁷⁴³

Relatedly, the Human Rights resolution on human rights in cities and other human settlements (2017) builds on previous international normative frameworks and calls for equitable, affordable and accessible sustainable basic physical and social infrastructure for all without discrimination while meeting the needs of persons with disabilities and urges States to implement road safety policies in line with the CRPD.⁷⁴⁴

CRPD Article 12.5 requires States Parties to take measures to ensure that persons with disabilities have the right to own or inherit property, to control their own financial affairs and to have equal access to financial services. These are linked to SDG target 11.3 that calls for enhanced inclusion and sustainable urbanization for sustainable human settlement planning and management in all countries.

The CRPD also specifies the need for inclusion in several sectors like education (Article 24), habilitation and rehabilitation (Article 26), employment (Article 27), and inclusion is also reflected in various SDGs.

Housing

Like SDG 11.1, which calls for adequate, safe and affordable housing, the CRPD also focuses on housing for persons with disabilities: Article 28 includes the right to housing, and calls on States Parties to ensure access by persons with disabilities to public housing programmes; Article 9 stipulates that measures should be taken to ensure to persons with disabilities access to housing, on an equal basis with others, and specifies that these measures shall include the identification and elimination of obstacles and barriers to accessibility.

Transportation

The CRPD also includes specific provisions regarding accessible transportation –covered in SDG target 11.2 - namely Article 9 calls on States Parties to take appropriate measures to ensure that persons with disabilities have access to transportation, on an equal basis with others, and specifies that these measures shall include the identification and elimination of obstacles and barriers to accessibility. The same measures are called for facilities open or provided to the public in Article 9, a provision in line with SDG 11.7 which calls for accessible green and public spaces. Article 30 further adds that States Parties shall take measures to ensure that persons with disabilities have access to sporting and recreational venues.

Relatedly, SDG target 11.2 calls for providing access to safe, affordable, accessible and sustainable transport systems for all with special attention to the needs of persons with disabilities. CRPD (Article 9) also stipulates that the public transport must be accessible on an equal basis with others. The New Urban

Agenda also commits to improve road safety and sustainable mobility and transport infrastructure for persons with disabilities.⁷⁴⁵

Accessibility of public spaces and services

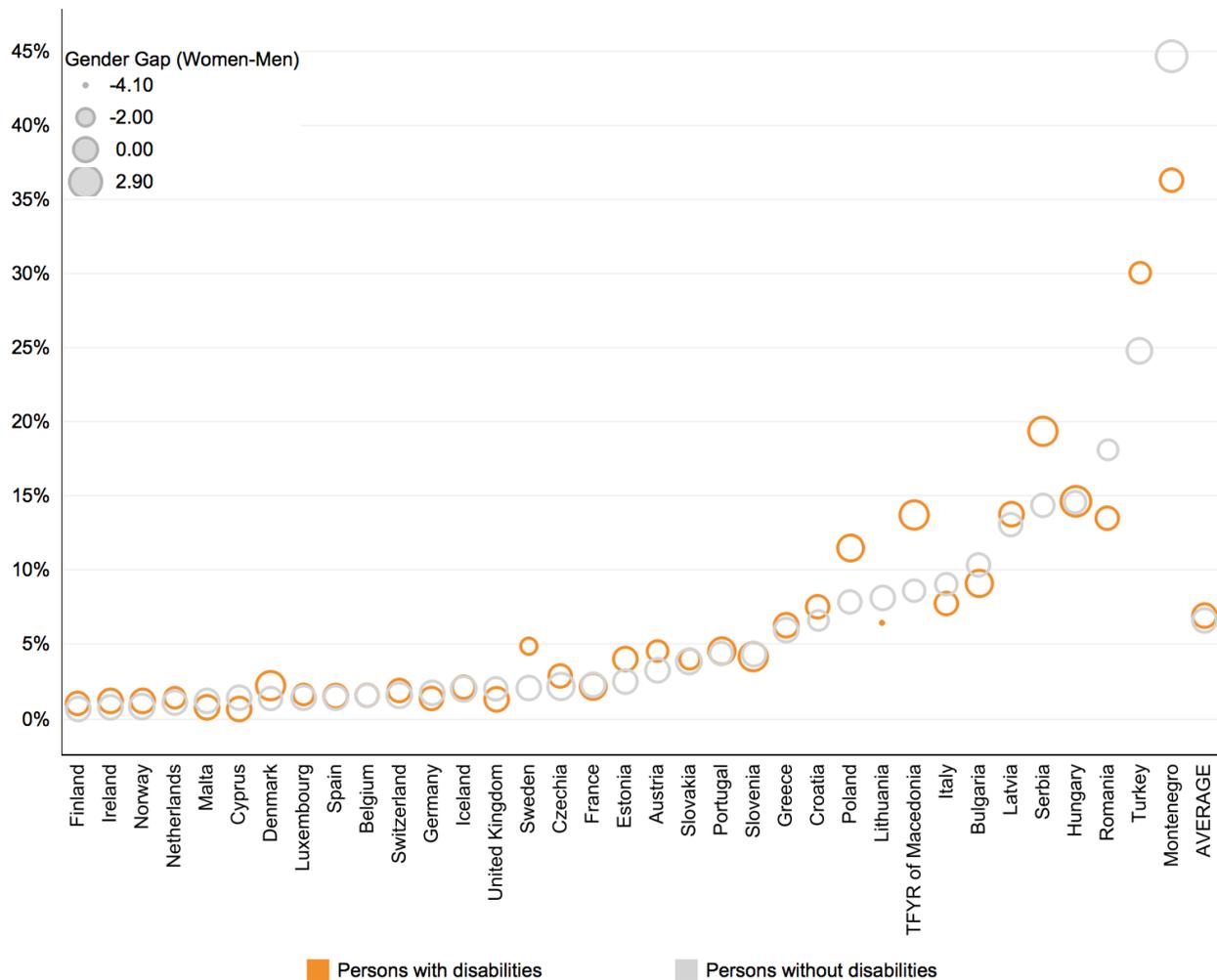
Accessibility is covered in various instruments. The World Program of Action concerning Disabled Persons (WPA), adopted in 1982, considers accessibility a key target area to advance full participation and equality for this population group.⁷⁴⁶ The Standard Rules on the Equalization of Opportunity for Persons with Disabilities (1994) also identifies accessibility (Rule 5) of the physical environment and of information and communication as target areas to foster equal opportunities.⁷⁴⁷ The CRPD requires state parties to ensure that programs and services are fully accessible by persons with disabilities through universal designs, reasonable accommodation, and elimination of discrimination. Public sector entities are also obliged to undertake accessibility audits, and develop and implement plans to realize the right to accessibility, which is called for by the CRPD “to ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities.” (Article 9.2(b)). States Parties must take all appropriate measures to urge private entities to make information and services available in accessible formats for persons with disabilities (Article 21 (c)). The CRPD also includes a provision for access to a range of support services in-home, residential and in community (Article 19 (b)), and the equal availability of services and facilities for general populations on an equal basis to persons with disabilities (Article 19(c)). SDG 11.7 calls for universal access to safe, inclusive and accessible green and public spaces in particular for persons with disabilities.

The situation of cities and human settlements regarding inclusion of persons with disabilities

Adequate, safe and affordable housing (SDG 11.1)

Among 35 countries, mostly in Europe, the average percentage of persons aged 16 and over living in severely deprived housing is similar for persons with disabilities (6.9%) and persons without disabilities (6.6%), as shown in Figure II.117. However, this average masks wider gaps in some countries. In three countries, the gap is about 5%: in Serbia, TYFR Macedonia and Turkey. Gender differences are small in most countries. The lack of indoor sanitation in housing is a great burden for people with disabilities, especially those with mobility difficulties (see section on SDG 6).

Figure II.117. Percentage of persons aged 16 and over living in severely deprived housing, by disability status, in 35 countries, in 2016.

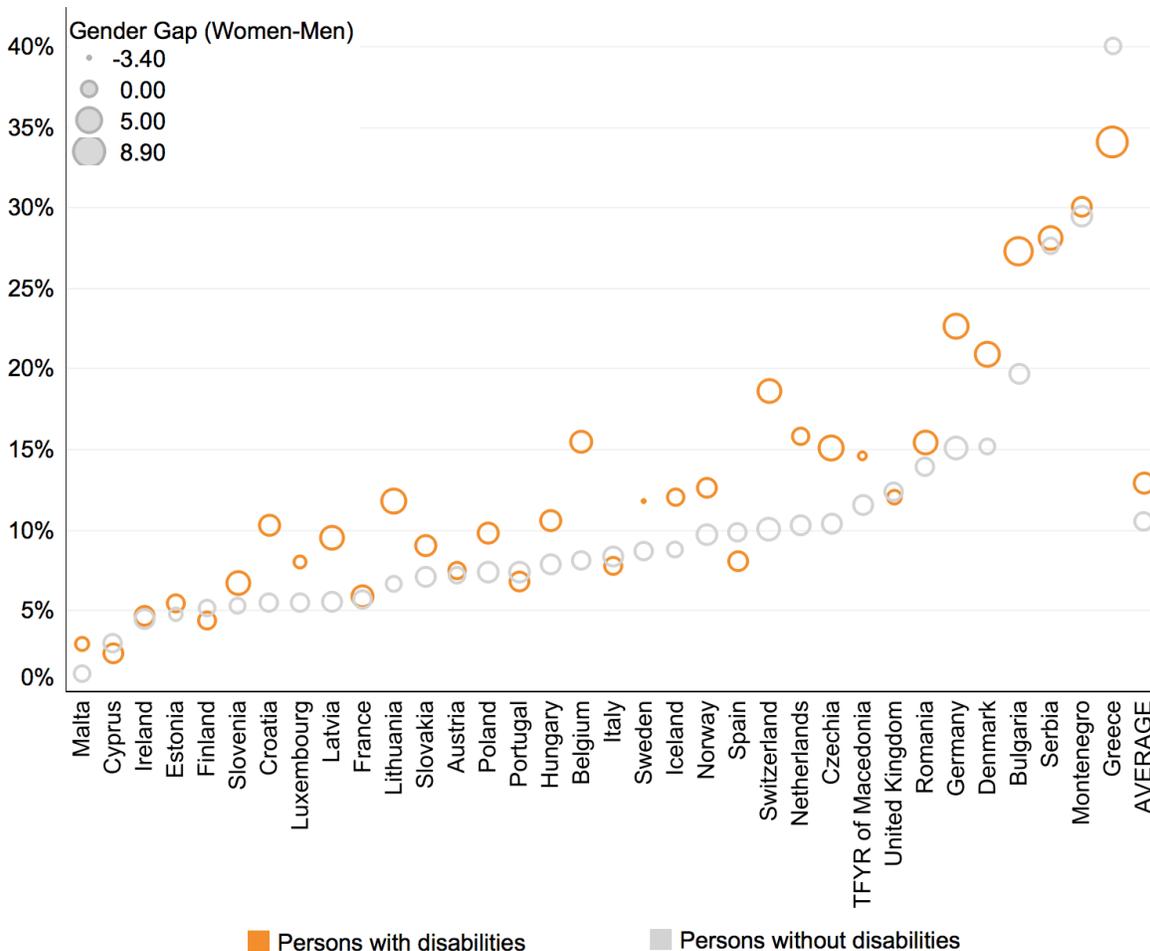


Source: Eurostat.⁸¹

Lack of affordability seems to be a challenge encountered more often by persons with disabilities. In particular, they are more likely to suffer a housing cost overburden than persons without disabilities, especially women with disabilities (

Figure II.118). The rate of housing cost overburden – i.e. the percentage of persons aged 16 and over living in households where the total housing costs represent more than 40 % of disposable income -- is slightly higher among persons with disabilities (13%) as compared to persons without disabilities (11%). Overall the rate of housing cost overburden is highest among women with disabilities: among persons with disabilities, the rate of housing cost overburden is 12% for men and 14% for women. Among persons without disabilities, the rate of housing cost overburden is 10% for men and 11% for women.

Figure II.118. Percentage of persons aged 16 and over living in households where the total housing costs represent more than 40 % of disposable income, by disability status, in 2016.

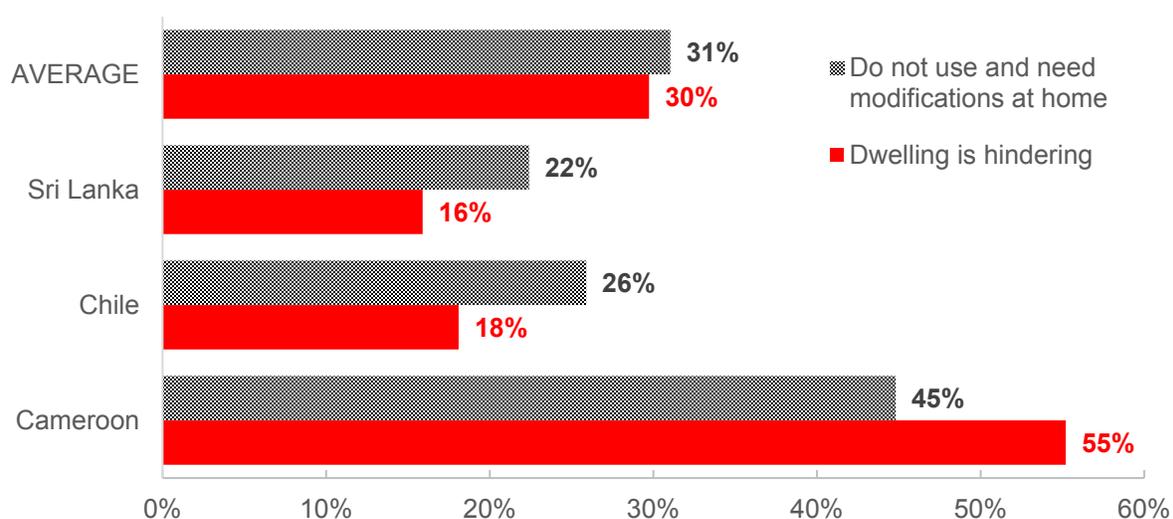


Source: Eurostat.⁸¹

Available evidence also suggests that there is a disproportionate number of persons with disabilities who are homeless.⁷⁴⁸ Due to entrenched stigmatisation and discrimination, persons with disabilities are more likely to encounter greater challenges accessing income, assets and services and are thus particularly vulnerable to being homeless. They have several barriers that prevent them from enjoying their right to adequate housing, such as lack of physical accessibility, discrimination and stigmatization, limited access to the labour market, and lack of social housing or community support.⁷⁴⁹ In particular, deinstitutionalization without the necessary community service compounded by the lack of affordable housing can leave many persons with disabilities living as homeless.⁷⁵⁰ Another challenge is limited security of tenure, particularly

for persons with intellectual or psychosocial disabilities whose legal capacity is often neglected: they are rarely able to obtain formal housing contract therefore often have to rely on less formal housing contracts.⁷⁵¹ This results in their increased vulnerability to forced evictions. In some countries, children with disabilities can be abandoned by families⁷⁵² and face the risk of being homeless and exploited for the purpose of begging in the streets or elsewhere.⁷⁵³ In addition, gender is also important in homelessness as women with disabilities have higher risk of violence and, when escaping violence, emergency shelters may not be accessible to them.⁷⁵⁴ In shelters, persons with disabilities particularly those with psychosocial disabilities are often turned away because of lack of accommodations to respond to their needs.⁷⁵⁵

Figure II.119. Percentage of persons with disabilities who (i) consider their dwelling hindering and (ii) do not use but need modifications at home, in 3 countries (MDS), around 2015.



Note: (MDS) identifies countries with data collected using the Model Disability Survey. Data from Cameroon was collected in selected regions and is not nationally representative.

Source: WHO.¹⁰⁷

Even if persons with disabilities succeed having an adequate dwelling, the dwelling may be hindering or very hindering for persons with disabilities as the dwelling may be insufficiently accommodative of their needs. In three countries around 2015, 30% of persons with disabilities on average indicated that their dwelling is hindering, from 16% in Sri Lanka and 18% in Chile to 55% in two districts in Cameroon (Figure II.119). Similar percentages of persons with disabilities indicate that they do not use but need modifications at home: 22% in Sri Lanka, 26% in Chile and 45% in the two districts in Cameroon.

Apart from lack of adequate, affordable and accessible housing, persons with disabilities also tend to live

in less safe accommodations and areas of residence where crime, violence or vandalism are common (see section on SDG 16).

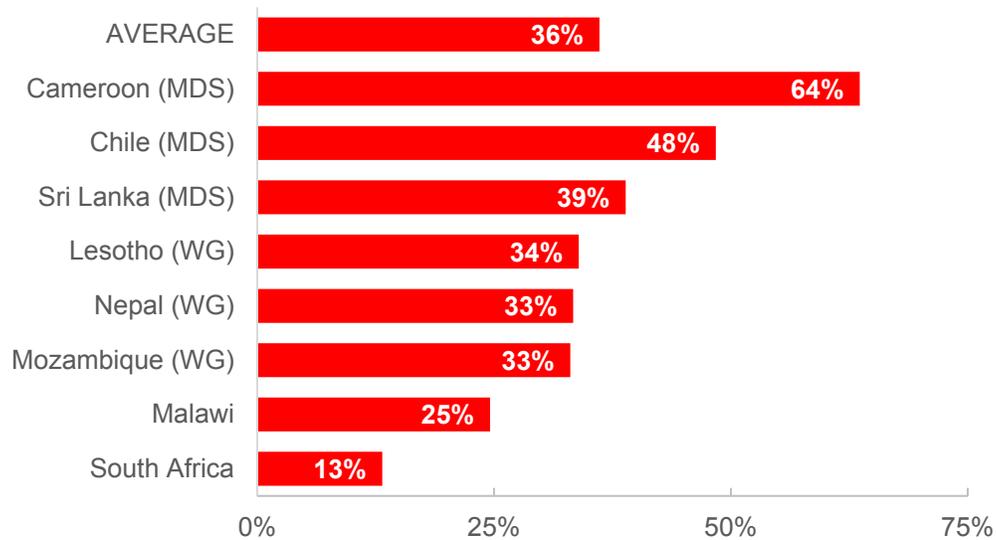
Main barriers to adequate housing for persons with disabilities include lower economic status (see sections on SDG 1 & 2 and 8); discrimination in legislation and policies that limit ability to exercise right to adequate housing; limited access to information on housing especially persons with sensory disabilities and those with intellectual disabilities; lack of physical accessibility; and inadequate monitoring mechanisms.⁷⁵⁶

Accessible transport for persons with disabilities (SDG 11.2)

The urban sprawl and decrease in job opportunities have turned rural areas into almost exclusively residential settlements, highly dependent on neighbouring towns. This fact directly impacts on persons with disabilities that may end facing long commutes to work, which can be a barrier for persons with disabilities to enter the job market due to the poor accessibility of public transport services.

Indeed, in many countries, the transportation system and public spaces are not always accessible for persons with disabilities. Data from eight developing countries indicates that the average proportion of persons with disabilities who consider transportation not accessible or hindering is 36%, ranging from 13% to 64% (Figure II.120). Crowd-sourced data mostly from developed countries indicates that as of 2017, 32% of public transportation facilities were not wheelchair accessible.⁷⁵⁷ In some countries, the only international airport available is not accessible for persons with disabilities.⁷⁵⁸ Evidence from Australia, in 2015, identified major obstacles for persons with disabilities in using public transportation: steps to get in or out of vehicles, barriers in getting to stops or stations, lack of seating or difficulty seating or difficulty standing, pain or discomfort when sitting, fear or anxiety, inaccessible doors to get in and out of vehicles and inadequate access to toilets (see Box 8).

Figure II.120. Percentage of persons with disabilities who consider that transportation is not accessible or hindering, 2004-2016.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions; (MDS) identifies countries with data collected using the Model Disability Survey. All data refers to not accessible transportation, except MDS data which refers to hindering transportation. Data from Cameroon and South Africa were collected in selected regions and are not nationally representative.

Source: SINTEF⁹ and WHO.¹⁰⁷

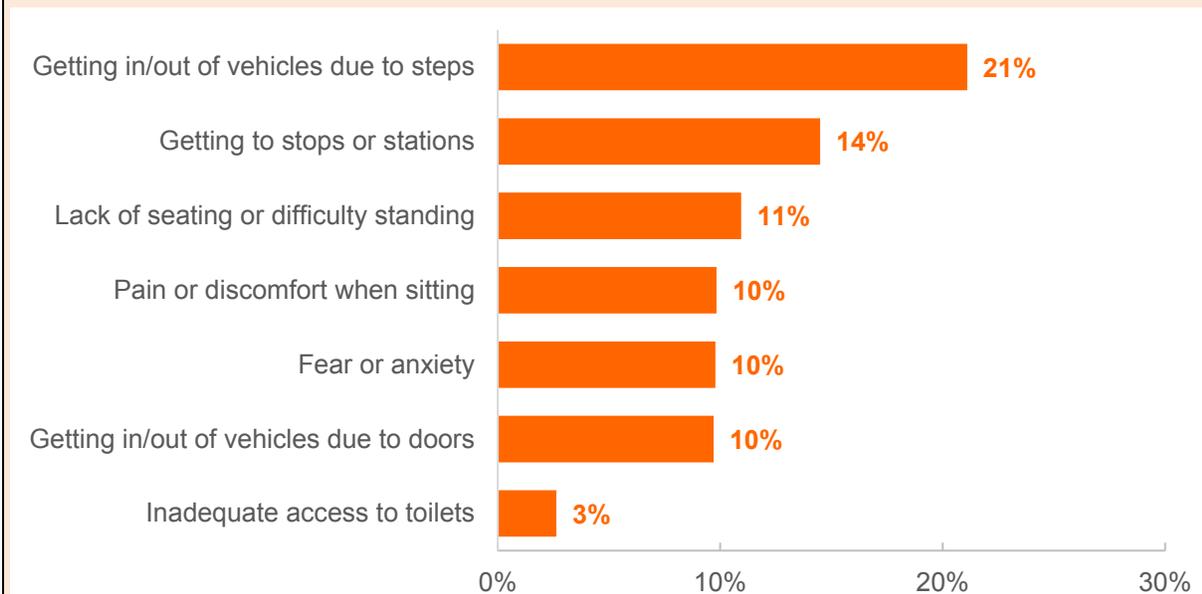
Box 8. Inclusivity and accessibility of public transportation prioritized in Australia

In Australia, the National Disability Strategy 2010-2020⁷⁵⁹ has as one of its main priorities the inclusivity and accessibility of public transportation. This is a priority area because access to transportation is correlated to the participation of persons with disabilities in community life. Data collected in 2015 showed that about 80% of persons with disabilities had public transport available in their local area.⁷⁶⁰ While this is a major feat, in 2015, 43% of persons with disabilities reported they were unable to use public transportation, mainly due to difficulties to get in or out of the vehicles due to steps (21%), to the stations (14%), pain (10%), fear (10%), inadequate access to toilets (3%) and other difficulties in accessing the mode of transport provided (

Figure II.121).

Toward resolving this, the Disability Standards for Accessible Public Transport has minimum requirements that must be met, including, “range of access paths, boarding devices, allocated spaces and handrails” in a 30-year implementation. Furthermore, in Australia the costs of using public transportation are subsidized or made more affordable through the use of concession cards for persons with disabilities. The cards offer cheaper options or discounts on certain services including public transport fare.⁷⁶¹

Figure II.121. Percentage of persons with disabilities, by reasons for being unable to use public transportation, in Australia, in 2015.

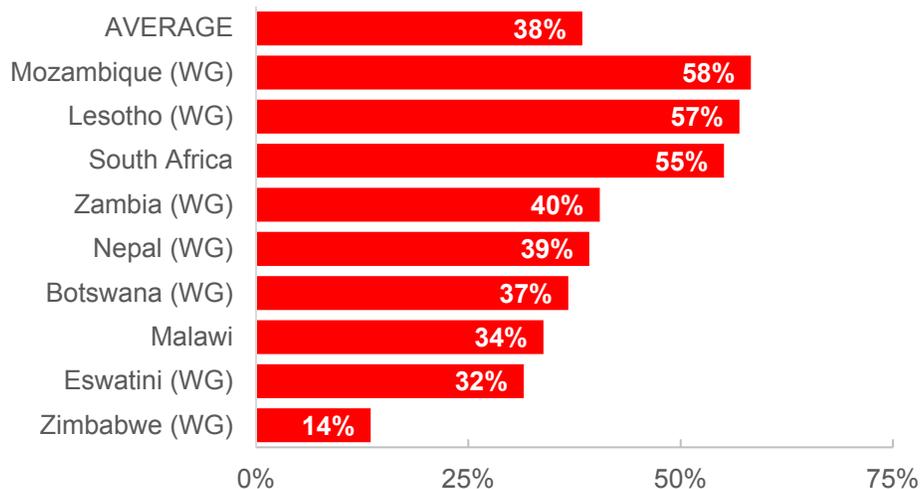


Source: ABS Survey of Disability, Ageing and Carers, 2015.⁷⁶²

Accessible public spaces (SDG 11.7)

Businesses and public places can also be a challenge for persons with disabilities. In some countries, more than 25% of persons with disabilities consider that banks, shops and post offices are hindering or not accessible.^{763,764} Data from nine developing countries indicated that on average 38% of persons with disabilities indicated that recreational facilities are generally not accessible to them (Figure II.122), from 14% in Zimbabwe to 58% in Mozambique. According to crowd-sourced accessibility data, out of more than 20,000 public leisure facilities analysed in various countries, mostly in developed regions, half were considered not accessible for persons using wheelchairs.⁷⁶⁵

Figure II.122. Percentage of persons with disabilities who report that recreational facilities (e.g. cinema, theatre, pubs, etc.) are generally not accessible to them, in 9 countries, around 2009.



Note: (WG) identifies countries with data produced using the Washington Group short set of questions. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF.⁷⁶⁶

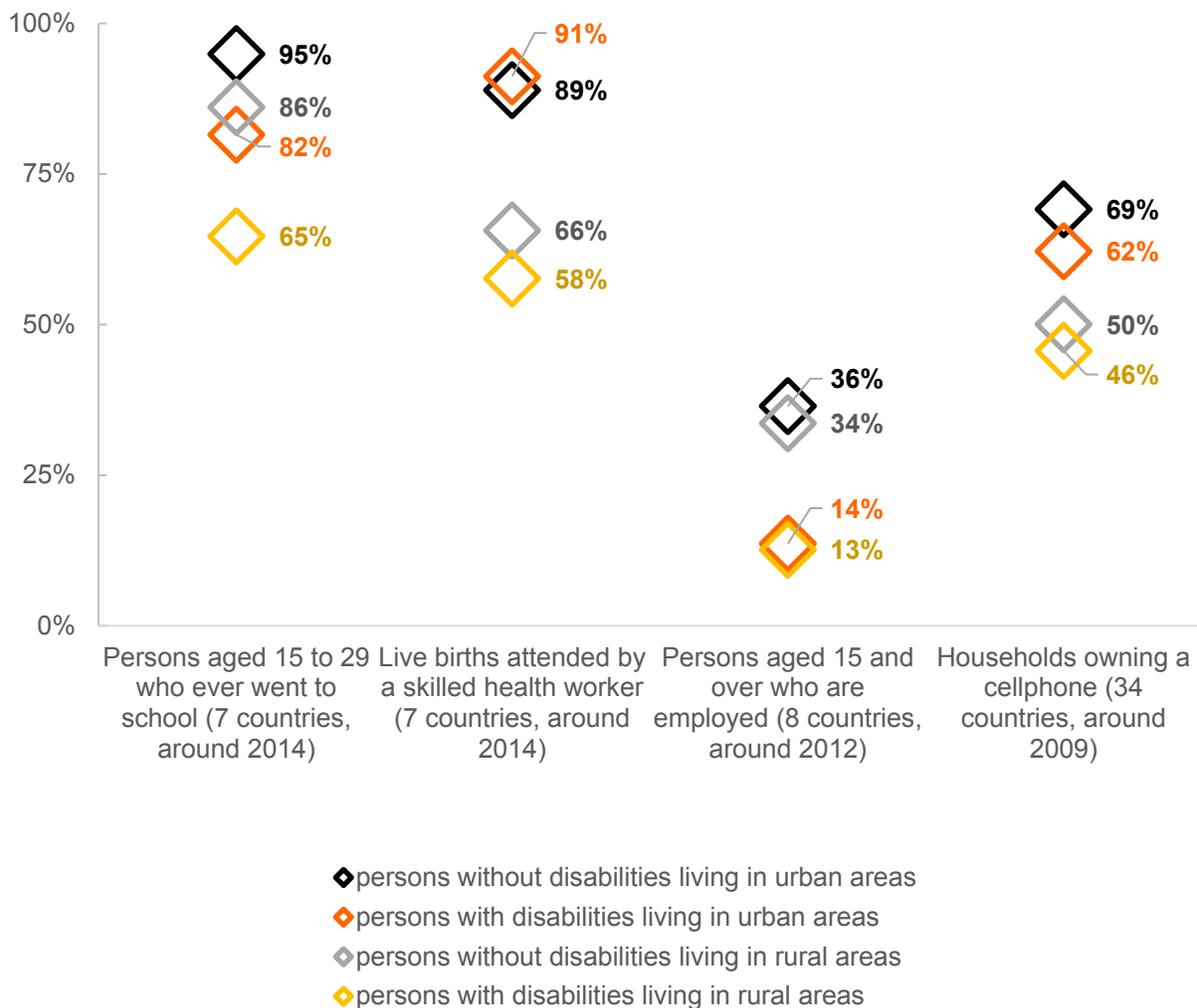
Challenges in urban versus rural settlements

Persons with disabilities in rural areas tend to be at a disadvantage. Existing data for a limited number of countries (

Figure II.123) indicates that, compared to persons with and without disabilities from urban areas and to persons without disabilities in rural areas, they are the least likely to ever have been to school (65%) and the least likely to be employed (13%). Births from mothers with disabilities who live in rural areas are the least likely to have the birth attended by a skilled health worker (58%). Households in rural areas with a family member with disabilities are the least likely to own a mobile phone (46%).

Urbanization is believed to better respond to persons with disabilities' needs as job opportunities and supporting facilities are more available in urban areas. But the percentage of persons with disabilities employed is similar in urban and rural areas (14% and 13%), and much lower than the same percentage for persons without disabilities in both urban and rural areas (36% and 34%), suggesting that the local of residence may not play a major role in the employment of persons with disabilities – possibly factors like discrimination and lack of accessibility at the workplace are major obstacles in both urban and rural areas. On the contrary for education, there is a clear gap between persons with disabilities in rural versus urban areas (65% versus 82%), suggesting that in urban areas persons with disabilities face fewer challenges in accessing education. The location of residence seems also to play a major role in access to a skilled health worker during birth. In urban areas, 91% of births from mothers with disabilities and 89% of births from mothers without disabilities have access to this service; while in rural areas, the coverage is much lower. Living in urban areas also appears to give households with persons with disabilities an advantage in owning a cell phone: 62% such households own a cell phone compared to 69% for urban households without persons with disabilities and 50% for households with persons with disabilities in rural areas.

Figure II.123. Four selected indicators on education, health, employment and access to ICT, by disability and by urban versus rural place of residence.



Source: DHS⁷⁶⁷, ESCWA,²⁴¹IPUMS²³¹ and SINTEF⁷⁶⁸.

Current practices in making cities and human settlements inclusive

There are numerous countries that have made efforts toward increasing access, inclusion and the participation of persons with disabilities in cities and human settlements. This is mostly done through adopting a national disability strategy and plan of action, adoption of accessibility standards for the built environment, policies and programmes to enable access to all public systems and services, increasing public awareness on disability, and investments in programmes and services for people with disabilities.⁷⁶⁹

Current practices in promoting adequate housing for persons with disabilities

Some countries have established standards for housing units to enhance accessibility for persons with disabilities. For example, the Swedish Building Code requires all units in residential buildings of three levels or more to have wheelchair access, large lifts and kitchen and bathrooms of certain dimensions. Implementation of this code allows persons with disabilities a broader choice for their own dwelling and enables them to visit others more easily. The additional cost of including these features has been estimated at less than one per cent of the total building costs.⁷⁷⁰

There are also initiatives to assist persons with disabilities to move from institutional living arrangements to choose their own housing or to live with their families. These initiatives are based on the provision of services in the community and support for independent living, including assistance in finding housing. The community services include mental health clinics, social care services, psychiatric outpatient facilities, health care services, a day care centre, financial support, support groups, community networking, awareness, and sensitization campaigns.⁷⁷¹

In Nepal, a programme has been developed in rural communities to offer affordable accommodations for persons with disabilities.⁷⁷² A number of countries has also put in place social programs to help persons with disabilities financially, including for housing costs (see section on SDGs 1 and 2).

Current practices in making public places accessible

Many countries established comprehensive national strategy and/or plans that encompass improvement of accessibility in the public space including public buildings, facilities and schools to promote inclusive community. Examples of such strategies and plans can be found in, *inter alia*, Australia, China, Ethiopia, France, Georgia, Lao PDR, Nepal, Norway, Rwanda, South Africa, UAE, and United Kingdom.⁷⁷³ As an illustration, Norway has committed to be “Universally designed by 2025”.⁷⁷⁴

Some countries passed acts, laws, standards or policies on accessibility of the public space. For example, through integration of accessibility in the design and construction of buildings,^{775,776,777} passing laws concerning accessibility of public space for persons with disabilities, including making all public and private space accessible,^{778,779} establishment of a framework for developing accessibility standards for entities in the public and private sectors including design of public spaces, employment, information/communication, and customer service,⁷⁸⁰ as well as incorporating accessibility into federal buildings, barrier-free standards in buildings, and laws on information and communication technology.⁷⁸¹ For example, in Barbados⁷⁸², accessibility is mandatory in public buildings. And evidence suggests that this practice is gradually being adopted by the private sector. Accessibility standards have also been adopted to regulate how information to navigate in public buildings is displayed. For example, in Japan, accessibility standards applicable to buildings require that main facilities must be indicated to persons with visual disabilities in braille.⁷⁸³

The accessibility of the documentation and information about standards and regulations on accessibility in the public space is also improving. For example, in Chile, such standards were made accessible to persons with disabilities in easy-to-read format by offering an accessibility guide that simplifies the building regulations by using pictures and pictograms to make the information more accessible to wider users.⁷⁸⁴

Businesses and civil society organizations also took initiatives to enhance accessibility to better serve persons with disabilities. In Ireland, the central bank enhanced physical accessibility in their facilities including parking, waiting area, reception desks, bigger doors and lifts, handrails, amongst others.⁷⁸⁵ A business in Spain provided a more accessible shopping service through ensuring physical accessibility, using sign language for persons with hearing impairments, and organizing products by size and using different colours to make shopping easier got persons with cognitive disabilities.⁷⁸⁶ Hotels also took actions to promote physical accessibility for persons with disabilities, through appointing an accessibility director to promote accessible hotel facilities, providing training courses on accessibility to staff, and installing suitable height of beds, lower shower heads, hearing loops, etc.⁷⁸⁷

Awareness of accessibility is not only increasing in urban areas. In Sri Lanka, public buildings including schools, polling stations, and religious sites, were made physically accessible to persons with disabilities in rural areas.⁷⁸⁸ In Nepal, a programme has been developed in rural communities to raise awareness and remove physical barriers amongst the communities: the program helped reconstructing schools, health care centres, and public toilets to be more accessible.⁷⁸⁹

Access to recreational facilities and events can be vital to promote the participation of persons with disabilities in the communities. In Colombia, accessible cinema for persons with disabilities has been offered. Accessibility features included: audio description; sign language interpretation; and subtitles displayed in high contrast colours on the screen.⁷⁹⁰ Museums in Austria and the United States offer accessible facilities and services to meet the needs of persons with disabilities, including through easy language and audio description of art work.^{791,792} Similarly in Spain, an art exhibition was made accessible to persons with disabilities by providing information by audio, sign language, braille, and a beacon-based navigation system.⁷⁹³ Accessible programs are offered in museums in Albania, Bosnia & Herzegovina, Greece, Macedonia and Serbia, such as workshops in art pottery for persons with and without disabilities and braille guides and tactile maps.⁷⁹⁴

Some countries installed the footpaths for persons with disabilities to enjoy outdoors,⁷⁹⁵ and built ramps and placed braille and audio for persons with disabilities in tourist sites.⁷⁹⁶ In the United States, an accessible community centre was designed with the principle of Universal Design by installing ramps, flat surface (stairs-free), hearing loops, and a wheelchair softball field, which enabled persons with disabilities to equally participate in sports and cultural events.⁷⁹⁷ Several countries have paid special attention to recreational spaces for children with disabilities. Accessible playgrounds including accessible equipment and restrooms can be found in Hungary, Israel, and Sweden.^{798,799,800}

Other initiatives include the development of a map with information on accessibility in a city, including in restaurants, public toilets, transport, and parking facilities,⁸⁰¹ and a website that provides information on accessibility of hotels, facilities, transport, and events.^{802,803}

Monitoring and assessment of policies and regulations on accessibility play a critical role to ensure the implementation. Such an initiative has been taken in Canada through a paper-based assessment form on accessibility in public spaces including pavements, crossing, and buildings in urban areas, and uses 114 accessibility indicators.⁸⁰⁴ Similarly in Europe, a model to rate accessibility of objects and public spaces based on a 300-question check list has been used in some countries.⁸⁰⁵

Current practices for making transportation accessible

Several countries have passed laws requiring all transport to be accessible,^{806,807} developed national strategies and/or action plans to enhance the accessibility of public transportation,^{808,809} and made more accessible sidewalks and pedestrian crossings through removal of obstacles. Regulations at times focus on specific modes of transportation, like in Germany, which incorporated accessibility in regulations on railway construction and operation.⁸¹⁰

Accessibility standards have been developed to facilitate communication when persons with disabilities use transportation systems. For instance, in Japan, the Accessibility Standards applicable to the public transportation system provide that the system must be equipped with facilities that make it possible to achieve mutual understanding through use of written information.⁸¹¹

To facilitate mobility of pedestrian with disabilities, countries have installed barrier-free signals such as traffic sound signals for persons with visual impairment and escort zones at pedestrian crossings for their safety,⁸¹² ramps and tactile surface markings.⁸¹³

Mobility of persons with disabilities can be improved through accessible taxi services. Good practices include a taxi service offering wheelchair accessible vehicles with trained drivers in the United States, where users can call for a taxi through a mobile app, phone call, or email;⁸¹⁴ provision of subsidies for persons with disabilities for the use of taxis;⁸¹⁵ and a cash benefit for reimbursement of expenses on transport for persons with disabilities who may not use public transport.⁸¹⁶

Other initiatives are focusing on building capacities of persons with disabilities to move around in public spaces. A case in point is the training called 'Flashsonar', for persons who are blind or visually impaired, on the technique of human echolocation, which involves tongue-clicking and responding to reflected sound for persons who are blind or visually impaired to navigate themselves when walking down a street or outdoors.⁸¹⁷

Frequently, making urban transport accessible is seen as costly. However, some of the interventions for more accessible transport could be done with low to no cost, such as creating basic side walk and crossing design, minimize steps and other hazards, hazard marking, as well as having visual contrast, colour coding, clear/intuitive signs.⁸¹⁸ Moreover, existing examples show that consultation with disability communities for infrastructure planning and implementation is highly beneficial.⁸¹⁹

Conclusions and the way forward

The population of persons with disabilities is expected to increase in urban areas as the world continues to urbanize. Yet, persons with disabilities are in the situation where physical and social barriers such as inaccessible transportation, businesses and public facilities, and lack of adequate housing due to discrimination impede them from fully enjoying their livelihood equally. Achieving inclusive cities and communities for persons with disabilities entails removing these barriers.

Housing is a key component of inclusive urban development. Universal design principles should be incorporated from the outset in plans for new built environments and as much as possible in renovations to existing buildings and facilities to ensure accessibility for all. Examples of universal design include the use of braille on elevators' control panels and a hearing induction loop system for emergencies that allows people to speak with security through a microphone.

Accessible transportation not only provides mobility for all, but drives sustainable and inclusive growth. Continuity of accessibility throughout all segments of a journey from the starting point to the final destination is important and should be supported by urban policies and plans that identify and fix accessibility gaps in public spaces or from one built environment to another. Making transportation inclusive means also ensuring affordability of accessible transportation.

Information and communication technologies (ICTs) play a key role in building inclusive and accessible cities. Accessible ICTs, including mobile applications, government websites, public kiosks and automated teller machines, should be part of accessible urban development plans.

Compact cities could increase accessibility, as persons with disabilities living in these areas would have better access to concentrated resources and infrastructure. Although compact cities can offer enormous potential for persons with disabilities, this potential will not materialize unless accessibility and non-discrimination are prioritized.

This section showed that there are many other good practices. Although lack of resources cannot justify inaction, financial constraints to implement physical and structural adaptation in cities are still a hurdle to increase accessibility. But there are low-cost options which could be scaled up.

To make cities and communities inclusive and sustainable for persons with disabilities, more efforts are needed to:

- 1) **Ensure that national policies and laws on accessible housing, public infrastructure, transport, and services are in place and implemented.** Standards, laws and effective enforcement mechanisms are necessary to ensure accessibility of housing, public services and transport for persons with disabilities. Urban planning and development should be developed in consultation with persons with disabilities and include the needs of persons with disabilities, taking into account accessibility, affordability and quality of public spaces including transport, facilities, buildings and services, as well as cultural and recreational facilities and services. The ultimate aim of urban planning should be to provide an accessible environment where persons with disabilities can live independently.
- 2) **Develop national policies and laws that guarantee access to adequate and affordable housing for persons with disabilities.** Eliminate discriminative laws that prevent persons with disabilities, particularly those with intellectual or psychosocial disabilities, from exercising their right to adequate housing. Ensure that information relevant to housing is available in accessible format and that available housing is affordable for persons with disabilities.
- 3) **Raise-awareness on disability among communities and decision-makers** and create the enabling environment where persons with disabilities are included without discrimination and can participate equally in the communities.
- 4) **Share knowledge and good practices and build capacity.** There is an important lack of expertise and technical capacity to implement measures promoting accessibility and inclusion. In order to increase the involvement and commitment of government departments, capacity building is needed particularly among the government itself and building professionals such as architects, engineers, urban planners and managers.
- 5) **Improve research and data to monitor, evaluate and strengthen urban development to be more accessible and inclusive for persons with disabilities.** Conduct further research on the needs of persons with disabilities in cities and communities in the local context, including through data disaggregation by disability, sex, age, income, and status of housing, and monitor and evaluate regularly. Collect and disseminate data on the challenges faced by persons with disabilities in accessibility of housing, public spaces and transport, as well as on the affordability of adequate housing.

L. Building resilience of persons with disabilities and reducing their exposure to and impact from climate-related hazards and other shocks and disasters (SDGs 1.5, 11.5 and 13)

Persons with disabilities are particularly vulnerable during natural disasters, in conflict, extreme climate events and humanitarian emergencies. Barriers to their full participation in society prior to disasters and other emergencies, including inaccessibility of the physical environment, tend to be exacerbated by natural disasters and conflicts. Failure to consult with persons with disabilities and their representative organizations in the development of plans to respond to emergency situations means that these obstacles will remain in case of emergency. The exacerbated risks faced by persons with disabilities are widely acknowledged, but not adequately addressed. Moreover, disasters and humanitarian crises contribute to an increase of persons with impairments,^{820,821,822} a factor that needs to be considered in planning for disability-inclusive disaster responses.

This chapter presents international normative frameworks covering the protection of persons with disabilities in emergency situations such as natural disasters and conflicts, provides an overview of the status of the inclusion of persons with disabilities in disaster risk reduction and humanitarian actions, and outlines good practices and measures taken by countries in addressing the needs of persons with disabilities in such crises.

International normative frameworks on disability-inclusive disaster risk reduction

The cross-cutting nature of disaster risk reduction is mainstreamed in the SDGs, notably in the context of ending poverty through building resilience of the poor and those in vulnerable situations for climate-related extreme events (SDG 1.5), making human settlements sustainable and inclusive through ensuring the protection of people in vulnerable situations from disasters (SDG 11.5), and combating climate change through enhancing capacities for effective climate change-related planning and management with a focus on marginalized communities (SDG 13.b).

The Convention on the Rights of Persons with Disabilities (CRPD) recognizes that the rights of persons with disabilities are particularly exposed in situations of emergency, and it provides a framework to guide preparedness, response and recovery efforts in climate events and conflict situations. CRPD includes a specific provision (Article 11) that recognizes that situations of risk and humanitarian emergencies pose serious challenges to persons with disabilities and their rights. Article 11 of the CRPD reinforces and specifies States' obligations under international humanitarian law to ensure the protection and safety of persons with disabilities in situations of risk, including armed conflict, humanitarian emergencies and natural disasters.⁸²³ Several of the substantive articles are relevant to the protection of persons with disabilities in situations of conflict and emergencies as, for example, the right to access to justice (Article 13), to ensure

that persons with disabilities are protected in the situations of risk, conflict, and humanitarian emergencies, that they can live free from violence and abuse (Article 16) in such situations, the right to live independently and be included in the community (Article 19) for example in shelters, habilitation and rehabilitation (Article 26) as well as the right to an adequate standard of living and social protection (Article 28) including the right to access to food, water, and shelter particularly in post-conflict and/or post-disaster recovery and reconstruction, the need for statistics and data (Article 31) to understand the situation of persons with disabilities in the humanitarian situations, awareness-raising (Article 8) for stakeholders to ensure disability-inclusive disaster risk reduction and humanitarian actions, and national monitoring and implementation mechanisms (Article 33), including focal points in governments, coordination mechanisms and national human rights institutions, to involve all important actors in preparation, response and recovery efforts.

Another disability-focused agreement, the outcome document of the high-level meeting of the UN General Assembly on 'The realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond', which was adopted in 2013, specifically urges Member States to take actions "to continue to strengthen the inclusion of and focus on the needs of persons with disabilities in humanitarian programming and response, and include accessibility and rehabilitation as essential components in all aspects and stages of humanitarian response, inter alia, by strengthening preparedness and disaster risk reduction".⁸²⁴ Relatedly, the Charter on Inclusion of Persons with Disabilities in Humanitarian Action (2016) developed for the World Humanitarian Summit held in 2016 and endorsed by many states and stakeholders commits to "strive to ensure that services and humanitarian assistance are equally available for and accessible to all persons with disabilities, and guarantee the availability, affordability and access to specialized services, including assistive technology in the short, medium and long term".⁸²⁵

The inclusion of persons with disabilities is also emphasised in the context of combating climate change and disaster risk reduction. The Paris Agreement (2015) of the United Nations Framework Convention on Climate Change notes that parties should respect, promote and consider their respective obligations on human rights including the rights of persons with disabilities when taking actions to address climate change.⁸²⁶ The Sendai Framework for Disaster Risk Reduction 2015-2030 adopts a rights-based sustainable development agenda that calls for accessibility and the inclusion of persons with disabilities in disaster risk reduction policies, all stages of disaster risk reduction planning, and data disaggregation by disability.⁸²⁷ Similarly, the importance of strengthening the contingency planning and provisions for disaster preparedness and response, emergency relief and population evacuation for persons with disabilities was emphasized in the SIDS Accelerated Modalities of Action (SAMOA) Pathway, which also acknowledged the importance of engaging a broad range of stakeholders including persons with disabilities in the context of climate change.⁸²⁸

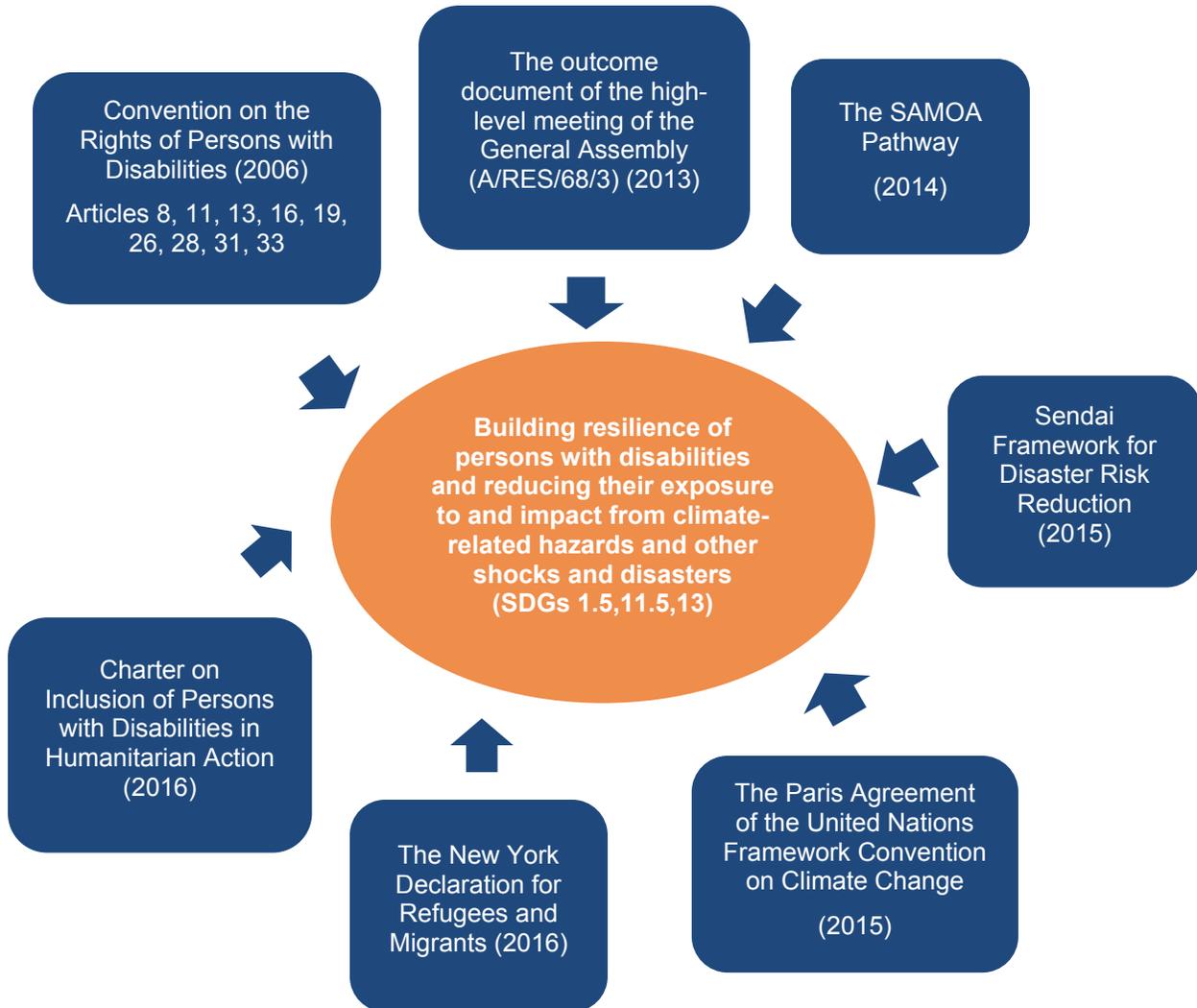
The New York Declaration for Refugees and Migrants (2016) and the recently negotiated Global Compact

for Safe, Orderly and Regularly Migration (2018)⁸²⁹ represent an elevated commitment by Member States to strengthen and enhance mechanisms to protect people who are forced to migrate due to conflict and/or humanitarian crisis. The Declaration commits to address the special needs of people in vulnerable situation including refugees and migrants with disabilities and calls for identification of specific assistance needs and protection arrangements for them.⁸³⁰ The final draft of the Global Compact rests on the Convention on the Rights of Persons with Disabilities, among other international norms, and in objective 7 calls for action to review relevant policies and practices to ensure they do not create, exacerbate or unintentionally increase vulnerabilities of migrants, including by applying a disability-responsive approach. It also makes calls to “establish comprehensive policies and develop partnerships that provide migrants in a situation of vulnerability, with necessary support at all stages of migration, through identification and assistance, in particular in cases related to persons with disabilities.⁸³¹ The Compact, in its objective 15 requires States to enact laws and take measures to ensure that basic services delivery does not amount to discrimination against migrants on the ground of disability and calls for establishing and strengthening holistic and easily accessible service points at local level that are migrants inclusive and offer relevant information on basic services in a disability responsive manner;⁸³² and in its objective 20, regarding transfer of remittances, it calls for opening up distribution channels to underserved population including for persons with disabilities.⁸³³

Box 9. Regional initiatives on disaster risk reduction and management for persons with disabilities

At the regional level, the European Commission developed the Action Plan on the Sendai Framework for Disaster Risk Reduction 2015-2030 (2016) that outlines priority actions including developing specific strategies for risk awareness and establishing urban resilience policy and practices that address the specific needs of persons with disabilities.⁸³⁴ The Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific (2012), Goal 7 calls for the inclusion of persons with disabilities in disaster risk reduction planning and strengthening the implementation of measures in support of persons with disabilities in responding to disasters.⁸³⁵ The Pacific Framework for the Rights of Persons with Disabilities 2016-2025 has a stand-alone goal on disaster risk management that aims to address the needs of persons with disabilities in all national climate change adaptation strategies and disaster risk management plans and legal framework as well as in post-disaster assessments.⁸³⁶ Furthermore, regional ministerial conferences on disaster risk reduction in Asia and the Pacific,⁸³⁷ the Americas,⁸³⁸ Africa,⁸³⁹ and Europe⁸⁴⁰ included disability in their outcome documents paving the way towards a disability-inclusive disaster risk reduction.

Figure II.124. International normative frameworks relevant for the achievement of SDGs 1, 11, 13 for persons with disabilities.



Situation of persons with disabilities in shocks, disasters and other emergencies

Among the 49 States that submitted a national report to the CRPD and reported on CRPD Article 11, eleven States have only generic emergency planning and no specific emergency plans for persons with disabilities.⁸⁴¹ In addition to the lack of national of emergency plans sensitive to persons with disabilities, on a personal level, available evidence indicates that many persons with disabilities remain unprepared in the eventuality of a disaster. A global survey⁸⁴² conducted in 2013 in 137 countries showed that 72% of persons with disabilities surveyed had no personal preparedness plan for disasters; 31% of them always have someone to help them evacuate but 13% did not had anyone to assist them. Only 21% answered that they could evacuate immediately without difficulty in the event of a sudden disaster; while 73% would face certain difficulty and 6% would not be able to evacuate at all. If given sufficient time, the percentage of those who could evacuate with no difficulty increased from 21 % to 38%. However, 58% felt they would still have difficulty while 4% would not be able to evacuate at all. In addition, only 17% of respondents were aware of a disaster management plan in their community.

The same survey also indicated that persons with disabilities remained alienated from emergency and disaster response planning. As few as 14% persons with disabilities said they had been consulted on disaster management plan in their community, although half of respondents expressed a wish to participate in community disaster management.

When conflicts, disasters or other humanitarian crises hit, persons with disabilities face higher risks and are disproportionately affected compared to persons without disabilities. Persons with disabilities may not be able to escape the situation and be left behind to fend for themselves.⁸⁴³ They may experience more obstacles in evacuating, because of lack of accessible transportation or accessible shelters, or not receive warnings in a format accessible for them.⁸⁴⁴ In particular, persons with psychosocial disabilities or intellectual impairments may be more adversely affected. For example, during the 2011 Japan earthquake and tsunami, the death rate among persons with disabilities was twice the death rate of the rest of the population.^{845,846} In the United States, studies found that, in the aftermath of three hurricanes, evacuation rates were 9% to 25% lower among households that had a member of the family with disabilities, compared to households that did not have a family member with disabilities.⁸⁴⁷

Moreover, the needs of persons with disabilities are often overlooked in the aftermath of disasters, especially during evacuations or in the early phases of humanitarian emergencies, and persons with disabilities may face additional barriers to accessing services and assistance, including rehabilitation and assistive devices.^{848, 849} In some countries, less than half of the emergency and disaster relief sites are accessible for persons with disabilities.⁸⁵⁰ Persons with disabilities may also encounter physical barriers in accessing basic services, like safe drinking water and sanitation, during evacuation. There is also a potential for more discrimination on the basis of disability when basic services and resources are limited. In Haiti, in the aftermath of the earthquake rehabilitation services were insufficient and faced increased

demand due to injuries resulting from the disaster.⁸⁵¹ In Jordan, in spite of stated policies that refugee children should have access to education, very few refugee children were found to be attending school – much less those with disabilities.⁸⁵²

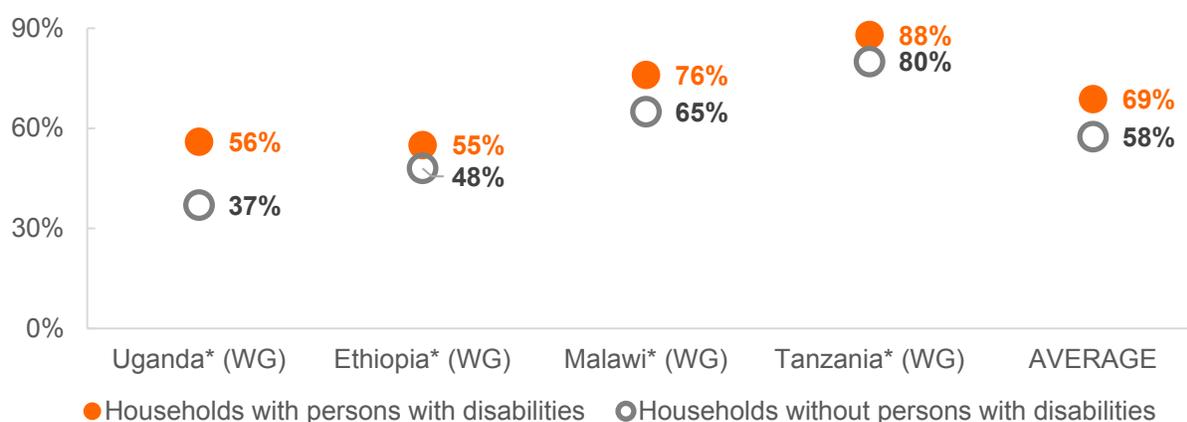
Moreover, because of poor identification and registration of persons with disabilities in humanitarian contexts, they are often under-identified, compromising the possibility to identify and address barriers to accessing assistance. For example, under-identification of disabilities is common among refugees because the identification process is often based on self-identification or the perception of the officer registering the refugee. In some settings, individuals are reluctant to self-identify to avoid stigma. Officers tend to only record visible disabilities. Therefore, sensory and mental disabilities are less likely to be identified than physical disabilities.⁸⁵³ Additional challenges to identification include isolation of persons with disabilities in the home and lack of staff awareness and knowledge of tools for identification.⁸⁵⁴

Persons with disabilities, particularly women, children and older persons with disabilities, are also be more vulnerable to exploitation, violence, physical, sexual and emotional abuse in the aftermath humanitarian crises, particularly refugees with disabilities,^{855,856} Persons with disabilities who are forced to leave their countries, and those who are internally displaced, have particular protection needs and experience multiple and intersecting forms of discrimination, both on the basis of disability and refugee/internally displaced status. Stigma faced by refugees and asylum seekers with disabilities is often compounded by experiences of xenophobia, racial discrimination and intolerance, further undermining dignity and equality⁸⁵⁷ as well as increasing risk of violence and abuse and limiting access to community support networks⁸⁵⁸.

The needs of persons with disabilities sometimes continue to be excluded over the more long-term recovery and reconstruction efforts.⁸⁵⁹

Furthermore, shocks - either environmental, like a major natural disaster, or financial, like death of the main bread winner, illness of family member or loss of a job - can have a considerable negative impact on households with persons with disabilities. They can lead to a decrease in income and assets as well as to a reduction in food production, food stocks or food purchases. Figure II.125 shows that in four sub-Saharan countries around 2011, on average, a higher proportion of households with persons with disabilities (69%) are negatively affected by shocks than households without persons with disabilities (58%). In all four countries, the majority of the households of persons with disabilities indicated being negatively affected by a recent shock, from 55% in Ethiopia to 88% in Tanzania. The highest gap between households with and without persons with disabilities is observed in Uganda, where 56% of households with persons with disabilities compared to 37% of households without persons with disabilities indicate a negative impact from a recent disaster.

Figure II.125. Percentage of households, with and without persons with disabilities, affected negatively by a shock, in 4 countries, around 2011.



Note: Shocks include death, illness or loss of a non-farm job of a household member, drought, flood, landslides, avalanches and heavy rains preventing work. (WG) identifies countries with data collected using the Washington Group short set of questions. An asterisk (*) indicates that the difference is statistically significant at 10% or less.

Source: Mitra (2018).⁸⁶⁰

Current practices to address the needs of persons with disabilities in disasters and other emergencies

Some countries incorporated persons with disabilities in national policies, laws, and plans on humanitarian actions, for example, through considering the needs of persons with disabilities in preparedness and response in national disaster or crisis response plans,^{861,862} adopting legislation requiring the government to prioritize persons with disabilities in emergency activities (medical, housing and humanitarian assistance) in response to natural disasters,⁸⁶³ establishing measures and aid actions to search, rescue, evacuate and provide primary health care for persons with disabilities,⁸⁶⁴ and ensuring protection, rehabilitation care, recovery and re-integration into social life for victims of natural disaster through a children’s act that protects the rights and welfare of children including those with disabilities.⁸⁶⁵ Other measures taken focus on engaging persons with disabilities, for example by including representation of persons with disabilities in disaster management committees monitoring and coordinating the implementation of emergency relief operations,⁸⁶⁶ engaging persons with disabilities in disaster risk analysis and assessment⁸⁶⁷ as well as awareness raising activities on disability inclusive disaster risk reduction⁸⁶⁸ and in the inclusion of persons with disabilities in humanitarian emergencies.^{869,870} Training sessions for humanitarian actors on the needs of persons with disabilities are also becoming more common, and at times focus on women and girls with

disabilities.⁸⁷¹

Other initiatives have focused on post-disaster needs, by providing cash transfers for persons with disabilities in the aftermath of a disaster or humanitarian crises.⁸⁷² For example, in Nepal after the earthquake in 2015, a cash-transfer grant was established with disability as one of the five criteria for enrolment; and in the Syrian Arab Republic, a cash transfer initiative targeted specifically persons with disabilities.⁸⁷³ Efforts have also been made to take post-disaster reconstruction as an opportunity to improve accessibility of the physical environment. For example, in Nepal, accessibility standards were improved following the April 2015 earthquake.⁸⁷⁴

Measures have also been taken supporting refugees with disabilities in humanitarian situations, for example, through services connecting refugee women and girls with disabilities to service providers from the humanitarian and development sectors,⁸⁷⁵ and raising awareness of the needs and perspectives of refugees with disabilities in community events.⁸⁷⁶

Guidance on disability-inclusive humanitarian actions was developed, including the ones targeted for humanitarian actors engaging in assisting refugees with disabilities,^{877,878} a practical guidance on actions focused on the inclusion of children and adolescents with disabilities from preparation for and recovering from emergency situations,⁸⁷⁹ and a guidance note for health actors working in emergency and disaster risk management that highlights steps to be taken to support persons with disabilities in emergency situations.⁸⁸⁰

Conclusions and the way forward

The scarce data on persons with disabilities in disasters suggests that the majority of persons with disabilities have no personal preparedness plan for disasters; few of them would be able to evacuate immediately without difficulty in the event of a sudden disaster and even fewer are aware of a disaster management plan in their community. When a disaster or a humanitarian crises hits, persons with disabilities are often left behind in the evacuation and are more likely to die as a result. Moreover, many persons with disabilities in situations of conflict and forced displacement are exposed to discrimination, exploitation, and violence, and excluded from humanitarian assistance.

Measures and actions have been increasingly taken in various countries to protect and include persons with disabilities in disaster preparedness, response and in humanitarian actions, through promoting their inclusion in the process of disaster preparedness and response plans as well as in the recovery process and enhancing capacity building for humanitarian actors in addressing the needs of persons with disabilities, among others. However, gaps remain in fully addressing and including persons with disabilities in humanitarian situations. It is still commonly believed that generic emergency planning will meet the needs of all people, including persons with disabilities. States and key stakeholders in emerging planning often

do not recognize the importance of inclusion and how persons with disabilities are at a disadvantage to accessing services if their needs are not considered.

Persons with disabilities may have different needs during and after disasters, conflicts and climate related events, and these needs should be factored into disaster risk reduction planning, in disaster response and in humanitarian action. This has often been compromised by an unclear allocation of responsibility for the inclusion of persons with disabilities, and lack of disability awareness, among governments and humanitarian actors. Human rights and humanitarian principles can guide the work of governments and humanitarian actors. A growing body of general and disability-specific international normative frameworks on disaster-risk reduction and humanitarian action provides the basis to guide these actors in respecting, protecting and fulfilling the rights of persons with disabilities. Moreover, in disaster response and emergency situations, efforts must consider all SDGs to ensure that basic needs of persons with disabilities are met in such situations, such as access to water and sanitation (SDG 6) and healthcare services (SDG 3). There must also be greater recognition of the intersection between humanitarian, development and peace building efforts, and of strategies developed to reach affected persons with disabilities displaced within or outside the borders of their country, protect their rights and promote their inclusion, and truly “leave no one behind”.

The following steps can contribute to ensure disability-inclusive disaster risk reduction and response as well as disability-inclusive humanitarian action:

- 1) **Ensure that persons with disabilities, including women and children with disabilities, participate in decision-making processes and are active stakeholders at all stages of disaster response and humanitarian action from planning to implementation, evaluation and monitoring.** The best way to ensure that the needs of persons with disabilities will be addressed, to significantly reduce their vulnerability and to increase the effectiveness of Government response and recovery efforts, is to include persons with disabilities in all planning and programming phases. When governments consider disaster or humanitarian policies or legislations, or when a community is developing an evacuation plan, an early warning system, or making decisions to combat climate change, it is crucially important to include persons with disabilities. This is also the case for the reconstruction phase to build back better after crises devastate infrastructures and community systems. This will enable plans to be inclusive and accessible not only to persons with disabilities but also for older persons, children, pregnant women, those who got injuries or severe psychological stress, thus leaving no one behind.
- 2) **Ensure that the national policies and programmes include operational standards and indicators for the inclusion of persons with disabilities in emergency preparedness, planning and response.** Ensure standard operating procedures and operational manuals of agencies involved in humanitarian action have clear guidance on inclusion in emergency preparedness, planning and response for persons with disabilities.

- 3) **Ensure that emergency information, commodities, infrastructures and services are inclusive and available in accessible formats.** Universal design should be employed in all aspects of disaster risk reduction and humanitarian response. In relation to this, it should be noted that some people might require specialized services in humanitarian situations in addition to these mainstreaming efforts. It is necessary to map needs of specialized services and commodities and prepare together with persons with disabilities before crises arise.
- 4) **Mobilize adequate, timely and predictable resources to operationalise commitments for inclusive emergency preparedness and response,** including by close cooperation of States with private sector and civil society organizations.
- 5) **Raise-awareness amongst persons with disabilities on disaster management plan at the local level** and ensure that emergency information and services are inclusive and available in accessible format with the principle of universal design. It is also necessary to strengthen capacity of persons with disabilities in the area of disaster risk reduction and humanitarian response. It will contribute not only to self-protection and survival of persons with disabilities, but also promote persons with disabilities as a key contributor in those crisis situations. Persons with disabilities are expected to contribute to planning and implementing disaster risk reduction and humanitarian action by bringing in new or overlooked perspectives, and by helping others after crises hit.
- 6) **Enhance the capacities and knowledge of aid workers on the needs and strengths of persons with disabilities in humanitarian actions.** It is necessary to provide training on disability for all aid stakeholders at both policy and practice levels. Aid workers should understand perspectives, needs and strengths of persons with disabilities, which will prove useful in working for and with persons with disabilities in crises situations. The hiring of persons with disabilities by humanitarian actors should also be encouraged and not limited to projects directly addressed to support persons with disabilities in humanitarian crises.
- 7) **States should ensure all post crisis recovery efforts, including reconstruction and rebuilding, are inclusive of persons with disabilities,** including by applying the principles of universal design in all reconstruction and rebuilding programmes. Emphasis should be given to accessibility features during planning and reconstruction of infrastructure as well as public facilities and adopting accessible technologies and communication systems. Conflicts devastate infrastructures and community systems. Thus, consideration should be given to inclusion of persons with disabilities in peace building, and reconciliation processes, too.
- 8) **States should ensure protection mechanisms in emergency and post crisis contexts to recognize and respond to the heightened risk of persons with disabilities, particularly women and children with disabilities, to violence, abuse and exploitation.** Make adaptations to ensure

that gender-based violence prevention and response, as well as sexual and reproductive health services, are accessible to persons with disabilities, particularly women and girls with disabilities. Ensure that all health, legal, social, and other services that respond to violence, exploitation and abuse, are accessible to children and young persons with disabilities.

- 9) **Undertake evidence-based research and develop a data collection system on persons with disabilities relevant to conflicts and disasters.** Systematic analyses and reviews of country preparedness, resources and experiences related to disability-inclusive disaster risk reduction and humanitarian response should be carried out regularly. In particular, data collection should assess overall numbers and different needs of persons with disabilities in certain communities when a disaster risk reduction plan is developed. Disability registers of persons with disabilities who might require support in crisis situations should be developed so that local authorities can immediately respond to the needs of persons with disabilities in need. Once an emergency situation develops, data that describes the situation of persons with disabilities in disasters and conflict situations is needed. Rapid assessments after crises should include a disability perspective and develop a systematic way to evaluate magnitude and type of needs among persons with disabilities after conflicts or disasters. To assess the number of injuries and deaths among persons with disabilities is not sufficient. Using reliable data in all phases – before, during and after crises – while paying attention to key but neglected aspects such as how to utilize new technologies, such as cell phones and social media, is crucial. It is also important to share the knowledge and experience by and on persons with disabilities under the real disasters and conflicts.
- 10) **States should ensure accountability mechanisms at national level for acts or omissions** leading to discrimination and exclusion of persons with disabilities in the context of humanitarian action and disaster response.

M. Promoting peaceful and inclusive societies for sustainable development, providing access to justice and building effective, accountable and inclusive institutions at all levels for persons with disabilities (SDG 16)

SDG 16 sets ambitious targets to reduce all forms of violence, to ensure access to justice for all, to build effective, accountable and inclusive institutions and to ensure responsive, inclusive, accountable and representative decision-making leaving no one behind, among others. Yet, for persons with disabilities, various barriers continue to hinder access to justice, to information, to public services and to decision-making: discrimination and stigma, lack of access and of accessibility, limited representation of persons with disabilities in decision-making, insufficient legal protection and remaining discriminatory laws and policies, particularly electoral laws and laws regulating access to justice and to information. Negative attitudes from society also make persons with disabilities more vulnerable to violence.

This section will focus on issues covered by SDG 16 which are critical for the inclusion of persons with disabilities, namely reducing exposure to violence (SDG16.1 and SDG16.2); providing access to justice⁸⁸¹ (SDG16.3); making public institutions accountable and transparent (SDG16.6); making participation in the public decision-making process inclusive (SDG16.7); securing birth registration (16.9); and enhancing access to information (SDG16.10). Non-discriminatory laws and policies (SDG16.b) are addressed in the section on SDG 10 as they covered also under SDG target 10.3. In relation to the six SDG 16 targets covered here, each sub-section below will begin by presenting relevant international normative frameworks, present data and evidence depicting the situation of persons with disabilities, discuss current practices and conclude with recommendations in each of these areas.

Reduce all forms of violence against persons with disabilities and end abuse, exploitation, trafficking and all forms of violence against children with disabilities (SDG 16.1 and 16.2)

Interpersonal violence is responsible for the death of half a million people each year⁸⁸² and millions more suffer from non-fatal violence and associated negative consequences.⁸⁸³ Persons with disabilities are at an increased risk of interpersonal violence due to stigma and discrimination, exclusion from education and employment, communication barriers and a lack of social support.⁸⁸³

International normative frameworks on protecting persons with disabilities from violence

SDG 16.1 calls for reducing all forms of violence and related death rates everywhere and SDG 16.2 calls for ending abuse, exploitation, trafficking and all forms of violence against and torture of children. For persons with disabilities, achieving these two targets is in line with the Convention on the Rights of Persons with Disabilities, Article 16, which specifies that States Parties should take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and

outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects. Particular protections from violence against women and children with disabilities have been established in various frameworks addressing generally women and children. The Convention on the Rights of Child (CRC), adopted in 1989, has called for States Parties' action "to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse"⁸⁸⁴ The Beijing Declaration and Platform for Action (1995) has highlighted the important of the elimination of all forms of violence against women and girls.⁸⁸⁵ The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (the Palermo Protocol), adopted in 2000, called for prevention and protection of women and children from trafficking.⁸⁸⁶ The Rome Statute of the International Criminal Court,⁸⁸⁷ adopted in 1998, in Article 7(1)(g), classifies rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity" committed "as part of a widespread or systematic attack directed against any civilian population" as crimes against humanity.

The situation of persons with disabilities: exposure to violence

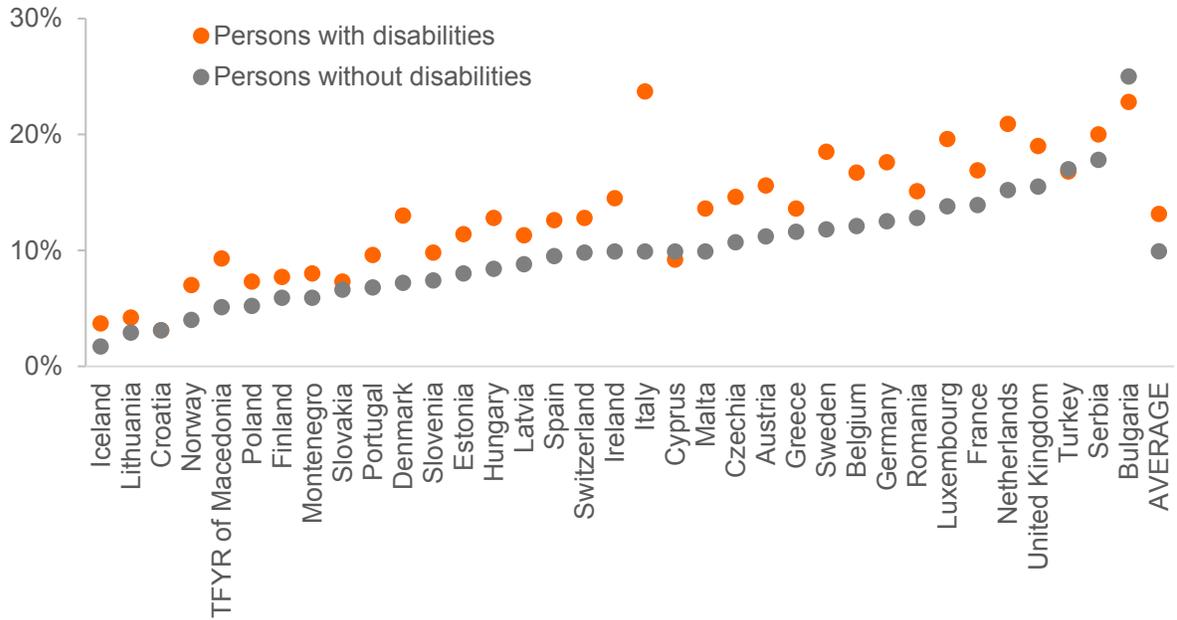
The interplay of individual, family-related, socioeconomic and structural factors has exposed persons with disabilities, especially children with disabilities, to the risks of abuse, exploitation, trafficking and violence. The societal attitude and stigma against persons with disabilities can easily influence the family and peer environment, and act as a trigger towards the acceptance of abuse, violence and exploitation.

In 35 countries, mostly in Europe, a higher percentage of persons with disabilities than persons without disabilities reports that crime, violence and vandalism are common in their accommodation or area of residence (Figure II.126). On average, 13% of persons with disabilities versus 10% persons without disabilities report so. In two countries, Iceland and Italy, the percentage of persons with disabilities experiencing this violent environment is more than twice than for persons without disabilities. Data from five developing countries (

Figure II.127) indicates that, on average, 21% persons with disabilities are beaten and scolded because of their disabilities, often by a family member (13%). From 14% of persons with disabilities in Botswana to 27% in Nepal suffer this type of violence. In Nepal, about three quarters of persons with disabilities who have been beaten or scolded indicated that the perpetrator was a family member; in the other 4 countries, more than half of them indicated so. A survey in Uganda, in 2016, indicated that both men and women with disabilities suffered physical violence at higher rates (60%) than their peers without disabilities (51%).⁸⁸⁸ In two countries in sub-Saharan Africa, about 7% of persons with disabilities reported that they had experienced violence because of their disability (

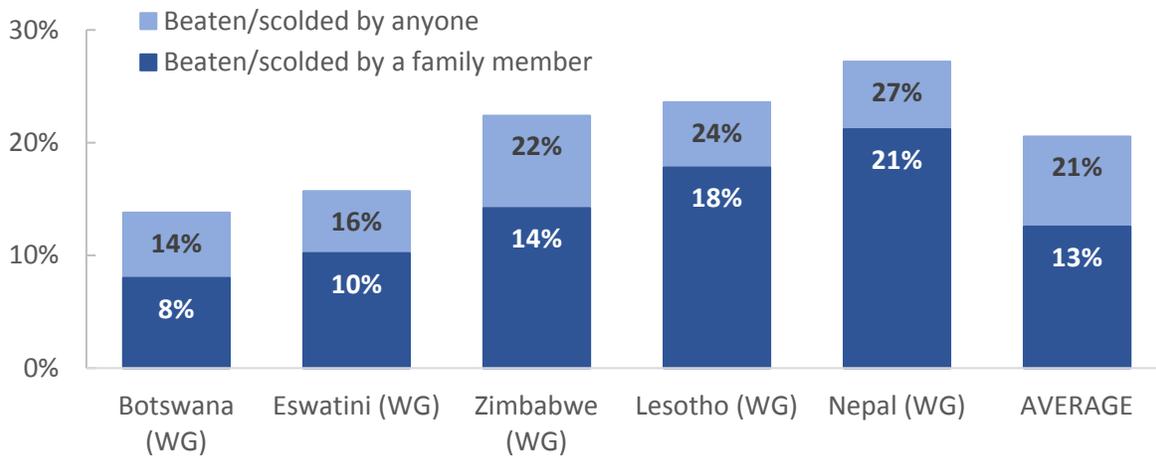
Figure II.128). Evidence suggests that persons with psychosocial disabilities experience even more violence: compared to persons without disabilities, while persons with disabilities are 1.5 times more likely to be a victim of violence, those with mental health conditions are at nearly four times the risk of experiencing violence.⁸⁸⁹

Figure II.126. Percentage of persons who report that crime, violence and vandalism are common in their accommodation or area of residence, by disability status,⁸⁹⁰ in 35 countries, in 2016.⁸⁹¹



Source: Eurostat.⁸¹

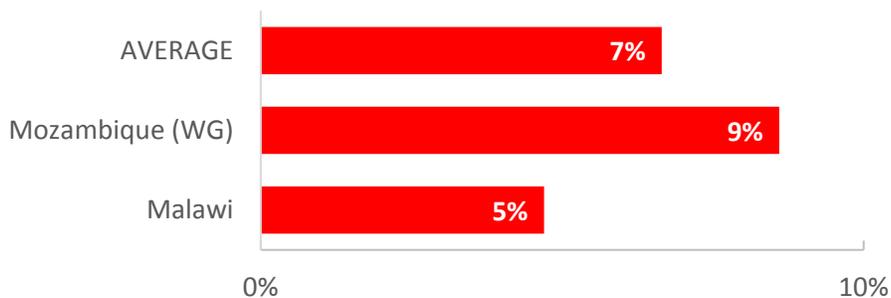
Figure II.127. Percentage of persons with disabilities who have ever been beaten or scolded because of their disability, in 4 countries, around 2010.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: SINTEF⁸⁹² and UNDESA.⁸⁹³

Figure II.128. Percentage of persons with disabilities who have ever experienced violence because of their disabilities, in 2 countries, around 2006.



Note: (WG) identifies data collected using the Washington Group short set of questions.

Source: SINTEF⁸⁹⁴ and UNDESA.⁸⁹⁵

Existing literature provides a wide range of the prevalence rates of violence against women with disabilities, yet it is widely agreed that women with disabilities are at a higher risk of suffering from sexual and physical abuse and violence.^{896,897,898} Based on available data from the 28 European countries, 34% of women with a health problem or disability had ever experienced physical or sexual violence by an intimate partner.⁸⁹⁹ Another study also indicated that women with physical disabilities experienced physical or sexual abuse for significantly longer durations than women without disabilities.⁹⁰⁰

In Uganda, in 2016, men with disabilities were almost three times more likely to have ever been victims of sexual violence than men without disabilities: 21% men with disabilities versus 8% of men without disabilities (Figure II.129). Adult men with disabilities suffered sexual violence in the last 12 months at much lower rates (6%) suggesting that sexual violence against men with disabilities may occur mostly in childhood. By contrast, the percentage of women with disabilities aged 15 to 49 who experienced sexual violence in the last 12 months is much higher, 22%, indicating that sexual violence is much more common in adulthood against women with disabilities than against men with disabilities. Women with disabilities were also the most likely to have ever experienced suffer sexual violence (34%).⁹⁰¹

For children with disabilities, they are almost four times as likely as their peers to suffer from physical violence and three times as likely to suffer from sexual violence⁹⁰². Children with mental or intellectual disabilities are five times more likely to be victims of sexual abuse than their peers without disabilities.⁹⁰³ Children in institutional settings are also more prone to physical, sexual and emotional abuse and this is exacerbated for children with disabilities.⁹⁰⁴ Data from 15 countries showed that severe physical punishment was more likely to be meted out by family members on children with disabilities in seven of these countries.⁹⁰⁵ Moreover, children with disabilities may be specifically targeted for abuse or exploitation because of disability. The cases where girls with learning or developmental disorders are involved in sexual exploitation as well as children with disabilities are exploited in child begging indicate that the traffickers take advantage of these vulnerabilities to involve the child in exploitative activities beyond his/her awareness, or to exploit prejudiced societal views toward disability.⁹⁰⁶ A study of children working in the sex industry in Thailand, for instance, found that some brothels purposively trafficked girls with hearing impairments under the assumption that they could not ask for help or communicate with others.⁹⁰⁷

Figure II.129. Percentage of persons aged 15 to 49 who have experienced sexual violence, at least once in their life time and in the past 12 months, by disability status and sex, in Uganda, in 2016.



Note: (WG) identifies data collected using the Washington Group short set of questions.

Source: DHS.

Current practices to protect persons with disabilities from violence

A wide range of initiatives have been taken in countries to reduce the abuse and violence against persons with disabilities and support victims with disabilities, from improving the personal safety of persons with disabilities and putting in place accessible forms of reporting violence to providing services to improve the skills of persons with disabilities to appear in court and provide evidence as a witness or expert.⁹⁰⁸ Examples include offering access to personal safety training for students with intellectual disabilities;⁹⁰⁹ providing a training programme to improve the personal safety of persons with little or no functional speech;⁹¹⁰ provision of “emergency call by fax” and “emergency call by email” system for persons with sensory disabilities to send an emergency message to police stations in case they are victims of a crime;⁹¹¹ offering training sessions for disability service providers, victim service organizations, and criminal justice agencies on sexual assault and domestic violence against persons with disabilities and on enhancing the quality of services to meet the needs of survivors with disabilities.⁹¹² Initiatives have also been taken to enhance access to justice by persons with disabilities, which will benefit all victims with disabilities (see sub-section below on SDG 16.3).

Conclusions and the way forward

Persons with disabilities, particularly children, women and those with intellectual disabilities, have higher exposure to violence due to stigma and discrimination. Measures taken to protect persons with disabilities from violence focus on violence prevention -- by empowering persons with disabilities through training -- to measures facilitating the reporting and legal persecution of violence against persons with disabilities. The following recommendations offer guidance on how to end abuse, exploitation, trafficking and all forms of violence against persons with disabilities, especially children with disabilities.

- 4) **Raise awareness at various levels**, among families and parent groups, service providers, policy makers and legislators. Public awareness and advocacy campaigns need to be targeted at changing mind-sets and social norms directed at persons with disabilities, especially children with disabilities.
- 5) **Offer trainings for persons with disabilities to enhance their knowledge on safety and ability to present themselves at police stations and in courts in an event of violence. The capacity of service providers of victims with disabilities should also be strengthened** to enhance the quality of services. All training and information should be provided in formats accessible to persons with disabilities.
- 6) **Establish mechanisms to report violence which are accessible for persons with disabilities** and provide appropriate and sufficient support to report violence. Accessible formats, sign language interpreters, services for victims with intellectual and mental disabilities should be established.

Ensure equal access to justice for all persons with disabilities (SDG 16.3)

Ensuring equal access to justice for persons with disabilities contributes to their legal empowerment, allowing them to be able to use the law, the legal system and legal services to protect and advance their rights and interests as citizens, contributing to a more inclusive and sustainable society. Equal access to justice for persons with disabilities is linked to their right to recognition everywhere as persons before the law and to the enjoyment of legal capacity.⁹¹³ However, access to justice remains elusive for many persons with disabilities due to environmental, financial and attitudinal barriers.

International normative framework on access to justice and disability

SDG 16.3 calls for ensuring equal access to justice for all. In the Convention on the Rights of Persons with Disabilities, Article 13 requires States Parties to ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations in all legal proceedings; and calls for the promotion of appropriate training for those working in the field of administration of justice. The right to recognition everywhere as persons before the

law and to the enjoyment of legal capacity are covered in the Convention on the Rights of Persons with Disabilities, in Article 12, which reaffirms that persons with disabilities have the right of recognition everywhere as persons before the law, guarantees the right to legal capacity for persons with disabilities, and requires States Parties to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. According to the General Comment No. 1 of the United Nations Committee on the Rights of Persons with Disabilities, 'equal recognition before the law', included in Article 12, requires governments to move away from substitute decision-making (in which a proxy makes legal decisions on behalf of the person with disabilities)⁹¹⁴ in favour of supported decision-making, in which persons with disabilities enjoy full recognition and equality under the law and can exercise their legal capacity to make legal decisions. ⁹¹⁵ In the supported decision-making paradigm, the individual receives support from a trusted individual, network of individuals or entity to make legal decisions.

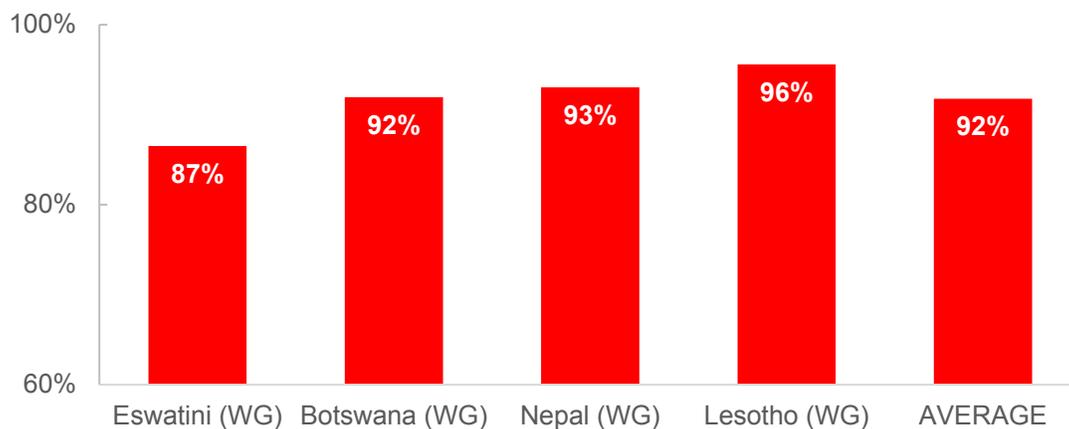
Situation of persons with disabilities in access to justice

For many persons with disabilities, access to justice remains a challenge. In 4 countries in 2012, on average, among persons with disabilities who needed legal advice, 92% of them were not able to receive it (Figure II.130). This unmet need for legal advice among persons with disabilities is very high in all four countries, varying from 87% in Eswatini to 96% in Lesotho. Many persons with disabilities face many obstacles to access education, and without education, persons with disabilities may lack the skills to seek legal advice. Lower education levels and barriers to employment also lead to less financial resources to meet the high costs of legal services. Those who are able to overcome these obstacles, and pursue to seek legal advice, will face further barriers. Lack of disability awareness among legal officers is an ongoing obstacle for persons with disabilities to enjoy equal access to justice. Moreover, legislation, legal information and documents are still not always disseminated in an accessible manner. Legal services, court rooms and police stations remain in many places inaccessible and lacking reasonable accommodations. In five developing countries, on average, 31% of persons with disabilities indicated that the courts and the police stations were not accessible (

Figure II.131). From about 15% of persons with disabilities in South Africa to about 45% of persons with disabilities in Lesotho experienced that lack of accessibility.

Equal access to justice for all including persons with disabilities cannot be achieved without their equal recognition before the law and the enjoyment of legal capacity. The Constitution is the cornerstone of a country's rule of law and the legal system for all the citizens. However, among the 193 UN Member States, four guarantee the rights of persons with disabilities in their Constitutions⁹¹⁶ but allow for exceptions if disability prevents persons from exercising his/her rights, thus compromising equal recognition before the law and the enjoyment of legal capacity.⁹¹⁷ In addition, upon ratification⁹¹⁸ of CRPD, another nine countries expressed restrictions on the enjoyment of legal capacity by all persons with disabilities: six countries declared that their understanding of Article 12 is to have both substituted and supported decision-making; and three countries declared to apply conditions or restrictions to legal capacity.⁹¹⁹

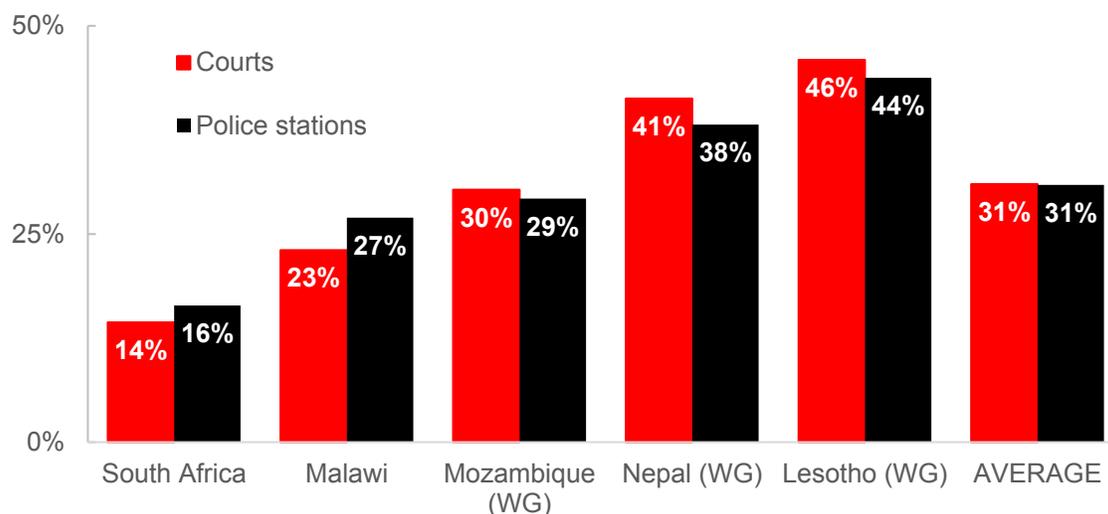
Figure II.130. Percentage of persons with disabilities who needed but were not able to receive legal advice, in 4 countries, around 2012.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions.

Source: SINTEF⁹²⁰ and UNDESA.⁹²¹

Figure II.131. Percentage of persons with disabilities who reported that magistrate's office/traditional courts and police stations are not accessible, in 5 countries, in 2004-2015.



Note: (WG) identifies countries with data collected using the Washington Group short set of questions. Data from South Africa was collected in selected regions of the country and is not nationally representative.

Source: SINTEF⁹²² and UNDESA.⁹²³

Current practices

More and more countries are adopting accessibility guidelines for public buildings (see section on SDG 10), an effort which would also benefit accessibility of courts and police stations. To further enhance accessibility of justice, beyond accessibility of the premises, some countries took the following initiatives: employment of sign language interpreters at courts for persons with disabilities who are identified as a survivor, witness or alleged offender; establishment of standby teams of disability experts;⁹²⁴ establishing services by special investigators and speech language pathologists in support of communications in investigations involving persons with disabilities particularly those with intellectual disabilities;⁹²⁵ and making summonses in easy language for persons with intellectual disabilities.⁹²⁶ To address financial barriers, in some countries, persons with disabilities benefit from exemptions from paying court fees.⁹²⁷ There are also initiatives from civil society to provide free legal advisory services and legal support for persons with disabilities.⁹²⁸

Many countries have incorporated substitute decision-making (e.g., guardianship) rather than supported decision-making in their legislation. But there are positive initiatives from some countries in favour of abolishing substitute decision-making in favour of supported decision-making for persons with disabilities. For example, Germany has ceased the application for full guardianship since 1992. In Sweden, a 'legal mentor' acts as the individual's agent with the individual's consent from Sweden and, at any point, the

individual may terminate the mentorship and therefore, the wishes of the individual are met at every stage of their decision-making.⁹²⁹

Conclusions and the way forward

Persons with disabilities face barriers to full access to justice due to inaccessibility of courts and police stations, of legal documents as well as lack of disability awareness of legal officers, and laws that limit their legal capacity and equal recognition before the law. Yet, persons with disabilities are at a higher risk of violence and discrimination and may have more needs for justice. Existing evidence from developing countries shows that most persons with disabilities who need to access legal services do not receive these services.

Measures to improve access to justice for persons with disabilities have been taken but other measures need to be targeted at citizens with disabilities: basic legal services provision, legal support and financial support with legal fees.

To achieve equal access to justice for persons with disabilities, the following actions must be included:

- 1) Make courts, police stations, and other legal services and documents fully accessible for persons with disabilities.** Ensure that facilities are physically accessible and legal documents are available in an accessible format. Provision of basic legal services and legal support should accommodate specific needs of citizens with disabilities. Countries can use opportunities like the construction or renovation of court buildings to improve accessibility as it is usually less costly than to undertake renovations only for accessibility. Accessibility of legal premises and documents should be addressed in a systemic way through national guidelines.
- 2) Empower persons with disabilities to exercise their legal rights and access justice.** Training should be offered to persons with disabilities on legal information and their legal rights to enhance their ability to exercise their rights. All training should be provided in accessible formats.
- 3) Raise-awareness of disability and offer disability-training amongst legal service providers and legal officers** on specific needs of persons with disabilities and how to strengthen the quality of the legal services for persons with disabilities. All training should be provided in accessible formats.
- 4) Promote supported decision-making and offer support for legal support services for persons with disabilities.** There is a lack of legislative framework and policy in most jurisdictions as guardianship law and practice continue to dominate. These laws and policies will need revision to move towards supported legal decision-making. Financial resources and capacity building will be needed to develop and maintain the supported decision-making model. It will be necessary to provide training and education as well as training for the service providers of legal support.

5) **Conduct studies on the factors behind the unmet need for legal services among persons with disabilities**, to identify the challenges and barriers that persons with disabilities experience when seeking justice.

6) **Use disability surveys to collect and disseminate data on the unmet need for legal services among persons with disabilities and on the accessibility of courts and police stations.** Disability surveys target the population of persons with disabilities and can be used to monitor unmet need for legal services and the percentage of persons with disabilities who reports that courts and police stations are not accessible. The number of persons with disabilities surveyed should be sufficiently high to allow for disaggregation by sex, age, ethnicity, and urban versus rural location.

Inclusive institutions and decision-making for persons with disabilities (SDG 16.6, SDG 16.7)

Achieving inclusive societies for sustainable development require public institutions at all levels to be inclusive, participatory and accountable for all, including for persons with disabilities, and societies where persons with disabilities participate equally in public decision-making at all levels.⁹³⁰ Yet, many public institutions remain inaccessible for persons with disabilities. And the rights to equal participation in decision making for persons with disabilities, more often, are not secured in the relevant laws and policies.

International normative framework

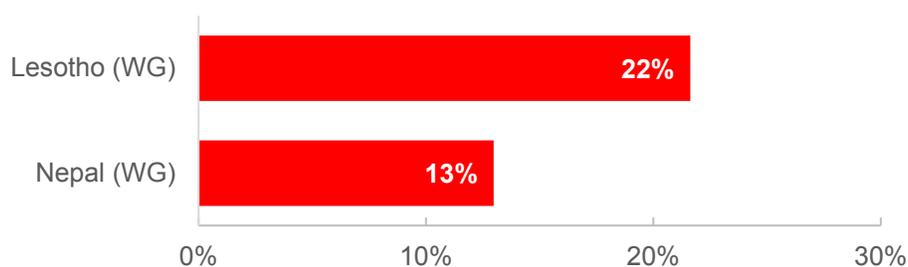
SDG 16.6 calls for effective, accountable and transparent institutions at all levels. SDG 16.7 calls for ensuring responsive, inclusive, participatory and representative decision-making at all levels. Inclusive-decision making is also one of the calls of the Convention on the Rights of Persons with Disabilities, whose Preamble encourages persons with disabilities to be actively involved in decision-making processes about policies and programmes, including those directly concerning them (paragraph (o)). In addition, Article 4 (paragraph 3) specifically require States Parties to closely consult with and actively involve persons with disabilities through their representative organizations in decision-making processes relating to persons with disabilities. Furthermore, Article 29 (paragraph (a)) stipulates that States should ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives.

The situation of public institutions and decision-making vis-à-vis inclusion of persons with disabilities

Inclusive institutions

To be inclusive and effective, institutions and their services need to be accessible for persons with disabilities. However, many public institutions remain inaccessible for persons with disabilities. For instance, in 15 countries in the Asia-Pacific region, the proportion of accessible government buildings in the national capital varies from 25 to 100 %.⁹³¹ Online services provided by public institutions are also often non-accessible for persons with disabilities. For example, in 2012, among the 193 UN Member States, online national governmental portals had features which were not accessible, especially for those with hand mobility and visual disabilities, in more than 60 % of these countries (for more details see section on SDG 9.c).⁹³² In 2018, among 28 countries, 7% of public libraries were not physically accessible, 16% did not offer accessible resources, and 34% did not have actual services dedicated to persons with disabilities.⁹³³ Moreover, apart from lack of accessibility, due to stigma and negative attitudes, persons with disabilities may also experience discrimination in public services. In two developing countries, around 2013, 13 to 22% of persons with disabilities reported being discriminated in public services (Figure II.132).

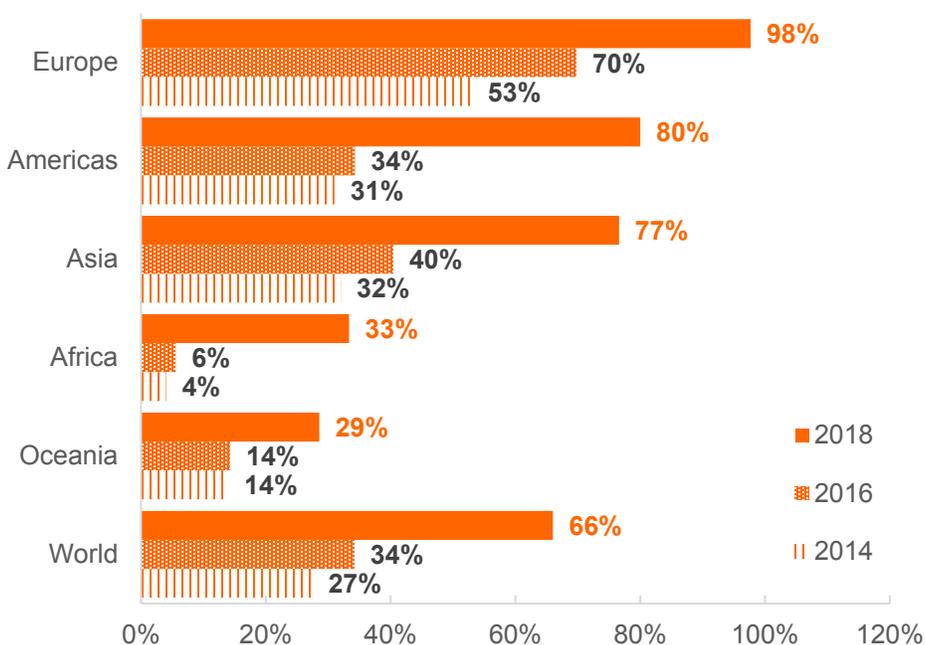
Figure II.132. Persons with disabilities who report being discriminated against in public services, in 2 countries, around 2013.



Source: SINTEF.^{934,935}

Countries have increasingly been investing in providing online government services for persons with disabilities (Figure II.133). In 2018, 66% of countries, up from 27% in 2014, had these services. As of 2018, most countries in Europe, the Americas and Asia had these services. In other regions, online services for persons with disabilities were not as common. In 2018, only 33% of the countries in Africa and 29% in Oceania had this service.

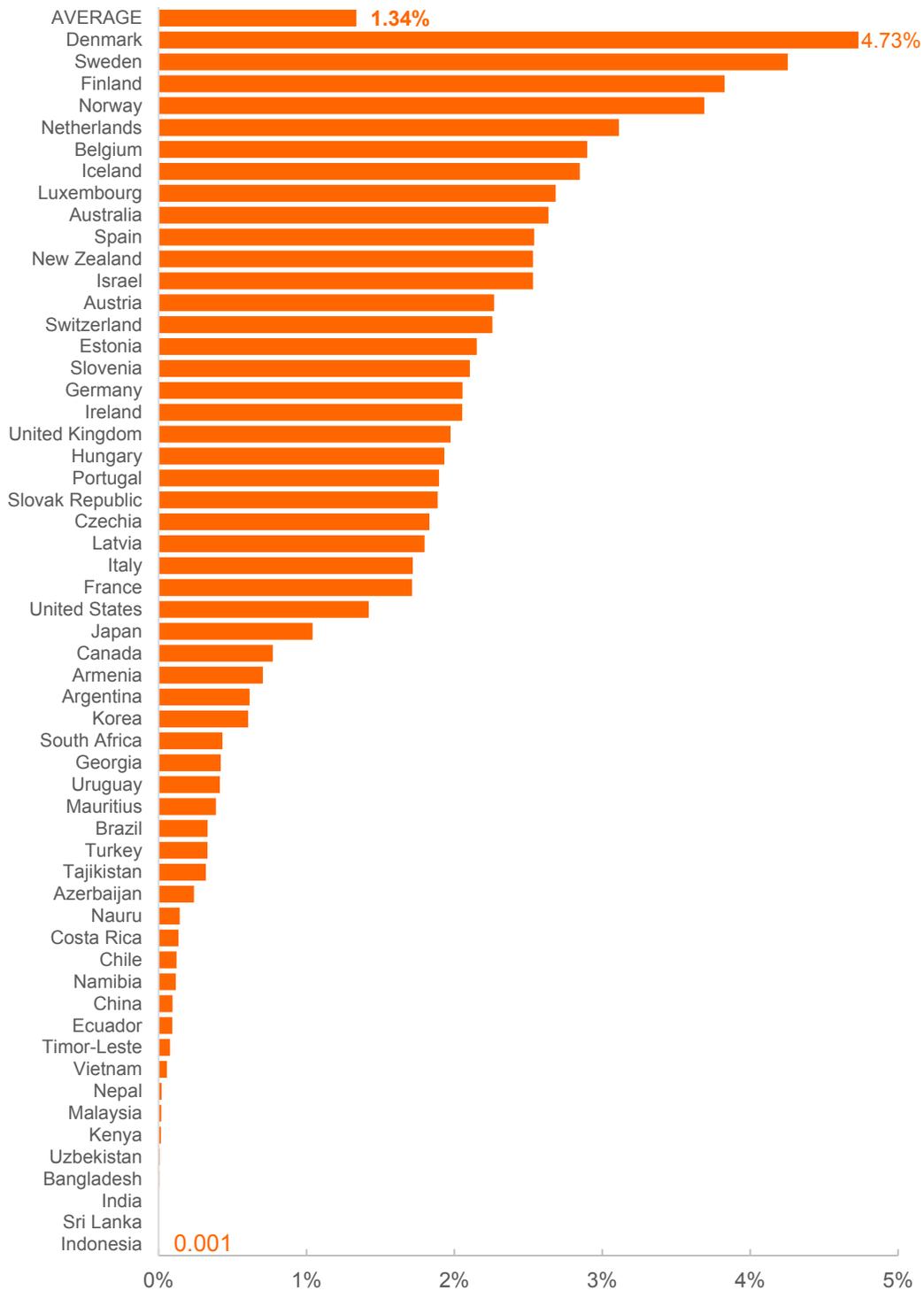
Figure II.133. Percentage of countries with online government services for persons with disabilities, in the world and by region, among 193 UN Member States, in 2014, 2016 and 2018.



Source: 2014, 2016 and 2018 United Nations E-Government Surveys.

Government spending on disability reflects a political commitment to promote an inclusive society in which persons with disabilities can fully participate. Government expenditures on disability can cover various public expenditures from making public buildings and services accessible for persons with disabilities to training public officers on disability to providing disability benefits. Data on these expenditures is not being tracked on a systematic level. However, data on public expenditures on disability benefits gives a snapshot, albeit partial, of the investments in disability services. Available data from 56 countries around 2014 indicates that public spending on social programmes for persons with disabilities is on average 1.34% of GDP, varying from 0.001% of GDP in Indonesia to 4.73% in Denmark (Figure II.134).

Figure II.134. Public spending on social programmes for persons with disabilities as a percentage of GDP, in 56 countries, around 2014.



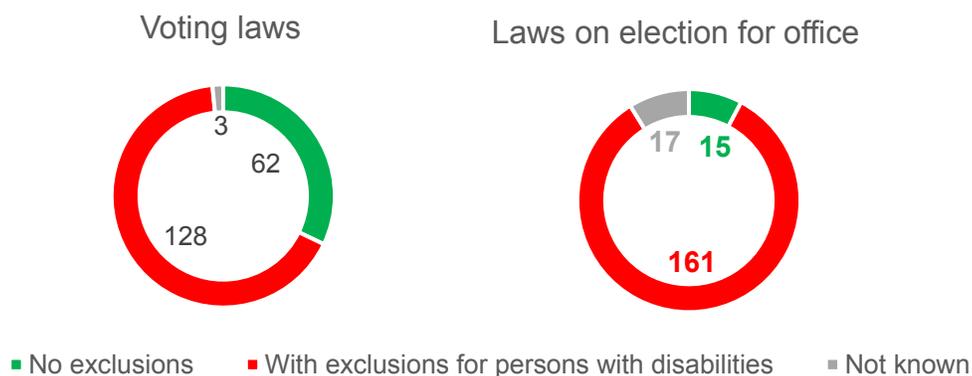
Source: OECD⁹³⁶ and Development Pathways.⁹³⁷

Inclusive decision-making

Persons with disabilities tend to be under-represented in decision-making bodies. Globally, the representation level of persons with disabilities in national legislative bodies remains low. In 2016-2017, in 21 countries in the Asia and the Pacific, for instance, in national parliaments, half had no parliamentarian with disabilities and in the other half parliamentarians with disabilities are, on average, only 2 % of all parliamentarians.⁹³⁸ Still in Asia and the Pacific, among 18 countries and territories, between 0 and 86% of representatives in national coordination mechanisms on disability matters are persons with disabilities. Persons with disabilities constitute more than 50% of these bodies in only two of these countries.

Wide participation in politics, including voting and being elected for office, is also key for inclusive decision-making. Yet, many persons with disabilities face obstacles when engaging politically. Restrictive electoral or voting laws are a concern across the world, particularly in terms of their frequent application to persons with intellectual or psychosocial disabilities, who are often deprived of the right to vote and to be elected for office. In addition, persons with disabilities are frequently denied their rights to political participation due to the institutional environments which directly exclude persons with disabilities due to the lack of accessibility or institutional prejudice or discrimination. Even when political rights are legally guaranteed for persons with disabilities, States limit the participations of individuals in these processes on the basis of disability directly or indirectly. Discrimination and lack of accessibility to information and public offices, for example, can undermine the ability of persons with disabilities to exercise their political rights.

Figure II.135. Number of UN Member States with exclusions for persons with disabilities in their legislation on voting and on election for office, 2018.



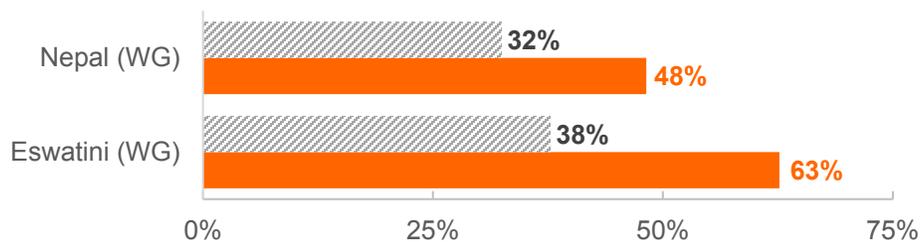
Source: UNDESA and International Foundation for Electoral Systems.⁹³⁹

In many countries, persons with disabilities have limited rights to vote and to be elected for office. Out of

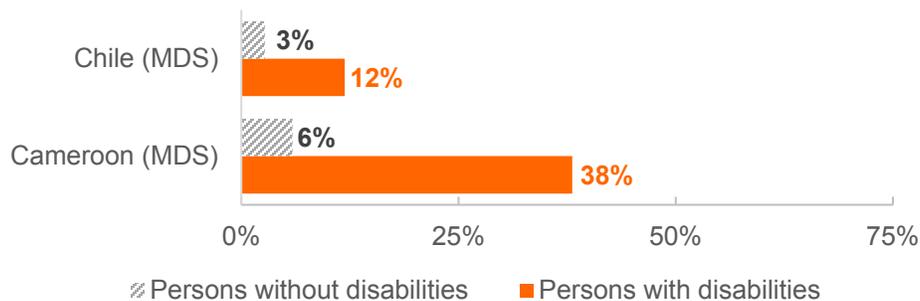
190 countries, 128 countries have exceptions in their constitutions, legislation, or laws, that could restrict the right to vote of persons with disabilities, out of which 94 countries have exclusions targeting persons with mental or intellectual disabilities. Only 62 countries give all citizens including persons with disabilities the right to vote with no exception. On the right of persons with disabilities to be elected for office, 161 out of 176 countries have exceptions, out of which 104 countries include exclusions targeting persons with mental or intellectual disabilities. Only 15 countries give all citizens including persons with disabilities the right to be elected for office without exception (Figure II.135).

Figure II.136. Percentage of persons who, in the last election, did not vote or found voting problematic, in 4 countries, around 2014.

(a) Did not vote in the last election



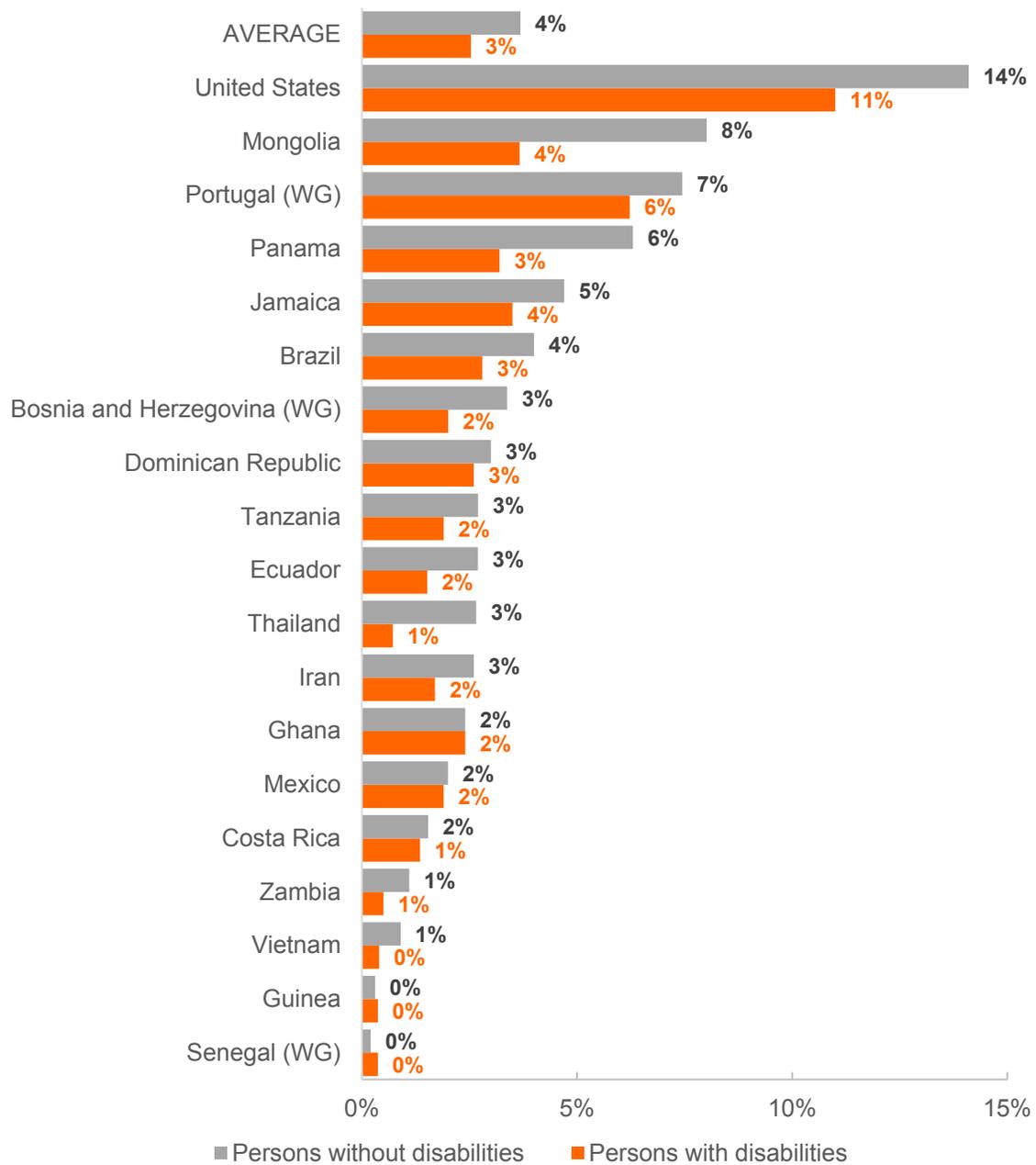
(b) Found voting in the last election problematic



Note: (WG) identifies countries with data collected using the Washington Group short set of questions; (MDS) identifies countries with data collected using the Model Disability Survey. All data refers to not accessible primary health care clinics, except MDS data which refers to hindering health facilities. Data from Cameroon was collected in selected regions and is not nationally representative.

Source: SINTEF⁹⁴⁰ and WHO.¹⁰⁷

Figure II.137. Percentage of employed persons aged 15 and over who work as legislators, senior officials and managers, by disability, in 19 countries, around 2010.



Source: IPUMS²³¹ and United Nations Statistics Division.

Voting is one of the most direct forms of political participation for citizens to exercise their political rights. But persons with disabilities have a lower participation rate in voting even in countries with a comprehensive disability act. The inaccessibility of polling stations has been an obstacle for persons with disabilities to exercise their right to vote. In 7 out of 13 capital cities in the Asia and the Pacific, less than 50% of polling stations were accessible⁹⁴¹ and in 2008 in the United States, only one in four polling stations was completely accessible.⁹⁴² Existing data from developing countries indicates that persons with disabilities are almost twice as likely to not have voted in the last election and more than 4 times as likely to have found voting in the last election problematic (Figure II.136). Typical obstacles reported by persons with disabilities in casting their ballots include difficulties in reading the ballot, waiting in line, finding and getting into the polling place, writing on the ballot and communicating with election officials.⁹⁴³

Many persons with disabilities face many obstacles in obtaining high-level decision-making roles, particularly due to negative attitudes. Among 19 countries, around 2010, persons with disabilities were less likely than persons without disabilities to hold a position as a legislator, a senior official and manager in 16 of these countries (Figure II.137).

Current practices

Public sector employment of persons with disabilities can promote inclusive and effective institutions by creating public institutions which reflect the perspectives of persons with disabilities. There are more than 90 countries with quota requirements for employment of persons with disabilities in the public sector, mostly ranging from 1 to 15%.⁹⁴⁴ In some countries, there are local accessibility policies for certain public buildings and services. For instance, among 28 countries, 43% of public libraries have a local policy on accessibility.

Some countries have constitutions, legislation, or laws in place to ensure that persons with disabilities with mobility difficulties and/or with visual impairment to vote as equally as others, for example, by allowing to vote from home, by mail or changing the polling station with notice in advance, and/or permitting someone to accompany the person to a poll station or to vote orally.⁹⁴⁵

Other measures taken to promote voting among persons with disabilities include carrying out accessibility assessments to identify and correct inaccessible polling stations, mobile voting in which voting equipment is brought to where persons with disabilities reside, training of election officials and poll workers on disability and accessibility, distributing voting information, campaign information and elections results in accessible formats, allowing voting by mail and eliminating discriminatory voting eligibility laws.^{946,947}

Positive measures have been taken in some countries to promote disability-inclusive decision-making, particularly, to ensure that the concerns and needs of persons with disabilities are effectively represented in their legislatures and government organs. In Uganda, for example, the Constitution requires that five national members of Parliament have personal experience with disabilities. The Local Government Act of

1997 provides for the election of one woman with a disability and one man with a disability in every a city division council, sub-country and district council, and two councillors with disabilities in each municipality and town, and the executive committee with the chairperson of the organisation for persons with disabilities in village and parish.⁹⁴⁸ Additionally, seats are reserved in the parliament for members who represent persons with disabilities in the country.⁹⁴⁹ In other countries, the executive may reserve a certain number of parliamentary seats and this policy has resulted in the presidential appointment of representatives with disabilities to parliament in Namibia.⁹⁵⁰ In South Africa, persons with disabilities can have representation through a commissioner in the national human rights commission.⁹⁵⁰

Conclusions and the way forward

Participation of persons with disabilities in decision-making processes is limited due to various barriers they face in the society, including discriminations and stigma. Many institutions are still not inclusive of persons with disabilities and in many places persons with disabilities are not allowed to participate in politics on an equal basis with others. For instance, persons with disabilities, particularly those with intellectual or psychosocial disabilities, are often deprived of legal capacity to vote or being elected for office due to unnecessarily restrictive laws.

Countries have been revising laws and policies to address these issues. One of the most widespread measures is the establishment of quota systems for employment of persons with disabilities in the public sector. Also, more and more countries have been providing online government services for persons with disabilities, although those are not always fully accessible for all persons with disabilities. National laws have also been formulated to ensure that more persons with disabilities can participate in voting by providing alternative voting methods, like electronic voting.

As essential steps towards effective, accountable and inclusive institutions at all levels for persons with disabilities and for inclusive decision-making, the actions below are recommended:

- 1) **Review existing national legal and policy frameworks on the political participation of persons with disabilities**, with a view to eliminate discriminatory laws on the rights of persons with disabilities, particularly those with intellectual and psychosocial disabilities, to vote or to participate in all aspects of political and public life. The Committee on the Rights of Persons with Disabilities recommended “the urgent adoption of legislative measures to ensure that persons with disabilities, including persons who are currently under guardianship or trusteeship, can exercise their right to vote and participate in public life, on an equal basis with others”. Engage persons with disabilities in the process of formulating these policies.
- 2) **Strengthen capacities of persons with disabilities to apply for public office**, including through series of training on legal rights and national constitutions, and mandating certain number of representation of persons with disabilities in legislatures and government organs.

- 3) **Ensure that public information on election and public services is accessible to persons with disabilities and reach out to households with persons with disabilities.** All public information should be provided in accessible format, for example, braille, easy-to-read and sign languages, amongst others.
- 4) **Make polling stations and public facilities physically accessible for persons with disabilities** and ensure that alternative methods of voting are available to accommodate various needs of voters with disabilities.

Provide legal identity to all children with disabilities, including birth registration (SDG 16.9)

Birth registration, the official recording of a child's birth by the government, establishes the existence of the child under law and provides the foundation for safeguarding many of the child's civil, political, economic, social and cultural rights. Due to stigma, families with children with disabilities sometimes fail to register them. This could have serious adverse implications for them in later years while accessing rights and entitlements.

International normative frameworks on disability and birth registration

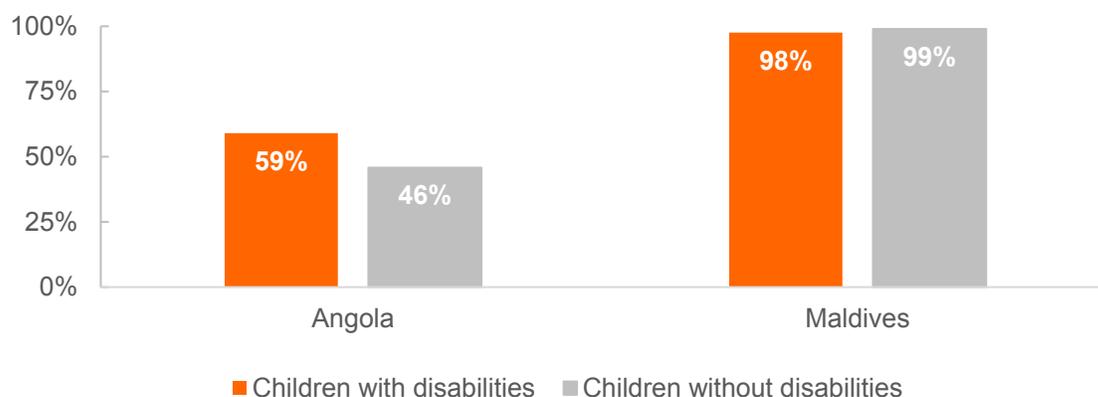
SDG 16.9 aims at providing legal identity to for all by 2030, including birth registration. Article 7 of the Convention on the Rights of the Child specifies that every child has the right to be registered at birth without any discrimination.

The situation of the birth registration of children with disabilities

Due to stigma and negative stereotypes, families sometimes opt to hide family members with disabilities and not register them at birth. Since these children tend to remain hidden, it is difficult to estimate the extent of the problem. There have been reports in some communities of 80 to 90 % of children with disabilities not having birth certificates.⁹⁵¹ However, other available data from two countries leads to different conclusions at national level. In the Maldives, in 2009, the birth registration coverage of children with and without disabilities aged 2 to 4 years of age were similar,⁹⁵² and in Angola in 2016, more children with disabilities below age 18 had been registered at birth than children without disabilities (

Figure II.138). A child may need to be registered to access services, which may be particularly important for the survival of children with disabilities, and this may act as an incentive for families to register children with disabilities. These findings should be interpreted with caution because if families are hiding and not registering children with disabilities, they are likely not reporting information about them when interviewed in surveys.

Figure II.138. Percentage of children with disabilities who have been registered at birth and who have a birth certificate, in two countries, around 2012.



Note: Data from Angola covers children under 18 years of age; data from the Maldives covers children 2 to 4 years of age.

Source: DHS.⁹⁵³

Current practices

Current practices in countries target birth registration of children with disabilities indirectly. Efforts commenced in countries to increase birth registrations, but these efforts usually target the population as a whole. A number of countries have taken measures to combating stigma and discrimination (see section on SDG 10), including by raising awareness on disability and by promoting the inclusion of persons with disabilities, addressing one of the key barriers to the registration of children with disabilities. Some countries have also been facilitating the process of registering a child at birth, namely by allowing registration by SMS.⁹⁵⁴ This could have the advantage for families to avoid stigma among officials in civil registration bureaus.

Conclusions and the way forward

Birth registration is needed to make children with disabilities visible and to empower them. In many countries, a birth certificate is needed to access school, education, justice and health services among others. Having a birth certificate also protects children with disabilities against early marriage (see section on SDG 5) and child labour. There is some evidence of children with disabilities not being registered at birth due to stigma in some communities, but there is also evidence that some countries have achieved similar or higher levels of birth registration among children with disabilities than among children without disabilities. Apart from combating stigma and negative attitudes towards persons with disabilities (see Chapter 2), to promote the registration of children with disabilities, the following targeted initiatives can be taken:

- 1) Promote studies that identify communities who experience barriers to register children with disabilities and target efforts towards these communities.
- 2) Support families with children with disabilities through community-based services and raise awareness among them of the importance of registering their birth.
- 3) Provide disability training for officers responsible for the civil registration process, both in civil registration offices and in health facilities, to combat negative attitudes towards disability.
- 4) Promote birth registration processes which are easier for families of children with disabilities, like remote birth registration.

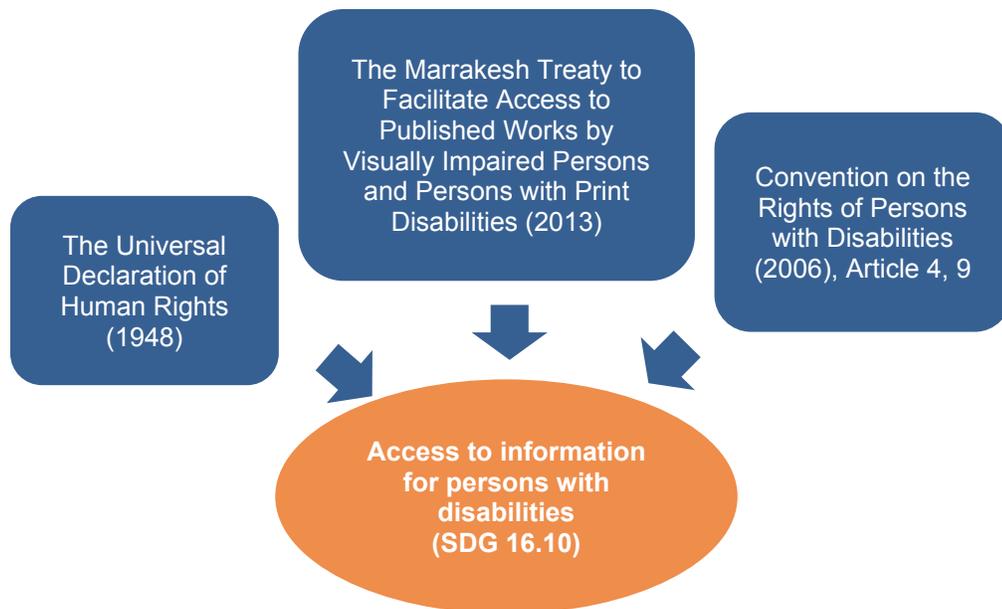
Access to information (SDG 16.10)

Access to information is the freedom or ability to identify, obtain and make use of data or information effectively. Information in our society is transmitted in various, through official and informal channels, in digital or hard formats. Access to public information is often regulated by national laws. For many persons with disabilities, accessing information is a path full of obstacles. Information is often not delivered in accessible formats or is stored in facilities which are not accessible for persons with disabilities.

International normative frameworks on access to information for persons with disabilities

The Universal Declaration of Human Rights establishes the right to seek and receive information.⁹⁵⁵ In line with this fundamental right, the Convention on the Rights of Persons with Disabilities, Article 4 on general obligations requires States Parties to provide accessible information to persons with disabilities as well as other forms of assistance, support services and facilities and Article 9 requires States Parties to take appropriate measures to ensure access to information and communications, including information and communications technologies and systems. Another important legal landmark is the Marrakesh Treaty to Facilitate Access to Published Works by Visually Impaired Persons and Persons with Print Disabilities (2013), which addressed the barriers that persons with visual impairments face to access published works in achieving equal opportunities in society and called for fostering the cross-border exchange of accessible format copies and make available information on policies and practices.⁹⁵⁶

Figure II.139. International normative frameworks relevant for the achievement of SDG 16.10 for persons with disabilities



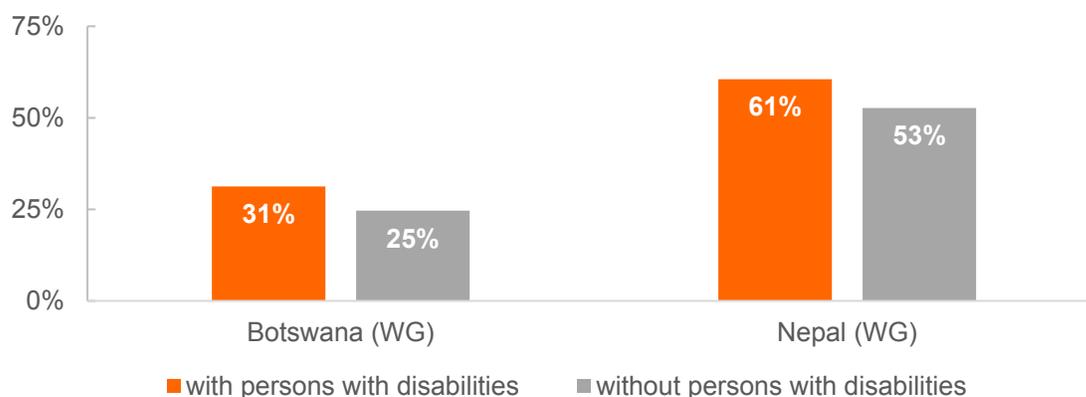
The situation of persons with disabilities in accessing information

Access to information is compromised if the media or the facilities to access information are not accessible. In 11 countries in Asia and the Pacific, the percentage of accessible TV news programmes varies from 1 % to 100 %.⁹⁵⁷ A survey of libraries in 28 countries, indicated that although 88 % are physically accessible, only 49 % have a local policy on accessibility and 63 % offer accessible resources.

Since households with persons with disabilities tend to have lower financial resources, information may be unaffordable to them which would result in lower access. For instance, in two countries around 2015, the percentage of households without access to newspapers was higher for households with persons with disabilities. The difference between the two types of households was 6 percentage points in Botswana and 8 percentage points in Nepal.

Lack of access to ICTs can also be a barrier to access information for persons with disabilities, as much information in our societies is conveyed digitally. Many ICTs are not affordable or not accessible for persons with disabilities (see section on SDG 9.c).

Figure II. 140. Percentage of households without access to newspapers, by households with and without disabilities, in 2 countries, around 2015.



Note: (WG) indicates surveys that used the Washington Group short set of questions.

Source: SINTEF⁹⁵⁸.

Current practices

Many countries adopt and implement constitutional, statutory and/or policy guarantees for public access to information.⁹⁵⁹ Access to public information is often covered in 'Freedom of Information Acts' (FOIA) secure access by the general public to data and information held by the government.⁹⁶⁰ In principle, FOIA grant this access, without discrimination on grounds of the applicant. However, only few countries emphasized the obligation of government officials to facilitate persons who are unable to make written requests due to disability, to seek the access to information.^{961,962} Governments are moving towards digital formats, or E-Government, ⁹⁶³ in making public information, services, records, and forums increasingly available online or electronically.⁹⁶⁴ For example the E-Government Act 2004 in Austria stipulates that measures should be taken to ensure that public websites comply with international standards for accessibility including access for persons with disabilities.⁹⁶⁵ To monitor policies on disability, a single, centralized national database of the socio-economic status of persons with disabilities and institutions engaged in their service was developed, along with an information system for assessment, planning, and implementation of national policies related to persons with disabilities.⁹⁶⁶

Other initiatives on promoting access to information include improving ICT skills for persons with disabilities (see section on SDG 9.c). Also, some countries have also move forward with guidelines and initiatives to make public media accessible (see also section on SDG 9.c).

Conclusions and the way forward

Persons with disabilities face a number of barriers in pursuing equal access to information. National laws on access to information do not always include the perspectives of persons with disabilities and lack accessibility provisions. Many countries adopt and implement 'Freedom of Information Acts' (FOIA), which secure access by the public to data and information held by the government. However, few countries have considered the needs of persons with disabilities in these acts, namely on the accessibility of information. Many providers of information are unaware of the needs of persons with disabilities and disseminate information in a non-accessible manner.

To enhance access to information for persons with disabilities, these issues need to be addressed namely by:

- 1) **Adopt guidelines on accessibility for providers of information, including for public offices and media**, to ensure the all information and informative services provided by government and by the media are accessible for persons with disabilities.
- 2) **Raise awareness of accessibility for persons with disabilities among public and media employees**. Train public employees on disability and accessibility to strengthen accessibility of the information disseminated. Training modules should discuss accessibility standards and available tools and methods that could be utilized for enhancing the accessibility of the information disseminated.
- 3) **Monitor and evaluate accessibility of information to persons with disabilities**. Conduct periodic surveys and collect feedback from persons with disabilities to understand the obstacles they face in accessing information. This can be done through survey inquiries about accessibility and affordability of information and informative services (like newspapers and TV programmes)

N. Increasing the availability of data disaggregated by disability (target 17.18)

SDG target 17.18 calls for, by 2020, enhanced capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated, *inter alia*, by disability.

This section provides an overview of international normative frameworks on data and statistics related to disability and presents tools that have been developed for the measurement of disability in data collection. This is followed by an overview of recent country level in data collection on disability, as well as on-going activities by various stakeholders at the international level to strengthen national capacity for official statistics on disability. The section concludes with the identification of strategies to enhance national capacity to meet data demands for disability inclusive development in the context of the Sustainable Development Goals.

International normative frameworks

The Convention on the Rights of Persons with Disabilities (CRPD) calls on States Parties to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies related to the Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights. States Parties are encouraged to disseminate the statistics and ensure their accessibility to persons with disabilities and others.⁹⁶⁷ Similarly, for follow-up and review of the 2030 Agenda for Sustainable Development, it is recognized that quality, accessible, timely and reliable disaggregated data will be needed to help with the measurement of progress and to ensure that no one is left behind as such data is key to decision-making.⁹⁶⁸ Through the 2030 Agenda, Member States have committed to enhancing capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by amongst others disability. The Small Island Developing States Accelerated Modalities of Action (SAMOA) Pathway also addresses the importance of improving the collection, analysis, dissemination and use of data disaggregated by disability in a systemic and coordinated manner at the national level.⁹⁶⁹

The conceptualization, definition and measurement of disability has achieved a milestone with the endorsement of the International Classification of Functioning, Disability and Health (ICF)⁹⁷⁰ by all WHO Member States in the 54th World Health Assembly in 2001 (resolution WHA 54.21⁹⁷¹). The ICF represents a breakthrough for collecting data on disability, moving beyond simply understanding disability as a direct consequence of a health condition or impairment, to recognising that disability results from the interaction between a health condition and the physical, human-built, attitudinal and socio-political environment.

In terms of methodological guidelines to collect disability data, in 2015, the United Nations Statistical

Commission adopted revised guidelines for the collection of disability data in national censuses.^{972,973} These guidelines present the recommendations of the Washington Group (see section below).

Current tools for the measurement of disability in data collection and status of their use in countries

This section presented currently available tools for the measurement of disability in data collection exercises, developed by the World Health Organization (WHO), by the Washington Group on Disability Statistics (WG) as well as by UN agencies in collaboration with the WG.

Tools developed by the World Health Organization for measuring disability

WHO currently supports member states to collect data on disability and functioning at the population level using the Model Disability Survey (MDS)⁹⁷⁴, a general population survey developed by WHO and the World Bank in 2012, in collaboration with a range of stakeholders from other international organisations, leading researchers, persons with disabilities and their collective organisations. The MDS is WHO's strategy to support its Member States in establishing and strengthening their monitoring and evaluation systems for disability – including information on needs and unmet needs, costs, barriers and quality of life. The MDS operationalises the ICF biopsychosocial model of disability, thereby acknowledging disability must be understood as what happens when a health condition plays out in an individual's environment and therefore cannot simply be inferred from the presence of the health condition or impairment. This gives a more complete understanding of the lived experience of disability and goes far beyond the understanding of disability as an individual attribute.

Data generated by the MDS can be used by countries to quantify both the impact of health conditions or impairments and the impact of diverse aspects of the environment on disability. This allows countries to determine which interventions at the individual and population levels, directed at the person or the environment, will likely produce the most benefit and to evaluate their impact over time. Additionally, a Brief MDS module was developed in 2016, following extensive analysis of data from pilot and national MDS datasets, consultations with international experts and engagement of persons with disabilities, to meet calls from Member States for a MDS version appropriate for integration in existing and regularly implemented household surveys, such as labour force or living standards and expenditure surveys.

Tools developed by the Washington Group on Disability Statistics for measuring disability

An outcome of the 2001 United Nations International Seminar on the Measurement of Disability⁹⁷⁵ was the formation of The Washington Group on Disability Statistics (WG), a group of representatives from national statistical agencies operating under the aegis of the United Nations Statistical Commission⁹⁷⁶, established to address the urgent need for improved and internationally comparable disability statistics. A major objective of the Washington Group is to provide basic necessary information on disability that is comparable

throughout the world. Countries participating in the Washington Group identified the need for a short set of questions for use in censuses and surveys as a priority. Washington Group questions are intended to provide comparable data cross-nationally for populations living in a variety of cultures with varying economic resources.

To date, the WG has developed a short set of questions (WG-SS) and an extended set (WG-ES) that can be added to censuses or surveys and, in collaboration with UNICEF, has developed a child functioning module (CFM).⁹⁷⁷ Also, in collaboration with UNICEF, a module on inclusive education is currently being tested to identify barriers to school participation for children with disabilities as is a module on inclusive employment, developed in collaboration with the International Labour Organization (ILO). An elaboration of the tools of the WG is provided below.

(i) Washington Group Short Set (WG-SS)

The WG-SS is a set of six questions that is intended to identify (in a census or survey format) persons with disabilities, namely those at greater risk than the general population for participation restrictions due to the presence of difficulties in six core functional domains, if appropriate accommodations are not made.⁹⁷⁸ The questions ask whether people have difficulty performing basic activities (walking, seeing, hearing, cognition, self-care and communication) and were originally designed for use on national censuses. Responses to each question are captured using four graded answer categories – no difficulty, some difficulty, a lot of difficulty or cannot do. The six questions and four answer categories allow for the calculation of estimates for the level of functioning within each domain or among different combination of domains.

(ii) Washington Group Extended Set (WG-ES)

Because the WG-SS was initially designed for inclusion in censuses, it was necessarily parsimonious and therefore identifies most, but not all, people with disabilities (in particular it was not designed to directly identify persons with psychosocial disabilities). The WG-ES includes domains that could not be included in the WG-SS, obtains more information on some domains than are provided by the WG-SS and obtains information on the use of mobility assistive devices in order to assess functioning. In addition to the six domains of the WG-SS, the WG-ES also includes the following functional domains: affect (anxiety and depression), pain, fatigue and upper body functioning. As with the WG-SS, the WG-ES questions have scaled response categories so that the level of functioning in each domain can be described. The domains can also be combined to create disability status indicators capturing different levels of difficulty in functioning.

(iii) Washington Group/UNICEF Child Functioning Module (CFM)

While the WG-SS questions can identify many children with functional difficulties, the Washington Group determined that a special set devoted to measuring child functioning was needed to improve and expand upon that identification, and to address the aspects of child development not addressed in previous

methods. To attend to the unique situation of children, the Washington Group therefore embarked upon the development of a separate module that would specifically address child functioning.

The questions of the Child Functioning Module⁹⁷⁹ follows the same principles as the WG-SS and WG-ES modules: to determine 'disability' through a series of questions on difficulty functioning that would place a child at risk of participation restrictions in a non-accommodating environment. The module is composed of two sub-modules: one for children 2-4 years of age; and another for children 5-17 years of age. Domains of functioning include: seeing, hearing, walking, communicating, learning and remembering, self-care (feeding and dressing), upper body functioning, behaviour, emotions (anxiety and depression), coping with change, focusing attention, playing and relationships.⁹⁸⁰

Where appropriate Child Functioning Module domains mirror those included in the WG-SS and WG-ES, but questions are formulated differently to be suitable for use on children. The child's mother or, if the mother is not alive or she is not living with the child, the primary caregiver is the recommended respondent for this module.

The module on child functioning was launched in October 2016 and is currently available in English, French, Spanish, Arabic, Russian, Chinese, Portuguese and Vietnamese. The module on child functioning as well as the WG-SS (for the population aged 18 and above) have been incorporated into UNICEF-supported Multiple Indicator Cluster Surveys (MICS).

(iv) UNICEF/Washington Group Module on Inclusive Education

To support the promotion of the right to education for children with disabilities through cross-nationally comparable data, UNICEF and the WG are working on the development of a survey Module on Inclusive Education to assess the school environment and participation. The purpose of this set of questions is to provide information that can inform policy, provide a statistical summary of environmental influences on participation in school, and identify key areas with bottlenecks that can be followed-up on. The questions focus on education through a formal mechanism (as opposed to home school or tutoring), and are designed to capture the interaction between the participant and the environment by obtaining parental responses to questions across three participatory domains.

The first set of questions, is intended for the general adult population, with the purpose of capturing attitudes towards education for all children, and specifically for children with disabilities. The second section is meant to be administered to caregivers of children who are attending school. It includes questions that evaluate the accessibility of the physical space, the curriculum, and other aspects of the school environment such as teachers' attendance, availability of toilet facilities, and access to social activities. The final component focuses on out-of-school children and attempts to gain a deeper understanding of the barriers to school participation, including safety, transportation, accessibility of the curriculum, and affordability.

Since 2013, the module has undergone several rounds of cognitive testing and revision, and is expected to be finalized in 2018.

(v) Washington Group/ILO module on disability and employment

Although there is strong policy interest in establishing and monitoring the effectiveness and impact of national legislation, programmes or policies to promote equal employment opportunity and treatment in employment for people with disabilities, comprehensive data on the employment situation of this population group is rarely available at the required level of detail and periodicity.

There is a need for more comprehensive information regarding labour force characteristics of persons with disabilities. Significant activities are needed to increase national capacity to venture into new data collection initiatives as well as to increase the frequency of data collection. Therefore, the Washington Group and the ILO collaborated to produce a new module on disability and employment for inclusion in labour force surveys. This module was designed to be as compact as possible while still being able to produce a useful set of indicators on disability and employment.

That module is currently undergoing cognitive testing and covers the following:

- (i) Disability identification – The WG-SS questions plus two additional questions on upper body mobility that focus on lifting and using one’s hands and fingers.
- (ii) Date of onset – The impact of disability on acquiring job skills and experience can depend significantly on when a person acquired a disability. It can also influence a person’s ability to adapt to their situation.
- (iii) Barriers – The module asks the respondent to identify all barriers – those related and unrelated to disability – that are limiting their work behavior, as well as identifying the most important barrier.
- (iv) Accommodations – Instead of asking if their workplace or schedules have been set up in a way to account for their difficulties, respondents are asked to identify if those accommodations are adequate (if needed).
- (v) Attitudes – Questions on attitudes are included because the support of family members can be critical in gaining employment for people with disabilities. Similarly, the attitudes of employers and co-workers are also important.
- (vi) Social Protection – Questions are included to determine if a person with disabilities is receiving cash or in-kind benefits related to their disability and how that corresponds with the onset of their disability.

National experiences in data collection on disability

This section presents some information on the experiences of several countries regarding the collection of data on disability.

In the 2010 census round,⁹⁸¹ among the 214 countries or areas that conducted a census, at least 120 included a set of questions on disability. The number of countries or areas that are collecting data on disability has progressively and significantly increased over census decades from a low of approximately 19 during the 1970 census round.⁹⁸²

A review of census questions shows differences among countries in the questions that are being asked to identify the population with disabilities during national censuses.⁹⁸³ Of the 120 countries that asked a question on disability in their censuses, 55 used questions that resemble those that are recommended by the Washington Group on Disability Statistics, while 65 used other types of questions. Within each of these two broad categories, there are still marked substantial differences among the countries in the questions that have been used in a variety of ways. These differences relate to the wording of the question(s), the terminology used, implied definition of the population to be identified, the number of items in the question(s), response categories, and the use of and wording of screener questions. the type of respondent, as well as the population covered in the collection of the data on disability (e.g., inclusion or exclusion of children). These all have implications for the quality and comparability of data among countries. The WG-SS has also been used in surveys in many countries and included in the Demographic and Health Surveys (see Box 10). The MDS has been implemented in national surveys in three countries in 2015 and 2016. Regional MDS surveys have been carried out in two countries in 2016 and 2017.

The experiences of countries show wide variations among regions in sources for the data on disability.⁹⁸⁴ For countries in Africa, South East Asia, the Caribbean, and the Arabic speaking countries, there is strong reliance on censuses to collect data on disability with only a few countries getting these data through sample surveys and administrative data sources. On the other hand, most of the countries in Latin America, as well as those in North and Central Asia and the Western Balkan States are using multiple sources (censuses, administrative records, surveys) to compile data on disability. There is also extensive use of administrative registers to generate disability statistics. In all the regions, however, there is recognition that this source of data on disability should be strengthened and better used.

Box 10. Operationalization of the WG-SS through the Demographic and Health Survey Program

The Demographic and Health Surveys (DHS) Program began in 1984 with more of a focus on demography, but over time, questions on health-related topics have been added. Questions on disability were first used in the 1993 Ghana DHS; since then at least 24 other surveys have used adaptations of Washington Group or MICS questions on disability, or country-specific questions with limited comparability. In 2015, The Demographic and Health Surveys (DHS) Program piloted and finalized an optional module of questions on disability,⁹⁸⁵ based on the Washington Group Short Set of questions. The DHS Program disability module is not included in surveys as a default, but can be added based on country interest. The module covers six core functional domains: seeing, hearing, communicating, remembering and concentrating, walking, and washing all over and dressing. It is included in the Household Questionnaire. The household respondent provides information on all household members and visitors who stayed in the household the night before the survey (de facto members) age 5 and above. There is a screening question for use of glasses or contact lenses, and an optional screening question on use of a hearing aid. Each person's level of difficulty in each domain is recorded as: no difficulty, some difficulty, a lot of difficulty, or cannot do at all.⁹⁸⁶ The final reports of surveys using the disability module provide tables on difficulty in the six domains among de facto household members age five and above. Following the Washington Group analysis recommendation, the prevalence of disability is presented as the percentage with a lot of difficulty or cannot do at all in at least one domain.

Ongoing capacity building activities

One of the main calls in SDG 17.18 is to support capacity building in developing countries in the collection of disability statistics. A number of stakeholders at the international level have been engaged in such work. Since mid-2016, UNSD, in collaboration with the Regional Commissions of the United Nations and other sub-regional organizations, has organized regional and sub-regional meetings⁹⁸⁷ on disability statistics and measurement in the context of the 2020 World Population and Housing Census Programme and the 2030 Agenda for Sustainable Development. The objectives of the regional meetings have been to review national experiences in disability measurement, including identifying challenges faced and lessons learnt during 2010 censuses; to discuss disability-related SDG indicators for monitoring progress towards inclusion of persons with disabilities in development programmes; and to share national experiences among participating countries and facilitate intra-regional cooperation aimed at enhancing national capacity in disability measurement and improving the quality of data for monitoring the SDGs.

WHO provides Member States with guidance and technical support throughout the implementation process of the MDS, with a strong focus on capacity-building strategies for national or regional statistical offices that oversee disability data collection and analyses.

The Washington Group has initiated regional and other workshops focused on the implementation of the Washington Group data collection tools and continues to provide assistance and advice through webinars and telephone and e-mail as required and requested.

In order to further promote an understanding of the key issues and priorities around the measurement of child disability, UNICEF, in collaboration with the Washington Group, developed a set of training materials to materials to support the delivery of technical workshops on the collection, analysis, interpretation and use of data on child disability. The workshops were tailored to a target audience comprising representatives from National Statistical Offices, organizations of persons with disabilities, government officials involved in disability measurement, UNICEF staff and academia.

UNSD, in collaboration with relevant stakeholders, is updating the United Nations *Principles and Guidelines for the Development of Disability Statistics*.⁹⁸⁸ The revised guidelines are intended to assist countries to better meet demands for good quality data for measuring and monitoring progress towards inclusion of persons with disabilities in development programmes while taking into account the context of the Convention on the Rights of Persons with Disabilities and the 2030 Agenda for Sustainable Development.

Conclusions and the way forward

The growing attention over recent decades of the international community and Governments to addressing the rights of persons with disabilities and to mainstreaming disability into national development agendas has included in an increase in national efforts to collect data on disability. National efforts to collect data on disability are expected to further increase as countries endeavour to generate fundamental information to support the evidence-based formulation of disability inclusive development policies and programmes, particularly in the context of the CRPD and the 2030 Agenda and to ensure that “no one is left behind”. At the same time, a number of organizations have been working to develop questions for use in censuses and sample surveys that are intended to provide standardized instruments to identify persons with disabilities for use by countries to measure disability. Also, the instruments that have been developed by the different organizations are not necessarily comparable in terms of content and approach.

To better serve the interests of the countries, it is important to note that the 2030 Agenda recognizes “that there are different approaches, visions, models and tools available to each country, in accordance with its national circumstances and priorities, to achieve sustainable development”. In this connection, it is important that the various stakeholders collaborate on how best to serve the interests of the countries as they endeavour to respond to the data demands for disability policy formulation and monitoring.

In many countries, there is also a need to establish a formal national coordination mechanism on data collection for all stakeholders with regard to the monitoring and reporting of disability data and of the SDGs. There is also a need for capacity development to increase the number of experts on disability statistics in

countries, who will have the knowledge and skill to collect, analyse, disseminate and utilize data on disability.⁹⁸⁹ It is important that the cooperation for capacity building envisaged by SDG target 17.18 therefore also address these institutional challenges.

To increase the availability of data disaggregated by disability, there is a need to:

- 1) **Continue building capacity in countries to collect, process, analyse and disseminate data disaggregated by disability.** This will require all relevant stakeholders at the international level working closely with their counterparts from the United Nations Regional Commissions and other regional entities to better serve the priorities of the different regions and countries therein.
- 2) **Regularly update international guidelines on the production of data disaggregated by disability.** The methodology for collecting disability data has been evolving. Regularly updated international guidelines assist all stakeholders involved in the collection and production of data.
- 3) **Invest in an international repository of disability data, compiling disability data at the country level.** A United Nations Disability Statistics Data Portal⁹⁹⁰ has been recently developed to disseminate country data on disability. This repository needs to be continuously updated and expanded to provide the necessary policy-relevant information to monitor progress towards the SDGs for persons with disabilities.

Chapter III. The way forward for disability-inclusive sustainable development

This report represents the first UN system wide effort to examine the situation of persons with disabilities vis-à-vis the 2030 Agenda for Sustainable Development and its Sustainable Development Goals, at the global level. The report has reviewed statistics, laws, policies and programmes, and identified good practices; and used this evidence to outline recommended actions to promote the implementation of the SDGs for persons with disabilities. The evidence included in this report indicates that persons with disabilities are still at a disadvantage compared with those without disabilities in the global, regional and national efforts towards the achievements of the SDGs. Despite the progress observed in laws and policies in line with the Convention on the Rights of Persons with Disabilities, progress in implementing such measures has been slow. Discriminatory laws are also still in place in many countries. To meet the SDGs by 2030, international and national development programmes will need to prioritize inclusive development. In particular, concrete action is needed to make persons with disabilities and their situations visible in policymaking and to build just and inclusive societies. This action should focus on four fronts: (1) addressing fundamental barriers causing exclusion of persons with disabilities; (2) mainstreaming disability in the implementation of the SDGs; (3) investing in monitoring and evaluation of progress towards the SDGs for persons with disabilities; and (4) strengthening the means of implementation of the SDGs for persons with disabilities.

1. Addressing fundamental barriers causing exclusion of persons with disabilities

The fundamental barriers causing the exclusion of persons with disabilities need to be urgently addressed: discriminatory laws and policies, lack of accessibility in physical and virtual environments, negative attitudes, stigma and discrimination, lack of access to assistive technology and to rehabilitation and lack of measures to promote independent living of persons with disabilities. Removing these barriers requires building capacity in countries. National legislation should protect the rights of persons with disabilities, either through constitutional, anti-discrimination or other national disability legislation. All national legal and policy frameworks should reflect the rights of persons with disabilities and be aligned with the Convention on the Rights of Persons with Disabilities, namely by eliminating discriminatory legislation and language. Accessibility is best pursued by means of regulations and guidelines at the community level and by thematic area, mandated by national laws and accountability mechanisms. Negative attitudes often result from a misunderstanding of disability and the potential of persons with disabilities as contributors to society. Gaining public awareness and understanding on disability is crucial to combat these stereotypes. Effective ways to combat negative stereotypes include awareness-raising campaigns, through the media and the education systems, as well as including persons with disabilities in public and social activities and in the mainstream education system.

2. Mainstreaming disability in the implementation of the SDGs

The report emphasized that in order to achieve the promise of the 2030 Agenda, disability must be mainstreamed into the implementation of all Sustainable Development Goals. Areas of particular importance for the realization of disability inclusive development include social protection (SDG 1.3), education (SDG 4), employment (SDG 8) and basic services, including healthcare services (SDG 3), water and sanitation (SDG 6), and energy (SDG 7). Accessible infrastructural development in urban and rural environments, public spaces, facilities and services (SDG11) is also of paramount importance to participation of persons with disabilities in all aspects of society and development. Progress in these areas can catalyse progress across all SDGs.

In designing and implementing social protection systems, States should ensure a flexible combination of income security and disability-related job support to promote the economic empowerment and employment of persons with disabilities. Social protection scheme should also take into account extra costs related to disability. It is also crucial that application processes be accessible, without discrimination and easy to understand for persons with disabilities. Discrimination remains a major barrier for access to employment, which must be addressed by States urgently, including through robust enforcement of policies and laws as well as disability awareness campaigns among employers. These campaigns should stress the value added of including persons with disabilities in a diversified and productive workforce.

Winning the war against poverty and inequality, and achieving the SDGs, requires increased investment in human capital. Equal access to education is essential and must be ensured. Inclusion of persons with disabilities into mainstream education should be promoted proactively. Schools and educational facilities as well as learning environments must be accessible and adapted for students with disabilities. Improving access to education for persons with disabilities is critical because educational disadvantage often leads to higher exposure to social exclusion and poverty, and therefore has a significant impact on capacity and opportunity to participate in society and development, particularly employment.

Having and maintaining good health is fundamental for achieving all SDGs, particularly for persons with disabilities who tend to need more medical attention. Increasing access to health for persons with disabilities requires accessible health services and training of health professionals on ways to adequately care for persons with disabilities.

Ensuring inclusive access to water and sanitation for person with disabilities requires accessible designs, including accessible toilets, water points, water carriers, bathing places and handwashing facilities. Access to energy is critical for persons with disabilities because many of them require electricity for use of assistive technology for independent living and participating in the society.

3. Investing in monitoring and evaluation of progress towards the SDGs for persons with disabilities

Further research and robust data and analysis are required to ensure that persons with disabilities occupy their rightful place in the SDG framework and its implementation, monitoring and evaluation. The lack of data and research on the situation of persons with disabilities severely constrains the international community from monitoring the situation of children, youths and adults with disabilities. Many relevant global and country indicators are still not disaggregated by disability status. Many countries collect data on disability, but the data remains unpublished. Countries should focus on establishing indicators to be collected and disseminated regularly to assess the situation of persons with disabilities and the challenges they face, including disability-specific indicators to capture progress in implementing policies and programmes aimed at their inclusion. Indicators should allow for the monitoring of the wellbeing of persons with disabilities in comparison to persons without disabilities, as well as of accessibility, including accessibility of physical and virtual environments. This monitoring exercise should engage persons with disabilities in the process.

In addition to disaggregating data by disability, *double-disaggregations* will be needed to achieve the SDGs for those who experience disadvantage based on more than one aspect of their identity, such as women and girls with disabilities. For example, data should be disaggregated by disability and sex to monitor girls and women with disabilities, by disability and age to monitor children and older persons with disabilities, by disability and income groups to monitor the poor with disabilities, by type of disability to monitor, among others, persons with psychosocial and intellectual disabilities, and by disability and social groups to include indigenous people with disabilities. Moreover, data should be collected on the extra costs associated with disability.

This report includes a number of indicators disaggregated by disability, in some cases in line with the SDG indicators. This demonstrates the feasibility of disaggregation of data by disability. However, greater political commitment and actions are required to scale up these efforts. To inform the development of disability-inclusive national policies and programmes, it is critical for disability disaggregation to become standard in all relevant monitoring systems of Governments and civil society organizations.

Studies on the impact of policies and programmes promoting disability inclusion are scarce. These studies will be needed to guide the implementation of the 2030 Agenda for persons with disabilities, in particular to help policy makers in designing new policies and in deciding to scale up, refine or discontinue existing policies. There are well-established methodologies to evaluate impacts of policy and the capacity of countries to use these impact-evaluation methodologies and interpret their findings should be built.

Given the increasing availability of data, including internationally comparable data, cross-country studies are becoming increasingly possible. Establishing an international repository of disability data, updated on a regular basis, combined with a regular assessment and report of progress for persons with disabilities towards the SDGs is necessary to better guide the efforts of the international community in implementing the 2030 Agenda for Sustainable Development. In addition, a global analysis of the impact of policies could

further assist countries in identifying good practices and policies for promoting disability inclusion. In order to improve accountability at the global level, the United Nations General Assembly and the Conference of States Parties to the CRPD could request regular global assessments of progress and Member States could use the voluntary national reviews for the High-Level Political Forum for Sustainable Development (HLPF) to conduct a joint assessment in this regard.

4. Strengthening the means of implementation of the SDGs for persons with disabilities

Finance

Adequate financial and other resources should be allocated to support (i) the enforcement of laws protecting the rights of persons with disabilities; (ii) the implementation of national disability policies and plans and (iii) the delivery of essential services to persons with disabilities. Effective mainstreaming of disability in development finance requires clear technical guidelines, robust partnerships between disability and sectoral experts and a system-wide obligation requiring results to be disaggregated by disability to avoid siloed approaches or disability being treated as an 'add on'.

Financing for sustainable development should be used to advance disability inclusive development, including by incorporating accessibility in all efforts funded, and by focusing on supporting disability services such as assistive technology, community-based services, social protection programmes, and employment assistance. Further support should be provided to organizations of persons with disabilities to enable them to engage in advocacy, planning and programming for the benefit of persons with disabilities.

Member States, donor agencies and international organizations should regularly monitor financial commitments to the inclusion of persons with disabilities. In particular, official Development Assistance (ODA) plays a vital role for mobilizing public resources and can catalyse disability-inclusive development. Disability inclusion markers are needed to monitor progress in ODA in this area. At the country level, effective financing should be pursued by including disability in the design, implementation, monitoring of budgets and fiscal policies and programming, and ensuring that the most marginalized persons with disabilities are included.

Technology

Access to technologies, including assistive technology and devices, is critical in facilitating persons with disabilities to live independently and to participate in and contribute to society. Inadequate support for access to assistive devices can undermine equal participation of persons with disabilities in society and development and hamper the realization of the SDGs.

In addition to the priority assistive products,⁹⁹¹ there are many assistive devices that have been developed for persons with disabilities in recent years, particularly information and communication technologies (ICT).

Gaps in access to assistive technology remain in many countries, particularly developing countries where assistive technology are often unavailable, unaffordable or inadequate. Moreover, ICT technology has a huge potential to improve the lives and participation of persons with disabilities and to contribute to the disability-inclusive achievement of the SDGs. As such, the promotion of accessibility in ICTs, following the approach of universal design, should be prioritized. Incentivizing research and development of and promoting accessibility to mainstream technologies, including assistive technology and devices, through national policies and programmes can help further accelerate the availability and dissemination of the technologies to benefit of persons with disabilities and the general population. International trade policies and agreements can also facilitate access to affordable assistive products in developing countries where assistive devices are often limited.

Capacity-building

The report has emphasized the need for capacity development for policy makers and other key stakeholders at the national level to support their formulation and implementation of laws and policies to advance disability inclusive development. There is also a need for capacity development for service providers to increase the quantity and quality of their services for persons with disabilities, and for persons with disabilities themselves to gain knowledge to exercise their rights and to better access available services and products that may benefit them. Good examples of organizations having disability-inclusive development policies and programmes are highlighted in this report, but many other organizations working on programmes related to the implementation of SDGs lack understanding and awareness of disability issues. Building their capacity is key for the success of any disability-related projects, products, and services.

Capacity development opportunities are also need for development and humanitarian actors and other stakeholders who have a role in protecting persons with disabilities in humanitarian crises and disasters. Capacity development programmes on accountability mechanisms are also needed. Furthermore, capacity building is critical to support skills building for monitoring and evaluation of SDG implementation for persons with disabilities.

Policy and institutional coherence

Many countries have established some form of public institution or mechanism dedicated to promoting the rights, inclusion and wellbeing of persons with disabilities. However, these institutions often lack the necessary human and financial resources to achieve their mandates. Moreover, disabilities issues are often spread across several ministries without no coordinated action among them. Establishing a robust institutional mechanism and coordination at the national level with adequate resources is critical for the effective implementation of the SDGs, as is the participation of persons with disabilities in the institutional arrangements. In addition, as countries revise laws and policies to align them with the CRPD, there is a

need to ensure that national legislation and development plans are coherent and that legal and policy provisions do not contradict each other.

Multi-stakeholder partnerships

The report has highlighted the important role of multi-stakeholder partnerships in realization the SDGs for persons with disabilities. Such partnerships may involve Member States, United Nations agencies, development, humanitarian and human rights actors, peace and security actors, local authorities and communities, private sector actors and civil society, in particular persons with disabilities and their representative organizations. These partners can collectively ensure that development activities and programmes include the perspectives and consider comprehensively the needs of persons with disabilities.

Data collection and dissemination, their disaggregation by disability, would also benefit from more cooperation among various stakeholders. Data activities require robust and systematic coordination among responsible ministries, working in partnership with civil society communities such as non-governmental organizations, particularly organizations of persons with disabilities, the private sector and research institutions.

Explanatory notes

For figures showing more than one country, the year indicated in the figures indicates the average year of the data presented.

Average values shown in charts show simple averages of the values across countries.

(WG) indicates data in which persons with disabilities were identified using the six questions of the short set of Washington Group on Disability Statistics. i.e. persons who indicated that they had a lot of difficulty or were unable to: see (even if wearing glasses), hear (even if using a hearing aid), walk or climb stairs, remember or concentrate, wash all over or dress, understand or being understood.

(MDS) indicates data in which persons with disabilities were identified by those having severe disabilities using the Model Disability Survey, unless otherwise indicated.

Eurostat data shows persons with some or severe difficulties.

In all other data, persons with disabilities are identified according to the definition of disability used in the national data collection.

National estimates calculated from IPUMS and SINTEF data were calculated or commissioned by UNDESA, unless otherwise stated.

National estimates calculated from DHS data were calculated or commissioned by UNDESA, unless otherwise stated.

Endnotes

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²¹⁹ General Comment No. 4 clarifies that all children with disabilities must be educated in inclusive environments and that it is the responsibility of the education system to adapt to accommodate the needs of all students, irrespective of abilities and impairments, within inclusive environments. Available at: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/GCRRightEducation.aspx>

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- ³²¹ Regional average is a simple average of countries in the region with available data. Composition of regions is available at: <https://unstats.un.org/sdgs/indicators/regional-groups/>
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- ³⁵⁹ Improved sanitation facilities are facilities that hygienically separate human excreta from human contact. Improved facilities include flush/pour flush toilets or latrines connected to a sewer, -septic tank, or

-pit, ventilated improved pit latrines, pit latrines with a slab or platform of any material which covers the pit entirely, except for the drop hole and composting toilets/latrines.

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http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf?ua=1

³⁶² The World Health Surveys were conducted in various countries during 2002-2004 and supported by WHO. The data come from sample surveys that were nationally representative and weighted to the national populations.

³⁶³ Persons with disabilities include persons with some or severe limitations.

³⁶⁴ Persons with disabilities include persons with some or severe limitations.

³⁶⁵ The data from Ireland, Italy, Luxembourg, Sweden and the former Yugoslav Republic of Macedonia are from 2015, Switzerland is from 2014, Montenegro is from 2013, Germany is from 2012, Turkey is from 2007 and Iceland is from 2005.

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³⁸¹ UNICEF Zimbabwe (2016), Rural WASH Project: Fell the change and impact form direct beneficiaries through human interest stories.

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³⁹⁰ World Vision (2014), Casting the net further: disability inclusive WASH.

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³⁹³ http://wedc.lboro.ac.uk/resources/learning/EI_Compendium_of_accessible_WASH_Technologies.pdf.

³⁹⁴ <https://wedc-knowledge.lboro.ac.uk/details.html?id=16357>.

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- ⁵⁵⁶ Like a raise dot on the number 5. This type of markers help orient fingers in the keypad.
- ⁵⁵⁷ Human operated service using a sign language interpreter to enable communication between a person with a hearing disability and anyone else.
- ⁵⁵⁸ Transfers both right and left audio to both ears – useful for those with hearing disabilities affecting one ear.
- ⁵⁵⁹ Like pre-programmed text messages which can be reused with the touch of fewer buttons than typing the whole text.
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