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Disability and Development Report 2024

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



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Department of Economic and Social Affairs

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Department of Economic and Social Affairs

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Foreword

by António Guterres

Secretary-General of the United Nations

With the global pledge to leave no one behind, the international community affirmed that the 2030 Agenda for Sustainable Development must be achieved by, for, and with persons with disabilities.

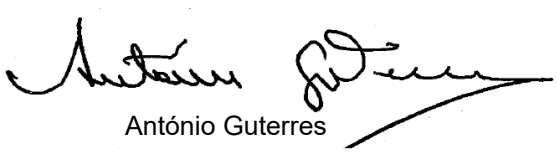
Yet, as the *Disability and Development Report 2024* shows, we are not on track. Persons with disabilities continue to face entrenched barriers.

While there has been progress in areas such as inclusive education and disaster preparedness, only 4 per cent of relevant indicators are on course. For the vast majority, progress is too slow, has stalled, or is simply unknown due to insufficient data.

This *Report* offers a clear path forward, anchored in the Convention on the Rights of Persons with Disabilities, our guiding framework for dignity, equality, and inclusion of persons with disabilities.

I urge governments and all partners to act decisively, in close collaboration with persons with disabilities. That is also the spirit and essence of our own UN Disability Inclusion Strategy.

Together, we can – and must -- build a world of justice, accessibility and dignity for all.



António Guterres

Foreword

An inclusive roadmap to accelerate progress towards the Sustainable Development Goals

by Li Junhua

Under-Secretary-General for Economic and Social Affairs

Since the adoption of the 2030 Agenda for Sustainable Development in 2015, the situation faced by persons with disabilities has improved. The political commitment, both at the international and national levels, to foster and guarantee an inclusive world is noteworthy. There have been continued efforts to mainstream disability in pursuit of the Sustainable Development Goals (SDGs). A growing number of governments have adopted laws and policies to promote the inclusion of persons with disabilities in all aspects of life.

The longstanding advocacy of persons with disabilities themselves, and their representative organizations, has been a key driving force behind the improvements we see today. It is clear that the full and effective participation of persons with disabilities is the only way forward to ensure the realisation of the 2030 Agenda.

Although great strides have been made, if we continue at the same pace we will not achieve the SDGs for persons with disabilities by 2030. We will not close the gaps that persist for persons with disabilities across all SDGs. Persons with disabilities and their households are much more likely than others to live in poverty and to face barriers to employment. They have more healthcare needs but are less likely to be able to meet these needs due to physical, financial, attitudinal, informational and communication barriers. Many persons with disabilities face barriers to access essential services and continue to be excluded from responses to emergencies and other crises.

Women with disabilities remain severely underrepresented in the labour market and in decision-making processes and face a higher risk of sexual violence. Indigenous persons with disabilities face additional barriers to accessing education and decent work. Persons with mental impairments or psychosocial disabilities are often excluded from fully participating in economic, political and social life.

The conclusion is clear: we must accelerate progress on disability inclusion to achieve the 2030 Agenda. Success will depend on the engagement and partnership of all relevant stakeholders, including governments, international and regional organizations and civil society, in particular, representative organizations of persons with disabilities.

This *Report* pulls together the latest available data and information on the situation of persons with disabilities. It identifies good practices and outlines the concrete actions urgently needed to achieve the

SDGs by, for, and with, persons with disabilities.

I invite you to engage with and learn from the contents of this *Report*, and I urge you to join in our efforts to ensure that no one – including every person with disabilities – is left behind.



LI Junhua

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Acronyms and abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CFM	Child Functioning Module
CRPD	Convention on the Rights of Persons with Disabilities
DHS	Demographic and Health Surveys
ECLAC	Economic Commission for Latin America and the Caribbean
ECOSOC	Economic and Social Council
EMIS	Education Management Information Systems
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
ESCWA	United Nations Economic and Social Commission for West Asia
FAO	Food and Agricultural Organization
GDP	Gross Domestic Product
GLAD	Global Action on Disability Network
HDI	Human Development Index
IADB	Inter-American Development Bank
ICF	International Classification of Functioning, Disability and Health
ICT	Information and communications technology
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
IPUMS	Integrated Public Use Microdata Series
ISO	International Organization for Standardization
ITU	International Telecommunication Union
LAC	Latin America and the Caribbean
LDCs	Least Developed Countries
MDS	Model Disability Survey
MFN	Most Favoured Nation

MICS	Multiple Indicator Cluster Surveys
NEET	Not in Employment, Education or Training
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
SAMOA	SIDS Accelerated Modalities of Action
SDGs	Sustainable Development Goals
SIDS	Small Island Developing States
SINTEF	Stiftelsen for industriell og teknisk forskning
TV	Television
TVET	Technical Vocational Education and Training
UN	United Nations
UNCTAD	United Nations Trade and Development
UNDESA	United Nations Department of Economic and Social Affairs
UNDRR	United Nations Office for Disaster Risk Reduction
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNPRPD	United Nations Partnership on the Rights of Persons with Disabilities
UNSD	United Nations Statistics Division
W3C	World Wide Web Consortium
WCAG	Web Content Accessibility Guidelines
WFP	World Food Programme
WHA	World Health Assembly
WGSS	Washington Group Short Set of Questions on Functioning

WHO	World Health Organization
WTO	World Trade Organization

Executive summary

Six years from the deadline for achieving the Sustainable Development Goals (SDGs), the *Disability and Development Report 2024* indicates that persons with disabilities are often being left behind. According to the available evidence, progress for persons with disabilities has been insufficient for 30 per cent of SDG targets; for 14 per cent, the target has been missed or progress has stalled or gone in reverse. These include targets on access to financial resources, healthcare, water and information and communication technologies (ICT), and on building the resilience of persons with disabilities during disasters and other emergencies. Only five indicators, related to five targets, appear to be on track, that is, the progress observed is consistent with achieving their respective targets for persons with disabilities by 2030. There is evidence of remarkable progress on passing laws mandating equal access to education, on providing early warnings of disasters in accessible formats, on providing online services for persons with disabilities, on making government ministries accessible for persons with disabilities and on the monitoring of bilateral aid dedicated to disability inclusion.

The available evidence indicates that wide gaps persist between persons with and without disabilities, particularly on food security, health, and access to energy and ICT – with gaps above 10 percentage points – and on multidimensional poverty and employment – with gaps above 20 percentage points. For women, Indigenous people and rural residents with disabilities, and for persons with intellectual or psychosocial disabilities, the gaps appear to be even wider.

There is evidence that the response to the COVID-19 pandemic was often not inclusive of persons with disabilities, especially in the early stages of the pandemic, with discriminatory practices in treatment, lack of information in accessible formats and reduced access to testing. According to a study carried out in 46 countries, 41 per cent of persons with disabilities versus 28 per cent of persons without disabilities did not have access to COVID-19 testing. Data from a few countries suggest that half of COVID-19 deaths occurred among persons with disabilities. Persons with disabilities lost jobs and income at higher rates than others. Early in the pandemic, a third of persons with disabilities lost access to personal assistance, assistive technology or accessibility services – a trend that continued throughout the pandemic driven by inflation and disruptions in supply chains, including a drop of 10 per cent in exports of assistive products. Based on a study conducted in 46 countries, persons with disabilities faced more difficulties than others accessing and affording food (52 per cent versus 46 per cent), water delivery (31 per cent versus 18 per cent), energy (31 per cent versus 24 per cent), housing (28 per cent versus 24 per cent), healthcare (34 per cent versus 22 per cent), medicines (40 per cent versus 32 per cent), masks (64 per cent versus 50 per cent) and sanitizers (66 per cent versus 54 per cent). Other studies indicate that one in five students with disabilities dropped out of school during the pandemic and 9 in 10 did not have the ICT needed to participate in remote learning. Half of workers with disabilities faced barriers to working remotely, such as inaccessible online platforms. The isolation created by lockdowns increased the risk of violence, with a

quarter of persons with disabilities experiencing violence at home and almost half of women with disabilities not feeling safe at home. Lockdowns disrupted data collection activities creating a lack of evidence to guide pandemic responses for persons with disabilities.

Not all countries introduced measures to support persons with disabilities in facing these challenges. Whereas more than 90 per cent of countries prioritized persons with disabilities in COVID-19 vaccination campaigns, only half of households with students with disabilities received financial support for the personal assistance and technology they needed for remote learning, less than half of countries targeted persons with disabilities in their COVID-19 social protection measures and only 10 per cent of countries conducted rapid emergency data collection activities on persons with disabilities during the pandemic.

Compared to the *Disability and Development Report 2018*, there is now much more data on persons with disabilities, and data availability is at the highest level since the adoption of the Convention on the Rights of Persons with Disabilities. Despite these advancements, only 50 per cent of SDG targets have indicators with enough data to assess progress. For 40 per cent of these targets, the available data provide a snapshot for a single point in time. For 10 per cent, there is not enough data for such a snapshot, including for the targets on extreme poverty, child mortality, the health impact of pollution, early childhood development, child labour and the impact of corruption and bribery.

In light of the progress made to date, we must conclude that the world will not achieve the SDGs by, for and with persons with disabilities by 2030. Depending on the target, progress needs to accelerate to between 2 and 65 times the current speed, especially for targets on making physical and virtual environments accessible for persons with disabilities, on adopting anti-discrimination legislation, on expanding social protection and on implementing measures to guarantee the safety and protection of all persons with disabilities during disasters and emergencies.

As the international community prepares for the Second World Summit for Social Development in 2025, all stakeholders need to increase their efforts to advance the SDGs, recognizing that disability inclusion is an essential part of the solution. The world needs to build on the lessons learned from the COVID-19 pandemic and to plan better for future crises. The *Disability and Development Report 2024* provides a snapshot of the current situation and of progress made by SDG and by target. It identifies concrete steps that global leaders and stakeholders at all levels can take to accelerate the achievement of the SDGs by, for and with persons with disabilities:

Ending poverty (Goal 1)

In almost all countries, the percentage of persons experiencing multidimensional poverty is higher for persons with disabilities than persons without disabilities – in some countries that percentage is more than double. Reducing this percentage by half by 2030, as called for in target 1.2, will require progress at least 1.3 times faster for persons with disabilities than for persons without disabilities.

Persons with disabilities tend to earn lower wages, face additional costs related to their disability and lack access to financial services. A quarter of banks worldwide, a quarter of ATMs in developed regions and half of the ATMs in developing regions remain physically inaccessible for wheelchair users.

In 2020, only 17 per cent of countries provided universal disability benefits. Progress since 2017 has been slow, with a slight increase of just 2 percentage points. Globally, in 2020, 34 per cent of persons with severe disabilities received cash benefits, up from 27 per cent in 2016. At this rate, only half the persons with severe disabilities are expected to have access to these benefits by 2030.

The following actions are recommended:

- Mainstream disability inclusion in national poverty reduction strategies, programmes and actions.
- Evaluate the impact of public policies, including social protection schemes, on extra costs associated with disability and on the financial well-being of persons with disabilities.
- Develop a national disability registry of individual disability (and needs) assessment to facilitate the targeting of individual social protection.
- Ensure accessibility across the social protection delivery chain.
- Develop a flexible combination of mainstream and disability-specific cash transfers, concessions, subsidies and support services.
- Involve persons with disabilities and their representative organizations in the design and implementation of national poverty reduction strategies and social protection policies.

Ending hunger, achieving food security and improved nutrition (Goal 2)

In developing countries, available evidence indicates that 55 per cent of persons with disabilities experience food insecurity. In Europe, the percentage of persons with disabilities who cannot afford daily meals with protein at least every second day has decreased since 2016, but this progress is insufficient to lower this percentage to zero by 2030.

Children with disabilities appear more likely than children without disabilities to be underweight or stunted, two common signs of malnutrition. Existing data point to 15 per cent of children with disabilities being underweight, 27 per cent stunted, 7 per cent wasted and 3 per cent overweight.

Although food banks are vital during food emergencies, two out of five are not accessible for wheelchair users. More than half of restaurants worldwide, 12 per cent of supermarkets in developed countries and 38 per cent in developing countries are inaccessible for wheelchair users.

The following actions are recommended:

- Mainstream disability inclusion into food security legislation, policies and programmes, based on consultations with persons with disabilities and their representative organizations.

- Improve coordination among various sectors (including the education, social protection, agriculture, fishery, livestock and forestry sectors) to enhance access to food and improve the accessibility, affordability and safety of food for persons with disabilities.
- Provide equal access to agricultural and other productive resources for persons with disabilities.
- Support the use of disability-inclusive agricultural technology, assistive technology and reasonable accommodation in agricultural employment.
- Ensure that food banks, supermarkets and restaurants are accessible for persons with disabilities.

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

The available evidence suggests that persons with disabilities are 15 times more likely to perceive their health as bad or very bad than persons without disabilities; and seven times more likely than others to lack access to healthcare when they need it. In various developing countries, more than half of persons with disabilities do not receive healthcare because they cannot afford it; and one quarter do not receive healthcare because they lack affordable transport to healthcare facilities. In some developed countries, more than 10 per cent of persons with disabilities do not receive healthcare because they cannot afford it or because the travel time or the waiting time to receive services is excessive.

Public health interventions to promote healthy lives and well-being, including nutrition information campaigns and regular testing and monitoring, often do not reach persons with disabilities. Studies in selected countries indicate that gaps in coverage between persons with and without disabilities range from 5 per cent to 45 per cent.

In various developing countries, more than 30 per cent of persons with disabilities report that healthcare facilities are not accessible, and in some countries, this percentage reaches 80 per cent. Worldwide, in 2022, 42 per cent of doctors' offices, 29 per cent of pharmacies and 15 per cent of hospitals were not accessible for wheelchair users. In these areas, progress over the past five years has been insufficient. Doctors' offices would need to become accessible at a rate three times faster and pharmacies seven times faster compared to current rates of change to achieve full accessibility by 2030. Progress in making hospitals more accessible has stagnated since 2018.

By 2022, only one third of countries had incorporated disability inclusion in their national health strategies.

The following actions are recommended:

- Include equity for persons with disabilities at the centre of every action taken by the health sector.
- Ensure the provision of affordable, integrated health services for persons with disabilities close to where they live.
- Strengthen multisectoral collaboration to address structural, social and health system factors that contribute to health inequities for persons with disabilities.

- Include and protect persons with disabilities in health emergency responses.
- Involve persons with disabilities, their families and representative organizations in decision-making in the health sector.

Reducing maternal mortality and ensuring access to sexual and reproductive healthcare services and reproductive rights (targets 3.1, 3.7 and 5.6)

Persons with disabilities are often excluded from the provision of sexual and reproductive healthcare. Based on data from various countries, more than 50 per cent of both women and men with disabilities do not have comprehensive knowledge of HIV/AIDS. In addition, more than 50 per cent of women with disabilities do not have their need for family planning satisfied with modern methods, do not have the births of their babies attended by skilled health personnel and do not receive a timely postnatal check. Moreover, a majority of women with disabilities do not have autonomy in making decisions about their reproductive health and thus are not empowered to exercise their reproductive rights.

The following actions are recommended:

- Promote and protect the bodily autonomy of persons with disabilities.
- Develop laws and policies that guarantee access to sexual and reproductive healthcare and reproductive rights for persons with disabilities.
- Make sexual and reproductive healthcare services safe and affordable and make healthcare facilities, communication and information accessible.
- Train sexual and reproductive healthcare workers on disability inclusion.
- Educate persons with disabilities about sexual and reproductive health and reproductive rights.

Ensuring inclusive and equitable quality education (Goal 4)

Available data from various countries illustrate the barriers that children with disabilities face in accessing education. While 11 per cent of children with disabilities of primary school age remain out of school, this percentage increases to 32 per cent for children with disabilities of upper secondary school age. Only 30 per cent of children with disabilities achieve reading skills equivalent to those expected at grade 2 or higher, compared to 37 per cent of children without disabilities; and 23 per cent achieve numeracy skills compared to 27 per cent of children without disabilities.

A few countries have succeeded in lowering out-of-school rates to very low levels for children with disabilities of primary school age, on par with levels for children without disabilities. Meanwhile, among more than 100 countries with available data, 87 per cent have laws or policies protecting the right to education for persons with disabilities, up from 74 per cent in 2016. At this rate of improvement, all countries could have legislation or policies in place to protect this right by 2030.

In 47 per cent of these countries, there are educational materials to support learners with disabilities, up from 34 per cent in 2016; 38 per cent have accessible physical school environments, up from 18 per cent in 2016; and 17 per cent legally guarantee an inclusive education in which learners with and without disabilities are taught in the same classrooms.

The following actions are recommended:

- Establish inclusive education for persons with disabilities in legislation and policies.
- Expand disability inclusion across all levels of education.
- Implement universal design principles and accessibility in schools and other learning environments.
- Provide access to assistive technologies in education.
- Develop teachers' capacities in inclusive education and promote the hiring of teachers with disabilities.
- Foster partnerships among representative organizations of persons with disabilities, communities, parents, caregivers, youth, the educational workforce and other stakeholders to advance inclusive education.
- Foster cross-sectoral approaches to education, including access to health, rehabilitation and social protection.
- Mitigate learning losses among students with disabilities caused by school closures during the COVID-19 pandemic.

Achieving gender equality and empowering all women and girls (Goal 5)

Women and girls with disabilities face multiple or aggravated forms of discrimination, suffer sexual violence and experience early marriage: existing data suggest that 8 per cent of women with disabilities feel discriminated against due to their disabilities and 9 per cent due to their gender; that 8 per cent of women with disabilities experienced sexual violence in the past 12 months; and that 7 per cent of girls with disabilities aged 15 to 18 are or have been married.

Women with disabilities appear to be engaged in unpaid work at levels similar to women without disabilities (10 per cent of both). Data from various countries indicate that 3 per cent of women with disabilities work as legislators, senior officials or managers, compared to 4 per cent of women without disabilities. Women with disabilities are underrepresented in national parliaments, local governments and national coordination mechanisms on disability. Only two countries specifically require the inclusion of women with disabilities in electoral lists or in elected local deliberative bodies.

Women with disabilities face barriers to economic resources, financial services and technology. Available data suggest that as many as 20 per cent of women with disabilities live in income poverty and that the wages of men with disabilities are 17 per cent higher than those of women with disabilities. By various

measures, women with disabilities were found to lag behind men with disabilities in digital access and experience.

Among 190 countries, 38 per cent have a gender equality law or a disability law with specific legal protections for women with disabilities; 27 per cent address the situation of women with disabilities in their domestic violence laws and 16 per cent in their sexual harassment laws. Only 9 per cent of countries have legal requirements for the provision of services to women with disabilities who are survivors of violence; a mere 14 per cent legally protect the parental rights of women with disabilities; and just 3 per cent give specific mention to women with disabilities in their laws on incentives for the employment of persons with disabilities and on reasonable accommodation for workers with disabilities.

Worldwide, 27 per cent of countries have specific legal protections for women with disabilities in their disability law as of 2022, up from 18 per cent in 2015. At this rate, only a third of countries are expected to have such legal protections in place by 2030.

The following actions are recommended:

- Develop legislation and policies that protect the rights and promote the inclusion of women with disabilities.
- Prohibit forced or coerced reproductive health interventions and guarantee free and informed consent in accessing health services.
- Fund interventions, such as grants and awareness-raising campaigns, to support the equality and empowerment of women with disabilities as experts and leaders.
- Build the capacity of non-governmental organizations to promote the equality and empowerment of women with disabilities.
- Increase the leadership and participation of women with disabilities in decision-making to promote peace and conduct humanitarian actions.
- Guarantee the right to vote and access to voting mechanisms, such as polling stations and remote voting.
- Guarantee the right to stand for election and to hold public office for women with disabilities.
- Establish mechanisms to eliminate violence against women with disabilities and to ensure that victims have access to gender- and disability-responsive services and support.

Ensuring the availability of water, sanitation and hygiene (Goal 6)

In many countries, persons with disabilities are less likely than persons without disabilities to live in a dwelling with a safe source of drinking water, improved sanitation, and a bath or shower on the premises, with gaps reaching over 10 percentage points in some countries.

Studies have suggested that a third of persons with disabilities in developing countries have toilets at their

homes that are not accessible. Moreover, in many countries, a third or more of water, sanitation and hygiene facilities in schools, healthcare facilities and other public settings are not accessible for persons with disabilities. In developing countries, 42 per cent of public places to obtain drinking water are not accessible for wheelchair users. In developed countries, 33 per cent of public toilets remain inaccessible for wheelchair users.

Lack of accessible water, sanitation and hygiene facilities impact the lives of women with disabilities, who are more likely than women without disabilities to miss school, work or social activities during their menstrual period.

The following actions are recommended:

- Mainstream disability inclusion in water, sanitation and hygiene policies and programmes.
- Involve persons with disabilities and their representative organizations in water, sanitation and hygiene policymaking and programme implementation.
- Allocate financial resources to promote disability-inclusive water, sanitation and hygiene services in households, schools and healthcare facilities.

Ensuring access to energy (Goal 7)

In many countries, access to electricity for persons with and without disabilities is close to universal. However, for countries with mid to low levels of electricity access, gaps between persons with and without disabilities remain and reach 10 percentage points or more in several cases. In various countries, among households that include persons with disabilities, the percentage with access to electricity in rural areas is less than half as high as in urban areas. Accordingly, households with persons with disabilities in rural areas were found to be twice as likely as those in urban areas to use polluting forms of energy, like wood and coal.

Many persons with disabilities rely on assistive technologies powered by electricity for independent living or survival. Yet, in 2023, only 39 per cent of countries appeared to have mechanisms to assist persons with disabilities in using this technology during a power outage, and only two-thirds of these mechanisms were designed in consultation with persons with disabilities.

Access to electricity in schools is crucial to allow the use of electricity-dependent assistive technologies. Worldwide, the latest data indicate that 76 per cent of primary schools have access to electricity, up from 66 per cent in 2015. In sub-Saharan Africa, only 32 per cent of primary schools have access to electricity, up from 30 per cent in 2015.

The following actions are recommended:

- Close the gap in energy access between persons with and without disabilities and close the rural-urban gap as well.

- Prioritize access to electricity for persons with disabilities who require or may benefit from electricity-dependent assistive technologies.
- Take into account the energy costs faced by persons with disabilities in designing social protection systems.
- Include special measures for persons with disabilities in energy programmes, such as social tariffs, grants and discounts.
- Promote modern and clean forms of energy in the households of persons with disabilities.
- Make the necessary investments to ensure universal access to electricity in schools.
- Promote coordination among ministries with mandates on disability, energy, assistive technology and social protection to address energy poverty among persons with disabilities.
- Include persons with disabilities and their representative organizations in governing bodies responsible for energy access.
- Make clean energy transition policies and climate mitigation policies inclusive of persons with disabilities.

Promoting full and productive employment and decent work (Goal 8)

Only 27 per cent of persons with disabilities are employed globally, compared to 56 per cent of persons without disabilities. The unemployment rate for persons with disabilities is 10 per cent, higher than the 8 per cent for persons without disabilities. Youth with disabilities are twice as likely as youth without disabilities to not be employed or receiving education or training. Persons with disabilities face lower wages and overrepresentation in the informal economy and in self-employment. Globally, the percentage of employed persons with disabilities would have to increase by at least 2 percentage points per year until 2030 to close the gap between persons with and without disabilities.

Many working places are not accessible and lack measures for reasonable accommodation and assistive technologies. The accessibility of employment agencies to wheelchair users reached 62 per cent in 2022, up from 56 per cent in 2018.

The following actions are recommended:

- Adopt legislation that protects persons with disabilities against discrimination on the basis of disability in all matters of employment.
- Promote the inclusion of persons with disabilities in the green and digital economies.
- Improve the situation of persons with disabilities working in the informal economy.
- Ensure that training, public employment services and programmes, work-based training and business development services are disability-inclusive.

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

For developing countries, available data indicate that Internet use is 11 percentage points lower for persons with disabilities than for persons without disabilities. To close this gap, Internet access among persons with disabilities will need to increase by 1.2 percentage points per year until 2030. In Europe, despite progress since 2015, persons with disabilities are still twice as likely as persons without disabilities to not be able to afford a computer; moreover, 1 per cent of persons with disabilities cannot afford a telephone or television, a percentage that has remained stagnant since 2015. In the least developed countries, on average 20 per cent of persons with disabilities use the Internet, far from the universal access by 2020 called for in SDG target 9.c.

In developing countries, households in urban areas with persons with disabilities appear to be twice as likely to have Internet access compared to those in rural areas. In some countries, the gap between women and men with disabilities exceeds 20 percentage points for Internet use and mobile phone ownership.

Available data indicate that a lower percentage of persons with disabilities report having basic information and communication technology (ICT) skills, with a gap of 3 percentage points on average compared to persons without disabilities but reaching more than 10 percentage points in several countries.

The vast majority, or 98 per cent, of the top 1 million websites do not comply with international web content accessibility guidelines, and the same is true for 63 per cent of the online portals of national governments. This lack of accessibility is particularly high in Africa, affecting 87 per cent of countries. Based on available data, in 2022 only 27 per cent of Internet cafes were accessible for wheelchair users, up from 20 per cent in 2019.

In 2020, 69 per cent of countries had a regulatory framework on accessibility of ICT. Europe is the region where these regulations are the most common (85 per cent of countries) and Africa the least (45 per cent).

The following actions are recommended:

- Develop and strengthen the implementation of ICT accessibility policies and regulations.
- Make disability inclusion a core feature of digital development investments and programmes.
- Build capacity on ICT accessibility and universal design, including on easy-to-understand ICT formats.
- Involve persons with disabilities and their representative organizations in ICT development.
- Provide affordable Internet access for persons with disabilities.
- Promote digital skills training for persons with disabilities.

Reducing inequalities and promoting inclusion (target 10.2)

Community services are beginning to develop in various countries to support the inclusion of persons with disabilities, but data from various countries show that gaps remain: among persons with disabilities, 43 per cent indicate that joining community activities is problematic, 22 per cent report needing more personal assistance than they receive, and 44 per cent recognize the need but lack such assistance.

Persons with disabilities who need support to make their own decisions seldom receive this support, and someone else is designated to make decisions for them. Available data indicate that only 34 per cent of persons with disabilities report making decisions about their daily lives, including decisions about where and with whom to live and how to spend money.

The lack of community support systems has pushed persons with disabilities to be placed in institutions, in contravention to the Convention on the Rights of Persons with Disabilities.

The following actions are recommended:

- Adopt legislation and policies to facilitate access to care and support systems for persons with disabilities.
- Invest in community support and care systems.
- Invest in programmes to assist families of persons with disabilities.
- Build capacity on community inclusion.
- Invest in inclusive infrastructure and services.
- Replace segregated institutions with community-based support.
- Make the care agenda inclusive of persons with disabilities.

Eliminating discriminatory laws, policies and practices (targets 10.3 and 16.b)

Available data suggests that around one in ten persons with disabilities feel discriminated against on the basis of their disability. To combat such prejudice, countries have been adopting legislation prohibiting discrimination on the basis of disability in various domains, including employment (79 per cent of countries) and education (54 per cent of countries). However, progress has been too slow to ensure that persons with disabilities in all countries will be legally protected against discrimination by 2030; for direct discrimination in the workplace, for example, progress would need to be twice as fast. Expansion of these legal protections is needed especially in Eastern and South-eastern Asia, Oceania and sub-Saharan Africa.

The following actions are recommended:

- Review laws and policies to abolish discriminatory provisions against persons with disabilities.
- Combat negative stereotypes against persons with disabilities through public campaigns.
- Develop mechanisms for reporting and addressing discrimination.

Making cities and human settlements inclusive and sustainable (Goal 11)

According to data for developing countries, 33 per cent of persons with disabilities indicate that their dwelling is not accessible. In Europe, 5 per cent of persons with disabilities live in severely deprived housing, in other words, overcrowded housing with a leaking roof, no bath or shower, or too dark; and 10 per cent have high housing costs that take up more than 40 per cent of their disposable income. In North America, only 1 per cent of rented dwellings meet the standards of universal design.

Data from a number of countries indicate that a third of persons with disabilities report that recreational facilities are not accessible; for 28 per cent, modifications would be needed to facilitate their participation. Moreover, 43 per cent of persons with disabilities in developing countries consider the transportation system to be inaccessible. Worldwide, only about 70 per cent of transit stations and platforms and bus stations are accessible to wheelchair users.

In developing countries, the accessibility of transportation has been decreasing since 2018. In developed countries, the accessibility of transit platforms for wheelchair users has been deteriorating; for transit and bus stations, however, accessibility has been increasing. At current rates of change, it is projected that 79 per cent of transit stations and 91 per cent of bus stations will be accessible by 2030.

Since 2015, among persons with disabilities in Europe, the percentage who reside in severely deprived housing or for whom housing costs are overly burdensome has decreased. At current rates of change, these percentages are projected to reach 2 and 9 per cent, respectively, by 2030.

Concerning public spaces, at current rates of change, accessibility for wheelchair users is projected to increase from 81 per cent in 2022 to 85 per cent in 2030 for car parking lots, from 73 per cent to 76 per cent for libraries, from 72 per cent to 75 per cent for commercial buildings, from 57 per cent to 60 per cent for buildings, from 52 per cent to 55 per cent for playgrounds and from 51 per cent to 55 per cent for museums.

The following actions are recommended:

- Ensure inclusion and equal participation of persons with disabilities in their communities.
- Build awareness and capacity in accessibility and disability-inclusion among architects, engineers, urban planners and managers.
- Adopt commitments to inclusion, universal design and accessibility for public spaces, roads, pedestrian environments and transportation.
- Establish participatory and accessible mechanisms for the inclusive budgeting, planning, design and implementation of urban strategies and policies.

Building resilience and reducing exposure and impact from climate-related hazards, other shocks and disasters (targets 1.5, 11.5 and 11.b and Goal 13)

Persons with disabilities often experience a disproportionate negative impact during and in the aftermath of disasters, at times suffering mortality rates twice as high as for persons without disabilities. Worldwide, 84 per cent of persons with disabilities have no preparedness plan for disasters; 39 per cent would have much difficulty or could not evacuate during a sudden disaster; 28 per cent need but have no one to assist them during an evacuation; 11 per cent indicate that information on disaster management or risk reduction is not accessible; more than 80 per cent are not aware of national and local disaster risk reduction plans; and 86 per cent are not involved in decision-making processes on community disaster management and risk reduction. In situations of conflict and forced displacement, more than 30 per cent of persons with disabilities find essential services unaffordable or lack accessible transport or physical access to the services.

From 2013 to 2023, many aspects of disaster preparedness deteriorated. For example, the percentage of persons with disabilities who lack a preparedness plan for disasters increased by 12 points; the percentage who need but have no one to assist them to evacuate increased by 15 points; and the percentage who are not aware of national and local disaster risk reduction plans increased by 3 points.

Other aspects of disaster preparedness showed little progress or were stagnant over this period. The percentage of persons with disabilities who are not involved in decision-making processes on community disaster management and risk reduction was the same in 2023 as in 2013; and the percentage who would have much difficulty or not be able to evacuate during a sudden disaster decreased by 2 points.

Available data suggest that accessible formats are increasingly available for laws and policies on climate change adaptation (78 per cent of countries), on disaster risk reduction (96 per cent), on safe evacuation from public buildings (75 per cent), on safe evacuation from private premises (86 per cent), for information on prevention, preparation and recovery from disasters (96 per cent) and early warnings (100 per cent). Most information is only released in accessible doc/pdf, with Braille, easy-to-understand and ePub formats less commonly used. The existing data also indicate that more than 60 per cent of countries consult with persons with disabilities and their representative organizations in developing disability-inclusive laws, policies and measures related to climate change, disasters and evacuation.

The following actions are recommended:

- Involve persons with disabilities in decision-making processes on disaster response and humanitarian action.
- Develop laws, policies, standards, checklists and indicators for the inclusion of persons with disabilities in emergency preparedness, planning and response and in climate change adaptation.

- Ensure that emergency information, commodities, infrastructure and services are inclusive and accessible for persons with disabilities.
- Mobilize resources for disability-inclusive emergency preparedness and response.
- Raise awareness among persons with disabilities of disaster management plans.
- Build capacity among humanitarian actors on disability inclusion.
- Maintain a register of persons with disabilities that records and maps the needs of persons with disabilities during and after disasters.
- Make post-crisis recovery efforts inclusive of persons with disabilities.
- Ensure protection mechanisms for persons with disabilities in emergency and post-crisis contexts to minimize the risk of exposure to violence, abuse and exploitation.
- Ensure accountability for acts or omissions leading to discrimination against, or the exclusion of, persons with disabilities in humanitarian action and disaster response.

Ensuring sustainable consumption and production patterns, conserving and sustainably using the oceans, seas and marine resources, protecting, restoring and promoting sustainable use of terrestrial ecosystems (Goals 12, 14 and 15)

Persons with disabilities face barriers in acting as agents of change to achieve sustainable patterns of consumption and production and the sustainable management and efficient use of natural resources. Worldwide, only 59 per cent of recycling premises are accessible for wheelchair users, down slightly from 60 per cent in 2018; and only 67 per cent of shops selling organic or sustainable products are accessible, up from 60 per cent in 2018.

Persons with disabilities face barriers that limit their participation in environmental activism. In 2021, no references to persons with disabilities were found in the academic literature covering environmental activism among youth and in social media from youth groups engaged in environmental activism. When involved, persons with disabilities are often engaged as environmental learners and given few opportunities to act as environmental advocates or educators.

The following actions are recommended:

- Involve persons with disabilities in environmental discussions and decision-making.
- Make recycling facilities and premises for sustainable products and services accessible to persons with disabilities.

Reducing all forms of violence and ending abuse, exploitation, trafficking and all forms of violence against children (targets 16.1 and 16.2)

In some countries, more than 1 in 6 persons with disabilities are beaten or scolded because of their

disability; more than 1 in 3 women and 1 in 12 men with disabilities are victims of sexual violence; and more than 1 in 2 children with disabilities receive severe punishment from their caregivers.

Worldwide, available data indicate that 1 in every 3 children with disabilities suffer neglect as well as sexual, physical or emotional violence; they are twice as likely to encounter such violence as children without disabilities. One of the most common forms of violence is in-person bullying by peers, affecting 37 per cent of children with disabilities. Children with psychosocial disabilities are at greatest risk of sexual violence (with a prevalence of 18 per cent) and maltreatment by adults (36 per cent). Children with multiple disabilities are the most likely to experience in-person and online bullying (47 per cent).

Persons with disabilities are also victims of human trafficking for forced begging, sexual exploitation, forced labour, organ removal, forced participation in armed conflict and theft of their disability benefits.

Countries have taken measures to facilitate the reporting and legal prosecution of violence against persons with disabilities and created accessible services to support them. Available data suggest that, in 2023, 58 per cent of countries had emergency telephone numbers accessible to persons with disabilities, 59 per cent had accessible shelters, and 74 per cent provided mental health and psychological support services to those who are victims of violence.

The following actions are recommended:

- Provide training on combating violence against persons with disabilities among families and parent groups, the justice system, teachers and educational staff, service providers, policymakers and legislators.
- Offer training for persons with disabilities on their rights and on skills to keep safe and to present themselves at police stations and courts.
- Establish accessible mechanisms to report violence.
- Make shelters and services for victims of violence accessible.
- Design and implement policies and programmes to address violence against persons with disabilities.
- Promote multi-country collaboration to end the trafficking of persons with disabilities.

Ensuring equal access to justice (target 16.3)

Persons with disabilities face obstacles accessing justice. Guardianship laws remain in place in many countries, depriving persons with disabilities of their legal capacity. The justice system often lacks accessibility features and reasonable accommodations for persons with disabilities. In studies conducted in developing countries, a third of persons with disabilities have reported that courts and police stations are not accessible. In some countries, more than two thirds of persons with disabilities do not have access to legal services when they need them, and many officials throughout the justice system have no training on disability inclusion.

Progress has been made in recent years, with more countries moving away from guardianship laws to systems of “supported decision-making”. There has been slow progress in raising the percentage of courts and police stations accessible to wheelchair users, which grew from 54 per cent in 2018 to 59 per cent in 2022.

The following actions are recommended:

- Promote supported decision-making and abolish laws and policies that impose substituted decision-making in legal proceedings against the will of persons with disabilities.
- Empower persons with disabilities to exercise their legal rights and access justice.
- Make the justice system disability-inclusive.
- Train justice officials on disability inclusion.

Developing inclusive institutions, ensuring inclusive decision-making and reducing bribery and corruption (targets 16.5, 16.6 and 16.7)

National public spending on social programmes for persons with disabilities averages 1 per cent of gross domestic product (GDP), a level that has remained stagnant since 2017. A majority of countries, or 77 per cent, offer online government services for persons with disabilities, up from 27 per cent of countries in 2014. At this rate of increase, such services would become available in all countries by 2030.

In various countries, more than 10 per cent of persons with disabilities experience discrimination in public services. Persons with disabilities tend to be underrepresented among public service personnel, with representation lower than half their share in the national population in several countries. In some countries, employed persons without disabilities are twice as likely as persons with disabilities to work as legislators, senior officials or managers. Available data suggest that about 30 per cent of persons with disabilities find that voting is not accessible.

In 2022, only 66 per cent of town halls, 63 per cent of governmental ministries, and 48 per cent of non-governmental organizations were accessible to wheelchair users. Progress since 2018 has been insufficient. To achieve full accessibility by 2030, progress should be 4 times faster for town halls and 19 times faster for non-governmental organizations. Significant progress has been made since 2018 in the accessibility of governmental ministries, which rose from 42 per cent in 2018 to 63 per cent in 2022, and these premises are on track to achieve full accessibility for wheelchair users by 2030.

Limited data suggest that persons with disabilities are slightly less likely to pay or be asked to pay a bribe when interacting with government officials. During disasters, conflicts and other emergencies, persons with disabilities often encounter bribery when attempting to access services.

The following actions are recommended:

- Eliminate legislation that violates the right of persons with disabilities to vote and to participate in political and public life.
- Ensure that public institutions and public services are accessible.
- Increase the participation of persons with disabilities in national public service.
- Support persons with disabilities who stand for political office.
- Make the voting process accessible.
- Strengthen the skills of persons with disabilities to defend their political rights.
- Prevent and respond to instances of electoral violence against persons with disabilities.
- Ensure the participation of persons with disabilities and their representative organizations in the development and implementation of anti-corruption programmes.
- Keep adequate levels of public spending for disability inclusion.

Providing legal identity, including birth registration (target 16.9)

In some countries, birth registration is less likely for children with disabilities than for children without disabilities, and in several countries, more than 50 per cent of children with disabilities remain unregistered. These countries would need to increase the registration rate for children with disabilities by 7 or more percentage points each year to ensure that all children with disabilities are registered by 2030.

The following actions are recommended:

- Conduct studies to identify barriers to register children with disabilities and target efforts to address those barriers.
- Provide online, telephone-based or mobile means of birth registration, especially in remote areas and during crises and emergencies.
- Provide disability training for officers responsible for the birth registration process.

Ensuring public access to information (target 16.10)

National laws on access to public information do not always address the needs of persons with disabilities: only 6 per of countries mention accessible formats in these laws and only 1 per cent of countries explicitly refer to accessible formats for information online. One barrier to the wider use of sign language in the provision of public information is that just 3 per cent of countries recognize at least one sign language as an official language.

The following actions are recommended:

- Adopt or revise laws on access to information to ensure equal access for persons with disabilities.
- Train staff involved in access to public information on disability inclusion.
- Allocate resources to ensure the accessibility of public information.

Mobilizing official development assistance (target 17.2)

Bilateral aid in support of disability inclusion surpassed 15 billion US dollars in 2021, corresponding to 17 per cent of total bilateral aid. However, only around 3 per cent of disability-inclusion aid targets disability inclusion as the main objective of the activity; for the other 97 per cent, disability inclusion is a secondary objective. The sectors receiving the most disability-inclusion aid are transport and health.

The following actions are recommended:

- Encourage donors to incorporate disability inclusion in their aid, including for climate action and for combating intersectional discrimination.
- Encourage sectors other than disability inclusion to participate in the coordination of disability-inclusion aid.
- Raise awareness of the Convention on the Rights of Persons with Disabilities among the private sector involved in aid.
- Involve representative organizations of persons with disabilities in international cooperation activities.

Enhancing the use of enabling technology (target 17.8)

In countries with low levels of the Human Development Index (HDI), only 11 per cent of the persons who need assistive products can obtain them; in countries with medium levels of the HDI, only 33 per cent can do so. The most frequent barrier is cost, affecting 31 per cent of those who lack the assistive products they need. Although 90 per cent of countries have a financing mechanism to fully or partially cover the costs of assistive technology, in practice these costs are often borne out-of-pocket by users, families or friends.

Over the past few years, promising steps have been taken to improve access to assistive technology. More than 80 per cent of countries have laws and regulations to support access to assistive technology. Adequate services, human resources and education on assistive technology has progressed more slowly, with less than 50 per cent of countries providing these. At least seven countries have developed national lists of priority assistive products to facilitate acquisition.

The transfer of assistive technology from developed to developing countries can boost access to this technology worldwide. Innovations are concentrated in a few countries, with more than 80 per cent of patents for assistive technology filed in China, Japan or the United States. Bilateral aid dedicated to providing access to assistive technology is small, corresponding to only 0.1 per cent of all bilateral aid dedicated to disability inclusion.

The following actions are recommended:

- Improve access to safe, effective and affordable assistive technology.

- Involve users of assistive products, their families and representative organizations of persons with disabilities in policy development and programme planning.
- Include assistive technology in emergency and humanitarian responses.
- Provide technical and financial assistance through international cooperation.
- Encourage local production of assistive products.

International trade (targets 17.10 to 17.12)

Trade can serve as an incentive to promote laws and practices to ensure the realization of the rights of persons with disabilities and their inclusion in society. Among preferential trade agreements negotiated from 2010 to 2020, 27 per cent included such clauses, which were entirely absent before 1970.

Trade can also play a major role in the availability and affordability of assistive technology. International trade of assistive products is concentrated in developed countries, which account for 74 per cent of the value of exports of assistive technology. Imports are similarly concentrated: developed countries account for 82 per cent of the value of imported assistive technology. These shares have remained stagnant since 2014. Europe, Northern America and Oceania import annually more than 50 US dollars of assistive products per capita, compared to less than 10 US dollars for Asia, Latin America, the Caribbean and sub-Saharan Africa.

Many assistive products have tariffs imposed at the border. Worldwide, the average tariff is 5 per cent for wheelchairs, orthotics, prosthetics and hearing aids and 5 per cent to 10 per cent for glasses and lenses. Behind these average values lies a wide range of tariffs, with some being as high as 35 per cent.

About 20 per cent of countries or areas are parties to trade agreements with preferential tariffs for assistive products. About 80 per cent of such agreements set tariffs at zero for assistive products. About 20 per cent of least developed countries have such preferential trade agreements.

The following actions are recommended:

- Ensure that international trade agreements do not perpetuate inequalities experienced by persons with disabilities.
- Reduce barriers to the international trade of assistive technology.
- Keep commitments on exports of assistive technology during emergencies and crises.
- Promote the trade of assistive technology among developing countries.

Increasing the availability of data (target 17.18)

An increasing number of countries collect data on persons with disabilities and use internationally comparable methods to do so. However, the capacity to use these methods is lacking especially in least developed countries. Since 2015, questions developed by the Washington Group of the United Nations

Statistical Commission have been used in national surveys in more than 30 countries and in 42 of the 51 countries that collected disability data in censuses. The Model Disability Surveys have been conducted in 14 countries.

The availability of data disaggregated by disability in the United Nations SDG Indicators Database has increased slowly since 2018. At the current rate, fewer than half of the SDG indicators explicitly requiring disability disaggregation are expected to have such data available by 2030.

The following actions are recommended:

- Integrate and harmonize the collection of disability data in national information systems.
- Use internationally comparable methods to collect data on persons with disabilities.
- Establish and maintain regular and standardized systems for disability data collection and consider establishing a register of persons with disabilities to produce timely, frequent and accurate data.
- Involve persons with disabilities and their representative organizations in data production and analysis, especially in census planning and operations.
- Build statistical capacity in developing countries, particularly in least developed countries.
- Create a global, online and accessible repository of data on persons with disabilities.
- Increase the amount of data disaggregated by disability in the United Nations SDG indicator database.
- Release online and hard copy data in accessible formats for persons with disabilities.

Introduction

Persons with disabilities all over the world have persistently faced barriers to their full inclusion and participation in the life of their communities. The United Nations flagship report, *Disability and Development Report 2018,* was the first stocktaking of the situation of persons with disabilities vis-à-vis the implementation of the 2030 Agenda for Sustainable Development and its 17 Goals. That report identified substantial gaps in the implementation of the Sustainable Development Goals (SDGs) for persons with disabilities and, in order to help address this challenge, the General Assembly requested the Secretary-General, in coordination with all relevant United Nations entities, "to provide an update on the Disability and Development Report to the General Assembly at its seventy-eighth session".[1] The *Disability and Development Report 2024 – Accelerating the realization of the SDGs by, for and with persons with disabilities,* responds to that request and comes at a critical time. The *Report* is the second stocktaking of where we stand on key aspects of mainstreaming disability globally in light of the 2030 Agenda and it is released six years from the 2030 deadline for achieving the Sustainable Development Goals. This stocktaking is crucial to identify what is needed to make progress for persons with disabilities in society and development and to provide wide-ranging recommendations for transformative change. Ultimately, the report builds on the 2030 Agenda, together with the Convention on the Rights of Persons with Disabilities (CRPD), to offer a road map towards a more inclusive and sustainable world.

The 2030 Agenda for Sustainable Development, its 17 SDGs and 169 targets were adopted by all 193 Member States of the United Nations in 2015. It set 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, which as of June 2024, received 191 ratifications and has been implemented for over a decade and a half.

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 the current situation and progress made so far towards the SDGs and shows that efforts need to be accelerated to ensure that the goals and targets are achieved for persons with disabilities.

The following chapters focus on the goals and targets of the 2030 Agenda, providing available evidence on the situation and progress for persons with disabilities in relation to each SDG, as well as related best practices. The *Report* also identifies possible strategies to mainstream disability in the implementation, monitoring and evaluation of each SDG.

The final chapter provides an overview of SDG progress for persons with disabilities and analyses how

disability, as a cross-cutting development issue, will impact the ongoing efforts of the international community towards inclusive and sustainable development.

Definition of disability

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".[2] Similarly, in the International Classification of Functioning, Disability and Health,[3] 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.

The overall experience of disability is diverse as it is the combination of limitations in functioning across multiple domains (for example, walking or seeing), each on a spectrum of severity, 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 in terms of the meaning, scope and severity of disability. This *Report* uses country-led data in order to respond to current national circumstances and priorities, while considering methodologies for internationally comparable data developed by international organizations and groups operating under the aegis of United Nations entities. In particular, data produced using the UNICEF/Washington Group Child Functioning Module, the Washington Group Short Set of Questions[4] and the World Health Organization's Model Disability Survey[5] are identified throughout the *Report.*

Sources of evidence

Over 200 experts from United Nations agencies and international financial institutions, Member States and civil society (including research institutions and representative organizations of persons with disabilities) contributed to this *Report*. 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 the Demographic and Health Surveys;[6] the Economic Commission for Latin America and the Caribbean; the Economic and Social Commission for Western Asia; the Economic and Social Commission for Asia and the Pacific; Eurostat;[7]

the International Labour Organization; Integrated Public Use Microdata Series;[8] the Organization for Economic Co-operation and Development; SINTEF;[9] Sozialhelden;[10] the United Nations Educational, Scientific and Cultural Organization; the United Nations Children's Fund; the United Nations Department of Economic and Social Affairs; the United Nations Statistics Division; the United Nations Sustainable Development Goals Database; the World Bank Group; the World Health Organization; and the World Policy Analysis Center.

The current *Report* covers a wider range of data than the *Disability and Development Report 2018* and contains the first global attempt to assess progress towards the SDGs for persons with disabilities. It also covers new areas for which no global research was previously available (for example, the role of international cooperation and global trade in enabling the inclusion of persons with disabilities in society). In addition, non-traditional forms of data were explored to complement data gaps: more than 1.7 million data points of crowdsourced data from computer and smartphone applications were examined to inform an analysis of the accessibility of physical spaces, and social media data were used to analyse the involvement of persons with disabilities in climate change activism and in the representation of women in services for persons with disabilities. Finally, reviews of legislation from all 193 United Nations Member States were conducted and analysed to highlight best practices and to assess the current status of discriminatory laws and inclusive legislation for persons with disabilities.

Assessment of progress

Throughout the *Report*, an assessment of progress is conducted for relevant indicators with data available over time. This progress is evaluated by forecasting the estimate for the target year, which is 2030 for most SDG indicators, although a few targets were set for 2025 and some were set for 2020.[11] Based on these analyses, the *Report* indicates whether the respective target is expected to be met by the target year, if the situation has deteriorated or stagnated, or if there was progress but this progress has been insufficient (that is, if the trends observed thus far continue, the target will not be met by the target date). In the latter case, the *Report* also indicates the acceleration in the observed trend needed to meet the target by the target date.

For indicators with an explicit numerical target, this analysis uses that number as the target. For indicators without an explicit numerical target, where relevant, the assessment is based on closing the gap between persons with and without disabilities by the target date.

Ending poverty (Goal 1)

This section presents an overview of the situation of persons with disabilities vis-à-vis Goal 1, which calls to end poverty in all its forms. Targets under Goal 1 include: 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 (target 1.2); implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable (target 1.3); and ensure that all men and women have access to financial services (target 1.4).

Poverty among persons with disabilities is a key concern in the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD calls on States Parties to ensure access by persons with disabilities to poverty reduction programmes (article 28), equal remuneration for work of equal value (article 27) and equal access to retirement benefits and programmes (article 28). The 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), and rights to an adequate standard of living and social protection (article 28).

Current situation and progress so far

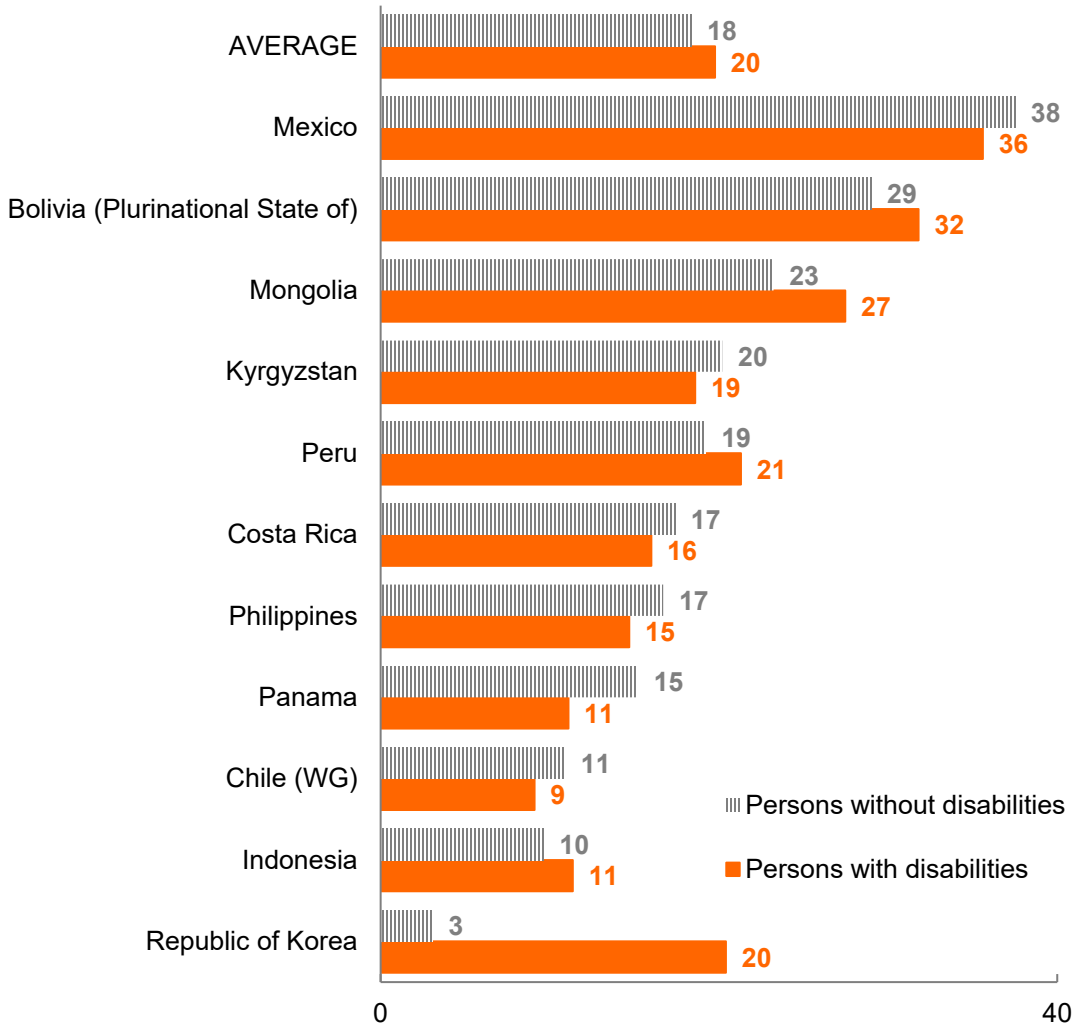
Persons with disabilities, and their households, are more likely to live in poverty, as shown in income poverty measures and, more significantly, in multidimensional poverty measures.

Income poverty measures tend to reveal more modest gaps in poverty rates between persons with and without disabilities and mask real poverty gaps. These measures tend to assume that the income poverty line, that is, the monetary amount that is needed to meet basic needs, for persons with and without disabilities, is the same. However, persons with disabilities have a higher cost of living due to higher medical bills and the costs associated with assistive technology, special transport and support services. Omitting these costs will make persons with disabilities look wealthier than they are. For example, income poverty, among 11 countries, reveals a small gap: on average 20 per cent of persons with disabilities versus 18 per cent of persons without disabilities lived under the national poverty line (Figure 1). Due to a lack of comparable data over time, it remains difficult to assess on a wide scale the evolution of income poverty rates among persons with disabilities. An exception is Costa Rica and Peru, for which comparable data over time suggest that poverty rates among persons with disabilities have remained stagnant between 2015 and 2021 (Figure 2).

An assessment of poverty in non-monetary forms provides a more comprehensive picture of the current situation of persons with disabilities. Among 33 countries or areas, 80 per cent of persons with disabilities compared to 60 per cent of persons without disabilities are multidimensionally poor, that is, they experience deprivations in more than one of the following dimensions: health, education, employment,

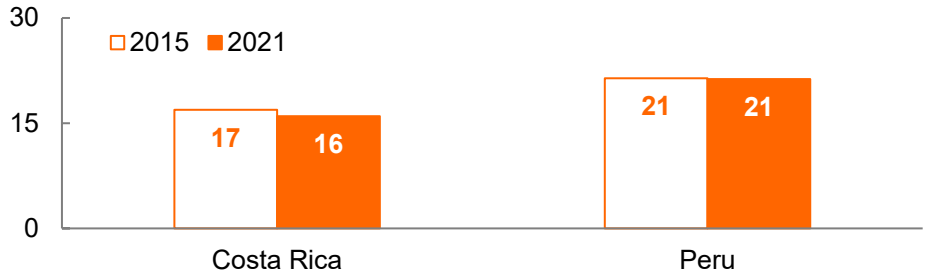
and living standards (Figure 3). In all countries except Djibouti, adults with disabilities are significantly poorer on a multidimensional level compared to adults without disabilities. The most common drivers of multidimensional poverty are lower levels of education and lack of employment among persons with disabilities.

Figure 1. Percentage of persons living under the national poverty line, by disability status, in 11 countries, in 2021 or latest year available.



Note: Poverty lines for Bolivia (Plurinational State of), Chile, Costa Rica, Mexico, Panama and Peru were defined by regional methodology developed by ECLAC.[12] (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: ECLAC[13] and ESCAP.[14]

Figure 2. Progress in the percentage of persons with disabilities living under the national poverty line, in 2 countries, from 2015 to 2021.



Source: ECLAC.[13]

Box 1. Target 10.c: by 2030, reduce to less than 3 per cent the transaction costs of migrant remittances and eliminate remittance corridors with costs higher than 5 per cent

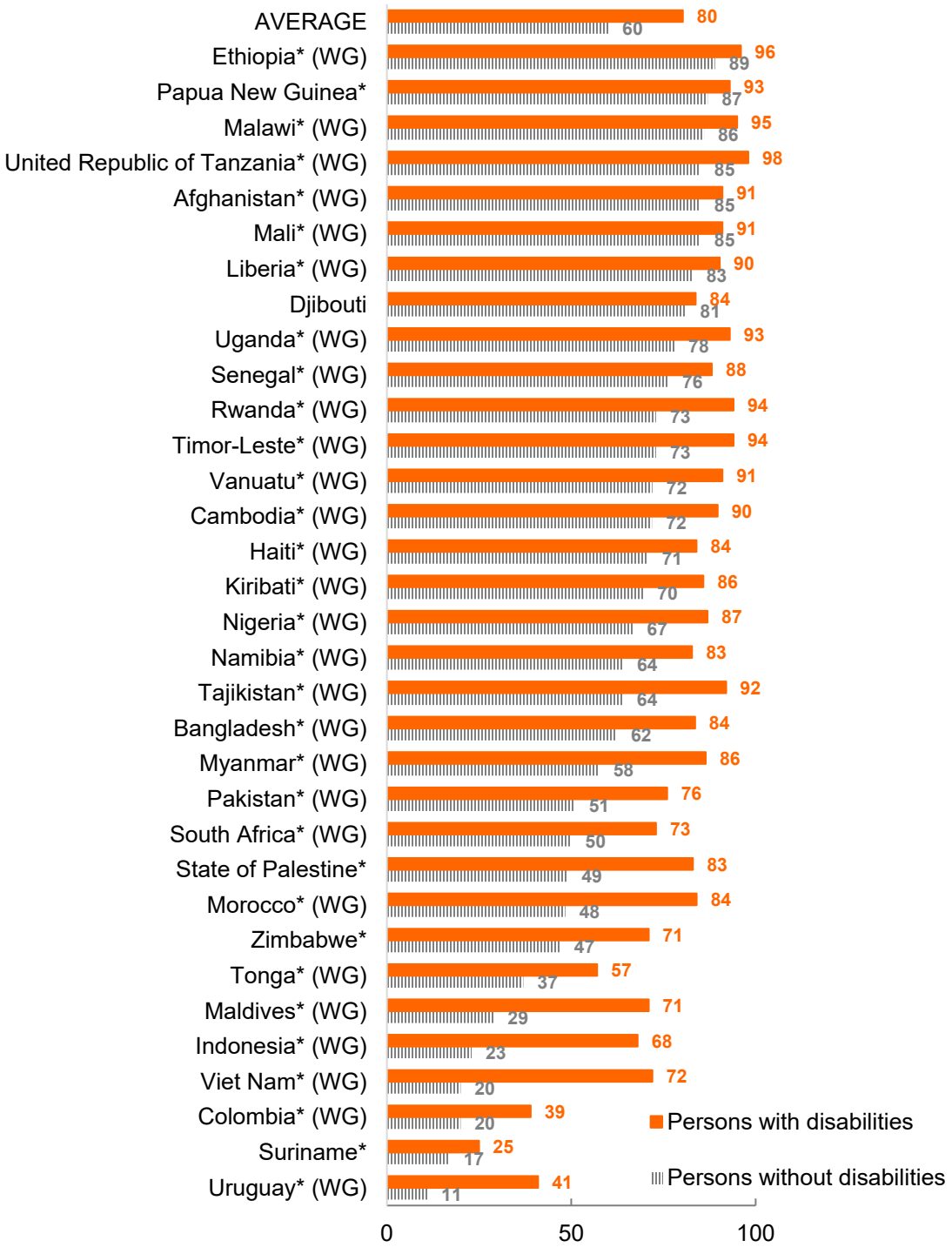
Remittances, that is, the money immigrants send to their families back home, can be instrumental in lifting their families out of poverty. The Global Compact for Safe, Orderly and Regularly Migration (2018), in its objective 20 regarding transfer of remittances, calls for opening up distribution channels to underserved populations including for persons with disabilities.[15]

Persons with disabilities are part of migrant populations and may need to send remittances home. For persons with disabilities who stay back home, receiving remittances from relatives abroad can be essential especially if they are struggling financially or cannot afford the assistive technology, healthcare, rehabilitation and other crucial services they may need.

When sending and receiving remittances, persons with disabilities may face financial barriers such as transaction costs, as well as physical and other barriers to accessing financial services, such as not having accessible transportation to these services. In some cases, accessible transportation may be available but more costly than other non-accessible transportation.

The COVID-19 pandemic disproportionally impacted remittance flows for persons with disabilities. In a worldwide study among 46 countries in 2020, 49 per cent of parents or caregivers with disabilities reported that they had lost usual cash transfers and remittance flows since the beginning of the pandemic compared to 31 per cent of parents or caregivers without disabilities.[16]

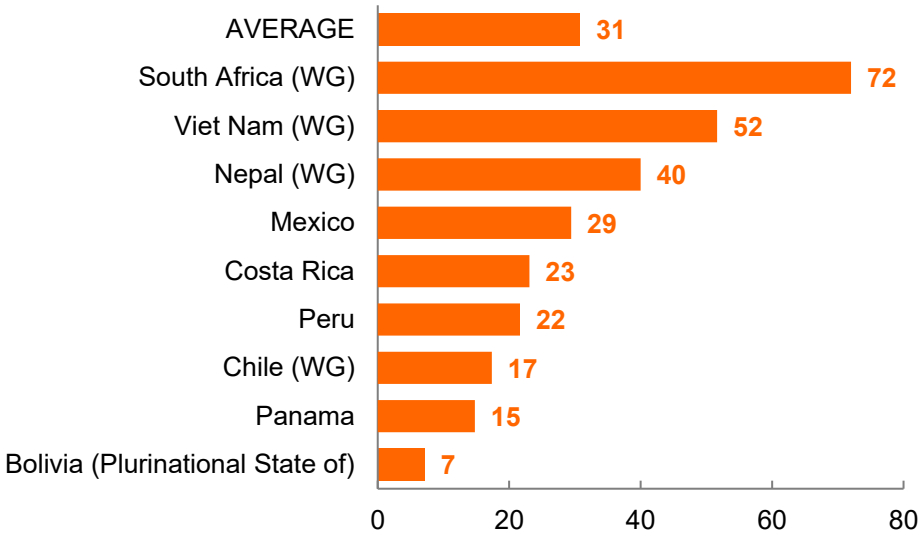
Figure 3. Multidimensional poverty rates,[17] by disability status, in 33 countries or areas, in 2018 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference is statistically significant at the level of 5 per cent or less. Source: Mitra and Yap (2021).[18]

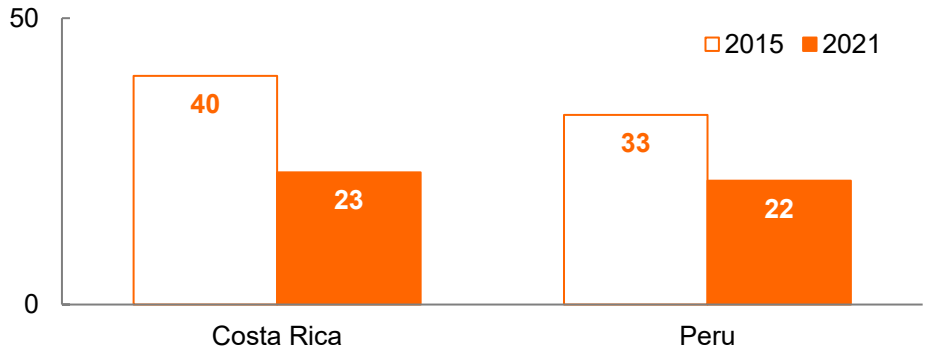
Persistent gaps in income and wages between persons with and without disabilities contribute to higher poverty rates among persons with disabilities. Persons with disabilities have lower incomes and wages than persons without disabilities and households with persons with disabilities earn a lower income per capita than those without persons with disabilities (Figure 4). Income per capita in Nepal, South Africa and Viet Nam is 40 per cent to 72 per cent higher in households without persons with disabilities than those with. In Latin American countries, the average wage for persons without disabilities tends to be 7 per cent to 29 per cent higher than for persons with disabilities. In Costa Rica and Peru, progress has been made in reducing this gap. In 2015, the wage of persons without disabilities was 40 per cent higher than that of persons with disabilities in Costa Rica and 33 per cent higher in Peru; in 2021, the wage was only about 20 per cent higher in both countries (Figure 5). Households with persons with disabilities may experience additional reductions in their income if a household member has to provide care for persons with disabilities and cannot participate in the labour market. They may also face increased barriers to receiving remittances from family members abroad (see Box 1).

Figure 4. Income/wage gaps between persons without and with disabilities, in percentage, in 9 countries, in 2021 or latest year available.



Note: Data show the ratio of the average wage of persons without disabilities aged 15 and over to the average wage of persons with disabilities aged 15 and over, in percentages; expect for Nepal, South Africa and Viet Nam for which the data show the ratio of the median income per capita of households without persons with disabilities to the median income per capita of households with persons with disabilities, in percentages. (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: ECLAC,[13] Banks et al. (2021)[19] and South African General Household Survey 2016.

Figure 5. Progress in income/wage gaps between persons with and without disabilities, in percentage, in 2 countries, from 2015 to 2021.



Source: ECLAC.[13]

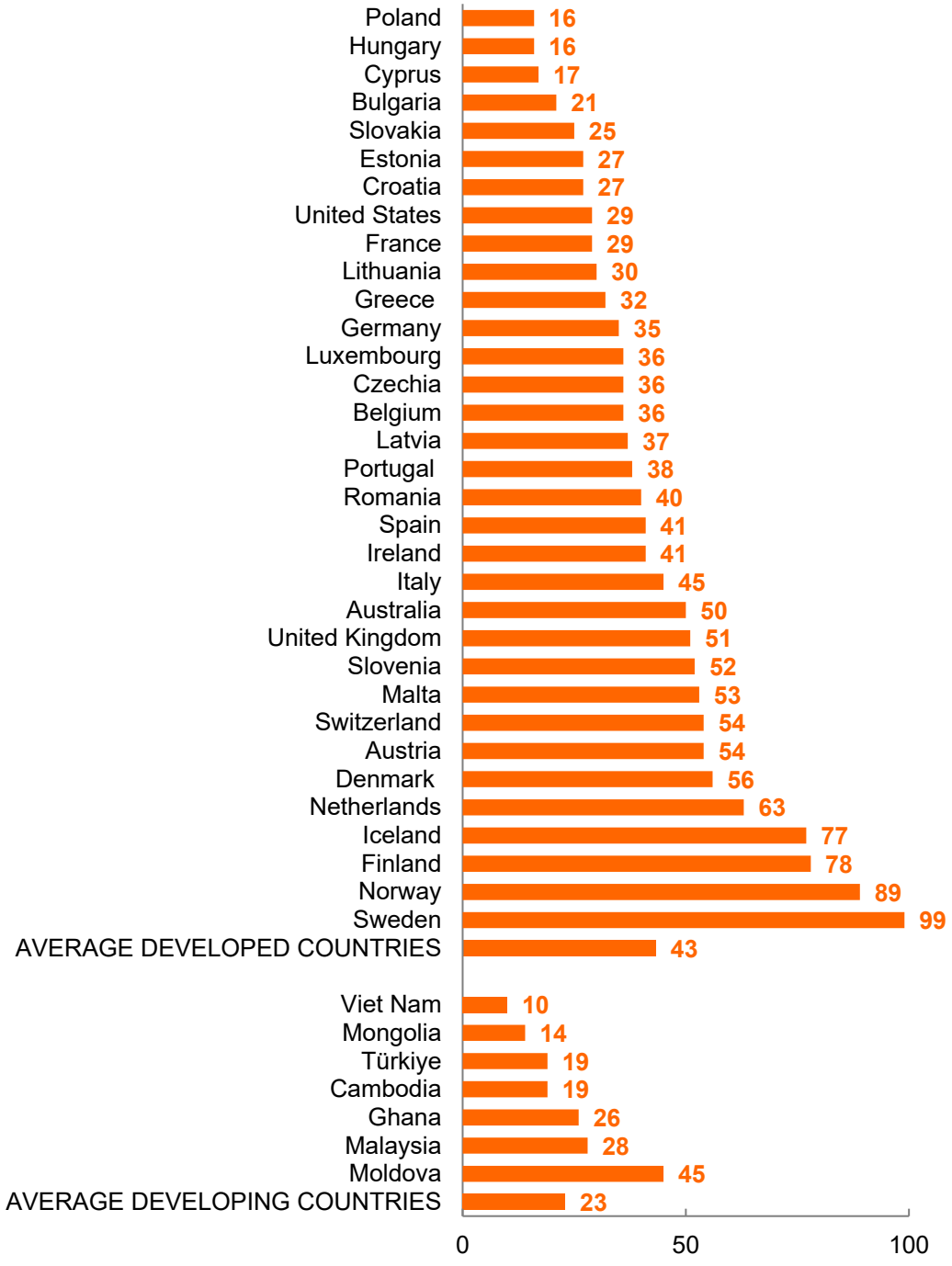
Extra costs associated with disability

Poverty for persons with disabilities can be aggravated because of extra costs related to disabilities. These costs are additional expenses that persons with disabilities require to achieve a similar level of participation and well-being compared to persons without disabilities. Common sources of extra costs include healthcare and transportation as well as rehabilitation, personal assistance and assistive technology. Such costs can be impoverishing, severely depleting household resources. Further, the inability to meet these costs can limit social participation, which in the long run can worsen poverty and the fulfilment of human rights. Extra costs are often substantial (Figure 6). Overall, among 40 countries, the average spending on these extra costs represents between 10 per cent (Viet Nam) and 99 per cent (Sweden) of household income.

There are substantial differences among persons with disabilities, as the type and magnitude of extra costs vary by factors such as type and severity of disability, age, individuals' environments and level of participation.[20] For example, in Viet Nam, while spending on extra costs represents 10 per cent of household income on average, costs varied widely by type of disability (from 9 per cent for persons with self-care limitations to 29 per cent for persons with communication difficulties) and severity (costs are seven times higher for persons with severe disabilities compared to moderate disabilities).[21]

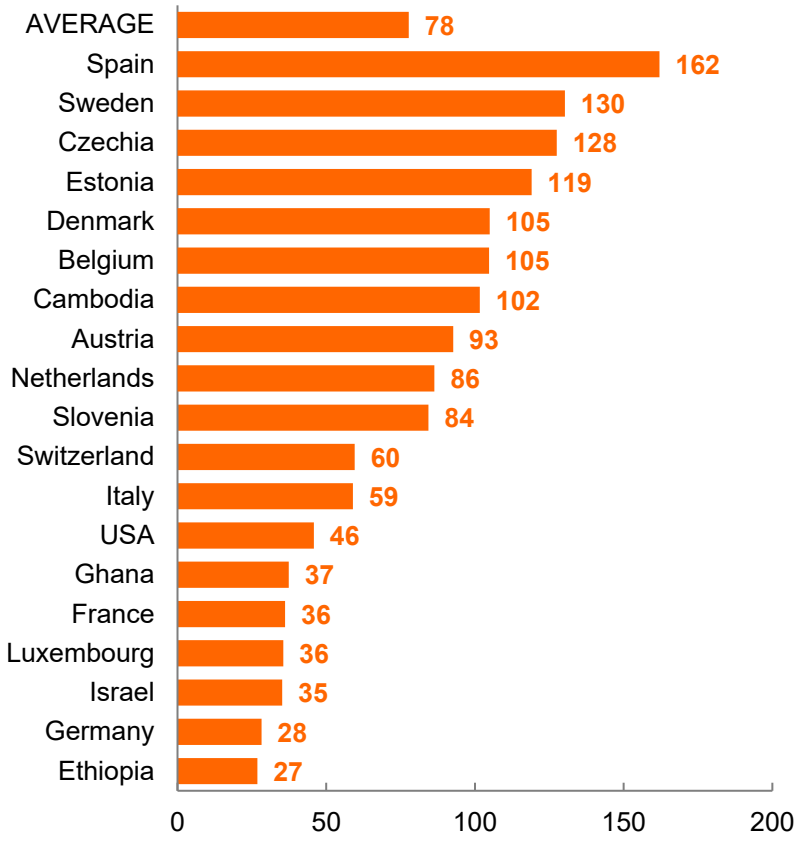
Most methods used for estimating extra costs only capture what people have spent rather than what they would require for full participation. Focusing on actual rather than required spending underestimates the true value of extra costs, as many persons with disabilities are unable to afford the complete range of goods and services they require. Additionally, certain items may not be widely available in some settings, or people may lack information about how to access them.[22] Lower availability of required goods and services as well as lower capacity to pay may explain why estimates of spending on extra costs tend to be higher in developed countries than in developing countries (Figure 6).

Figure 6. Extra disability-related costs as a proportion of household income, in 40 countries, in 2018 or latest year available.



Source: Antón and others (2016); İpek (2020); Ozdamar and others (2020); Minh and others (2015); Touchet and Morciano (2019); Morris and others (2020); Vu and others (2020); Palmer and others (2019); Carrar and Cumpa (2014); Asuman and others (2021); Amin and Adros (2019).[23,24]

Figure 7. Percentage increase in income poverty among persons with disabilities, when extra costs related to disability are considered, in 19 countries, in 2018 or latest year available.



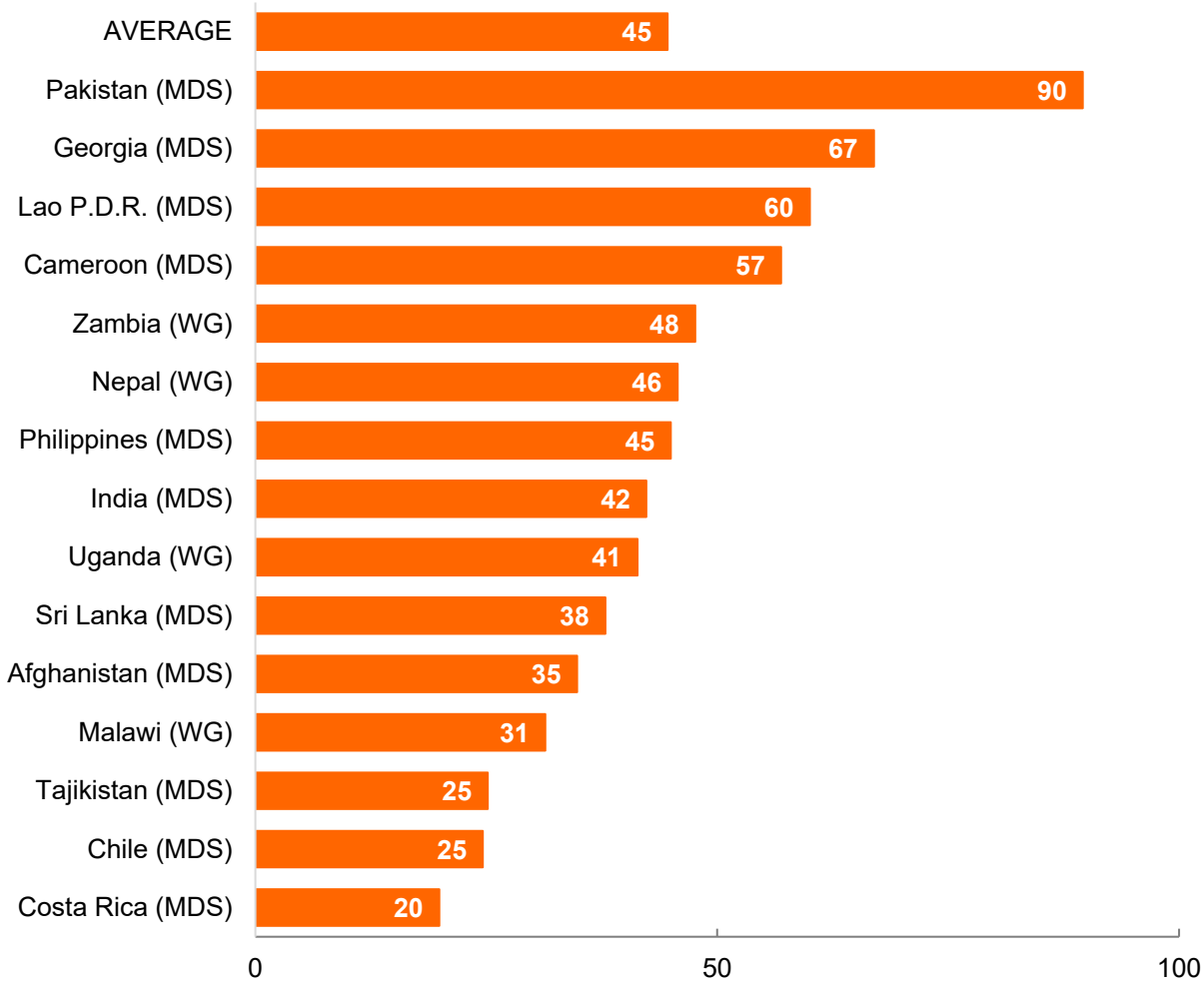
Note: Data for Ethiopia are based on health costs only.
Source: Asuman and others (2021); Palmer and others (2019); Morris and others (2020); Morris and Zaidi (2020); Hailemichael and others (2019).[25]

Extra costs are rarely considered when measuring income poverty, as most poverty assessments, whether for producing national poverty measures or for identifying benefits under social protection programmes, assume persons with and without disabilities need to spend the same amount to meet their daily needs. Incorporating even modest estimates of extra costs can substantially increase the proportion of persons with disabilities living in income poverty. The percentage increase in income poverty headcount among persons with disabilities when raising the poverty line by the average amount spent on extra costs ranges from an increase of poverty rates by 27 per cent in Ethiopia to 162 per cent in Spain (Figure 7).

Knowing the amount and the causes of extra costs is key for policy and planning, including for social protection programmes.[26] For example, healthcare is a major source of extra costs. Healthcare and assistive technology costs are highly variable among individuals and can require high, but infrequent, spending (for example, for a new assistive device). As such, social health protection (for example, national health systems or social health insurance) that covers disability-related health services may be

suited for these costs. In Türkiye, the introduction of universal healthcare was estimated to have cut persons with disabilities' total spending on extra costs by more than half.[27]

Figure 8. Percentage of persons with disabilities who consider banks, post offices and shops in their community hindering or not accessible, in 15 countries or areas, in 2021 or latest year available.

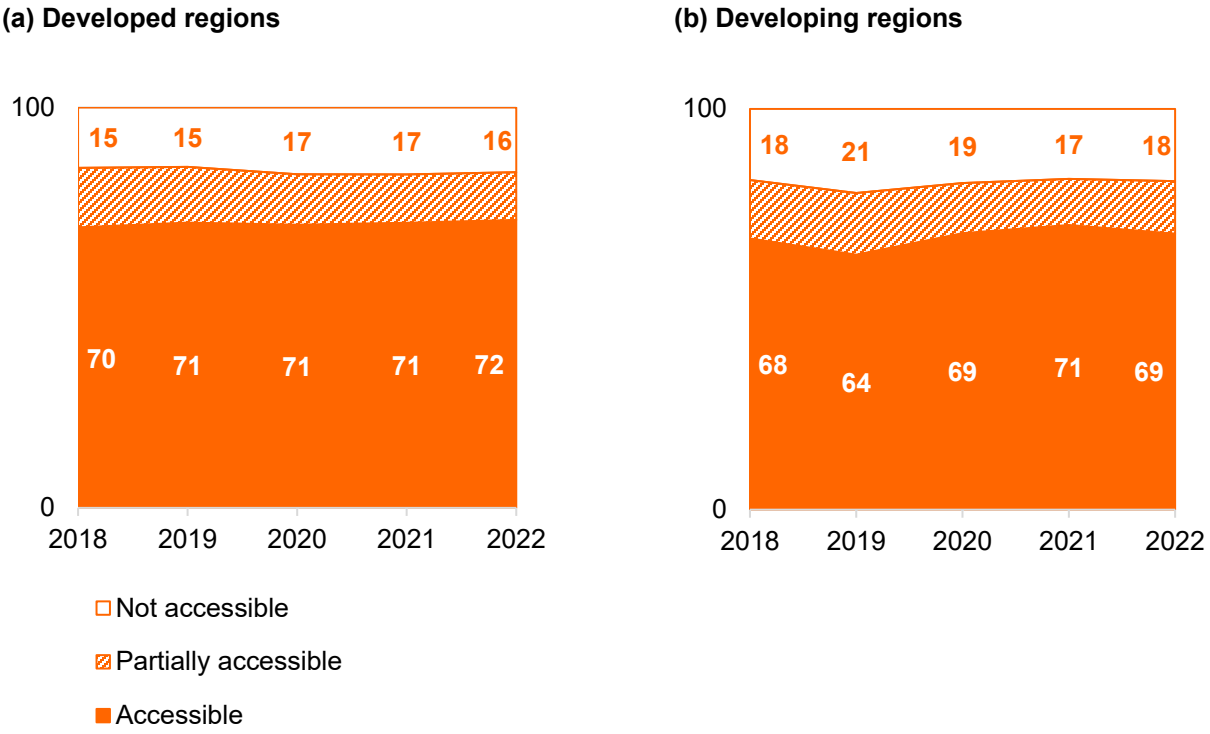


Note: Data for Malawi, Nepal, Uganda and Zambia refer to banks only. Data from Cameroon and Pakistan were collected in selected regions of these countries and are not nationally representative. (MDS) identifies data produced using the Model Disability Survey. (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO (on the basis of data from the Model Disability Surveys).

Access to financial services

Access to financial services is a critical component of financial stability and can help people out of poverty. Without access to financial services (such as a bank account), individuals cannot obtain credit and may face higher costs for conducting financial transactions through alternative financial service providers. Such individuals find it more difficult to save money and plan for the future, leaving them more vulnerable to the impacts of medical or job emergencies that may endanger their financial stability. The lack of longer-term savings undermines their ability to improve their skills, purchase a home, or pay for their education or that of their families.

Figure 9. Percentage of banks that are accessible for wheelchair users, in developed and developing regions, from 2018 to 2022.



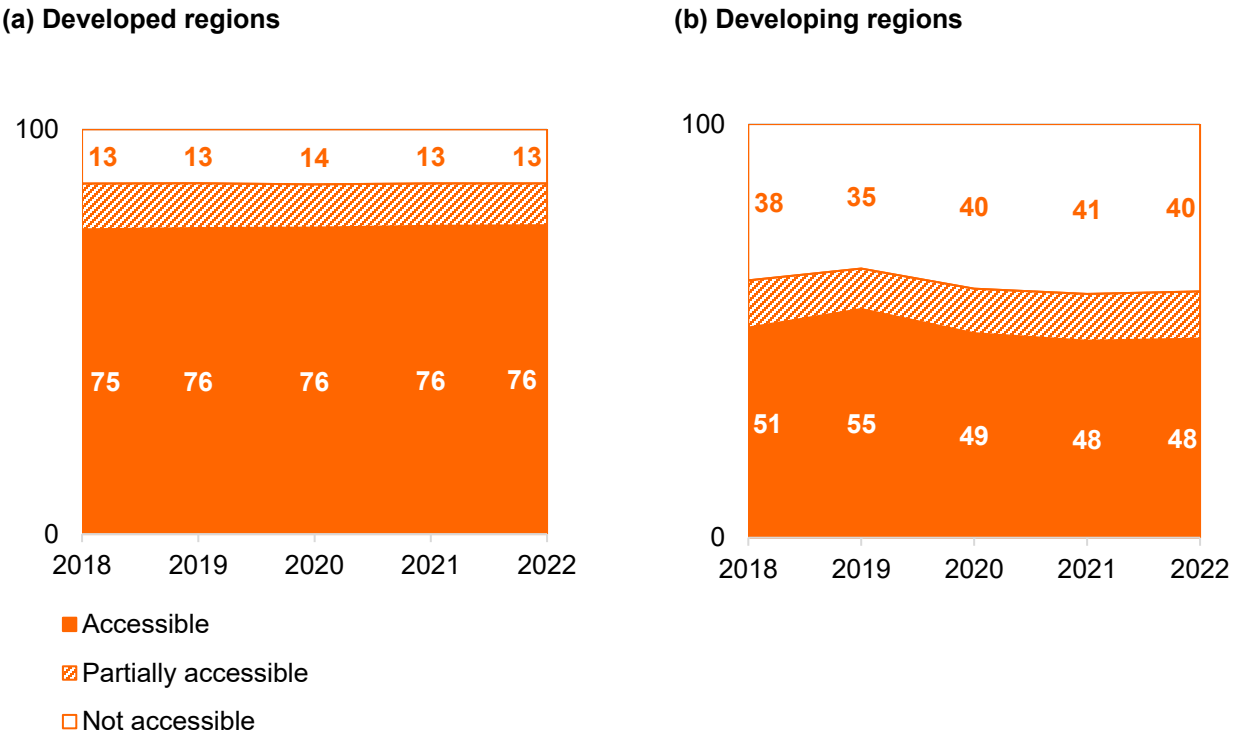
Source: UNDESA (on the basis of data from Sozialhelden[10]).

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. In 15 countries or areas, between 20 per cent and 90 per cent of persons with disabilities consider that the banks, post offices and shops in their communities are not accessible (Figure 8). In Nepal, Uganda and Zambia, more than 40 per cent of persons with disabilities consider banks not accessible. Crowdsourced data suggest that, in 2022, about

a third of banks in both developed and developing regions were not accessible or only partially accessible for wheelchair users, a percentage that has remained relatively constant since 2018 (Figure 9). Automated teller machines (ATMs) tend to be considerably less accessible for wheelchair users in developing regions. As of 2022, about a quarter of ATMs in developed regions were not accessible or only partially accessible for wheelchair users, while about half of ATMs in developing regions were not accessible or only partially accessible for wheelchair users (Figure 10). These percentages have remained fairly constant since 2018.

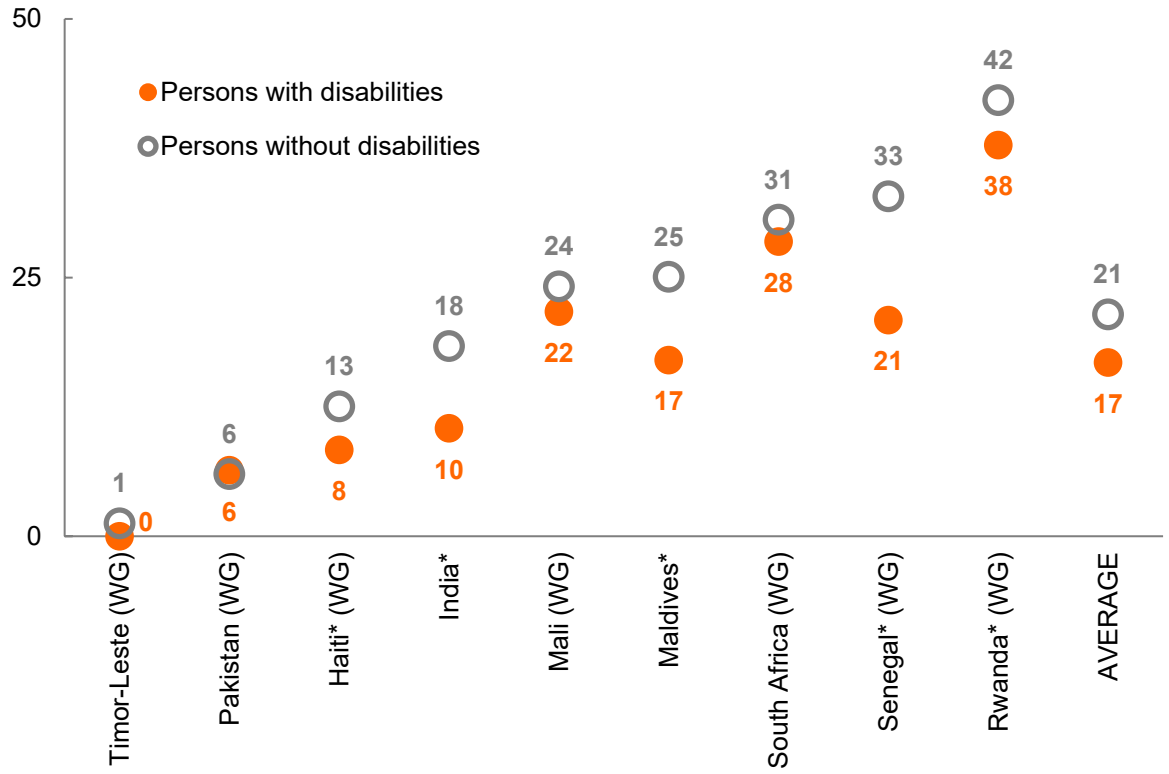
Online baking has become an essential tool for accessing financial services. Yet, many persons with disabilities face barriers to using these services. Among nine countries, on average, 17 per cent of persons with disabilities versus 21 per cent of persons without disabilities conduct financial transactions with a mobile phone (Figure 11). This small gap of 4 percentage points masks wide variations across countries, with the largest gaps observed in Senegal (12 percentage points), India (8 percentage points) and the Maldives (8 percentage points).

Figure 10. Percentage of ATMs that are accessible for wheelchair users, in developed and developing regions, from 2018 to 2022.



Source: UNDESA (on the basis of data from Sozialhelden[10]).

Figure 11. Percentage of persons who use a mobile phone for financial transactions, by disability status, in 9 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference is statistically significant at the level of 5 per cent or less. Source: UNDESA (on the basis of data from DHS[6]).

Access to social protection

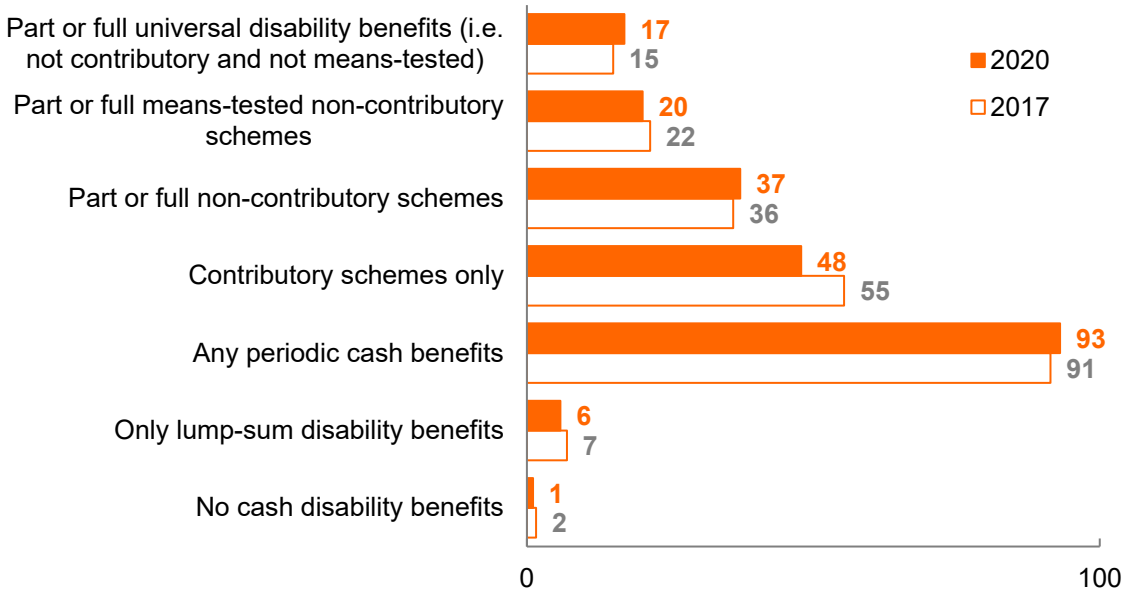
Considering the inequalities and greater vulnerabilities that persons with disabilities face, inclusive social protection is a critical element to strengthen the resilience, inclusion and participation of children, adolescents, working age adults and older persons with disabilities. Social protection systems, in particular disability-targeted benefits, can help individuals and their families meet both their extra costs related to their disabilities as well as common needs like shelter, food, healthcare, water and electricity. Globally, as of 2020, only 1 per cent of countries had no disability benefit programs, down from 2 per cent in 2017 (Figure 12). However, despite the fact that most countries have some kind of disability benefits, their coverage – in terms of percentage of persons with disabilities covered by the benefits – tends to be low: these benefits only covered 34 per cent of persons with severe disabilities worldwide (Figure 13).

Moreover, not all benefits offer the same security. Some benefits are only a one-time lump-sum benefit, while others offer periodic benefits: in 2020, 6 per cent of countries had only lump-sum disability benefits, reflecting a 1 percentage point decrease from 2017 to 2020 (Figure 12). As of 2020, 93 per cent of

countries had schemes that provided periodic cash benefits for persons with disabilities, up from 91 per cent in 2017 (Figure 12).

One factor that restricts the coverage of disability benefits is the limitation of these benefits to contributory schemes only. Contributory schemes provide income security for persons working or who have worked in the formal sector (and who have therefore contributed or are contributing to social protection), but they are of limited support to those who have never contributed, such as children with disabilities and most persons with disabilities in many developing countries who are more likely to be working in the informal economy or unemployed (see the chapter on Goal 8). In 2020, about 48 per cent of the countries had contributory schemes – a decrease from 2017, when 55 per cent of countries had contributory schemes (Figure 12).

Figure 12. Percentage of countries with cash disability benefits programmes anchored in national legislation, by type of programme and benefit, in 2017 and 2020.



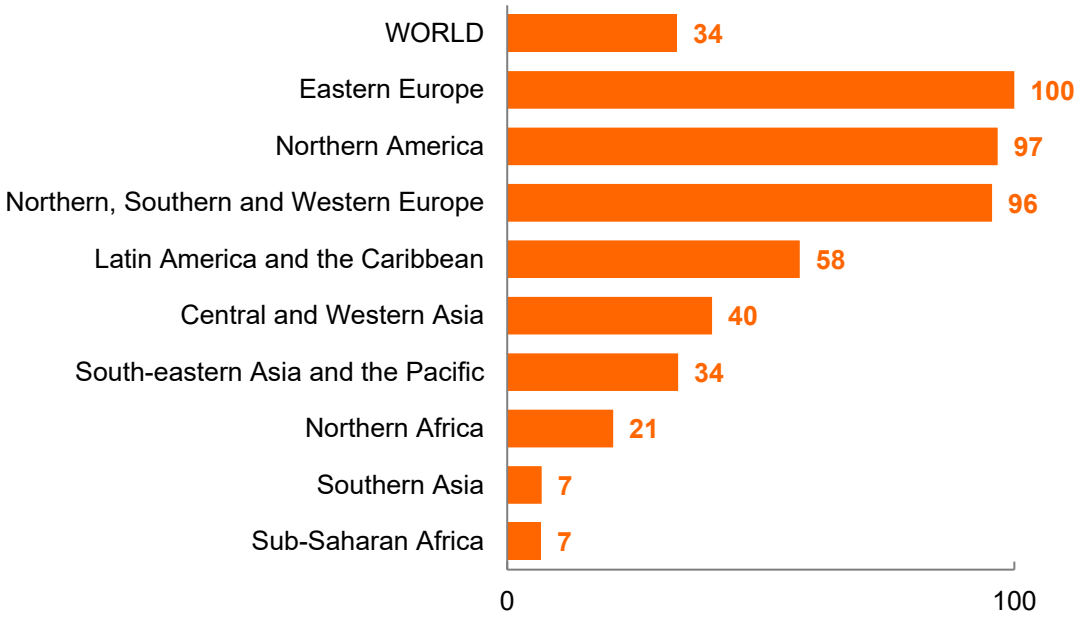
Note: Data for 2017 are based on 186 countries; 2020 values are based on 188 countries.
Source: The 2017 data were provided by ILO for this Report; for the 2020 data: ILO (2021).[28]

Non-contributory schemes tend to have wider coverage, as they are not limited to those who have worked in the formal sector and contributed for a number of years. As of 2020, only 37 per cent of countries provided non-contributory benefits, a small increase from 36 per cent in 2017. But many non-contributory benefits targeting persons with disabilities are means-tested, that is, they protect only persons or households whose economic means fall below a certain threshold: 20 per cent of countries in 2020 had such a scheme, down from 22 per cent in 2017. Often, means-testing eligibility thresholds do not consider extra costs related to disabilities and therefore are insufficient to address the inequalities experienced by

persons with disabilities. In 2020, only 17 per cent of countries provided universal disability benefits, that is, non-contributory and not means-tested schemes, up from 15 per cent in 2017 (Figure 12).

In addition, many disability benefit programmes have narrow eligibility criteria, framed mostly by limitations of earning capacity and incapacity to work and leaving out persons with disabilities who work but would still need social protection to address the challenges and barriers they face, including disability-related costs such as the cost to obtain and maintain assistive technology and the cost of specialized services. Particularly, in developing countries, social protection systems rarely account for the cumulative impact of barriers to earning income and the diversity of disability-related costs across a person's life. A sole focus on incapacity to work, in social protection programmes, misses completely the disability-related costs needed to seek and keep work as well as the support needs of children and older persons with disabilities.

Figure 13. Percentage of persons with severe disabilities receiving cash benefits, worldwide and by region, 2020 or latest year available.



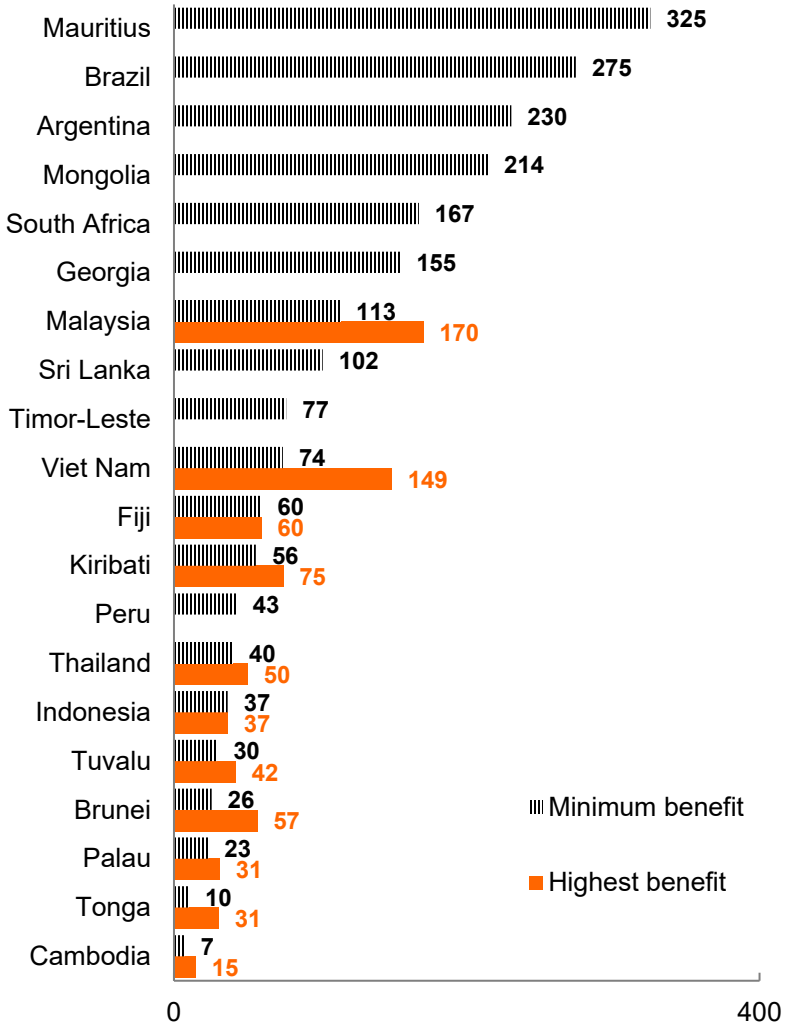
Source: ILO (2022).[29]

Beyond these issues, access to social protection is further limited by the extensive challenges faced by countries to develop accessible, comprehensive and reliable disability assessment mechanisms, which would enable the effective identification of persons with disabilities who need support, the effective management of their cases, and would facilitate policy planning. Moreover, even when benefits are available, persons with disabilities may not be able to access them because of various barriers including non-accessible applications processes and lack of training of social protection officers. Other common

barriers to accessing social protection schemes, such as distance to registration and payment points, administrative complexity and inaccessibility of information, are magnified for persons with disabilities and their families.[30,31]

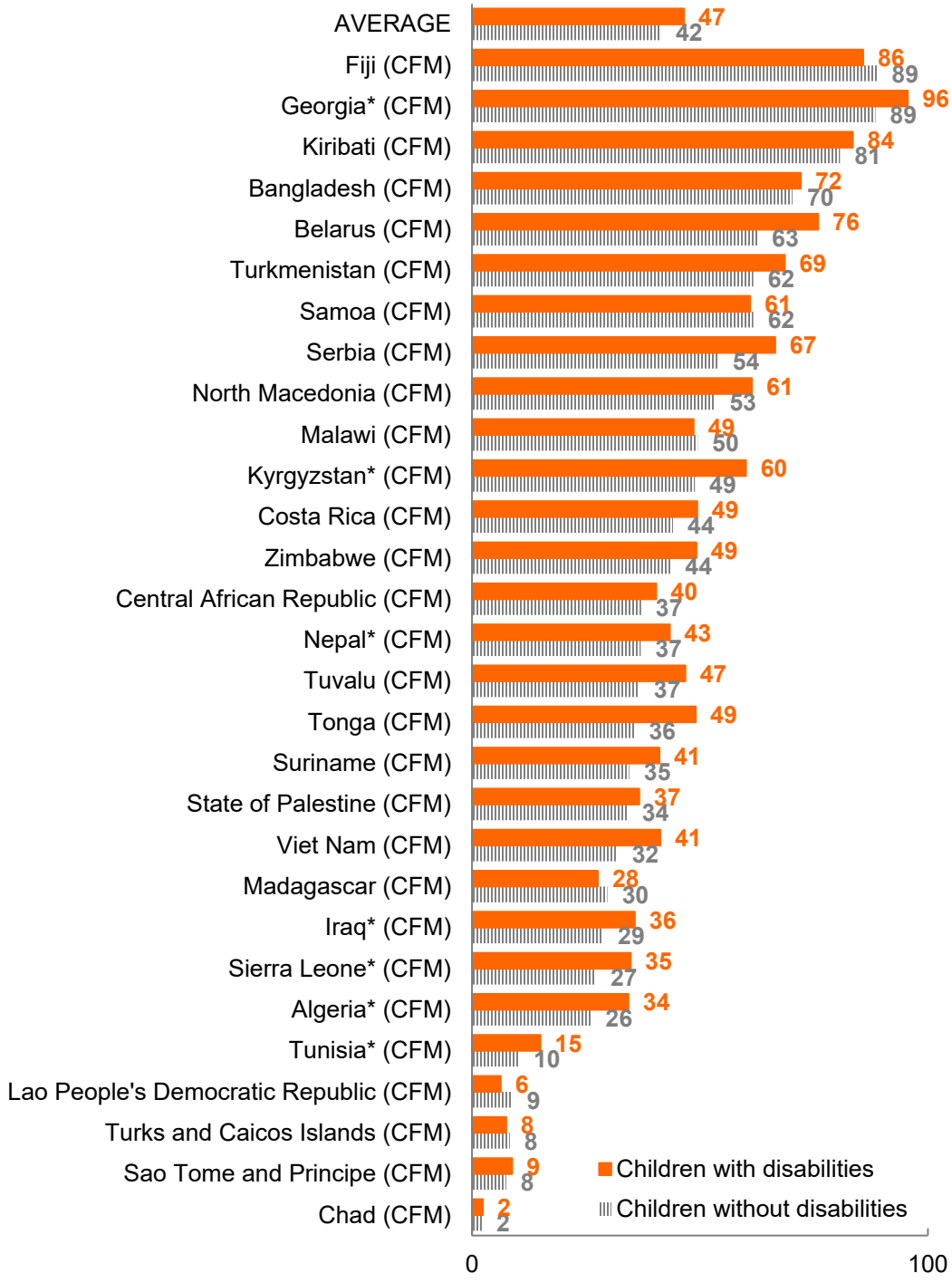
Globally, in 2020, only 34 per cent of persons with severe disabilities received any disability-related cash benefits (Figure 13), up from 27 per cent in 2016.[32] There were significant regional differences: countries in Africa and South Asia had the lowest coverage, while Europe and the Americas had the highest. These differences relate to economic development and the level of maturity of social protection systems.

Figure 14. Value of disability benefits as a percentage of the relevant international poverty line, in 20 countries, in 2022 or latest year available.



Note: The poverty lines included are PPP$2.15 (for low income countries), PPP$3.65 per day (for lower-middle income countries) and PPP$6.85 per day (for upper-middle income countries), based on 2017 PPPs.
Source: UNICEF (2023).[33]

Figure 15. Percentage of children aged 2 to 17 years living in a household that received any type of social transfers and benefits in the last three months, by disability status, in 29 countries, in 2021 or latest year available.



Note: (CFM) identifies data produced using the Child Functioning Module. An asterisk (*) indicates that the difference is statistically significant at 5 per cent or less.
Source: UNICEF (on the basis of data from MICS).

On average, countries spend 1.5 per cent of their gross domestic product (GDP) on social programmes for persons with disabilities (see the chapter on targets 16.6 and 16.7).

Adequacy of support is also critical to combat poverty and enable the inclusion of persons with disabilities in society. The value of non-contributory benefits in many developing countries does not reach the international poverty line (Figure 14).

Children with disabilities also face higher costs related to disability, including costs of specialized services, assistive devices and accessible transportation. For example, in 2021 in the Philippines, on average, a child with disabilities required an expenditure 40 per cent to 80 per cent higher than a child without disabilities.[34] Despite these higher costs, in 29 countries, children with disabilities are only slightly more likely than children without disabilities to live in households accessing any kind of social protection benefits, 47 per cent versus 42 per cent (Figure 15).

Impact of the COVID-19 pandemic

Many persons with disabilities lost income and benefits as a result of the COVID-19 pandemic. Persons with disabilities were often disproportionately affected by job losses and reduced earnings during periods of lockdowns and other restrictions, as they were more likely to work in the informal sector in jobs without security and which relied on face-to-face interactions (see the chapter on Goal 8). In a 2020 study in 37 countries worldwide, a total of 83 per cent of parents and caregivers with disabilities had lost more than half of their income since the start of the COVID-19 pandemic, compared to 66 per cent of those without disabilities.[16] Similarly, in Viet Nam, persons with disabilities were 20 per cent more likely to report their household income had decreased during the pandemic, compared to persons without disabilities.[35]

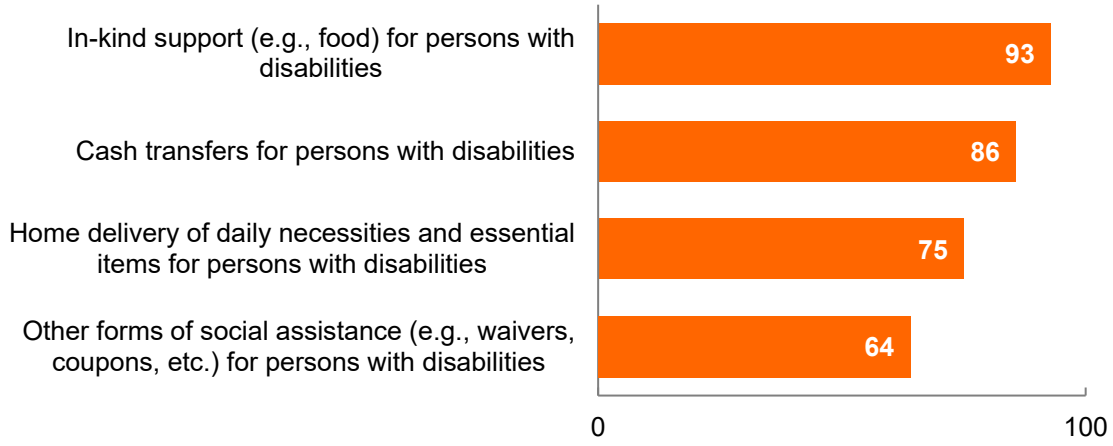
In addition, a large proportion of households with persons with disabilities lost their usual cash transfers or remittance flows after the start of the COVID-19 pandemic, including those from governments, friends or family. For example, in 2020, 49 per cent of parents and caregivers with disabilities from households that had received government benefits or benefits related to social safety nets before the COVID-19 pandemic reported that the household had lost them since the start of the pandemic, compared to 31 per cent of parents and caregivers without disabilities.[16] Many persons with disabilities have additional costs associated with disability, and may have experienced additional financial distress when earnings and benefits were cut, leading to reduced access to basic services as well as disability-related services and pushing persons with disabilities into financial instability or poverty.

Rising inflation since the start of the COVID-19 pandemic has also disproportionately impacted persons with disabilities due to pre-existing higher levels of poverty, increased socioeconomic impact of the pandemic (for example, job losses) and the need to also cover extra costs related to disabilities. The cost and availability of assistive products and services have also been affected, leading to increasing unmet

needs.[36] For example, in the Maldives, inflation was 8 per cent for assistive products and 9 per cent for medicines in the first quarter of 2022, compared to a national inflation rate of 0.6 per cent.[37]

Several countries were able to put in place a variety of measures to support persons with disabilities during the pandemic, including home delivery of daily necessities and essential items as well as in-kind and cash support. For instance, in Asia and the Pacific, in-kind support like the provision of food to persons with disabilities was the most common measure (93 per cent of countries or areas), followed by cash transfers (86 per cent), home delivery of daily necessities and essential items (75 per cent) and others forms of social assistance, such as waivers and coupons (64 per cent). See Figure 16.

Figure 16. Percentage of countries or areas that had social protection measures in place for persons with disabilities during the COVID-19 pandemic, by type of measure, in Asia and the Pacific, as of 2022.



Note: All data are based on 28 countries or areas; except data on other forms of social assistance, which are based on 25 countries or areas.
Source: ESCAP.[14]

However, many countries were not able to provide targeted additional support to persons with disabilities and their families during the COVID-19 crisis. Only 44 per cent of countries that announced COVID-19 social protection relief measures targeted or mentioned person with disabilities in these measures.[38] The most common response was an increase in the amount of cash benefits. It has proven very challenging for countries to rapidly expand the number of beneficiaries, pointing to the challenges of disability assessment in general and even more so in times of crisis. This demonstrates the importance of universal disability allowances and the need to have national disability registries and/or inclusive social protection information systems in place, especially in times of crisis.

Summary of findings and the way forward

Persons with disabilities are more likely to be economically insecure and to experience poverty in all its forms. In almost all countries for which data is available, the percentage of persons experiencing multidimensional poverty is higher for persons with disabilities than for persons without disabilities – in some countries that percentage is more than double among persons with disabilities. Reducing by half the percentage of persons with disabilities experiencing poverty in all its forms, by 2030, as called for in target 1.2, will require a rate of progress at least 1.3 times faster for persons with disabilities than for persons without disabilities.

Persons with disabilities tend to earn lower wages and to face additional costs related to disability, putting them at higher risk of poverty. Moreover, persons with disabilities face challenges in accessing financial services, which are crucial for financial stability. An illustrative example is the lack of accessible banks and ATMs: a quarter of banks worldwide, a quarter of ATMs in developed regions and half the ATMs in developing regions remain inaccessible for persons with disabilities. To make all banks accessible by 2030, banks in developed regions need to be made accessible at a rate six times faster than current rates and three times faster in developing regions. ATMs in developed regions need to be made accessible at a rate eight times faster than current rates. The accessibility of ATMs in developing regions is stagnant and needs major action: the percentage of accessible ATMs in developing regions should increase at a rate of at least 6 per cent a year to make all ATMs accessible for all by 2030.

The COVID-19 pandemic has led to losses of income and benefits for many persons with disabilities and rising inflation has led to increased costs in basic goods and services as well as in disability-related goods and services, including rising costs in assistive technology. The combination of these trends put many persons with disabilities at higher risk of poverty. Yet, many countries struggled with providing support for persons with disabilities: less than half of the countries with COVID-19 social protection measures included targeted provisions to support persons with disabilities.

Countries with strong and inclusive social protection systems are better positioned to provide support to persons with disabilities, in regular circumstances and in times of crisis, but such systems are still lacking in many countries. In 2020, only 17 per cent of countries provided universal disability benefits and in many countries the benefits were not sufficient to take people out of poverty or to cover disability-related costs. Progress in implementing universal disability benefits, that cover all persons with disabilities, has been slow, with a mere 2 percentage point increase in the percentage of countries providing these benefits from 2017 to 2020. Implementing these schemes in all countries by 2030 will require that the rate of progress accelerates to at least 10 times faster than the rate of progress observed so far.

Globally, in 2020, 34 per cent of persons with severe disabilities received cash benefits up from 27 per cent in 2016. At this rate of progress, about half the persons with severe disabilities are expected to not have access to these benefits by 2030. Providing this access to all persons with severe disabilities by 2030 would require an expansion of coverage three times faster than current rates of progress.

Data on poverty among persons with disabilities are still lacking in most countries, particularly data on extreme poverty rates disaggregated by disability (SDG indicator 1.1.1) as well as comparable data over time for all Goal 1 indicators.

To eradicate poverty among persons with disabilities and address the persistent gaps in coverage and adequacy in social protection for persons with disabilities, the following key actions are recommended:

1. Regularly collect data to enable disaggregation of income poverty and multidimensional poverty by disability status, type of disability, age of onset of disability, sex and urban versus rural settings. A comprehensive analysis on income and multidimensional poverty is imperative to inform national policies concerning poverty eradication for persons with disabilities. Such an assessment of income and multidimensional poverty requires the consistent collection of data on disability status in national surveys and censuses that collect data for assessing poverty rates. This is particularly important since the emergence of the COVID-19 crisis to determine the impact of the pandemic on persons with disabilities. In addition, adjusting poverty lines by extra costs can provide a more realistic determination of poverty among persons with disabilities.

2. Conduct research to better understand the extra costs associated with disability and evaluate the impact of public policies, including social protection schemes, on extra costs associated with disability and on the financial well-being of persons with disabilities. Identify sources and measure the magnitudes of extra costs among persons with disabilities and in different settings (for example, by type of disability and severity, gender and area of residence) and assess the extent to which they affect the financial well-being of persons with disabilities. Evaluate the impact of programmes and policies on out-of-pocket household spending on extra costs, on access to basic goods and services and on unmet needs for required disability-related goods and services.

3. Ensure that disability inclusion is mainstreamed in all national poverty reduction strategies, programmes and actions. Including disability in national poverty reduction strategies, programmes and actions is essential to ensure that persons with disabilities are not left behind in the fight against poverty. National poverty reduction strategies, programmes and actions should address the accessibility of infrastructure and services and include provisions to eliminate discrimination and stigma against persons with disabilities. These provisions are key to ensure equal opportunities to persons with disabilities and lift them out of poverty. Persons with disabilities may require targeted support to overcome the barriers they face in their daily lives, such as targeted financial assistance, vocational training or healthcare subsidies.

4. Develop a national disability registry and management information system based on an accessible, comprehensive and reliable individual disability (and needs) assessment to facilitate the targeting of individual social protection, case management and policy planning for persons with disabilities. Build a disability assessment mechanism adapted to available human resources and service infrastructure at the local level to ensure the greatest access possible across the country. Enhance interoperability with social protection information systems to facilitate case management. Engage with

representative organizations of persons with disabilities to make registries relevant for users with disabilities and to promote registration.

5. Develop a flexible combination of mainstream and disability-specific cash transfers, concessions, subsidies and support services to be responsive to the diversity of needs of all persons with disabilities, across their life cycles. Progressively expand disability support towards universal coverage, that is, access to social protection programs and services by all persons with disabilities. Progressively ensure compatibility between disability allowances and other social protection benefits such as household social assistance, child benefits, old age pensions as well as with paid work. Ensure that the design of social protection schemes fosters inclusion, greater participation and autonomy of persons with disabilities and supports disability-related costs.

6. Address extra costs and their consequences in social protection policies and programmes. Means-tested social protection programmes can adjust poverty thresholds and entitlement levels for persons with disabilities by considering extra costs. Adjusting poverty lines in this way can provide a more accurate determination of poverty among persons with disabilities for eligibility for poverty-targeted social protection programmes. Additional programmes can offer cash or the in-kind provision of required goods and services. Social health protection programmes can include adequate coverage of disability-related health services and products (such as assistive devices and rehabilitation), while subsidies for transportation or schemes for personal assistance can improve their affordability. Make overarching policies and environments disability-inclusive, such as in education, health and employment, infrastructure and communication, to reduce barriers that drive extra costs.

7. Ensure accessibility across the social protection delivery chain. This should include accessibility in communications, facilities, outreach, payment systems, mechanisms to address grievances, monitoring and evaluation to ensure persons with disabilities do not encounter barriers to accessing social protection.

8. Ensure the meaningful participation of persons with disabilities and their representative organizations in the design and implementation of national poverty reduction strategies and programmes as well as social protection policies and programmes. Such engagement is critical to ensure ownership of reforms and adequate attention to the inclusion requirements of persons with disabilities in both routine programmes and in response to crises.

9. Invest in the development of community care and support services for persons with disabilities. Community-based rehabilitation programmes, known to promote the inclusion of persons with disabilities, should be promoted and supported. The establishment and continuation of community-based rehabilitation programmes can facilitate the inclusion and wellbeing of persons with disabilities and their families. Invest in the improved integration of support services in early childhood development, education and economic empowerment.

10. Improve the collection and analysis of data for inclusive social protection. Include questions to identify persons with disabilities, using internationally recognized methods, in relevant data collections including routine social protection surveys, management information systems, population censuses as well as household income and expenditures and labour force surveys to: (i) facilitate the monitoring of socio-economic inequalities faced by persons with disabilities in general and among users and non-users of the social protection system; and (ii) assess the scope and level of disability-related costs faced by the diversity of persons with disabilities and their families throughout their lives to inform the design and development of inclusive social protection schemes.

Ending hunger, achieving food security and improved nutrition (Goal 2)

Focusing on Goal 2, which calls to end hunger for all, this chapter presents emerging evidence on the situation of persons with disabilities regarding hunger, food security, nutrition and income-generating agricultural activities, and lists a set of recommended actions to achieving SDG 2 for persons with disabilities. In particular, the chapter lays out the situation of persons with disabilities vis-à-vis three SDG 2 targets: target 2.1, which calls for ending hunger and ensuring access by all people to safe, nutritious and sufficient food all year round; target 2.2, which calls for ending all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting (low height for age) and wasting (low weight for height) in children under 5 years of age;[39] and target 2.3, which calls for doubling agricultural productivity and incomes of small-scale food producers and equal access to land and other productive resources. Since the adoption of the SDGs in 2015, the international framework on disability and food security has been further advanced by various resolutions adopted by United Nations bodies, including Security Council Resolution 2417, adopted in 2018, and General Assembly Resolution 76/264, adopted in 2022. Both recognize the disproportionate impact of food-related crises on persons with disabilities.

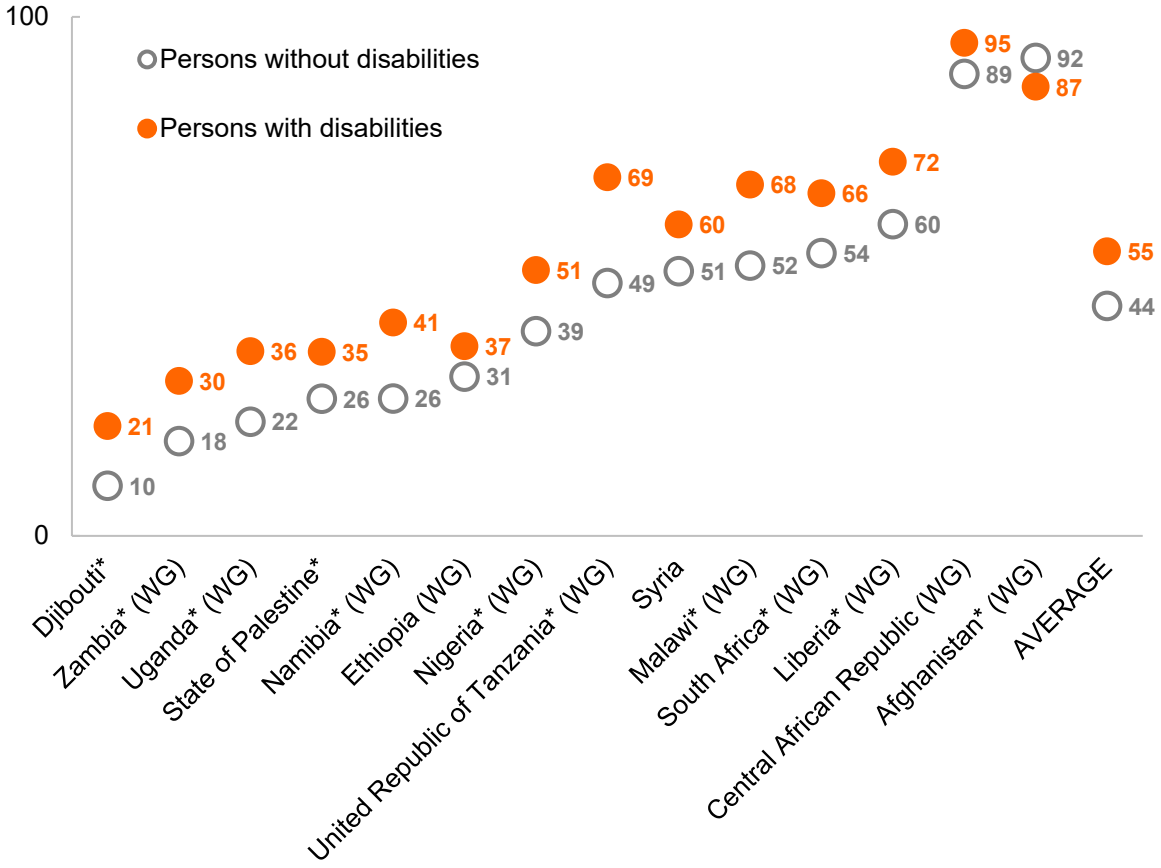
The right to adequate food has been enshrined in the Universal Declaration of Human Rights and in the International Covenant on Economic, Social and Cultural Rights. The right to adequate food for persons with disabilities has been further reaffirmed in article 28 of the Convention on the Rights of Persons with Disabilities (CRPD).

Current situation and progress so far

Persons with disabilities are more likely to not always have enough food to eat, that is, to be food insecure, than persons without disabilities. Among 14 countries or areas in Africa and Asia, on average, the percentage of persons living in food insecure households is higher for persons with disabilities at 55 per cent, than for persons without disabilities at 44 per cent (Figure 17).

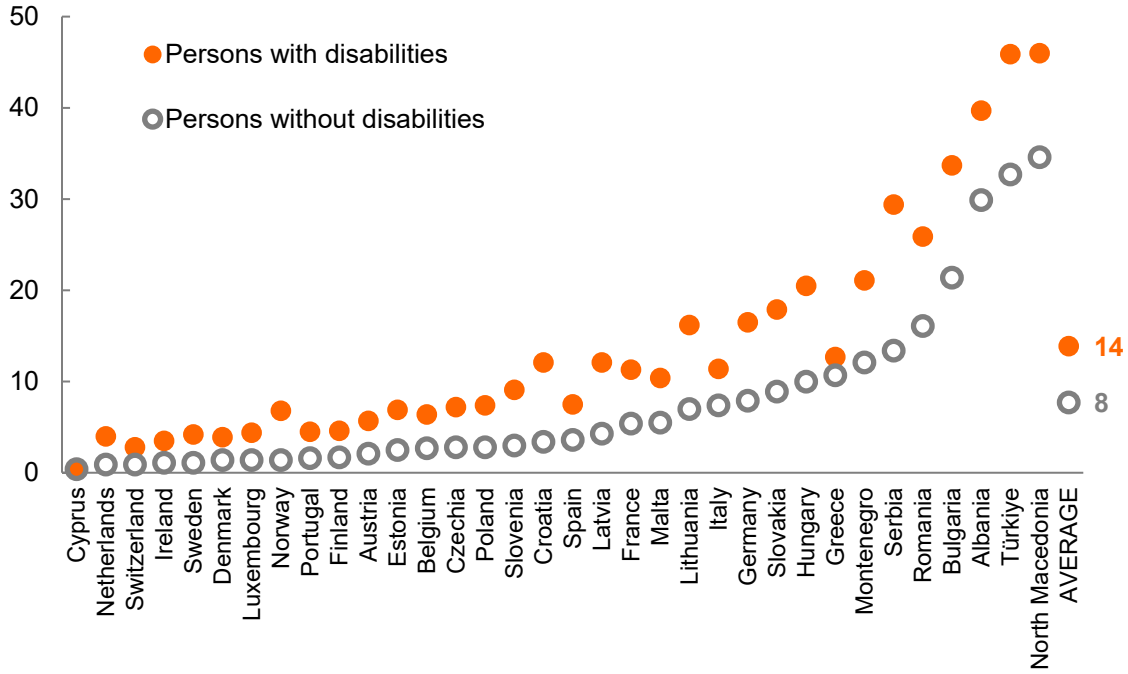
Similarly, among 34 countries, mostly in Europe, persons with disabilities are more likely to be food insecure: the percentage of persons with disabilities that are unable to afford a meal with meat, chicken, fish or a vegetarian equivalent is 14 per cent compared to 8 per cent for persons without disabilities (Figure 18). Despite variations across countries, the gap between persons with and without disabilities is present in all countries: the percentage of persons unable to afford a meal with meat, chicken, fish or a vegetarian equivalent every second day is consistently higher for persons with disabilities – on average almost twice as high – than for persons without disabilities. Women with disabilities tend to face more food insecurity than their male counterparts (see the chapter on Goal 5).

Figure 17. Percentage of persons who did not always have food to eat, by disability status, in 14 countries or areas, in 2021 or latest year available.



Note: Data for the Central African Republic and Syria refer to households with and without persons with disabilities. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the 5 per cent level.
Source: Mitra and Yap (2021),[40] OCHA (2022),[41] UNDESA (on the basis of data from SINTEF[9]) and WFP (2021).[42]

Figure 18. Percentage of persons who cannot afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day, for persons aged 16 and over, by disability status, in 34 countries, in 2021.

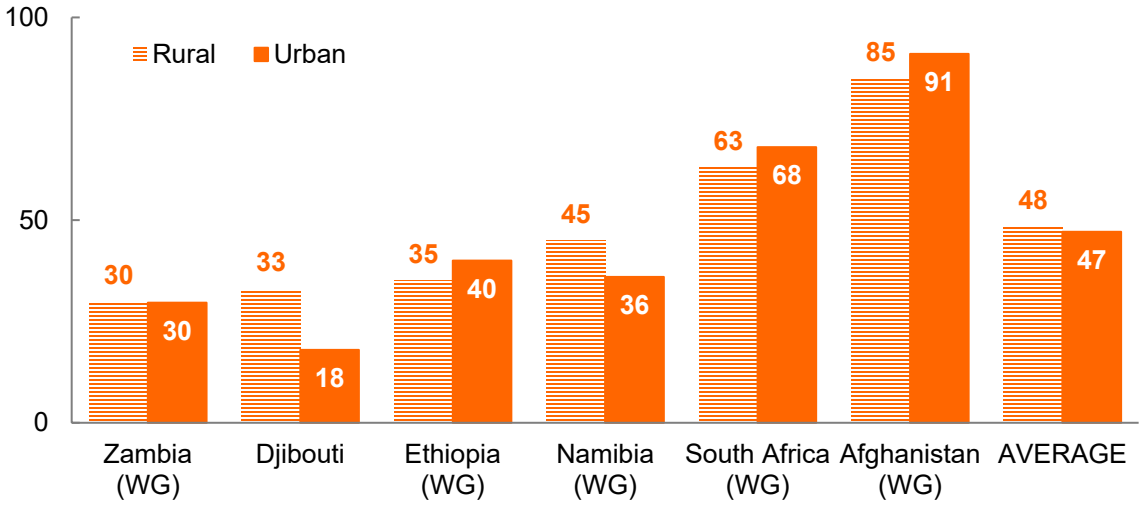


Source: Eurostat.[7]

Many households with persons with disabilities have fewer financial resources than others and more challenges affording food. Persons with disabilities can often have additional expenditures related to their disability (see the chapter on Goal 1), which further restricts the resources available for food. For instance, in the Central African Republic, in 2020, compared to households without persons with disabilities, households with at least one person with disabilities were more likely to have high expenditures, that is, more than 75 per cent of their household income, on food (30 per cent versus 21 per cent) and to adopt emergency strategies – such as selling one's house, land or last female animal – to cope with food shortages (24 per cent versus 17 per cent).[42]

Economic, physical and attitudinal barriers experienced by persons with disabilities to accessing food may be exacerbated by factors related to their area of residence. On average, among six countries, the percentage of persons with disabilities who did not always have food to eat was slightly higher in rural areas (48 per cent) than in urban areas (47 per cent), but the gaps between urban and rural areas vary by country (Figure 19). In Djibouti and Namibia, persons with disabilities living in rural areas are more likely to not always have food to eat, while this is not the case in Afghanistan, Ethiopia, South Africa and Zambia.

Figure 19. Percentage of persons with disabilities who did not always have food to eat, by area of residence, in 6 countries, in 2018 or latest year available.



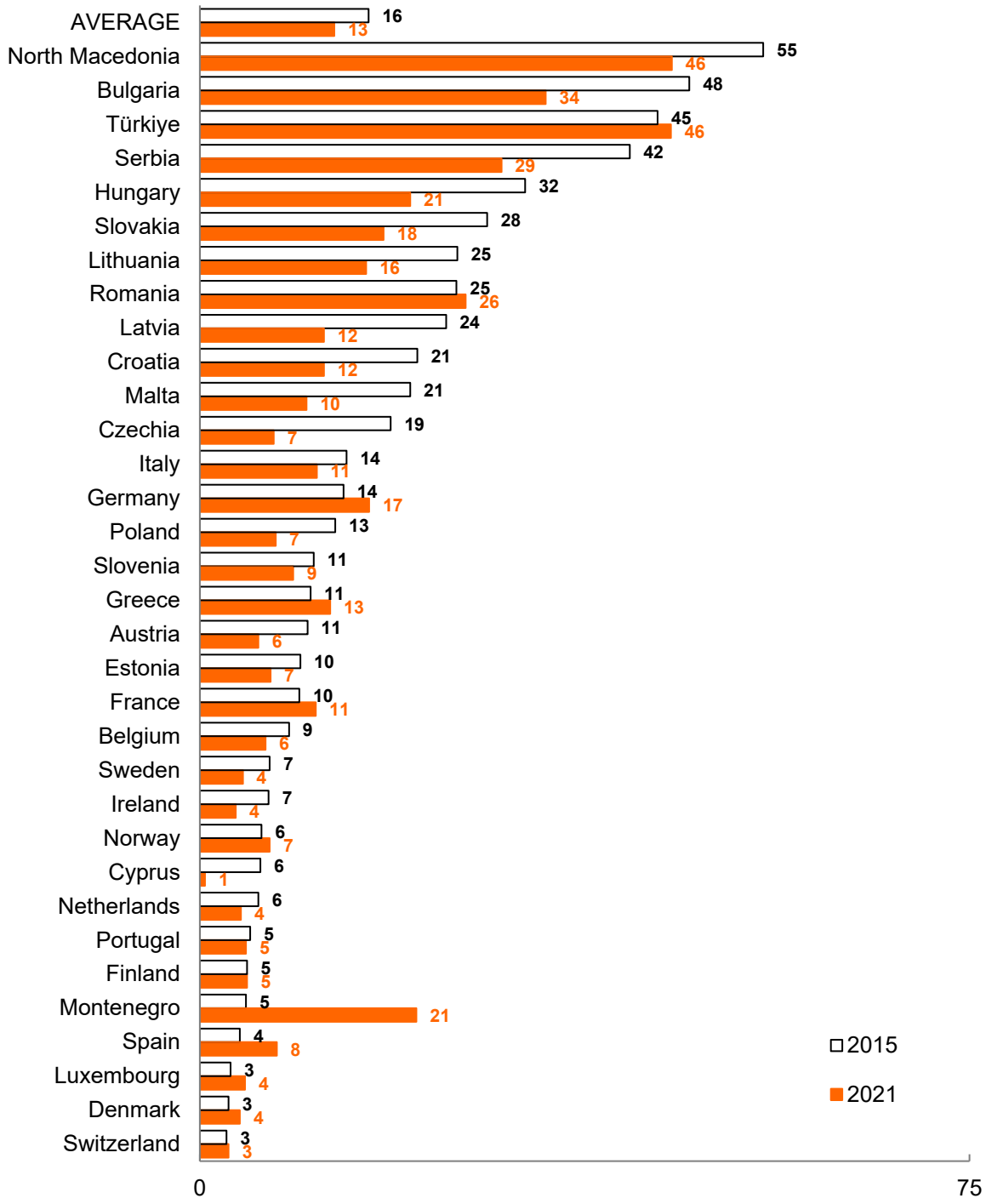
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: Mitra and Yap (2021)[43] and UNDESA (on the basis of data from SINTEF[9]).

Comparable information over time on food security disaggregated by disability status remains scarce, with most of the data available originating from developed countries. In 33 countries, mostly in Europe, between 2015 and 2021, the percentage of persons with disabilities who could not afford a meal with protein every second day decreased from 16 per cent to 13 per cent (Figure 20). This progress was similar to the progress for persons without disabilities, a decrease from 10 per cent to 7 per cent in the same period,[7] meaning that the gap between persons with and without disabilities remained the same. But these averages mask different trends in different countries. While this percentage decreased from 2015 to 2021 in about two thirds of these countries, in about one third of them it increased or remained the same. Comparable information over time for developing countries is insufficient and does not allow for an assessment of progress.

Ensuring a sufficient intake of essential nutrients is key to ending all forms of malnutrition. In 2021, among five countries in the Pacific, households with at least one person with disabilities were slightly less likely to have consumed vitamin A, iron and protein in the past seven days than other households (Figure 21).

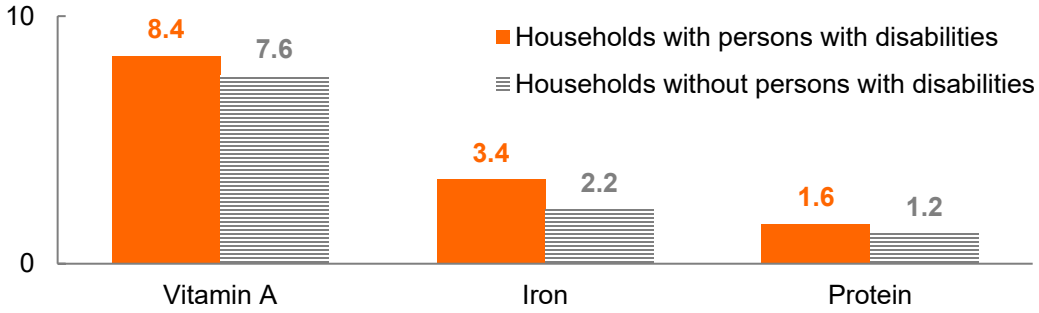
Food banks supply food free of charge to people in need, but persons with disabilities still face barriers to accessing food banks. Many food banks are not accessible because of physical barriers such as stairs and narrow doorways and lack of staff trained in sign language. Worldwide, in 2022, 20 per cent of food banks were not accessible for persons using wheelchairs and 19 per cent were only partially accessible (Figure 22). Although the percentage of non-accessible food banks has remained about the same since 2018, at around 20 per cent, the percentage of accessible food banks has increased from 53 per cent to 61 per cent during the same period.

Figure 20. Percentage of persons with disabilities who are unable to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day, in 33 countries, in 2015 and 2021.



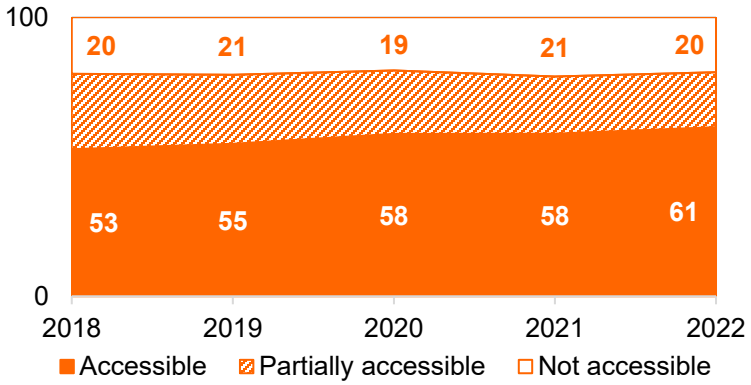
Source: Eurostat.[7]

Figure 21. Percentage of households not having consumed protein, vitamin A and iron in the past 7 days, for households with and without persons with disabilities, in selected areas in Fiji, Kiribati, Samoa, Tonga and Vanuatu, in February or March 2021 (WG).



Note: The percentage shows an arithmetic average of the percentages in each country. (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: WFP Pacific Multi-Country Office (2021).[44,45]

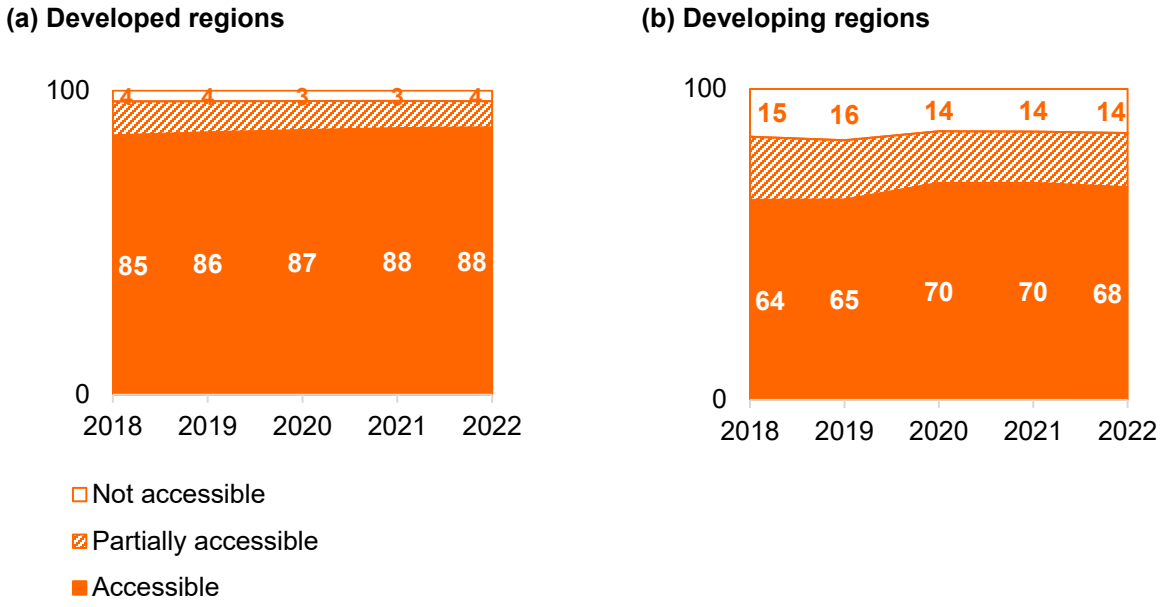
Figure 22. Percentage of food banks that are accessible for wheelchair users, worldwide, from 2018 to 2022.



Source: UNDESA (on the basis of data from Sozialhelden[10]*).*

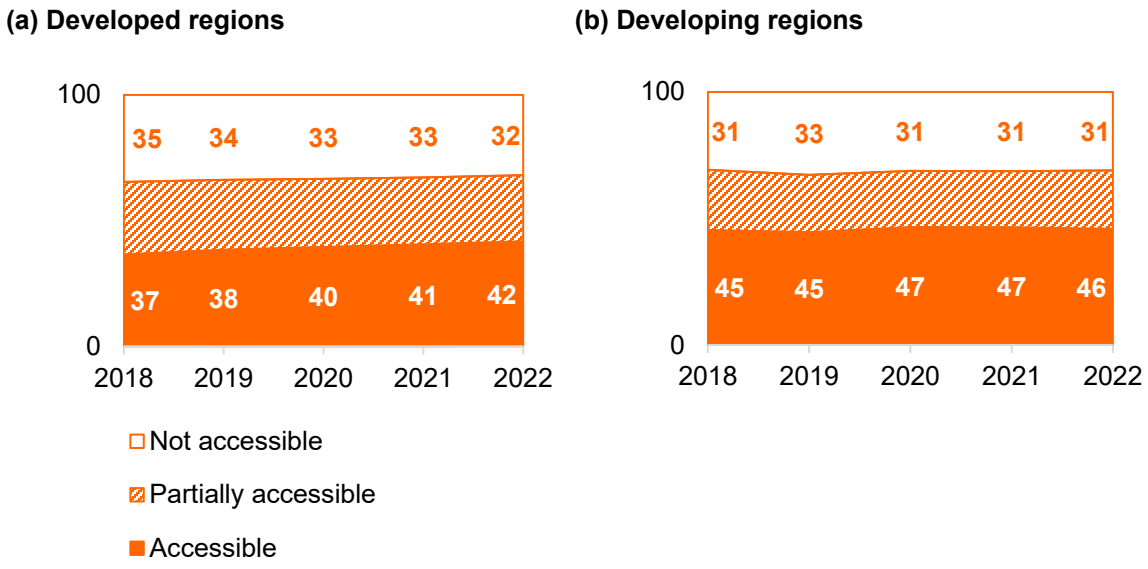
Many places to get food still have physical barriers for persons with disabilities, which are discriminatory and violate the CRPD. In 2022, in developed regions, 12 per cent of supermarkets were not accessible or were only partially accessible, down from 15 per cent in 2018; in developing regions, in 2022, 32 per cent were not accessible or partially accessible, down from 36 per cent in 2018 (Figure 23). Restaurants are much less accessible than supermarkets both in developed and developing regions. In 2022, 58 per cent of restaurants in developed regions and 54 per cent in developing regions were not accessible or only partially accessible to wheelchair users (Figure 24). Since 2018, these percentages have decreased slightly: a 5 percentage point decrease in developed regions and 1 percentage point decrease in developing regions.

Figure 23. Percentage of supermarkets that are accessible for wheelchair users, in developed and developing regions, from 2018 to 2022.



Source: UNDESA (on the basis of data from Sozialhelden[10]).

Figure 24. Percentage of restaurants that are accessible for wheelchair users, in developed and developing regions, from 2018 to 2022.

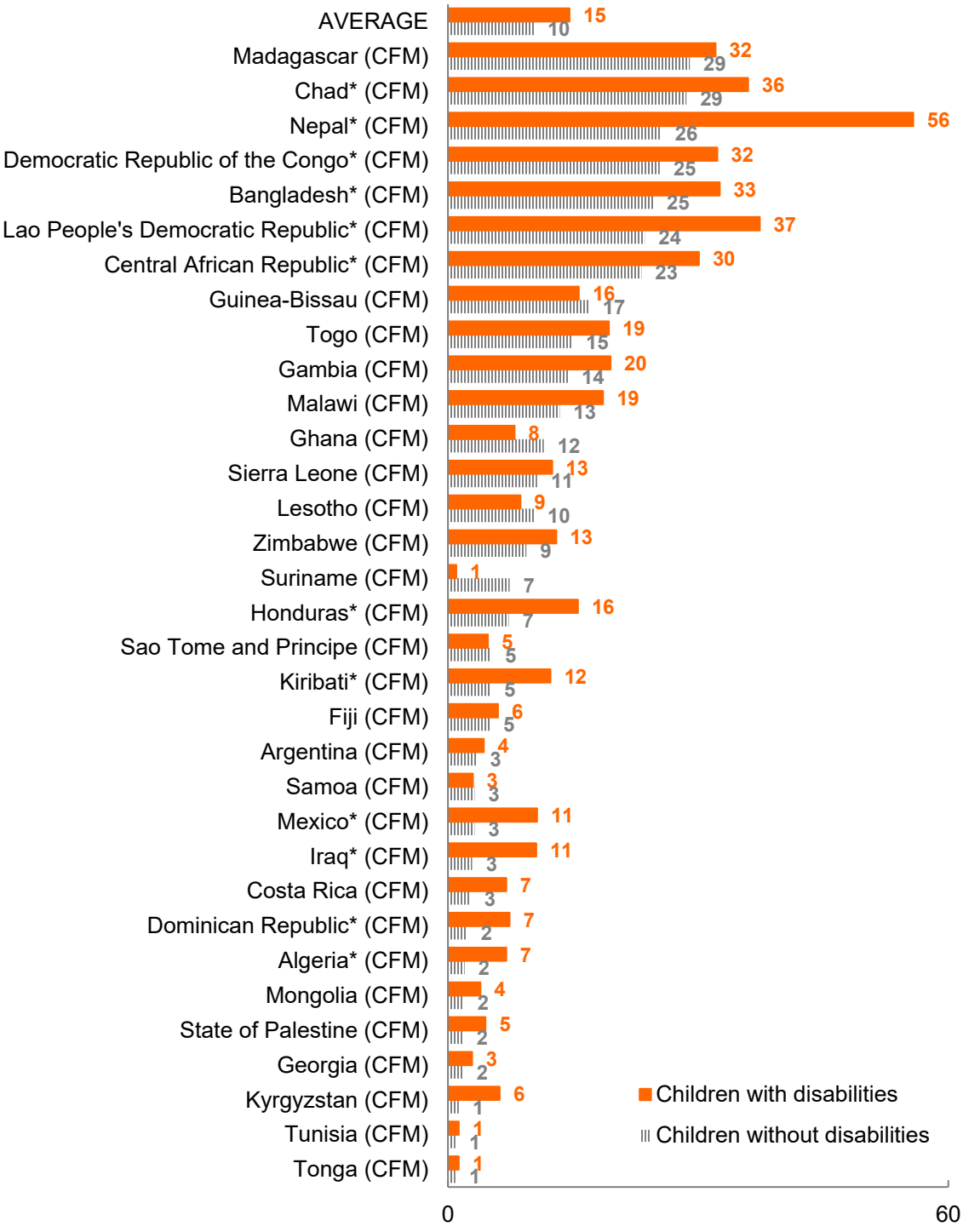


Source: UNDESA (on the basis of data from Sozialhelden[10]).

Children with disabilities experience malnutrition at a higher rate than children without disabilities, more often showing low weight or low height for their age, which are both signs of malnutrition. Among 33 countries or areas, the percentage of children aged 24 to 59 months who are underweight is 15 per cent for children with disabilities and 10 per cent for children without disabilities (Figure 25). Among 34 countries or areas, the percentage of children aged 24 to 59 months who are stunted (that is, have low height for their age) is 27 per cent for children with disabilities and 20 per cent for children without disabilities (Figure 26). For both indicators – underweight and stunting – there are country variations in the gaps between children with and without disabilities. Underweight is more prevalent in children with disabilities than children without disabilities in 27 of these countries. Stunting is more prevalent in children with disabilities than children without disabilities in 31 of these countries. Target 2.2 calls for a reduction by 2025 of 40 per cent in the number of children who are stunted, but due to lack of comparable data over time, it is not possible to assess whether the world is on track to achieve this target for children with disabilities. Wasting, that is, low weight for height, is less common for both children with and without disabilities, affecting 7 per cent of children with disabilities compared to 5 per cent of children without disabilities.[46] For children with disabilities, this percentage is still 2 percentage points higher than the 5 per cent threshold called for in target 2.2. Rates of overweight children, that is, excess weight for height, are similar in children with and without disabilities, at 3 per cent.[46]

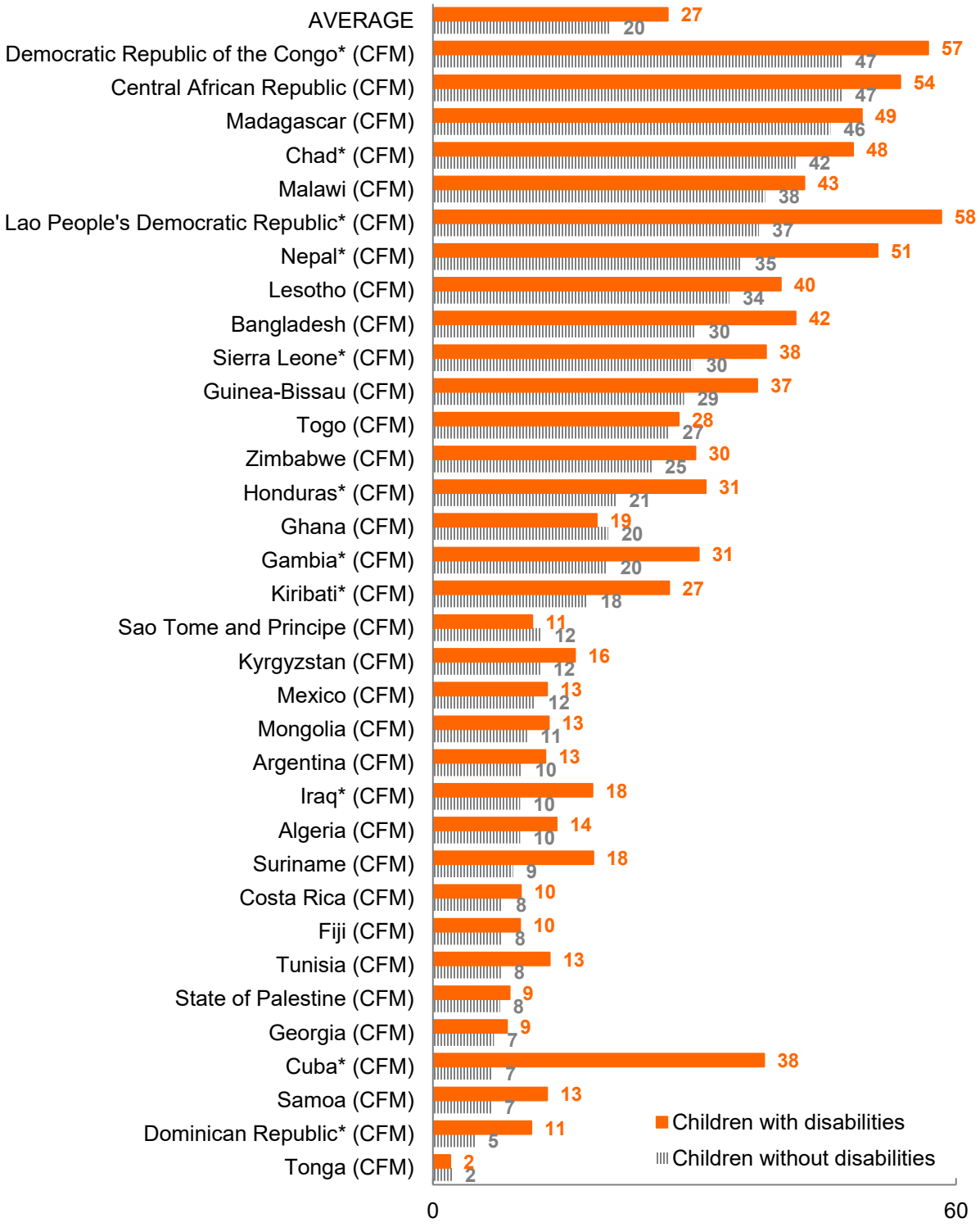
Persons with disabilities face various barriers and discrimination in the realization of SDG target 2.3, which calls for doubling the agricultural productivity and incomes of small-scale food producers and ensuring individuals' capabilities to sustain their livelihoods through equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment. These barriers to the access of, control over and ownership of productive resources perpetuate exclusion from agricultural employment opportunities. For instance, in three countries in sub-Saharan Africa (Ethiopia, Nigeria and the United Republic of Tanzania), households with persons with disabilities faced unequal opportunities and outcomes in their agricultural activities:[47] (i) in the United Republic of Tanzania, households with persons with disabilities had smaller lands; (ii) in Nigeria, among the households that engaged in agricultural activities, households with persons with disabilities were less likely to sell their harvest and had a lower share of income from livestock; and (iii) in Ethiopia, among those households that engaged in crop production, households with persons with disabilities were less likely to use improved seeds and more likely to use free seeds. In Ghana, almost half of the farmers with disabilities were food insecure, but farmers with disabilities who held decision-making power were more likely to be food secure than farmers with disabilities who participated only through labour and did not take part in decisions.[48]

Figure 25. Percentage of children aged 24 to 59 months who are moderately or severely underweight, by disability status, in 33 countries or areas, in 2015-2021.



Note: (CFM) identifies data produced using the Child Functioning Module. An asterisk (*) indicates that the difference between children with and without disabilities is statistically significant at the 5 per cent level.
Source: UNICEF (on the basis of data from MICS).

Figure 26. Percentage of children aged 24 to 59 months who are too short for their age (moderate or severe stunting), by disability status, in 34 countries or areas, in 2021 or latest year available.



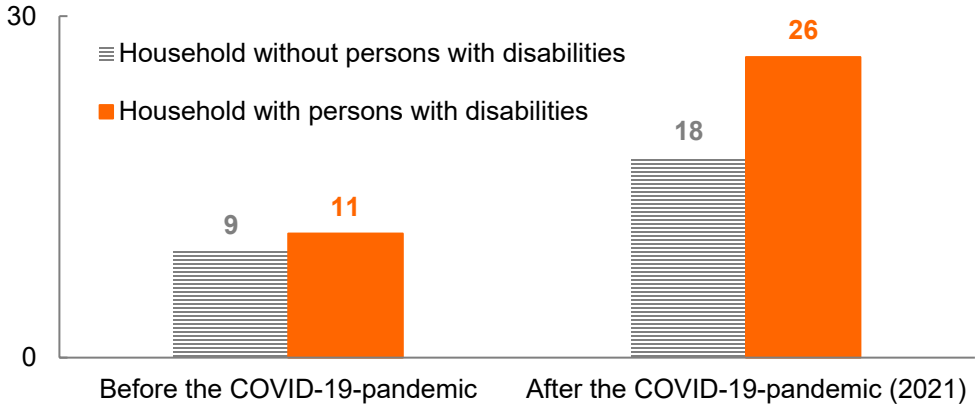
Note: (CFM) identifies data collected using the Child Functioning Module. An asterisk (*) indicates that the difference between children with and without disabilities is statistically significant at the 5 per cent level.
Source: UNICEF (on the basis of data from MICS).

Agricultural capacity-building programs are important as a poverty reduction and food security strategy for many persons with disabilities, but there are still many barriers to participating in these programs, including lack of physically accessible premises and lack of accessible communication. For example, in Northern and Eastern Uganda young farmers with disabilities are less likely to participate in capacity-building activities, resulting in reduced access to knowledge, skills, information, production inputs and technologies.[49] In particular, persons with disabilities are less likely to participate when these activities are not accessible – for example, they do not provide sign-language interpretation – or when the training staff lacks disability awareness and training.[49] Moreover, lack of disability-inclusive technology in agriculture – technology that can be used by all, including persons with disabilities – as well as lack of assistive technology and reasonable accommodation in agricultural employment, compromise equal access to food and to productive resources and equal access to job opportunities in agriculture. By excluding persons with disabilities, potential overall productivity in the sector and wider community is reduced, thus compromising the achievement of target 2.3.

Impact of the COVID-19 pandemic

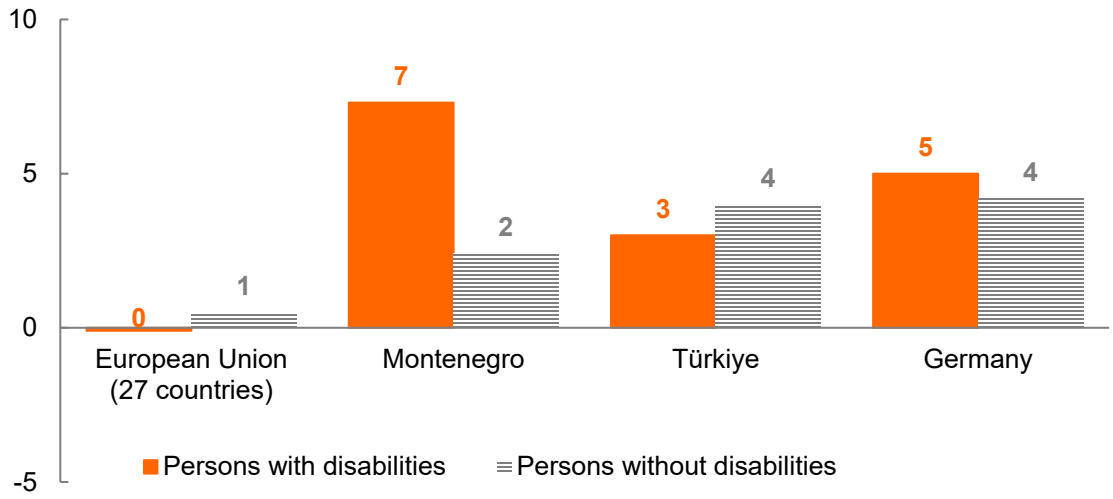
Many persons with disabilities lost jobs, income and access to social protection and benefits as a result of the COVID-19 pandemic (see the chapters on Goal 1 and on Goal 8). As earnings decreased, many households of persons with disabilities faced difficulties paying for food, leading to food insecurity. A number of countries implemented interventions addressing the economic impacts of COVID-19, such as food assistance, emergency cash transfers, unemployment assistance or expansions to existing social protection programs. But these measures were insufficient to reach all persons with disabilities who needed support to secure food. In a study in 37 countries worldwide, conducted in 2020, 47 per cent of parents and caregivers with disabilities reported that they had to reduce the quality, size or frequency of meals, compared to 35 per cent for those without disabilities.[16] A slightly higher proportion of parents and caregivers with disabilities, compared to those without disabilities, reported needing and not having access to food delivery (52 per cent versus 46 per cent).[16] In Brazil, 11 per cent of households with at least one person with disabilities ran out of food due to lack of money before the pandemic, whereas a higher percentage (26 per cent) of these households reported this challenge after the pandemic, in 2021 (Figure 27). This deterioration in food security was more pronounced among households with persons with disabilities than in other households.

Figure 27. Percentage of households that ran out of food in the past 30 days due to lack of money, before and after the COVID-19 pandemic (2021), in Brazil.



Note: Before the COVID-19 pandemic refers to before February 2020.
Source: World Bank (2021).[50]

Figure 28. Percentage point increase in the percentage of persons who are unable to afford a meal with meat, chicken, fish (or vegetarian equivalent) every second day, in the European Union and in 3 countries, from 2019 to 2020.



Source: Eurostat.[7]

In the European Union as a whole, the impact of the pandemic on food security seems to have been minimal. Between 2019 and 2020, the percentage of persons who were unable to afford a meal with meat, chicken or fish (or a vegetarian equivalent) remained stagnant among persons with disabilities and increased by 1 percentage point among persons without disabilities (Figure 28). However, in two European countries (Germany and Montenegro) and in Türkiye, this percentage increased among persons with disabilities between 3 percentage points and 7 percentage points.

Several countries were able to put in place a variety of social protection measures to support food security among persons with disabilities during the pandemic, including home delivery of daily necessities and essential items as well as in-kind and cash support – for instance, in Asia and the Pacific, 93 per cent of countries provided in-kind support, including the provision of food, to persons with disabilities (see the chapter on Goal 1).

Summary of findings and the way forward

Persons with disabilities are still often left behind in the commitment to achieving zero hunger, with 55 per cent of persons with disabilities in developing countries experiencing food insecurity. Persons with disabilities are more likely than persons without disabilities to not always have food to eat and are less likely to be able to afford nutritious food.

Children with disabilities are more likely than children without disabilities to be underweight (low weight for their age) and stunted (low height for their age), both signs of malnutrition. Among children with disabilities, 15 per cent are underweight, 27 per cent are stunted, 7 per cent are wasted and 3 per cent are overweight. These levels point to the need to increase efforts for children with disabilities to achieve target 2.2, which calls for ending malnutrition by 2030, and bring these percentages to zero. Moreover, more efforts are needed to bring the percentage of children with disabilities who are wasted to less than 5 per cent by 2025, as also called for in target 2.2.

The COVID-19 pandemic exacerbated this situation, as many households of persons with disabilities faced additional difficulties paying for food, especially in developing countries.

In most countries, the lack of comparable data over time hampers the assessment of progress for persons with disabilities for the targets of Goal 2. European countries are an exception, as data show that the percentage of persons with disabilities who cannot afford daily meals with protein at least every second day has decreased since 2016, but this progress is not enough to bring this percentage to zero by 2030. Rates will have to decrease twice as fast as rates observed so far to eliminate this affordability barrier.

Food banks, as well as supermarkets and restaurants, are often inaccessible for persons with disabilities. Although vital in emergency situations, two out of five food banks are not fully accessible for wheelchair users. In everyday life, persons with disabilities face discriminatory barriers to procuring food: more than half of restaurants remain inaccessible for wheelchair users worldwide. Many supermarkets are also inaccessible, especially in developing countries: more than 12 per cent of supermarkets in developed countries and 38 per cent in developing countries are inaccessible for wheelchair users. Improvements since 2018 have been slow. Making food banks and supermarkets fully accessible for persons with disabilities by 2030 will require expanding the accessibility of these facilities twice as fast as the rate of progress observed so far. For restaurants, more accelerated efforts are needed. Making restaurants fully

accessible for persons with disabilities by 2030 will require expanding accessibility in developed countries four times as fast and in developing countries 17 times as fast as the rates of progress observed thus far.

With only a few years until 2030, immediate global, scalable and concerted food security action must be disability-inclusive and address key barriers. To end hunger for persons with disabilities, a number of actions are recommended:

1. Mainstream disability inclusion into existing and future food security legislation, policies and programmes, by harmonizing them in line with the CRPD and by consulting with persons with disabilities and their organizations. Remove discriminatory provisions to ensure food security for persons with disabilities, including women, Indigenous people, displaced persons and other marginalized groups of persons with disabilities. Monitor the effectiveness of existing legal and policy frameworks in ensuring the inclusion of persons with disabilities. Improve accountability in the protection of the right to food for persons with disabilities.

2. Improve coordination among various sectors to enhance access to as well as affordability and safety of food for persons with disabilities, including children with disabilities, and to ensure access to a sufficient amount of nutritious food. Recognize the linkages between malnutrition and: (i) access to education (education can provide essential information on nutrition and school meals may buffer malnutrition, but the meals and information will not reach children with disabilities unless schools are accessible and education systems are inclusive); (ii) social protection, which can support access to nutritious food through in-kind or cash transfers; and (iii) targeted interventions of in-kind or cash transfers in agriculture, forestry, fishery and livestock production to foster persons with disabilities' access to sustainable livelihoods. Raise awareness about persons with disabilities' right to food among all relevant stakeholders, including among agricultural development organizations.

3. Provide equal access to agricultural and productive resources for persons with disabilities. Consider designing programmes targeting persons with disabilities for the promotion and distribution of available (productive) resources, especially credit and micro finance systems as well as entrepreneurship development training. Make these programmes – and all plans and programmes addressing sustainable food systems, access to resources and markets as well as climate change – accessible for persons with disabilities and consult persons with disabilities in their design and implementation. Design skill-building interventions in agricultural and other livelihood-generating practices for persons with disabilities, including for women, Indigenous persons and displaced persons with disabilities. Consult with persons with disabilities and their organizations in designing these interventions, for example, through establishing partnerships with them. Include persons with disabilities in producers' organizations and agricultural cooperatives and ensure that persons with disabilities, including women, Indigenous people, displaced persons and other marginalized groups, have equal access to decision-making in these organizations and cooperatives.

4. Support the use of disability-inclusive technology to promote equal access to food and to productive resources. Ensure that agriculture-related technology is available, accessible and affordable to persons with disabilities and can be used by persons with disabilities. Ensure that persons with disabilities have access to the assistive technology they need to access food. Make sure that assistive technology and reasonable accommodations are available in agricultural employment to provide equal job opportunities for persons with disabilities (see the chapter on Goal 8).

5. Make supermarkets and restaurants accessible for persons with disabilities. Accessible supermarkets and restaurants are crucial to ensure that persons with disabilities can access food without barriers or discrimination. These venues can improve wheelchair accessibility, provide signage in easy-to-understand language, accessible payment options such as large print and Braille receipts as well as accessible payment terminals, accessible online ordering and delivery options, and staff can be trained in including customers with disabilities.

6. Make food banks accessible for persons with disabilities. Making food banks accessible will help address food insecurity and ensure that everyone has access to food. Food banks can partner with organizations of persons with disabilities and representative advocacy groups to better understand the rights and needs of persons with disabilities. By working together, these organizations can identify areas where improvements can be made and support and inform the development of strategies to make food banks accessible for everyone.

7. Improve the availability of high-quality data on persons with disabilities to monitor progress towards Goal 2. Collect disability disaggregated data on access to, ownership of and control over food, land and related resources. Monitor food security programmes' outcomes at the household level, and through data disaggregated by disability, to inform the design of appropriate interventions.

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

This chapter discusses the current situation of persons with disabilities vis-à-vis the realization of Goal 3 and the progress made by countries in the past several years. It provides an overview of the health inequities experienced by persons with disabilities, the factors contributing to these inequities, and the efforts countries have made to address them and to promote the implementation of Goal 3 by, for and with persons with disabilities. The chapter also lists recommended actions to promote progress towards Goal 3.

Goal 3 calls for ensuring healthy lives and promoting well-being for all. This implies achieving the highest attainable standard of health for all persons with disabilities. Persons with disabilities have an equal right to the highest attainable standard of health, on an equal basis with others. This right to health is inherent and universal and is enshrined in international law through human rights treaties. Despite this universal right, persons with disabilities continue to experience a wide range of health inequities, which are largely avoidable and due to unjust and unfair factors at both the societal and health system levels. These contributing factors have not changed in the last decade, and many persons with disabilities continue to die prematurely and have poorer health. The COVID-19 pandemic fully exposed the disadvantaged position of persons with disabilities within the health sector and the need to act in an urgent manner.

Since 2006, the Convention on the Rights of Persons with Disabilities (CRPD) has provided an international framework that promotes and protects the right of persons with disabilities to enjoy their highest attainable standard of health through, inter alia, the provision of healthcare of the same quality to persons with disabilities as to others, including on the basis of free and informed consent (article 25). In addition to article 25, there are other articles in the CRPD relevant to health, such as article 9 on accessibility, which states that health facilities and information must be accessible to people with different types of impairments, and article 26, which includes strengthening comprehensive habilitation and rehabilitation services and programs to maximize the independence, inclusion and participation of persons with disabilities in all aspects of life. Several recent high-level declarations have highlighted the importance of universal health coverage and of promoting healthier populations and addressing health emergencies as global health priorities. For universal health coverage, a central and guiding document is the Declaration from Astana (2018).

During the COVID-19 pandemic, momentum for disability inclusion in the health sector was created as countries recognized and committed to act towards health equity for persons with disabilities. A landmark World Health Assembly resolution (WHA 74.8) on “The highest attainable standard of health for persons with disabilities” was adopted by countries in 2021. This resolution reiterated the need for a commitment to ensure that persons with disabilities exercise their full right to health. The Resolution aims to advance the agenda of disability inclusion in the health sector in countries, focusing on three key areas – access to effective health services within the context of universal health care; access to cross-sectorial public health interventions to improve the health and well-being of persons with disabilities; and protection during

health emergencies.

Current situation and progress so far

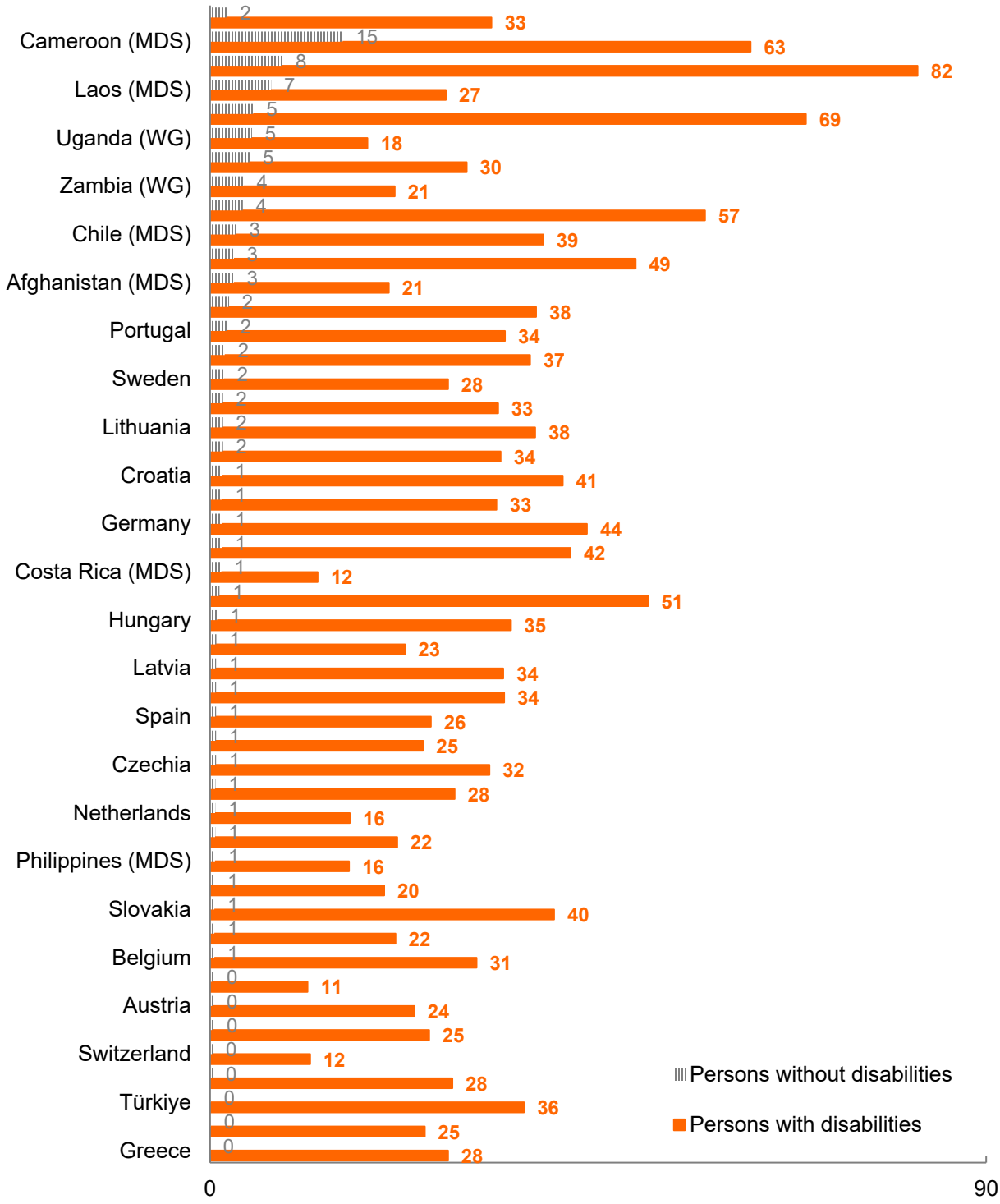
Persons with disabilities still experience health inequities in terms of higher premature mortality and morbidity rates.[51] In 2017, the crude annual death rate for persons with intellectual disabilities was double compared to the general population in the United Kingdom, with children with disabilities being eight times more likely to die before the age of 17,[52] and older adults with disabilities dying significantly more often within 30 days of hospitalization compared to those without disabilities.[53]

There are also health inequities in morbidity faced by persons with disabilities. Persons with disabilities have higher incidences of communicable and non-communicable diseases such as tuberculosis, diabetes, stroke, cardiovascular problems and asthma.[54] The differences in prevalence of comorbid health conditions between those with and without disabilities continue into older age[55] and apply also to women's health issues (see the chapter on targets 3.1, 3.7 and 5.6). For example, there is evidence that significantly more women with physical (33 per cent), sensory (30 per cent), intellectual (49 per cent) and multiple (42 per cent) impairments have a postpartum emergency visit compared to those without these impairments (24 per cent).[56] Persons with disabilities are also significantly more likely to report having been diagnosed with a sexually transmitted infection or mental health condition, compared to individuals without disabilities.[57,58,59]

Persons with intellectual disabilities have a range of secondary chronic conditions in higher rates than those without disabilities, including thyroid dysfunction,[60] viral or infective diseases, neurological disorders, blood diseases, eye diseases, respiratory system diseases, digestive system diseases, skin diseases and diseases of the genitourinary system.[61,62,63,64] Similarly, adults with intellectual disabilities have higher rates of diabetes, asthma, arthritis, cardiac disease, and hypertension, than those without intellectual disabilities.[65,66] These differences are visible from a very early age. For example, children with developmental disabilities are three times more likely to have diabetes than other children.[67]

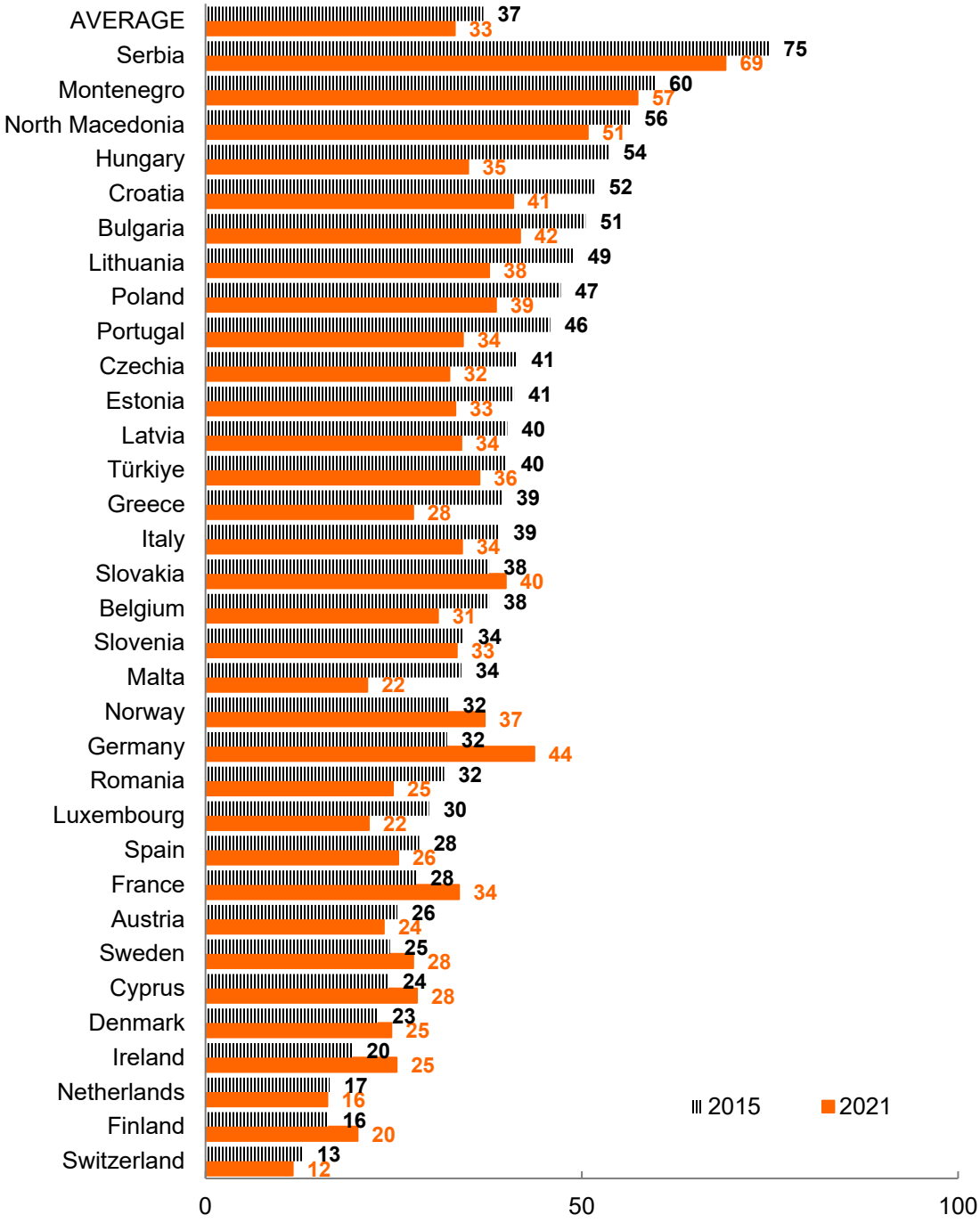
These health inequities are observed in national data on the health of individuals, in which persons with disabilities systematically report poorer health than others. In 47 countries or areas, health is self-perceived as bad or very bad by an average of 33 per cent of persons with disabilities compared to 2 per cent of persons without disabilities (Figure 29). Persons with disabilities are more likely to experience poor health than persons without disabilities in all 47 countries. Data from European countries suggest there has been some progress since 2015. Among 33 countries, on average, 33 per cent of persons with disabilities self-reported bad or very bad health in 2021, down from 37 per cent in 2015 (Figure 30). But the progress has been mixed, with a higher percentage of persons with disabilities reporting bad or very bad health in 2021 than in 2015 in nine countries.

Figure 29. Percentage of persons with self-perceived health as bad or very bad, by disability status, in 47 countries or areas, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey. (WG) identifies data produced using the Washington Group short set of questions on functioning. Data from Cameroon were collected in selected regions of the country and are not nationally representative.
Source: Eurostat,[7] UNDESA (on the basis of data from SINTEF[9]) and WHO.

Figure 30. Percentage of persons with disabilities with self-perceived health as bad or very bad, in 33 countries, in 2015 and 2021.



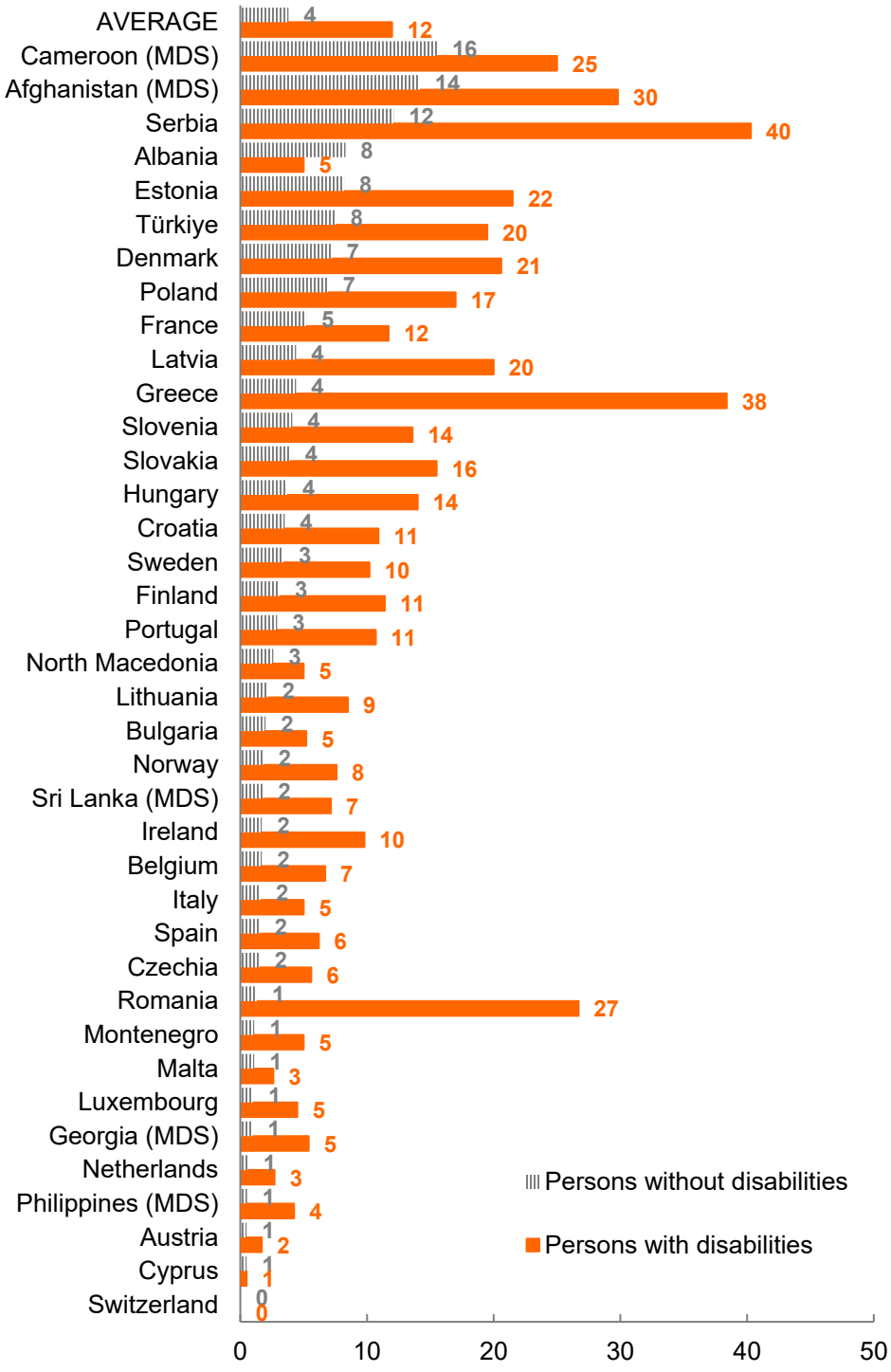
Note: Persons with disabilities include persons with some or severe limitations. Data for Montenegro, North Macedonia, Norway, Serbia, Slovakia, Switzerland and Türkiye are for 2020 instead of 2021.
Source: Eurostat.[7]

Target 3.8 calls for achieving universal health coverage. Universal health coverage means that all people have access to the full range of health services they need, including preventive, promotive, treatment, rehabilitative or palliative care, without financial hardship. Yet, many persons with disabilities face barriers to accessing these services, including: (i) higher health expenses for persons with disabilities who need additional healthcare due to their disability; (ii) higher costs of living for persons with disabilities which make healthcare more unaffordable for them; (iii) lack of accessibility of health facilities; and (ii) lack of accessible transportation to and from healthcare services. In addition, persons with disabilities tend to earn lower wages than persons without disabilities and therefore have fewer financial means to pay for healthcare.

Indeed, evidence shows that persons with disabilities have less access to health services compared to those without disabilities (Figure 31). In 38 countries or areas, persons with disabilities are on average three times more likely than persons without disabilities to be unable to get healthcare when they need it: 12 per cent of persons with disabilities versus 4 per cent of persons without disabilities indicated that they needed but could not get healthcare. In nine of these countries – Afghanistan, Albania, Cameroon, Denmark, Estonia, Greece, Romania, Serbia and Türkiye – more than 20 per cent of persons with disabilities are not able to get healthcare when they need it.

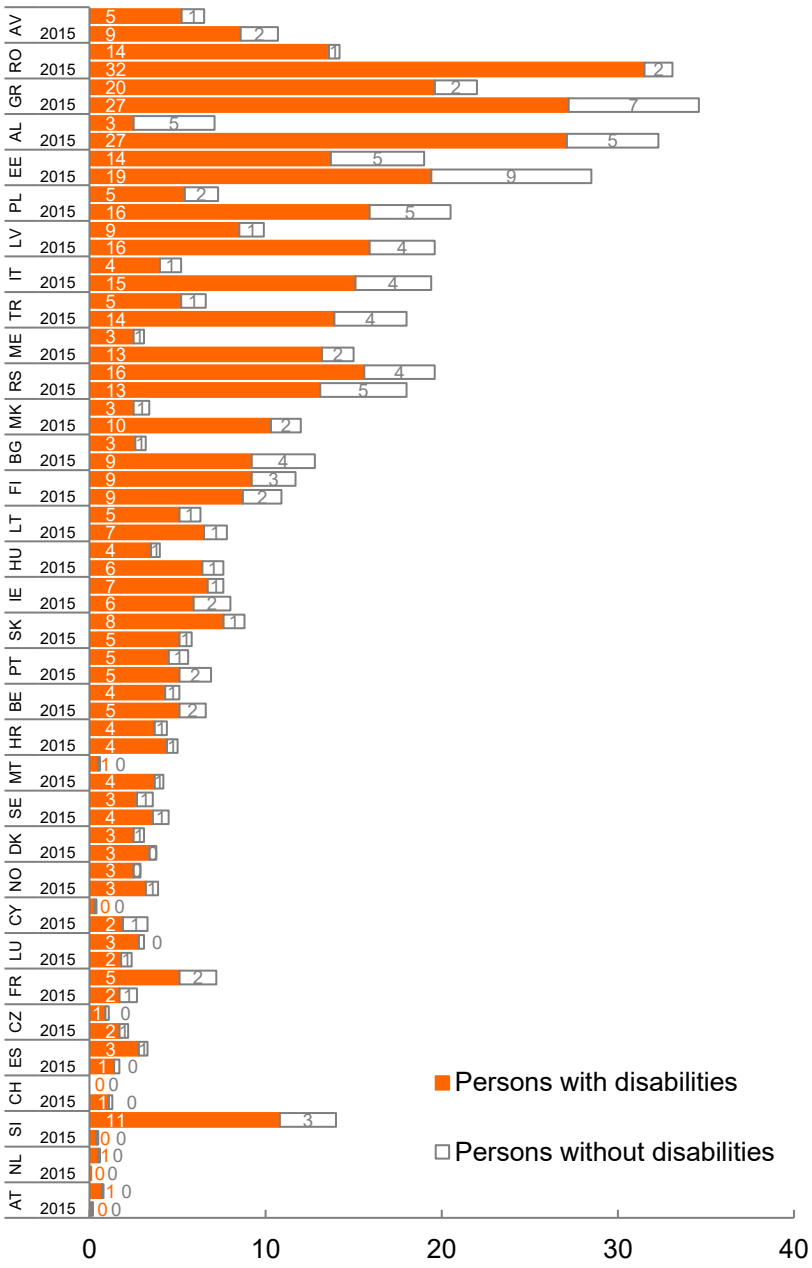
In European countries, the costs of the services, the geographical location (which can be difficult for persons with disabilities to reach) or the long waiting lists (which disproportionately affect persons with disabilities) are major factors contributing to persons with disabilities' reduced access to health services (Figure 32). Among 33 countries, in 2021, 5 per cent of persons with disabilities could not get medical care when they needed it because of these barriers. Even though a positive trend is observed between 2015 and 2021 and progress has been made in many countries in removing barriers for persons with disabilities, the differences in unmet needs for medical examination between persons with disabilities and the rest of the population are still significant. For example, in Poland, the percentage of persons with disabilities who needed but could not get medical examinations because of cost, distance or waiting lists, decreased from 16 per cent to 5 per cent from 2015 to 2021, but this figure is still larger than that for persons without disabilities (2 per cent). Similarly, in Latvia, there was a decrease of 7 percentage points for persons with disabilities in a period of six years, yet the difference with persons without disabilities is nine-fold.

Figure 31. Percentage of persons who needed but could not get healthcare, by disability status, in 38 countries or areas, in 2021 or latest year available.



Note: Data from Cameroon were collected in selected regions and are not nationally representative.
Source: Eurostat[7] and WHO.

Figure 32. Percentage of persons who needed but could not get a medical examination because the examination was too expensive, too far to travel to or the person was still on a waiting list, by disability status, in 33 countries, in 2015 and 2021.

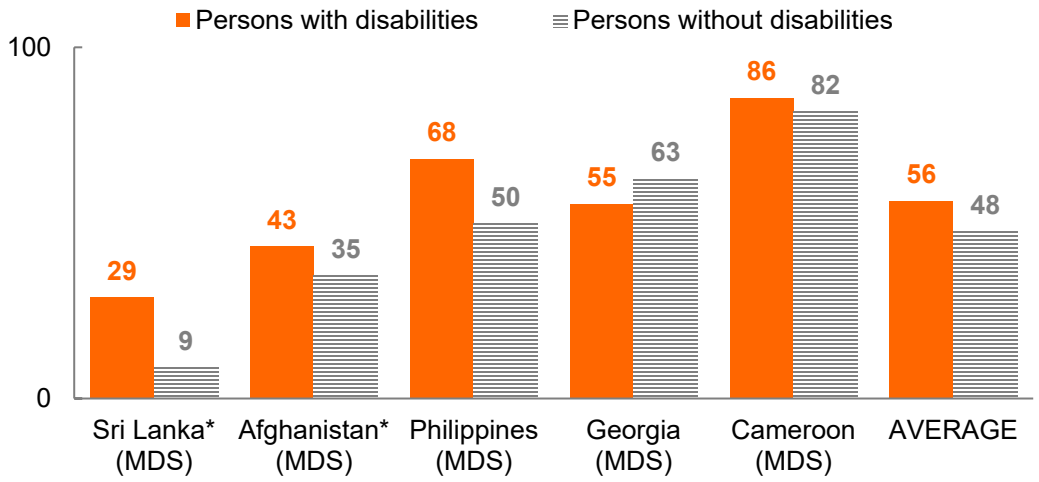


Note: AV, AVERAGE; AL, Albania; AT, Austria; BE, Belgium; BG, Bulgaria; CH, Switzerland; CY, Cyprus; CZ, Czechia; DK, Denmark; EE, Estonia; ES, Spain; FI, Finland; FR, France; GR, Greece; HR, Croatia; HU, Hungary; IE, Ireland; IT, Italy; LT, Lithuania; LU, Luxembourg; LV, Latvia; ME, Montenegro; MK, North Macedonia; MT, Malta; NL, Netherlands; NO, Norway; PL, Poland; PT, Portugal; RO, Romania; RS, Serbia; SE, Sweden; SI, Slovenia; SK, Slovakia; TR, Türkiye. Data for Albania are from 2017 and 2020; data for Montenegro, North Macedonia, Norway and Slovakia are from 2020 instead of 2021.
Source: Eurostat.[7]

Table 1. Coverage gaps between persons with and without disabilities for various health interventions.

Intervention	Countries	Coverage gap
Cardiovascular health and diabetes control[68,69,70]	Israel, United States	13-45 per cent
Cervical cancer and HPV screening[71,72,73,74,75,76]	Canada, Republic of Korea, United Kingdom, United States	5-33 per cent
Healthy diet[77]	United States	Up to 20 per cent
Physical activity programs[78,79]	United Kingdom	Up to 14 per cent
HIV knowledge, testing or counselling[80,81,82]	South Africa, Uganda	Up to 8 per cent
Family planning[83,84,85]	India, United States	Up to 5 per cent

Figure 33. Percentage of persons with disabilities who did not get healthcare when needed because they could not afford its cost, in 5 countries, in 2021 or latest year available.

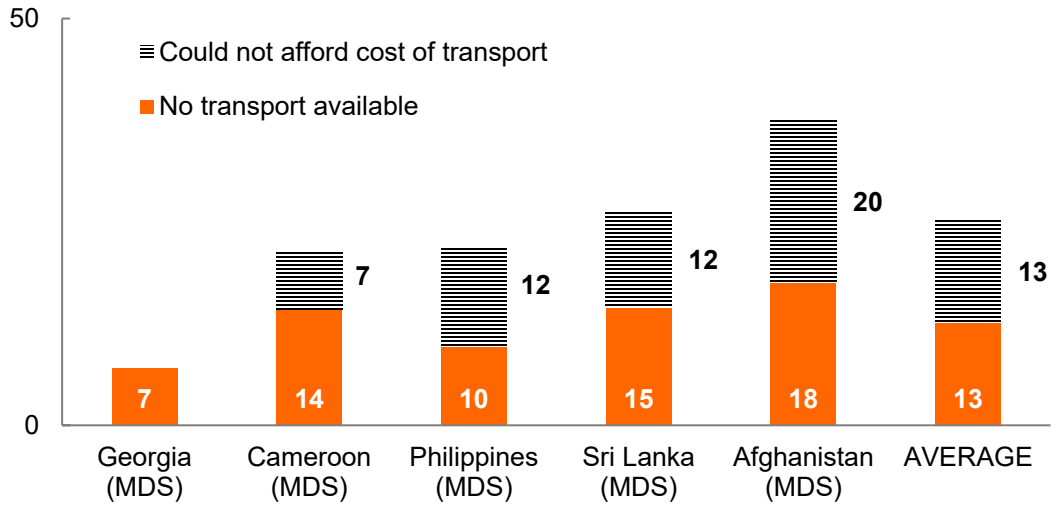


Note: (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon and Pakistan were collected in selected regions of the country and are not nationally representative.
Source: WHO.

Cost is also a major barrier to healthcare for persons with disabilities in other developed countries. In the United States, persons with cognitive impairments and persons with physical impairments have up to five times more medical expenditures compared to those without disabilities.[86] In the United States, a greater percentage of older adults with disabilities compared to older adults without disabilities delay seeing a doctor due to cost (6 per cent versus 3 per cent).[87] In the United Kingdom, persons with disabilities living

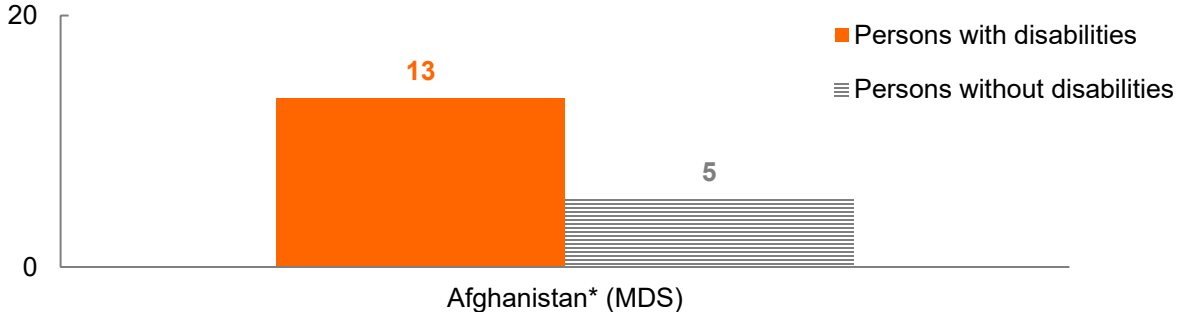
in the community are five times more likely to have unmet needs for mental healthcare due to cost, including the cost of prescribed medicines, with women with disabilities seven times more likely than men with disabilities to have unmet needs due to the cost of care or medication.[88]

Figure 34. Percentage of persons with disabilities who did not get healthcare when needed because transport was not available or not affordable, in 5 countries or areas, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon were collected in selected regions of the country and are not nationally representative.
Source: WHO.

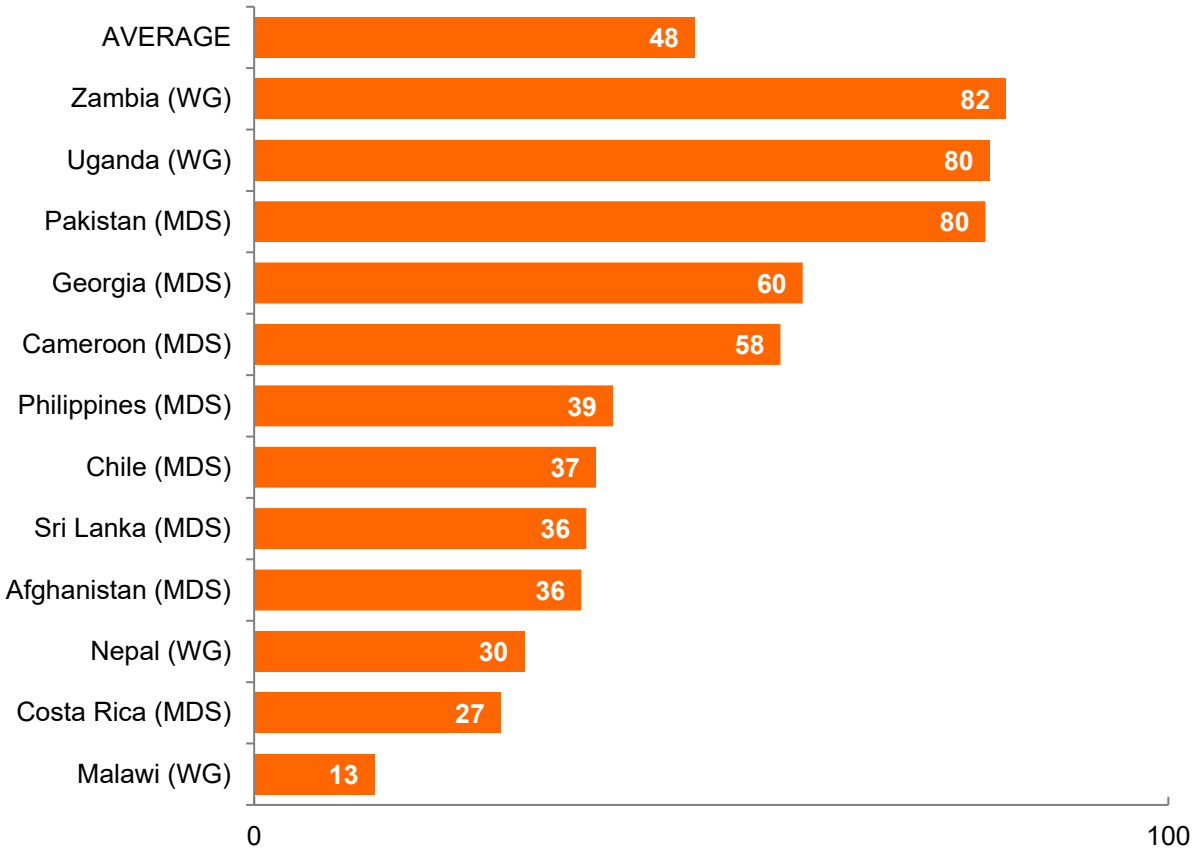
Figure 35. Percentage of persons who were badly treated during inpatient or outpatient healthcare, by disability status, in Afghanistan, in 2019.



Note: (MDS) identifies data produced using the Model Disability Survey. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: WHO.

In developing countries, the inability to pay for healthcare or the inability to get transport to the healthcare facility tends to be a major barrier for persons with disabilities. Among five countries, an average of 56 per cent of persons with disabilities could not afford the cost of needed healthcare, compared to 48 per cent of persons without disabilities (Figure 33). In Cameroon, 86 per cent of persons with disabilities who needed but could not get healthcare indicated unaffordability as the barrier. In the Philippines, 68 per cent indicated they could not afford the healthcare service; 55 per cent in Georgia; 43 per cent in Afghanistan; and 29 per cent in Sri Lanka. Lack of transport hinders access to health services to a much larger extent for persons with disabilities than for persons without disabilities. Among five countries or areas, on average, 13 per cent of persons with disabilities could not get healthcare when needed because they had no transport, and another 13 per cent because the transport was not affordable (Figure 34). In Afghanistan, 20 per cent could not afford the cost of transport to the health facilities and 18 per cent had no transport available to get to the facilities.

Figure 36. Percentage of persons with disabilities who reported that healthcare facilities were hindering or not accessible, in 12 countries or areas, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning; (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon and Pakistan were collected in selected regions and are not nationally representative.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO.

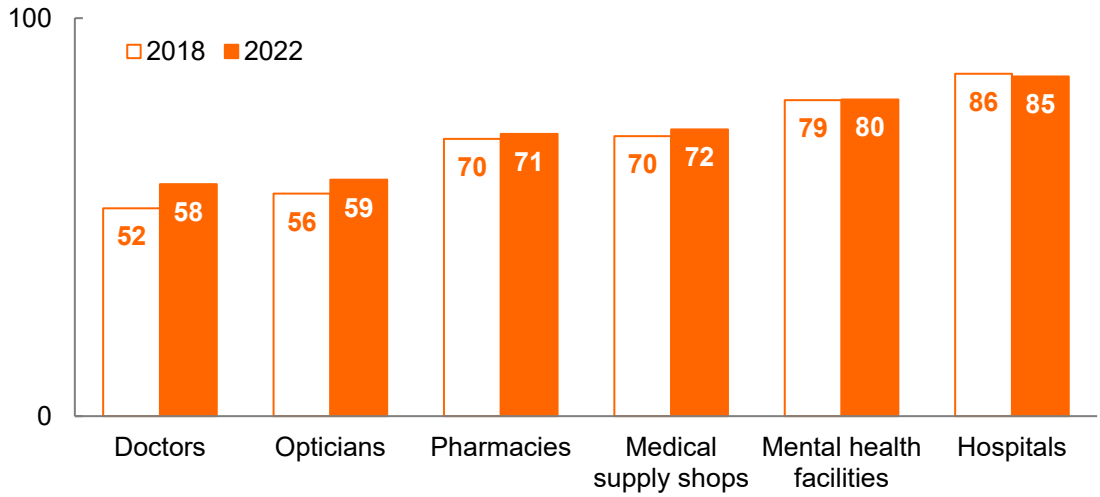
Attitudinal barriers also compromise access to healthcare for persons with disabilities when health professionals have negative or stigmatizing attitudes towards these patients and do not treat them with respect. For example, in Afghanistan, in 2019, 13 per cent of persons with disabilities versus 5 per cent of persons without disabilities indicated that they were badly treated during inpatient or outpatient healthcare (Figure 35).

Persons with disabilities have lower rates of receiving population-wide interventions compared to persons without disabilities, including for various interventions such as cancer screening, HIV testing and treatment, family planning or prevention of noncommunicable diseases (Table 1). In terms of rehabilitation services, data from Uganda show that only 22 per cent of persons with disabilities who needed rehabilitation have received it in the past year. Similar unmet needs for rehabilitation are observed in many other low- and middle-income countries.[89]

Another major factor that hinders access to health services for persons with disabilities is the lack of physical accessibility of health facilities. On average, more than 48 per cent of persons with disabilities experience difficulties accessing health facilities due to physical barriers (Figure 36). This percentage is particularly high in Pakistan, Uganda and Zambia. Crowdsourced data mostly from developed countries indicate that in 2022, 58 per cent of doctors' premises, 59 per cent of opticians, 71 per cent of pharmacies, 72 per cent of medical supply shops, 80 per cent of mental health facilities and 85 per cent of hospitals were accessible for wheelchair users, with little or no improvement in accessibility since 2018 (Figure 37). Accessibility features in health services are also generally lacking. The use of surgical masks by medical professionals creates barriers for persons with hearing impairments who rely on lip-reading. Although transparent masks exist and eliminate these barriers, research into their efficacy in preventing the transmission of disease remains limited and they are still not typically used in healthcare settings.[90,91]

The health of persons with disabilities is often disproportionately affected by different risk factors, including physical inactivity, high body mass index, smoking, or drug and alcohol use. In terms of physical inactivity, adults with disabilities are significantly more likely to be physically inactive compared to persons without disabilities,[92,93] and this is observed from a very early age as children and adolescents with disabilities participate much less in sporting activities, compared to those without disabilities.[94] Obesity affects more adults with disabilities than those without.[95,96] In terms of alcohol and substance use, prevalence rates are higher among persons with disabilities as well.[97,98]

Figure 37. Percentage of doctors' premises, hospitals, medical supply shops, mental health facilities, opticians and pharmacies that are accessible for wheelchair users, worldwide, in 2018 and 2022.

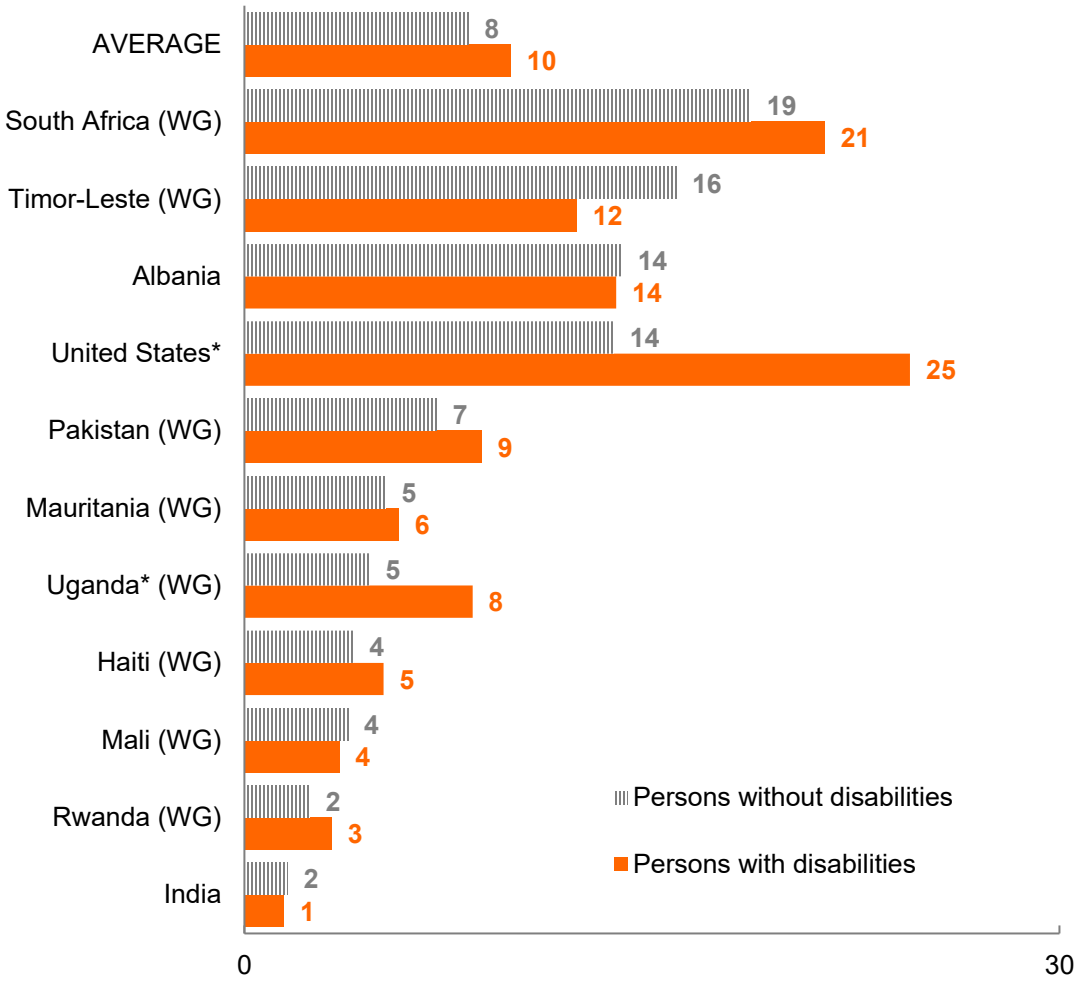


Source: UNDESA (on the basis of data from Sozialhelden[10]).

Depending on the country, smoking may be more or less prevalent among persons with disabilities (Figure 38). In the United States, there is a higher percentage of persons with disabilities who smoke than persons without disabilities, with 25 per cent of adults with disabilities currently smoking compared to 14 per cent of adults without disabilities. A higher prevalence of smokers among persons with disabilities compared to others is also observed in Haiti, Mauritania, Pakistan, Rwanda, South Africa and Uganda.

Multisectoral public health interventions to address these risk factors often miss persons with disabilities (Table 1) and therefore they do not benefit on an equal basis with others. For example, public health information is often not provided in accessible formats,[99] or not tailored to the information needs of persons with disabilities.[100] The physical environment where indoor or outdoor interventions take place is a barrier for many persons with disabilities. A lack of ramps, properly surfaced ground cover, accessible bathrooms, accessible changing spaces and accessible fitness facilities and equipment can all create barriers to inclusion.[101] Healthcare workers can block access to public health interventions by making assumptions about the appropriateness of referrals or recommendations for persons with disabilities.[102] A key reason for these existing barriers is the fact that responsibilities for public health and disability inclusion are often not clear within the government, with some countries struggling to define whose role it is to provide inclusive public health interventions.[103]

Figure 38. Percentage of smokers of cigarettes, by disability status, in 11 countries, in 2021 or latest year available.



Note: Data from the United States refer to current smokers aged 18 years and older; all other data refer to daily and occasional smokers aged 15 to 49. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: Okoro et al (2020)[104] and UNDESA (on the basis of data from DHS[6]).

Health emergencies – such as infectious disease outbreaks, natural hazards, conflicts, unsafe air, food and water, antimicrobial resistance and the effects of climate change, among others – exacerbate the challenges persons with disabilities experience in the health sector (see the chapter on targets 1.5 and 11.5 and Goal 13).

Regarding national legislation, there has been some progress in the last decades in terms of implementing the right to health for persons with disabilities in national constitutions. Prior to 1990, only 6 per cent of adopted constitutions guaranteed some form of this right. This percentage increased to 33 per

cent of constitutions adopted in the 1990s, 52 per cent adopted in the 2000s and 63 per cent of constitutions adopted in 2010.[105] However, overall guarantees of the right to health for persons with disabilities are still very low. As of 2022, only about one third of countries in the world had disability inclusion incorporated in their national health strategies.[106]

Regarding national policies, in the past decade, there are examples of practices and initiatives adopted by governments, international agencies or civil society organizations in various countries to advance disability inclusion in the health sector. One example is a policy initiative developed by WHO and aligned with the CRPD that aims at promoting the rights of persons with psychosocial disabilities across the globe by changing the attitudes of mental health professionals and other stakeholders. The initiative has been implemented in various countries, including in Armenia, Bosnia and Herzegovina, Czechia, Estonia, Italy, Kenya, Lebanon, Philippines, Poland, Türkiye and Zimbabwe.[107] The first large-scale implementation and systematic evaluation was done in the state of Gujarat in India, and showed improvements in the attitudes of health professionals towards persons with mental health conditions. The evaluation also showed that service users felt more empowered and had higher satisfaction with services.[108]

Some countries have supported access to health services by widening the inclusion of persons with disabilities in their social protection mechanisms (see the chapter on Goal 1). Brazil, for instance, has taken steps to achieve universal social protection for persons with disabilities, by offering benefits equivalent to the minimum wage to more than 2.3 million persons with disabilities and providing a disability pension for partial and full disability as well as sickness benefits for those working in the formal sector.[109]

Another area of progress is digital health, with some countries creating mechanisms to involve persons with disabilities in digital health innovation processes. One such example is Australia. The country adopted the Digital Transformation Strategy 2018-2025, which describes how digital developers must ensure that their services can be used by every person who needs them, including persons with disabilities.[110] Furthermore, some countries have invested in strengthening informal care services. For example, Slovakia and Slovenia have taken steps to support informal carers through care allowance and community-based training programs.[111]

Community-based rehabilitation programmes aimed at enhancing the social inclusion of persons with disabilities and their families[112] have been particularly prevalent in developing countries as a means to implement the CRPD, but have evolved to extend to education, social integration, livelihoods and empowerment.[112] Studies in Afghanistan[113] and Namibia[114] have demonstrated the positive impact of community-based rehabilitation programmes on emotional, social participation, unemployment, and communication challenges for persons with disabilities. In Afghanistan and India, research shows that the effects of community-based rehabilitation programmes have had positive results on improved wellbeing that have been maintained over time.[115]

Impact of the COVID-19 pandemic

The COVID-19 pandemic disproportionately affected the health of persons with disabilities and persons with disabilities were more likely to die from COVID-19 than others. For example, in the Republic of Korea and the United Kingdom, more than half of the COVID-19–related deaths occurred among persons with disabilities, and it can be assumed that this number was much higher in countries with lower resource settings where evidence is more limited.[116,117] In the Republic of Korea, in the early phase of the pandemic, the chance of dying once infected with COVID-19 was 16 per cent for persons with severe or moderate disabilities, 11 per cent for persons with mild disabilities and 2 per cent for persons without disabilities.[118] In England, persons with disabilities were up to three times more likely to die from the virus,[119] with those with intellectual disabilities being seven to eight times more likely to die than those without an intellectual disability.[120] This higher death rate especially impacted young persons with intellectual disabilities, aged 18 to 34, who were 30 times more likely to die from COVID-19 than others in the same age group.[121]

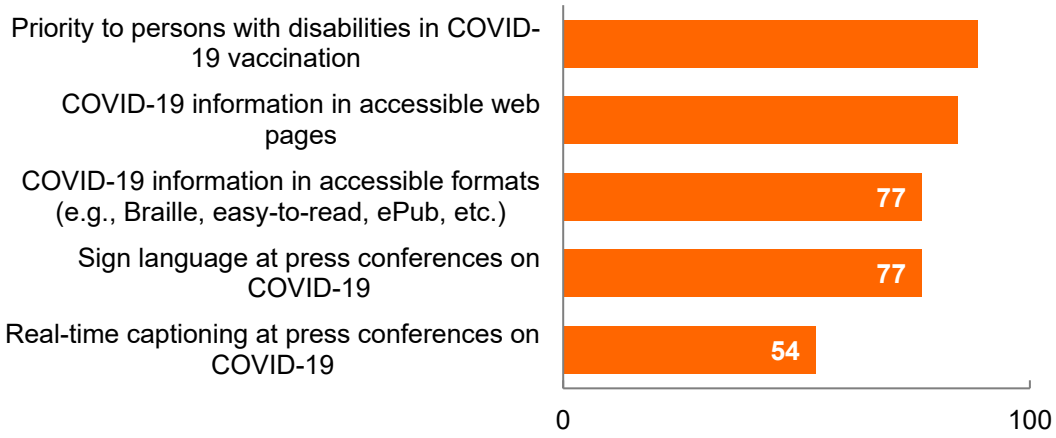
The higher mortality rates may be linked to various risks and barriers experienced by persons with disabilities during the COVID-19 pandemic.[122] Persons with disabilities with pre-existing conditions such as respiratory challenges, were at higher risk of developing critical conditions or dying once infected with COVID-19. Persons with disabilities also encountered barriers to accessing timely and equal medical attention due to a lack of accessible information about symptoms and primary steps in case of exposure to infection. For instance, in Asia and the Pacific, only 85 per cent of countries or areas provided COVID-19 information in accessible webpages for persons with disabilities; only 77 per cent provided COVID-19 information in other accessible formats (such as Braille, easy-to-read, and ePub, among others) and provided sign-language in COVID-19 press conferences; and only 54 per cent provided real-time captioning in these press conferences (Figure 39). Other barriers to accessing timely heath care once infected with COVID-19 included inaccessible health systems, inaccessible transportation, lack of financial resources, lack of adequate personal assistance or support, lack of access to COVID-19 testing, lack of access to personal protective equipment and discriminatory practices in COVID-19 treatment in health facilities.

Unconscious bias[123,124,125,126,127] and preconceptions of medical staff[123] have been linked to discriminatory triage practices in the COVID-19 response. In a review of triage policies for intensive-care units in 14 European countries, in 2020, in more than half of the countries' triage protocols recommended the consideration of functional status or frailty assessments,[128] terms which can be confused with "disability". In the United Kingdom, persons with intellectual disabilities infected with COVID-19 were 50 per cent less likely to be admitted to intensive care, despite having more severe symptoms on admission and similar rates of complications as their counterparts without disabilities.[129] Moreover, persons with disabilities encountered barriers in accessing personal protective equipment and COVID-19 testing during the pandemic. In 2020, a higher proportion of parents and caregivers with disabilities, compared to those

without, reported needing and not having essential items to protect them from the COVID-19 virus such as sanitiser (66 per cent versus 54 per cent) and masks (64 per cent versus 50 per cent).[16] And more parents and caregivers with disabilities than those without reported needing and not having access to COVID-19 testing (41 per cent versus 28 per cent).[16]

One of the barriers to access was cost, as many persons with disabilities could not afford essential items and services needed to stay healthy during the COVID-19 crisis.[16,130] Another obstacle was accessibility: COVID-19 testing as well as many COVID-19 outpatient and inpatient services, including online health services, were not accessible to many persons with disabilities.[128] In particular, the standard at-home COVID-19 tests have barriers for blind users as they rely on visual information that is not accessible to persons with visual impairments. The technology to produce accessible tests, which rely on non-visual information such as temperature, smell or sound, already existed at the start of the pandemic but they were not produced until about two years after the start of the pandemic.[131] Moreover, during the COVID-19 pandemic, wearing face masks became necessary within healthcare settings, but face masks hinder speech comprehension for persons with hearing impairments who rely on lip-reading. Although transparent face masks already existed in 2020, research into their efficacy in blocking the transmission of COVID-19 was not pursued in a timely manner to inform their usage during the pandemic.[132]

Figure 39. Percentage of countries or areas that prioritized persons with disabilities in the COVID-19 vaccine roll-out and provided information on COVID-19 in formats accessible to persons with disabilities, in Asia and the Pacific, as of 2022.



Note: Data on COVID-19 vaccination rates are based on 27 countries or areas; data on real-time captioning are based on 24 countries or areas; all other data are based on 26 countries or areas.
Source: ESCAP.[14]

Measures to control the COVID-19 outbreak – like community lockdowns, physical distancing requirements and prioritization of selected health services – without considering the needs of persons with disabilities may have caused a lack of sufficient physical activity as well as a reduction of essential health services, social care and support services for persons with disabilities, leading ultimately to higher

risks of new or worsening health conditions. About 70 per cent of persons with autism in Europe were left without everyday support due to interruptions in health and social care.[128] Regarding critical health services, worldwide, in 2020, more parents and caregivers with disabilities than those without reported needing and not having access to medicine (40 per cent versus 32 per cent) and to in-person healthcare (34 per cent versus 22 per cent).[16] This lack of access to health services and support may have deteriorated the health of persons with disabilities during the pandemic and made them more vulnerable to death when infected by COVID-19. Disrupted access to critical services such as regular health consultations, medication, psychosocial support, rehabilitation including assistive devices provision, as well as personal assistants and home support services also led to increased pressure on the families of persons with disabilities and on informal care mechanisms.[133,134,135,136,137,138,139]

The mental health and psychosocial wellbeing of persons with disabilities has also been impacted by the COVID-19 crisis. In 2020, a total of 82 per cent of parents and caregivers with disabilities reported reduced psychosocial wellbeing since the start of the COVID-19 outbreak.[16] Among persons with disabilities who looked for mental health support during the pandemic, 33 per cent said the support was not accessible to them.[140] The impact of COVID-19 on social interaction and play among children with disabilities as well as other pandemic stressors had an impact on the mental health and psychosocial wellbeing of children with disabilities: 69 per cent of parents and caregivers observed increases in signs of distress among their children with disabilities, compared to 47 per cent of parents and caregivers of children without disabilities.[16] Children with disabilities reported playing less, sleeping less, doing more chores and caring more for siblings or others since the beginning of the COVID-19 pandemic. They were less likely to be able to interact socially with their friends during the pandemic. In 2020, only 29 per cent of parents and caregivers of children with disabilities reported that their child could stay in touch with friends during the COVID-19 pandemic, compared to 45 per cent of parents and caregivers of children without disabilities.[16]

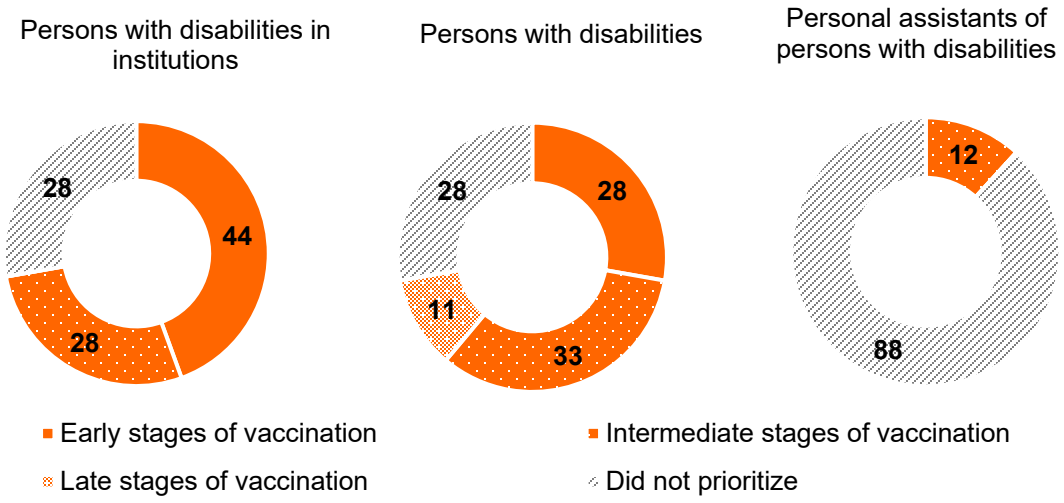
In addition, the health of persons with disabilities may have been disproportionately affected by the wider social and economic impacts of the pandemic. Already more likely to live in poverty and to face exclusion in the world of work, persons with disabilities faced job losses and fewer hours of work, reduced household income, and in some countries, food insecurity during the COVID-19 pandemic (see the chapters on Goal 1, Goal 2 and Goal 8) – all of which are determinants of health and well-being.

Persons with disabilities have expressed the need to be prioritized in national COVID-19 vaccination plans and the need to also prioritize their support networks, including personal assistants, family caregivers and persons working in disability-related services.[141] However, despite higher mortality rates, persons with disabilities and their support networks were not always prioritized in national vaccination campaigns. In Asia and the Pacific, persons with disabilities were prioritized in 89 per cent of countries or areas (Figure 39). In Latin America and the Caribbean, persons with disabilities living in institutions were prioritized at the early stage of COVID-19 vaccination in 44 per cent of countries and at the intermediate

stage in 28 per cent of countries (Figure 40). Persons with disabilities not living in institutions were less likely to be prioritized, with only 28 per cent of countries prioritizing them in the early stages, 33 per cent in the intermediate stages and 11 per cent in the late stages of COVID-19 vaccination. Some 28 per cent of countries did not prioritize persons with disabilities in their COVID-19 vaccination plans at any stage. Personal assistants were seldom prioritized, with just 12 per cent of countries in Latin America and the Caribbean prioritizing them and only at the intermediate stage of vaccination. Moreover, many online COVID-19 vaccination registration sites were not designed with accessible features for persons with disabilities (see the chapter on SDG target 9.c).

The COVID-19 pandemic has drawn attention, albeit too slowly, to the importance of including persons with disabilities in responses to health emergencies. Some countries have taken steps to make COVID-19 information available in accessible formats[142,143,144,145] and to address physical barriers that persons with disabilities faced in accessing COVID-19 vaccination.[146,147,148] In addition, there are isolated examples of public health responses[149] and clinical triage protocols[150,151,152] being adapted to avoid the discrimination faced by persons with disabilities during the COVID-19 pandemic. Civil society played a vital role during the pandemic, encouraging governments and health authorities to protect the rights of persons with disabilities and to act in accordance with the CRPD.[153,154]

Figure 40. Percentage of countries that prioritized persons with disabilities and their personal assistants in national COVID-19 vaccination plans, in Latin America and the Caribbean, as of 1 May 2021.



Note: Data on persons with disabilities, in and out of institutions, are based on 18 countries; data on personal assistants are based on 17 countries.
Source: UNESCO (2021).[155]

Summary of findings and the way forward

Persons with disabilities continue experiencing higher rates of mortality and morbidity; and the contributing factors to these inequities have not changed over the past decade. Persons with disabilities are 15 times more likely to perceive their health as bad or very bad than persons without disabilities and evidence since 2015 suggests that progress has been too slow. For example, in European countries, to achieve levels of health similar to persons without disabilities by 2030, the percentage of persons with disabilities self-reporting bad or very bad health would have to decrease five times faster than current trends.

The higher rates of mortality or morbidity among persons with disabilities can be explained to some extent by the underlying health conditions or impairments that some persons with disabilities may have. But a significant proportion of these differences in health outcomes between persons with and without disabilities are associated with unjust or unfair factors that are avoidable, including barriers to healthcare access.

Many persons with disabilities still do not receive health services according to their needs. Persons with disabilities are seven times more likely than others to not have access to healthcare when they need it. In various developing countries, more than half of persons with disabilities do not get healthcare when needed because they cannot afford the cost, and about a quarter because they do not have or cannot afford transport to healthcare facilities. In some developed countries, more than 10 per cent of persons with disabilities do not get healthcare when needed because they cannot afford the cost, the healthcare service is too far to travel to, or the waiting list is too long.

The evidence that exists for European countries suggests significant progress since 2015 in removing barriers for persons with disabilities related to healthcare cost, distance or waiting lists as the rates of unmet healthcare needs due to these barriers were halved since 2015. Keeping these successful rates of progress in Europe will ensure that the health needs of persons with disabilities are met by 2030 and contribute to the realization of universal health coverage and the achievement of Goal 3, specifically target 3.8. In other regions, there is insufficient evidence to evaluate progress towards this target.

Public health interventions to promote health and well-being for the population – like nutrition information campaigns and regular health testing and monitoring – often do not reach persons with disabilities. For various interventions, the gaps in coverage between persons with and without disabilities range from 5 per cent to 45 per cent. Promoting the health and wellbeing of persons with disabilities will require closing these gaps and establishing health policies and public health interventions that deal comprehensively with different determinants of and risk factors for the health of persons with disabilities.

Many health facilities remain inaccessible for persons with disabilities. In various developing countries, more than 30 per cent of persons with disabilities indicate that healthcare facilities are hindering or not accessible to them. In some countries, this percentage reaches 80 per cent. Crowdsourced data indicates

that worldwide, in 2022, 42 per cent of doctors' offices, 29 per cent of pharmacies and 15 per cent of hospitals were not accessible for wheelchair users. In the past five years, progress in increasing the accessibility of health-related premises has been slow or stagnant. Doctors' offices would need to become accessible for persons using wheelchairs at a rate three times faster and pharmacies seven times faster than current rates of progress to achieve full accessibility by 2030. Progress for hospitals' accessibility has stagnated and needs to be revived to achieve full accessibility by 2030.

The number of countries whose constitution guarantees the right to health explicitly for persons with disabilities has increased since the 1990s and indicates that the importance of this right has received greater recognition over the past decades and especially after the early 2000s. As of 2010, about two thirds of countries guaranteed this right for persons with disabilities in their constitutions. However, as of 2022, only about one third of countries had incorporated disability inclusion in their national health strategies.

The lack of disability-inclusive health policies and the gaps in healthcare access continued and were exacerbated during the COVID-19 pandemic. The response to the pandemic has largely not been inclusive of persons with disabilities, especially during the early stages of the pandemic. Persons with disabilities faced discriminatory practices in COVID-19 treatment in health facilities and were less likely to be admitted to intensive care despite having more severe symptoms on admission; had less access to personal protective equipment – like masks and sanitizer – and to COVID-19 testing; encountered barriers to accessing timely and equal medical attention due to a lack of accessible information about symptoms and primary steps in case of exposure to infection; and were not always prioritized in national COVID-19 vaccination campaigns. In 18 per cent of countries or areas in Asia, the Caribbean, Latin America and the Pacific, persons with disabilities were not prioritized. These barriers took a heavy toll on persons with disabilities: available evidence points to half of COVID-19 deaths occurring among persons with disabilities although they constitute only about 15 per cent of the world population. The pandemic also had a negative impact on the mental health and psychological wellbeing of persons with disabilities. Yet, many persons with disabilities do not have access to mental health care.

To make progress towards achieving Goal 3 for persons with disabilities, countries need to integrate targeted actions to advance health equity for persons with disabilities in their efforts to strengthen their health systems, using primary healthcare as a foundation. Moreover, addressing health inequities for persons with disabilities should not be a siloed activity conducted by the health sector, but rather a strategy that is integrated into the overall efforts of a country to strengthen its health systems. The implementation of any disability-targeted actions needs to take into consideration the contexts, strengths and weaknesses of the health system, and the national and local priorities of countries. Depending on the national and local circumstances, different entry points may be prioritized in addressing the health inequities that exist for persons with disabilities.

Some of the key areas in which governments, international agencies and civil society can collectively invest in efforts to trigger progress in health equity for persons with disabilities include:

1. Include health equity for persons with disabilities at the centre of every health sector action. This implies prioritizing, in any health sector action, the persons with disabilities who are most left behind, protecting their rights and addressing their needs, including when planning for health financing. It can also mean (i) establishing legal frameworks that prohibit discrimination against persons with disabilities; (ii) providing strategies and solutions to eliminate discriminatory practices, unjust power relations and other unjust conditions for persons with disabilities through different policies, such as developing disability-inclusion competencies among health and care professionals; (iii) addressing the right to legal capacity, as well as having systems for safeguarding to ensure that acts of violence and abuse against persons with disabilities in healthcare settings are appropriately investigated and prosecuted; and (iv) ensuring the accessibility of health services in terms of physical access to facilities and accessible communication and provision of reasonable accommodation. Promote research into accessibility features and services in the health sector, including on the efficacy of transparent face masks in surgical settings and by medical professionals with the aim of making transparent face masks the universal standard. Ensure the availability of accessible tests for COVID-19 and other medical conditions in order to remove barriers for blind users and users with visual impairments. Include health equity in any health sector action, which is strongly associated with adopting a human rights-based approach to health, as it involves a change in the mindset of the health sector and the way it operates. The human rights-based approach ensures that policies, programmes and their implementation are all guided by respect, protection and the realization of human rights.

2. Ensure the provision of integrated health services without financial hardship and close to where persons with disabilities live. This involves the provision of accessible and affordable people-centred healthcare across the life cycle, that is close to where persons with disabilities live and is responsive to their needs. This requires the provision of the full spectrum of services, including preventive, promotive, curative, rehabilitative and palliative care services, as well as services specific to the underlying health conditions or impairments of persons with disabilities. Strengthening linkages with social care is also fundamental, including expanding access to health insurance.

3. Strengthen multisectoral collaboration to address structural, social and health system determinants and factors that contribute to health inequities among persons with disabilities. Through the stewardship role of the health sector, progress in this area can be achieved by making multisectoral public health policies, actions and interventions inclusive of persons with disabilities. The responsibilities for public health and disability inclusion need to be better defined within the government to improve the provision of inclusive public health interventions. Establishing good coordination mechanisms with the private sector is also important.

4. Ensure that the management of health emergencies includes and protects persons with disabilities. If countries invest in having an inclusive and well-functioning health system, they will be better prepared and able to respond to health emergencies like the COVID-19 pandemic. In practice, this can be done through strengthening essential health service coverage and public health interventions, contributing to the prevention of outbreaks, mitigating risks and building community resilience to such hazards. In addition, responses to health emergencies should take into account accessibility and impact on the overall lives of persons with disabilities. More efforts are needed to put in practice existing technology and produce at scale tests for medical conditions that are accessible for blind users and users with visual impairments, including accessible COVID-19 tests. Persons with disabilities, their family members, support services and healthcare providers should play a central role in health-emergency planning, response and implementation, working together to identify the needs of persons with disabilities.

5. Ensure the empowerment and meaningful participation of persons with disabilities, their families and representative organizations in decision-making about their health. This can be achieved through: (i) enabling persons with disabilities to take control of their own health needs and make decisions by improving health education opportunities and health information; (ii) making sure that persons with disabilities and organizations of persons with disabilities are engaged when packages of care, in the context of universal health coverage, are decided and when designing responses and planning for health emergencies is underway; and (iii) providing opportunities to persons with disabilities to participate in health research as well as in the healthcare workforce.

6. Monitor and evaluate the extent to which health sector actions advance health equity for persons with disabilities. A well-planned monitoring and evaluation process is fundamental to track progress and adjust actions as the context evolves. This normally includes collecting data through indicators that measure the extent of progress towards the achievement of objectives. Integrating disability data collection and disaggregation in national health information systems is a key element of such a framework. Monitoring and evaluation also allow for the entire health system to learn what works and what does not work, and to inform constant improvement. In addition, more data is needed to understand the extent to which higher rates of mortality or morbidity among persons with disabilities are due to underlying health conditions or impairments or due to avoidable conditions, in order to guide policies to eliminate these unavoidable conditions.

7. Develop a research agenda on the health system and policies to advance health equity for persons with disabilities. Developing and implementing a research agenda on the health system and policies will help countries address health inequities for persons with disabilities. Research can identify mechanisms and innovative strategies that work to advance health equity for persons with disabilities in different contexts. To do so, countries need to establish well-functioning links between ministries of health

and research organizations and institutions for a collaborative approach to ensure that research is aligned with national disability and health priorities.

Reducing maternal mortality and accessing sexual and reproductive health services and reproductive rights (targets 3.1, 3.7 and 5.6)

This chapter reviews the current situation of sexual and reproductive health and reproductive rights for persons with disabilities, in the context of targets 3.1, 3.7 and 5.6. Target 3.1 calls for reducing maternal mortality, target 3.7 calls for universal access to sexual and reproductive health services, including for family planning, and Target 5.6 calls for ensuring access to sexual and reproductive health and ensuring reproductive rights. The Convention on the Rights of Persons with Disabilities (CPRD) was the first international treaty to explicitly recognize the need for sexual and reproductive health for persons with disabilities, with article 25 underscoring the need to provide persons with disabilities with the same range, quality and standard of free or affordable sexual and reproductive healthcare and programmes as provided to other persons. Moreover, article 23 calls on States Parties (i) to recognize the right of persons with disabilities to decide freely and responsibly on the number and spacing of their children; (ii) to recognize the right of persons with disabilities to have access to age-appropriate information, and reproductive and family planning education; (iii) to provide the means necessary to enable persons with disabilities to exercise these rights; and (iv) to ensure that persons with disabilities, including children, retain their fertility on an equal basis with others. Other important articles to sexual and reproductive health are article 6 (women and girls with disabilities), article 12 (legal recognition before the law), article 16 (freedom from exploitation, violence and abuse) and article 21 (access to information).

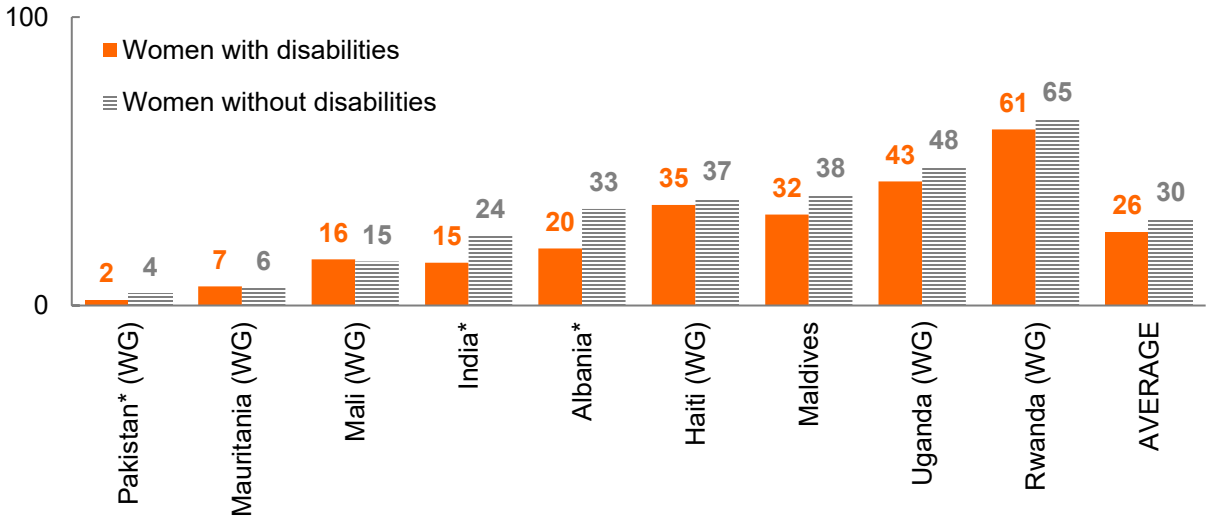
Sexual and reproductive health and reproductive rights are defined by three concepts: the right to make decisions on reproduction and sexuality free from discrimination, coercion and violence; the right to the highest standard of sexual and reproductive health; and the right to access a range of sexual and reproductive health facilities, services, goods and information.[156,157] Sexual and reproductive health services include contraceptive counselling information, education, communication and services; education and services for prenatal care, safe delivery and postnatal care; the prevention and appropriate treatment of infertility; safe abortion services; the prevention and treatment of sexually transmitted and reproductive tract infections; and sexual and reproductive health information, education and counselling.[158,159,160] While sexual and reproductive health is often discussed in terms of women's health, boys and men with disabilities also are entitled to sexual and reproductive health and often remain excluded from sexual and reproductive health services.

This chapter presents an overview of the current situation of persons with disabilities regarding their right to make decisions on reproduction and sexuality, access to sexual and reproductive healthcare and services and the realization of their reproductive rights. The chapter concludes with recommendations for moving towards the realization of targets 3.1, 3.7 and 5.6 for persons with disabilities.

Current situation and progress so far

Persons with disabilities have typically been excluded from sexual and reproductive healthcare and their sexual and reproductive health needs have been neglected.[161,162] Women with disabilities, especially those living in low- and middle-income countries, face the most significant barriers to accessing sexual and reproductive healthcare and realizing their reproductive rights.[163,164]

Figure 41. Percentage of women aged 15 to 49 with comprehensive knowledge about HIV/AIDS,[165] by disability status, in 9 countries, in 2021 or latest year available.

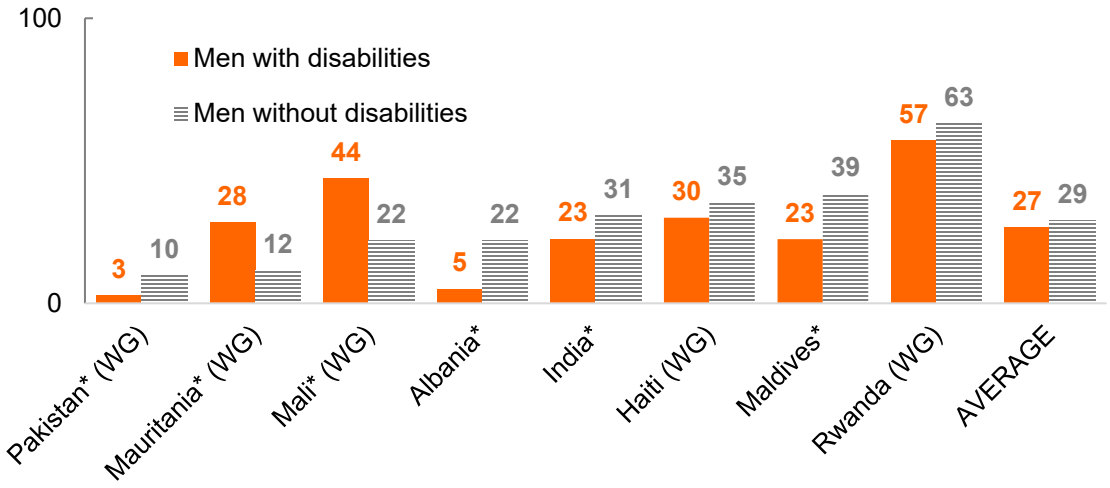


Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.
Source: UNDESA and UNFPA (on the basis of microdata from DHS[6]).

A persistent barrier for persons with disabilities is their lack of access to information about their reproductive rights as well as about sexual and reproductive health and related services. Due to this lack of access, persons with disabilities, especially individuals with intellectual disabilities, end up with low levels of sexuality education and sexual and reproductive health knowledge,[166] including low levels of knowledge on the prevention and transmission of sexually transmitted diseases. Among nine countries, 26 per cent of women with disabilities versus 30 per cent of women without disabilities have comprehensive HIV knowledge (Figure 41). The percentage of women with disabilities with this knowledge varies from 2 per cent in Pakistan to 61 per cent in Rwanda, with the largest gaps between women with and without disabilities observed in Albania and India. Among eight countries, 27 per cent of men with disabilities versus 29 per cent of men without disabilities have comprehensive HIV knowledge (Figure 42). The percentage of men with disabilities with this knowledge varies from 3 per cent in

Pakistan to 57 per cent in Rwanda. In Mali and Mauritania, the percentage of men with disabilities with comprehensive HIV knowledge is considerably higher than for men without disabilities; while in Albania and the Maldives, the opposite occurs. Lack of knowledge about HIV/AIDS can lead to risky sexual behaviours, such as low levels of condom and contraceptive use and HIV testing, even though persons with disabilities report being as sexually active as their peers without disabilities.[167] Compared to persons without disabilities, adults with disabilities are at equal or increased risk of sexually transmitted infections.[168,169,170] Likewise, children and youth with disabilities have a similar or increased risk of sexually transmitted infections compared with other youth, while girls with disabilities experience higher rates than boys with disabilities.[171] Persons with disabilities are at heightened risk of being subjected to sexual violence and abuse (see the chapter on Goal 16), which increases their risk of contracting sexually transmitted infections.

Figure 42. Percentage of men aged 15 to 49 with comprehensive knowledge about HIV/AIDS, [172] by disability status, in 8 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between men with and without disabilities is statistically significant at the 5 per cent level.
Source: UNDESA (on the basis of microdata from DHS[6]).

Several factors act as barriers for persons with disabilities to access information on sexual and reproductive health. Stigma and stereotypes significantly limit access to sexual and reproductive healthcare by persons with disabilities and the realization of their reproductive rights, from both community and healthcare providers.[173] The sexuality of persons with disabilities is generally considered a taboo subject.[174] Relatives, teachers and healthcare providers are often anxious, untrained and lack confidence about discussing sexuality with them.[175] There is a prevalent assumption that persons with

disabilities are either non-sexual or hypersexual.[176] Those stigmas and prejudices are particularly strong about persons with intellectual and psychosocial disabilities.[177] Stigma and stereotypes about sexuality can also lead to the exclusion of girls and young women with disabilities, as well as boys and young men, from existing sexuality education programmes by their parents, guardians and teachers.[178] There is a general lack of guidance for families and teachers about how to talk about sexuality and equality with children and youth with disabilities.[179]

Other stereotypes include the false beliefs that girls and young women with disabilities can be targeted for exploitation and abuse,[180] are unsuitable for marriage, and are unable to manage their fertility or raise children. These misplaced beliefs negatively impact women with disabilities and act as barriers to accessing education, information and services to enable them to enjoy safe and healthy sexual and reproductive lives free from violence.[181]

Box 2. Key concepts related to autonomous decision-making in sexual and reproductive health and reproductive rights

Equal recognition before the law is a right of all people, everywhere, under human rights law. Article 12 of the CRPD provides that States must realize this right for persons with disabilities. Understanding the right of persons with disabilities to equal recognition before the law[182] is necessary among sexual and reproductive health service providers to ensure that they do not violate this right.

Legal capacity is the capacity to be both a holder of rights and an actor under the law. Legal capacity entitles a person to the full protection of their rights by the legal system, with the power to engage in transactions and create, modify or end legal relationships; supported decision-making may be necessary to empower some persons with disabilities to exercise their legal rights.[183]

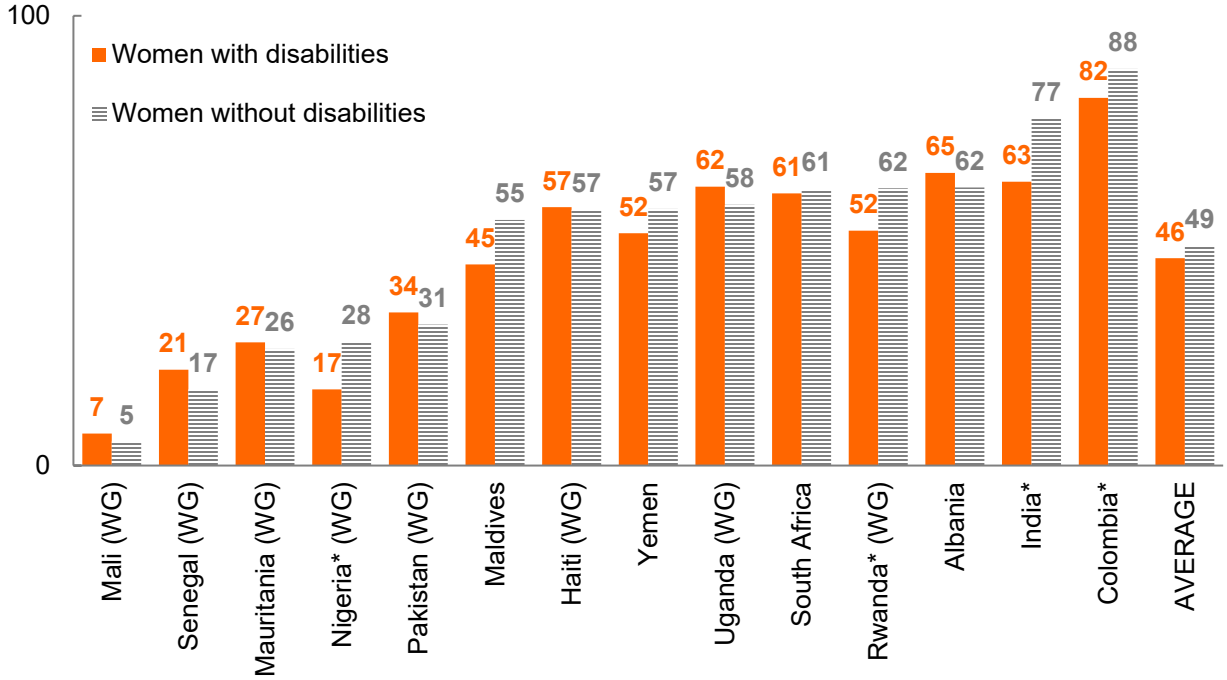
Informed consent is a communication process between a service provider and a service recipient that results in the service recipient giving, withdrawing or refusing permission for a procedure based on full knowledge of the procedure.[184]

Supported decision-making comprises various support options which give priority to a person's will and preferences and respects human rights norms. It should protect all rights, including those related to autonomy (for example, the right to legal capacity and the right to equal recognition before the law) and to freedom from abuse and ill-treatment (for example, the right to life and the right to physical integrity). Supported decision-making stands in contrast to substituted decision-making models, such as guardianship, which perpetuate power imbalances and can make persons with disabilities vulnerable to gender-based violence and other forms of abuse and ill-treatment.[185]

Moreover, sexuality education is not always delivered in accessible formats, sign languages and other alternative accessible modes of communication, and very often, it does not address disability-specific needs.[186] Furthermore, in many parts of the world, girls and boys with disabilities are often excluded from

the education system (see the chapter on Goal 2) or drop out of school too early to receive access to sexuality education. For girls and boys with disabilities who attend special education, sexual education programmes are also often unavailable in these education settings.

Figure 43. Percentage of women aged 15 to 49 exercising autonomy in reproductive health decision-making and empowered to exercise their reproductive rights (also known as 'bodily autonomy'), by disability status, in 14 countries, in 2021 or latest year available.



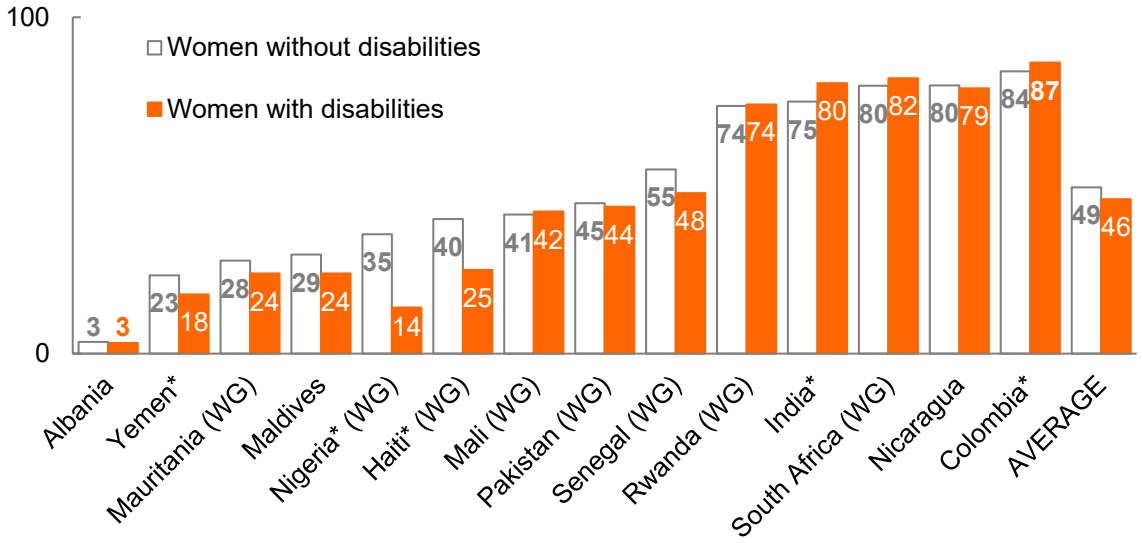
Note: Women are considered to have autonomy in reproductive health decision-making and to be empowered to exercise their reproductive rights if they (i) decide on healthcare for themselves, either alone or jointly with their husbands or partners, (ii) decide on use or non-use of contraception, either alone or jointly with their husbands or partners and (iii) can say no to sex with their husband or partner if they do not want to. Data on (iii) were not collected in Colombia, India, Senegal and Yemen. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.
Source: ESCWA, UNDESA and UNFPA (all based on data from DHS[6]).

In addition to these barriers, for persons with disabilities, the right to make decisions about their bodies, health and sexuality is often not realized. Bodily autonomy encompasses an individual's power and agency to make choices about one's body, health, life and future, and having the information, services and means to do so free from discrimination, coercion and violence. It includes fundamental decisions such as whether to have sex, use contraception or seek healthcare. Key concepts related to autonomous decision-making regarding sexual and reproductive health and reproductive rights include equal

recognition before the law, legal capacity, informed consent and supported decision-making (see Box 2). In many societies, the decision-making power of persons with disabilities is subordinated to that of their families, guardians or the State. Social norms, sometimes enshrined in law, deem them incapable of making their own choices.

Women who have bodily autonomy – that is, they make decisions about their healthcare and their use of contraception, and they can say no to their husbands or partners if they do not want to have sexual intercourse – are empowered to realize their reproductive rights. Among 14 countries, the proportion of women with disabilities able to make these autonomous decisions ranges from 7 per cent in Mali to 82 per cent in Colombia (Figure 43). In four of these countries, women with disabilities have significantly less bodily autonomy than women without disabilities, with India and Nigeria showing the largest gaps between them. In the other countries, women with disabilities have similar bodily autonomy than women without disabilities.

Figure 44. Percentage of women aged 15 to 49 years who have their needs for family planning satisfied with modern methods, in 14 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.
Source: UNDESA (on the basis of data from DHS[6]).

Despite having the same sexual and reproductive needs and rights, and being as sexually active as their peers,[187,188] persons with disabilities face many barriers to accessing sexual and reproductive healthcare and services. In addition, the widespread false belief within the general population that persons with disabilities do not need as much sexual and reproductive health services as persons without disabilities,[189] deters many persons with disabilities from seeking sexual and reproductive healthcare and

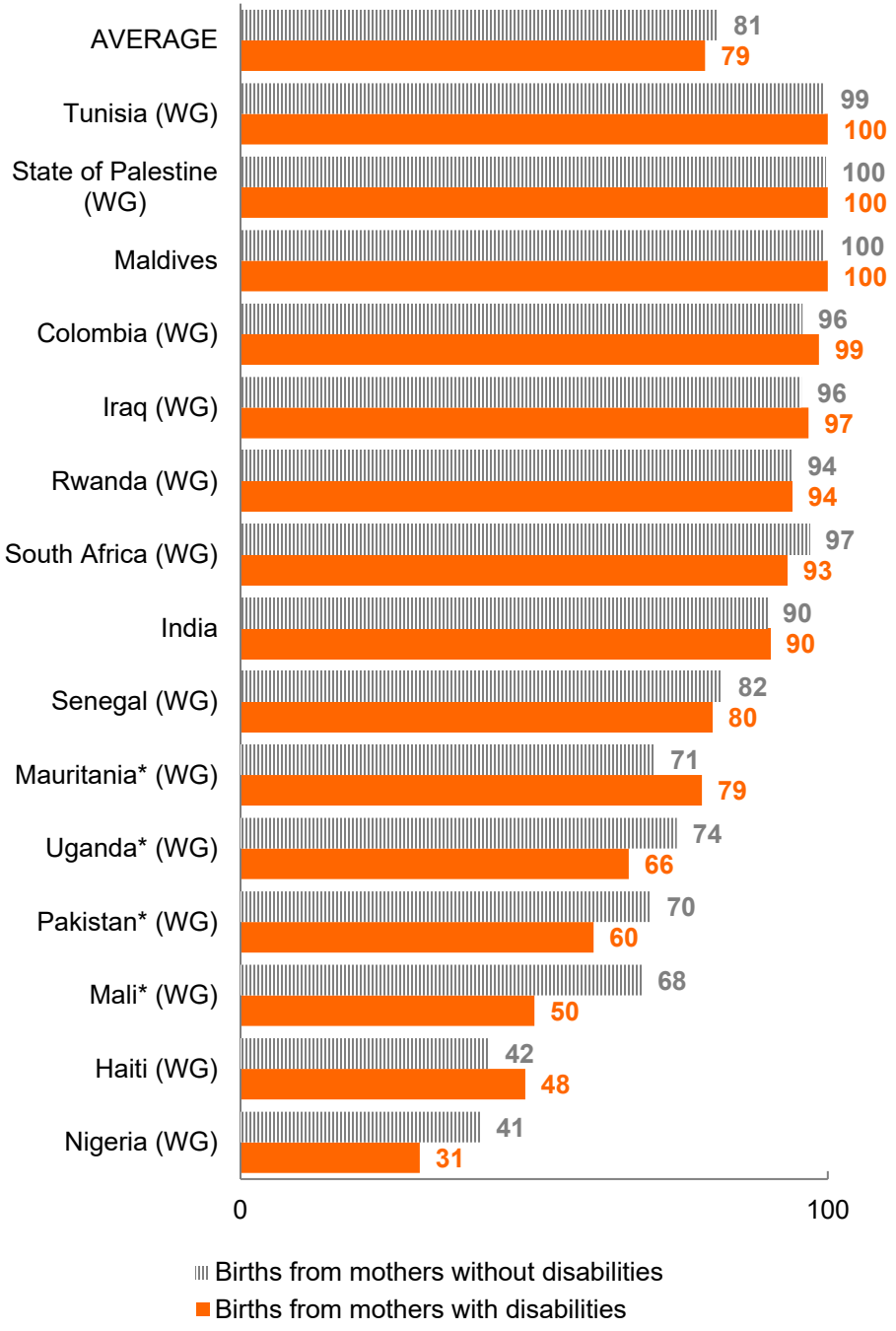
services.

For example, although family planning is a crucial component of sexual and reproductive health services, many women with disabilities who want to stop or delay childbearing do not have access to family planning. As a result, their needs to stop or delay childbearing remain unmet. Among 14 countries, on average, the percentage of women who have their need for family planning met with modern methods is 46 per cent for women with disabilities and 49 per cent for women without disabilities (Figure 44). The percentage of women with disabilities who have their needs for family planning met with modern methods ranges from 3 per cent in Albania to 87 per cent in Colombia. Particularly in countries with lower access to modern methods for family planning, such as Haiti, Maldives, Mauritania, Nigeria, Senegal and Yemen, fewer women with disabilities than women without disabilities have their family planning needs met with modern methods.

Maternal health is another key component of sexual and reproductive health services. It includes the health of women during pregnancy, childbirth and post-natal periods. Improved access to skilled health personnel for childbirth – such as a midwife, doctor or nurse – is crucial to improving maternal health and reducing maternal mortality for women with disabilities. Among 15 countries or areas, births from mothers with disabilities are slightly less attended by a skilled health worker (79 per cent) than births from mothers without disabilities (81 per cent), see Figure 45. In Maldives, State of Palestine and Tunisia, all births from mothers with disabilities are attended by a skilled health worker. In Colombia and Iraq, more than 95 per cent of births from mothers with disabilities are attended by a skilled health worker. In Mali, Nigeria, Pakistan and Uganda, mothers with disabilities are markedly less likely to be attended by a skilled health worker than mothers without disabilities, with a gap of 8 or more percentage points. The widest gap is found in Mali – 18 percentage points – where 50 per cent of births from mothers with disabilities compared to 68 per cent from mothers without disabilities are attended by a skilled health worker. The gap between births from mothers with and without disabilities could be due to several factors, including income disparities with more mothers with disabilities unable to afford medical care, negative attitudes among skilled health workers and a lack of accessible information on childbirth options for mothers with disabilities. Moreover, disrespect and abuse by service providers of women with disabilities during childbirth and obstetric procedures remains common.[190]

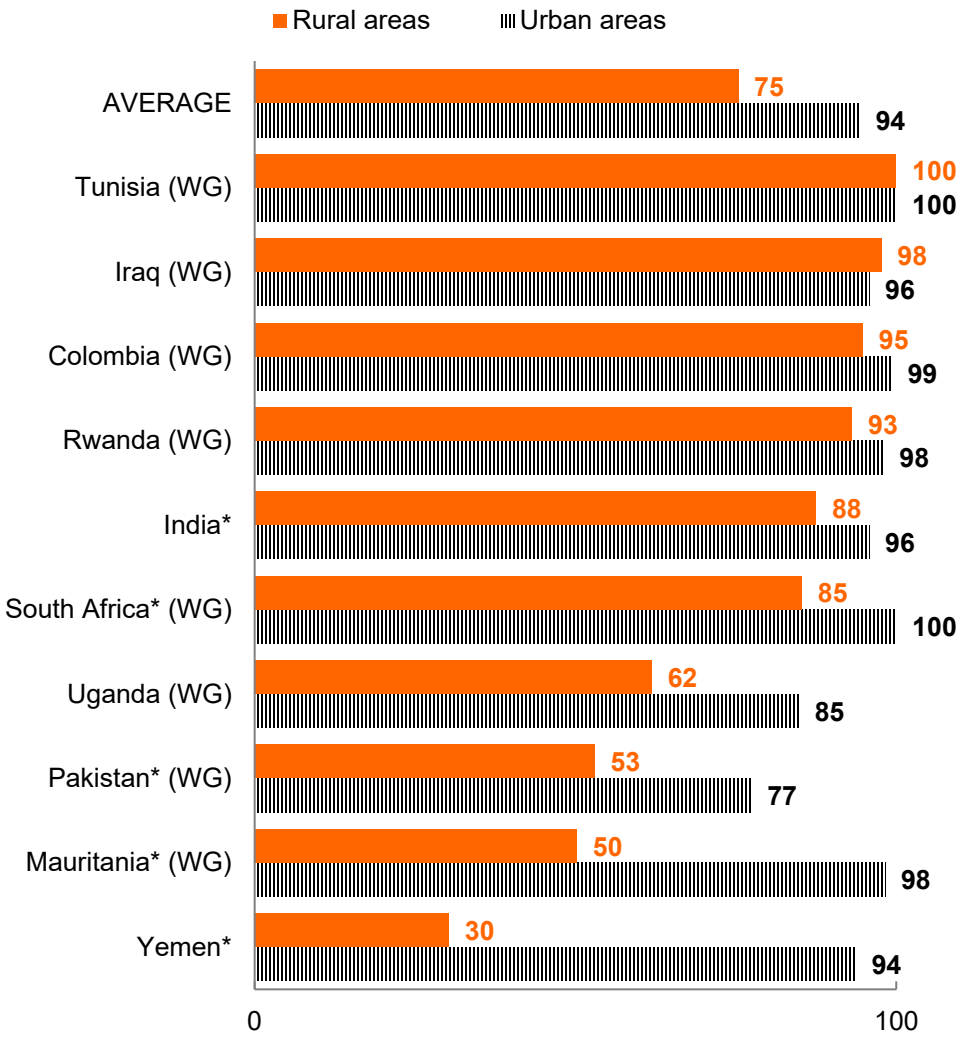
The country averages mask differences between urban and rural areas: 94 per cent of births from mothers with disabilities in urban areas were attended by a skilled health worker compared to 75 per cent of births from mothers with disabilities in rural areas, with several countries showing gaps larger than 20 percentage points between urban and rural areas (Figure 46).

Figure 45. Percentage of births attended by skilled health personnel, by disability status of the mother, in 15 countries or areas, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between the births of women with and without disabilities are statistically significant at the 5 per cent level.
Source: ESCWA (on the basis of data from MICS), UNDESA and UNFPA (on the basis of data from DHS[6]).

Figure 46. Percentage of live births attended by skilled health personnel, by area of residence of the mother with disabilities, in 10 countries, in 2021 or latest year available.

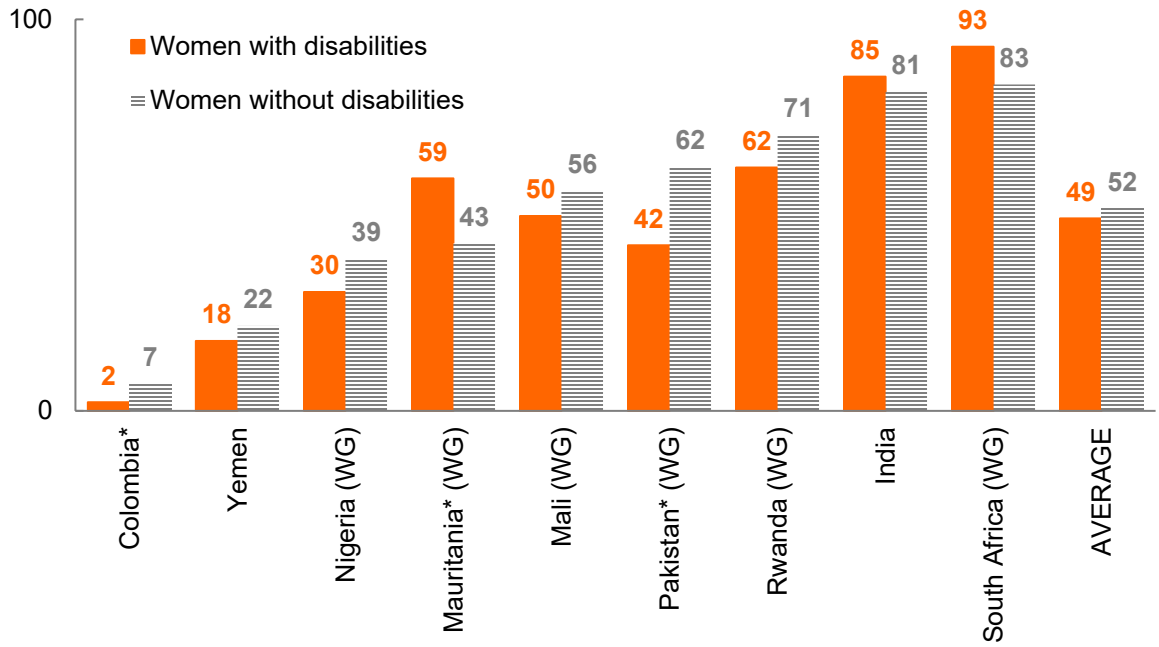


Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between the births of women with disabilities in rural and urban areas are statistically significant at the 5 per cent level.
Source: ESCWA (on the basis of data from MICS) and UNDESA (on the basis of data from DHS[6]).

Mothers with disabilities do not always receive a timely postnatal check after birth, that is, a check two days after giving birth (Figure 47). In nine countries, the percentage of women with disabilities who received a timely post-natal care visit for their last birth ranges from 2 per cent in Colombia to 93 per cent in South Africa. In Colombia and Pakistan, a significantly lower percentage of women with disabilities than women without disabilities received a timely post-natal care but in Mauritania, a significantly larger percentage of women with disabilities received such a visit. The lack of access to healthcare can be particularly impactful on women with disabilities because they are at greater risk than women without

disabilities for perinatal complications. For example, in Canada, significantly more women with physical (33 per cent), sensory (30 per cent), intellectual (49 per cent) and multiple (42 per cent) impairments have a postpartum emergency visit compared to those without these impairments (24 per cent).[191]

Figure 47. Percentage of women aged 15 to 49 who received a timely postnatal check, by disability status, in 9 countries, in 2021 or latest year available.



Note: This indicator reflects the percentage of women with a live birth during the two years preceding the survey who received a postnatal check in the first two days after giving birth. The measure includes women who received a check from a doctor, midwife, nurse, community health worker or traditional birth attendant. Data from Colombia do not reflect the type of health provider performing the postnatal check. (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.
Source: UNDESA and UNFPA (on the basis of data from DHS[6]).

Poorer access to sexual and reproductive healthcare among women with disabilities increases their risk of contracting additional disabilities related to sexual and reproductive health, including obstetric fistula and uterine prolapse. Obstetric fistula, a hole in the birth canal caused by prolonged labour without medical intervention, leaves a woman with chronic incontinence and, in most cases, a stillborn baby. If left untreated, fistula can also lead to ulcerations, kidney disease and nerve damage. Fistula occurs when obstetric care is unavailable which is why women with disabilities living in remote rural areas are most at risk. Surgery can normally repair the injury, but this procedure can be unaffordable for women with disabilities. Uterine prolapse occurs when the uterus sags or slips from its normal position into the vagina. Uterine prolapse can result from prolonged labour, too early or too closely spaced pregnancies, improper

delivery techniques and resuming work too soon after childbirth. This condition can also lead to additional disabilities unless there is a surgical intervention, a procedure which is not always available, particularly in remote areas, and is often unaffordable for women with disabilities.

Furthermore, sexual and reproductive health facilities in many low- and middle- income countries are physically inaccessible, lack adaptations such as ramps or moveable equipment,[192,193] and frequently have long waiting times.[194] Even when the facilities are physically accessible, the information in these services is often not available in accessible formats. For example, sexual and reproductive health and AIDS clinics rarely have access to sign language interpreters.[195] Distant healthcare facilities are also a barrier for many, especially when transportation is inaccessible, unreliable or expensive. The need for some persons with disabilities to have someone accompany them on the health visit not only increases costs, but also raises issues of confidentiality, especially when sexual and reproductive health issues are involved.

Moreover, healthcare professionals often share socially entrenched negative attitudes about disability and sexuality,[196,197,198 ,199] which can lead to distressing experiences for persons with disabilities when seeking care. Persons with disabilities are often denied sexual and reproductive health information and resources; and discouraged from becoming sexually active. Such barriers to sexual and reproductive health services arise because those working in public health and clinical services often have little knowledge or training on disability,[200,201] and the needs and perspectives of persons with disabilities are not considered when planning interventions, services and public information campaigns.

Compounding these barriers, persons with disabilities are frequently excluded in other domains of life, such as education, employment and socialization (see the chapters on Goals 4, 8 and 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. Many persons with disabilities continue to live in institutions (see the chapter on Goal 10), where they are often not allowed to decide on their sexual and reproductive healthcare or access such services.

Child marriage can compromise sexual and reproductive health and affects girls with disabilities at similar rates as girls without disabilities (see the chapter on Goal 5). Child marriage subjects girls with disabilities to sexual violence, risky pregnancies, fistula and HIV. It is linked with early childbearing, leading to death and injury for many young mothers with disabilities. Girls with disabilities are likely to be married early in communities where child marriage occurs, as families see it as a way to ensure long-term security and protection for their children.

Little is known about access to sexual and reproductive health services for men with disabilities,[202,203] but given the existing barriers to access for persons with disabilities in general, it is anticipated that men with disabilities will also show lower levels of knowledge about and lower access to sexual and reproductive health services than their peers without disabilities.

Recent initiatives to improve the sexual and reproductive health of persons with disabilities include: the adoption of national policies on the sexual and reproductive health of persons with disabilities;[188,204] ensuring access by persons with disabilities to relevant information and services; engaging persons with disabilities in the planning, implementation, monitoring and evaluation of sexual and reproductive health programmes;[205] creating effective community support networks; and formulating evidence-based revisions of legislation, policies, strategies and guidelines concerning the sexual and reproductive health and reproductive rights of adolescents with disabilities.[206] In addition, increasing numbers of healthcare professionals have been trained on supported decision-making and the CRPD principles around legal capacity and reproductive autonomy, a key development for women with disabilities to make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare.

The sexual and reproductive health of persons with disabilities and their reproductive rights are negatively impacted by sexual and gender-based violence. Persons with disabilities, both men and women, are more likely to face sexual violence and abuse than persons without disabilities.[188] Girls and women with disabilities are disproportionately affected by this type of violence, including sexual violence and abuse (see the chapter on Goal 16); forced sterilizations and invasive and irreversible involuntary treatments; forced abortion; forced pregnancy; forced menstrual suppression; forced pregnancy prevention; criminalisation of abortion; denial or delay of safe abortion and post-abortion care; forced continuation of pregnancy; abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services; as well as trafficking and harmful practices such as child and forced marriage and female genital mutilation.

Many of those forms of sexual violence might happen while a person with disabilities performs daily tasks such as dressing, toileting or receiving health treatment. Sexual violence occurs at home, in institutions, schools, health centres and other public and private facilities. Perpetrators are frequently relatives, caregivers and professionals on whom the girl or woman with disabilities may depend. Women with intellectual and psychosocial disabilities are particularly vulnerable. For example, a study among women with intellectual disabilities revealed that 43 per cent had been sexually abused at the gynaecologist's office.[188]

The risk of sexual abuse tends to be higher during conflict, post-conflict and other humanitarian situations; among refugees, internally displaced persons, migrants or asylum seekers with disabilities; among persons with disabilities deprived of their liberty in hospitals, residential institutions, juvenile or correctional facilities; and among persons with disabilities who are homeless or live in poverty.

Persons with disabilities are less likely to have equal access to prevention and response services for sexual violence and abuse.[188] Higher rates of sexual violence among women with disabilities puts them at higher risk of unplanned pregnancies, and higher rates of sexual violence among both men and women with disabilities puts them at higher risk of sexually transmitted infections.[207]

Sterilization of women and girls with disabilities has been reported at three times higher rates than the general population.[208] While the sterilization of persons with disabilities constitutes discrimination,[209] many legal systems still allow judges, healthcare professionals, family members and guardians to consent to forced sterilization procedures on behalf of persons with disabilities as being in their best interest. Forced sterilization is an unacceptable practice with lifelong consequences on the physical and mental integrity of girls and women with disabilities. Many, particularly those with intellectual disabilities, have been subjected to involuntary sterilization in various countries.[210,211] For instance, a study among women with intellectual disabilities found that half had been recommended for sterilization by a family member and close to half of these had been sterilized. Moreover, 6 per cent had not been informed that the surgery was sterilization.[188]

Girls and women with disabilities are also frequently pressured to end pregnancies owing to negative stereotypes about their parenting skills and concerns about giving birth to a child with disabilities.[212,213] Moreover, there are reports about compulsory gynaecological checks and forced abortions in institutions as a way to contain the institution's population.[214] Forced contraception is also often used to control menstruation at the request of health professionals or parents.[215] Moreover, while the contraceptive needs of girls and young women with disabilities are the same as those without disabilities, they receive contraception more often through injection or intrauterine devices rather than orally, as it is less burdensome for families and service providers.[216] These forced interventions are still common in some healthcare settings. Often, mistreatment in sexual and reproductive health services and institutions is perpetuated by laws that discriminate against women's bodily integrity in general and that of women with disabilities in particular.

Female genital mutilation is also a concern for girls with disabilities. This practice can lead to additional disabilities, either at the time of the procedure or through complications at the time of childbirth.

Impact of the COVID-19 pandemic

The COVID-19 pandemic has exacerbated existing barriers and created new challenges to the achievement of sexual and reproductive health and the realization of reproductive rights for persons with disabilities. There has been a lack of disability perspectives and inclusion in planning and developing the responses to the pandemic. The COVID-19 pandemic resulted in service disruptions that affected access to abortion, contraceptives and testing for HIV and sexually transmitted infections.[217] For persons with disabilities, these service disruptions and epidemic control measures such as school closures[218,219] and lockdowns, exacerbated existing barriers to access information and services.[220,221,222] Remote learning and school closures (see the chapter on Goal 4) led to the lack of access to sexuality education taught in schools. Strained healthcare resources during the pandemic resulted in policies and practices that failed to take disability into account, such as exclusion from remote learning platforms for comprehensive

sexuality education.[223,224] Remote-based information and services were not always made accessible to persons with disabilities.

Box 3. Ensuring accessible sexual and reproductive health services and goods for women and girls with disabilities in Tajikistan, during the COVID-19 pandemic

At the beginning of the COVID-19 pandemic, in May 2020, the Ministry of Health of Tajikistan in collaboration with the United Nations Population Fund (UNFPA) and organizations of persons with disabilities launched a project to provide access to information, free sexual and reproductive health services, sanitation and hygiene products and psychosocial support for persons with disabilities to ensure continuing sexual and reproductive health and to realize reproductive rights during the pandemic.

Since many of the centres providing sexual and reproductive health services were not accessible, particularly to persons with physical disabilities, five accessible rooms were built in local reproductive health centres or local non-governmental organizations. Staff were hired specifically to counsel, observe and refer persons with disabilities to services for issues related to sexual and reproductive health. Through these services, women with disabilities received ultrasounds to detect reproductive diseases or other issues, including cervical cancer; contraceptives; counselling on healthy lifestyles, family planning and sexually transmitted infections; psychosocial support for stress or violence; and referral for further testing and services. Women with disabilities learned about these rooms through social networks, the website of the National Association of Persons with Disabilities and leaflets distributed by organizations of persons with disabilities.

A working group was also established to develop standard operating procedures for providing sexual and reproductive health services for persons with disabilities. Following the adoption of these standard operating procedures, in December 2020, training sessions were conducted with a wide range of healthcare specialists on the rights of persons with disabilities and the need to ensure that persons with disabilities are treated with dignity.

Source: UNFPA (2021).[225]

Family planning clinics closed in local communities and lack of accessible and affordable transportation meant that women and girls with disabilities could not travel to other communities to receive sexual and reproductive health services. Even when they were able to access the services, women and girls with disabilities who required the assistance of sign language interpreters or other assistants to access these services were no longer allowed to bring those individuals with them due to social distancing rules. Additionally, as many women and girls with disabilities lost jobs and income during the pandemic, their ability to afford and fully exercise their sexual and reproductive health rights was impacted. This lack of access to sexual and reproductive health services has been detrimental to the health of women and girls with disabilities and, in extreme emergency cases, has put their lives at risk.

Box 4. Addressing the sexual and reproductive health needs of women with disabilities in Kenya, during the COVID-19 pandemic

The COVID-19 pandemic significantly impacted the lives of women with disabilities in Kenya. Sexual and reproductive health and reproductive rights among girls and women with disabilities were of particular concern, as an increase in sexual violence led to increases in unwanted pregnancies and caused families to consider sterilization as a misguided protection measure. To respond to these challenges, the organization This-Ability in collaboration with UNFPA, the Global Fund for Women and the African Women Development Fund gathered women with disabilities together in supportive networks and organized training programs and accessible e-learning platforms during the COVID-19 pandemic to learn about important topics, including sexual and reproductive health.

Source: UNFPA (2021).[225]

A number of initiatives were taken in various countries to improve the sexual and reproductive health of persons with disabilities during the COVID-19 pandemic (see Box 3 and Box 4), including establishing violence-related peer-to-peer support for women with disabilities, conducting public awareness campaigns during the pandemic about gender-based violence against women with intellectual or developmental disabilities, and allowing support persons to accompany persons with disabilities to sexual and reproductive health services.[225]

Summary of findings and the way forward

Sexual and reproductive health is as important to persons with disabilities as it is for all members of society. Persons with disabilities are as sexually active as persons without disabilities and have similar sexual and reproductive health needs. 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 levels of awareness and misperceptions about the sexual and reproductive health needs of persons with disabilities. In various countries, more than 50 per cent of women with disabilities do not have comprehensive knowledge regarding HIV/AIDS, do not have their needs for family planning satisfied with modern methods, do not have the births of their babies attended by skilled health personnel, do not receive a timely postnatal check, do not have autonomy in making decisions about their reproductive health – with others making decisions for them – and are not empowered to exercise their reproductive rights. Similarly, in various countries, more than 50 per cent of men with disabilities do not have comprehensive knowledge regarding HIV/AIDS.

Without access to sexual and reproductive health services, persons with disabilities are at higher risk of unwanted pregnancies and sexually transmitted infections. The COVID-19 pandemic exacerbated the barriers to sexual and reproductive health and reproductive rights for women and girls with disabilities.

The collection and analysis of quantitative and qualitative data on persons with disabilities' access to sexual and reproductive health services and reproductive rights remain insufficient in many countries. This lack of data makes it impossible to assess global trends since 2015. The data available from a limited number of countries suggest that greater efforts are needed to speed up progress towards targets 3.1, 3.7 and 5.6 for persons with disabilities, namely regarding universal access to sexual and reproductive health services and ensuring their reproductive rights. In particular, the percentage of women with comprehensive knowledge of HIV/AIDS needs to increase at least 8 percentage points per year in order to make this knowledge available to all women with disabilities by 2030; the percentage of women with disabilities with their family planning needs met with modern methods needs to increase at least 6 percentage points per year to meet the needs of all women with disabilities by 2030; the percentage of births from mothers with disabilities attended by skilled health personnel needs to increase at least 2 percentage points per year to achieve 100 per cent coverage by 2030; the percentage of women with disabilities receiving a timely post-natal check needs to increase at least 6 percentage points per year to achieve 100 per cent coverage by 2030; and the percentage of women with disabilities empowered to exercise their reproductive rights, and with autonomy to make their own decisions about their reproductive health, needs to increase at least 6 percentage points per year in order to ensure that all women with disabilities can exercise these rights and autonomy by 2030.

A series of actions should be considered to support this progress, achieve targets 3.1, 3.7 and 5.6 for persons with disabilities and ensure that their sexual and reproductive health and reproductive rights are realized:

1. Promote and protect the bodily autonomy of persons with disabilities. Provide a national legal and policy framework that guarantees persons with disabilities the right to make decisions about their reproduction and sexuality, to better support reproductive self-determination for persons with disabilities. Ensure the participation of persons with disabilities in developing these laws.

2. Develop national laws and policies that guarantee access to sexual and reproductive health services 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. Reproductive and obstetric violence should be defined, addressed and prohibited in local, national and regional gender and sexual and reproductive health strategies, policies and action plans. Ensure the participation of persons with disabilities in developing these laws and policies, as part of national programme planning and decision-making processes.

3. Remove barriers to access of sexual and reproductive health services, including by making the services safe and affordable and the care facilities, communication and information accessible. Healthcare facilities must be physically accessible and the information on sexual and reproductive health must be provided in accessible formats. Persons with disabilities must feel safe at the hands of healthcare providers and mechanisms to monitor, report and eliminate gender-based violence in healthcare settings must be in place. There is an urgency to promote access to maternal health, family

planning and contraception and safe abortion for persons with disabilities and to address barriers to the ability to seek, reach, afford and use such services to achieve sexual and reproductive health and to protect reproductive rights. Programmes working to eliminate female genital mutilation must consider and include girls with disabilities in all outreach efforts.

4. Train sexual and reproductive healthcare workers on disability inclusion, focusing on eliminating discrimination and negative attitudinal barriers and improving service delivery for persons with disabilities. To counter discriminatory practices, training programmes should be delivered on enhancing the understanding of the diverse needs of persons with disabilities, including autonomous and supported decision-making. Engage persons with disabilities in designing, implementing and evaluating such training programmes.

5. Educate persons with disabilities, including adolescents, on sexual and reproductive health and reproductive rights. Educate persons with disabilities, including by increasing the dissemination of high-quality, age-appropriate, accessible materials about sexual and reproductive health and reproductive rights. These materials should be accessible for persons with disabilities and developed in consultation with persons with disabilities and their organizations. These resources should be available to educators and advocates of sexual and reproductive health and reproductive rights. Reaching out to all children and youth with disabilities, including out-of-school children and youth with disabilities, is critical.

6. Strengthen research and data to monitor, evaluate and guide the development of sexual and reproductive health services for persons with disabilities. Conduct research and collect high-quality data disaggregated by disability on sexual and reproductive health and reproductive rights as well as on access to sexual and reproductive healthcare and services, emphasizing low- and middle-income countries and including more intersectional data, such as sexual and reproductive health among women from ethnic and minority communities. Produce data not only for women with disabilities but also for men with disabilities. Persons with disabilities must be engaged in such studies.

7. Build on the lessons from the COVID-19 pandemic to plan better for future crises and emergencies with regard to the provision of disability-inclusive sexual and reproductive healthcare and services and the protection of reproductive rights of persons with disabilities. Countries must better enforce existing international guidance on disability inclusion, sexual and reproductive health and reproductive rights, freedom from violence and related rights during crises and emergencies. Persons with disabilities must be included in preparing for, responding to and recovering from crises.

Ensuring inclusive and equitable quality education (Goal 4)

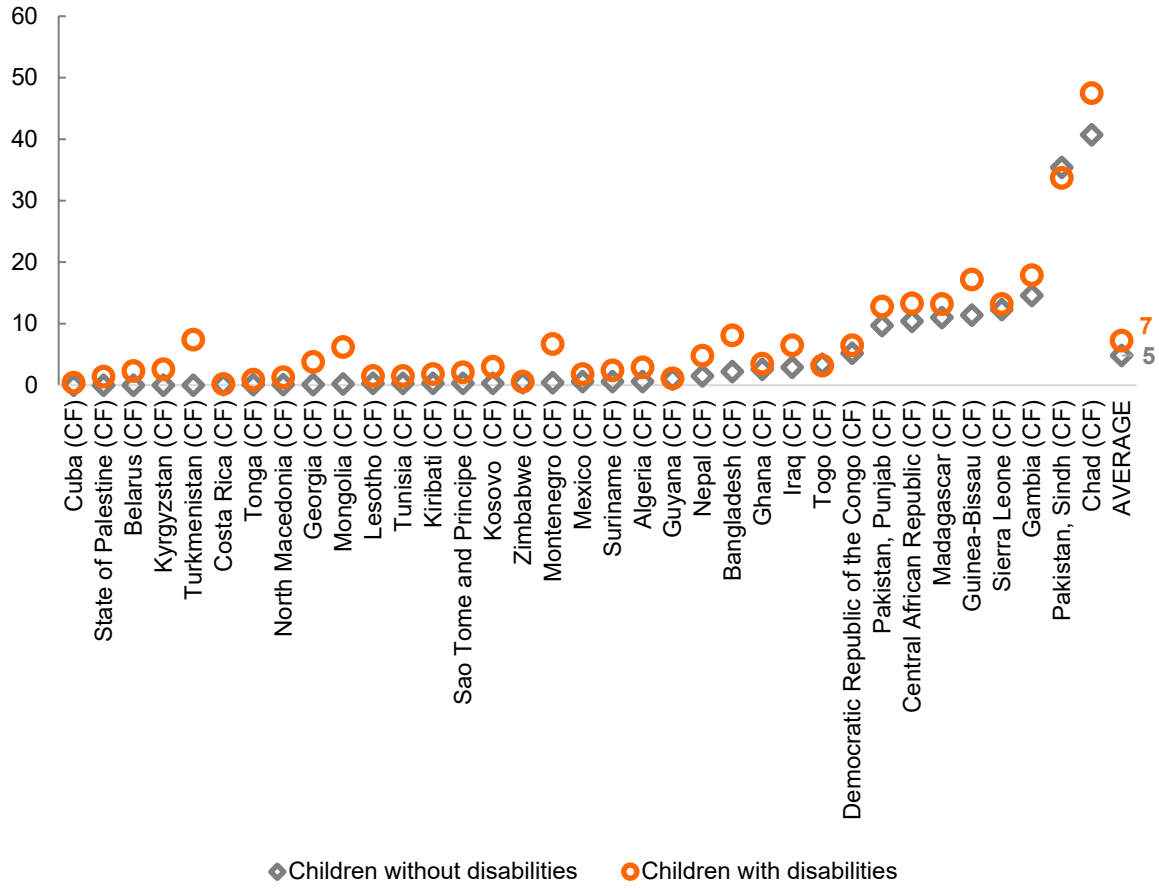
This chapter focuses on the realization of Goal 4 for persons with disabilities. Goal 4 calls for ensuring inclusive and equitable quality education and promoting life-long learning opportunities for all. While all Goal 4 targets are crucial to achieve equal education for persons with disabilities, two 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, which calls for building and upgrading education facilities that are disability sensitive and providing inclusive learning environments for all. Moreover, the 2030 Agenda for Sustainable Development recognizes that persons with disabilities should have access to life-long learning opportunities that help them acquire the knowledge and skills needed to participate fully in society.[226] The Convention on the Rights of Persons with Disabilities provides a guiding framework for the implementation of Goal 4. It has an article devoted to education, article 24, which stipulates that States Parties should ensure access to inclusive, quality and free primary education and secondary education on an equal basis with others.

Since the first edition of the *Disability and Development Report* in 2018, advances in making national education systems inclusive have been adversely affected by the global COVID-19 pandemic. While there has been some progress in various countries in legislation, policies and practices addressing the needs of learners with disabilities, many children and youth with disabilities continue to be excluded from quality education – a situation that has been exacerbated by the pandemic. This chapter uses available evidence to provide an overview of the challenges that persons with disabilities still face in accessing and completing education. It also identifies recommendations to advance inclusive education and achieve Goal 4 for persons with disabilities.

Current situation and progress so far

Many children with disabilities have never attended school. This was the case when the 2030 Agenda was adopted and remains the case today. On average in 35 countries or areas, 7 per cent of children with disabilities aged 10 to 17 years have never attended school compared to 5 per cent of children without disabilities of the same age (Figure 48). The percentage of children with disabilities who have never attended school varies from 0.4 per cent in Cuba to 48 per cent in Chad. Countries in which more than 10 per cent of children with disabilities have never attended school include: Chad, Central African Republic, Gambia, Guinea-Bissau, Madagascar, Pakistan (Punjab and Sindh provinces) and Sierra Leone. In five countries, the gap between children with and without disabilities is more than 5 percentage points, with the largest gap in Chad (48 per cent of children with disabilities versus 41 per cent of children without disabilities). But there are already examples of countries that have successfully closed such gaps: in Cuba and the State of Palestine, the percentage of children with disabilities who never attended school is close to zero and the gaps between children with and without disabilities are minimal.

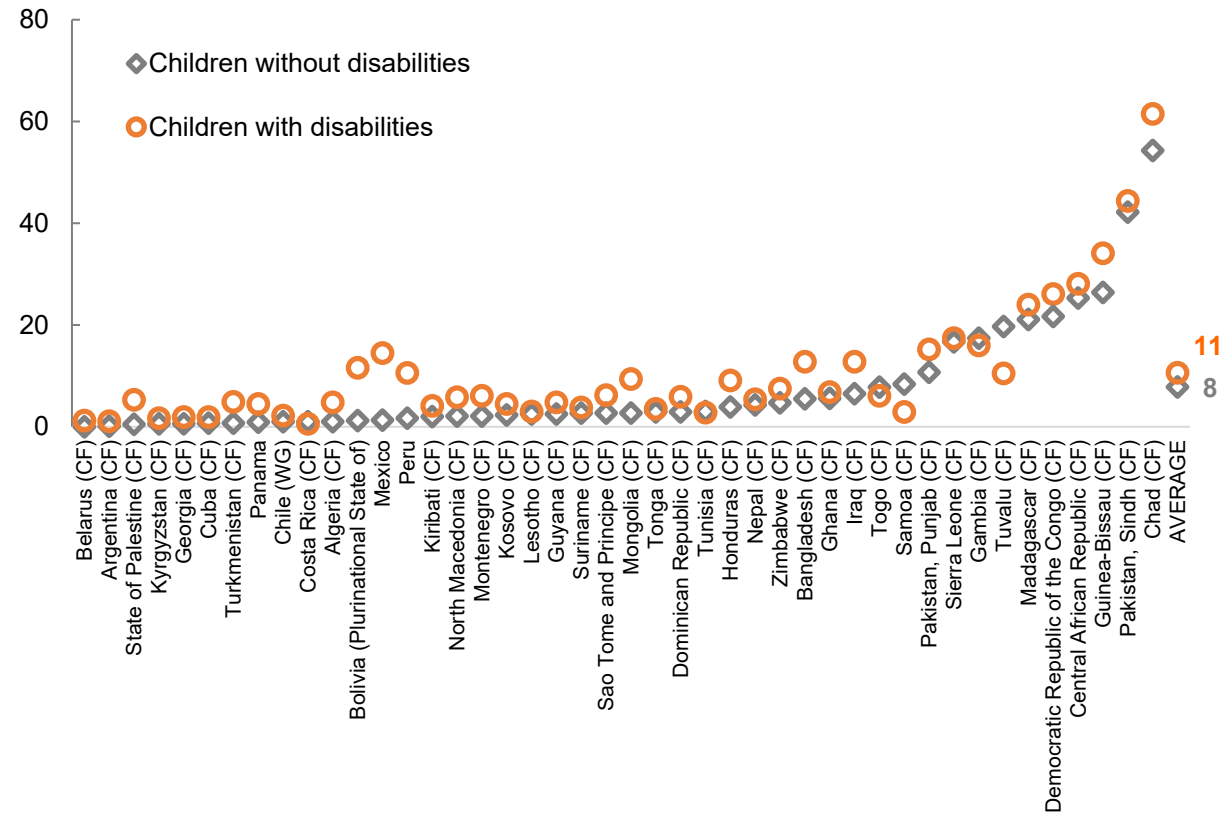
Figure 48. Percentage of children aged 10 to 17 years who never attended school, by disability status, in 35 countries or areas, in 2020 or latest year available.



Note: (CF) identifies data produced using the Child Functioning Module. For Pakistan, the data refer to selected provinces in Pakistan. The data on children with disabilities from Turkmenistan are based on 25 to 49 observations and should be interpreted with caution.
Source: MICS.[227]

At all ages and levels of education, children with disabilities are more likely to be out of school than children without disabilities. The older the child with disabilities the more likely he or she is out of school (Figure 49, Figure 52 and Figure 55). Although only 11 per cent of primary school age children with disabilities are out of school, 16 per cent of lower secondary school age and 32 per cent of upper secondary school age children with disabilities are out of school. Some of the children out of school may have formerly attended school but have dropped out, some may still enter school in the future, and some may never enrol in any school.

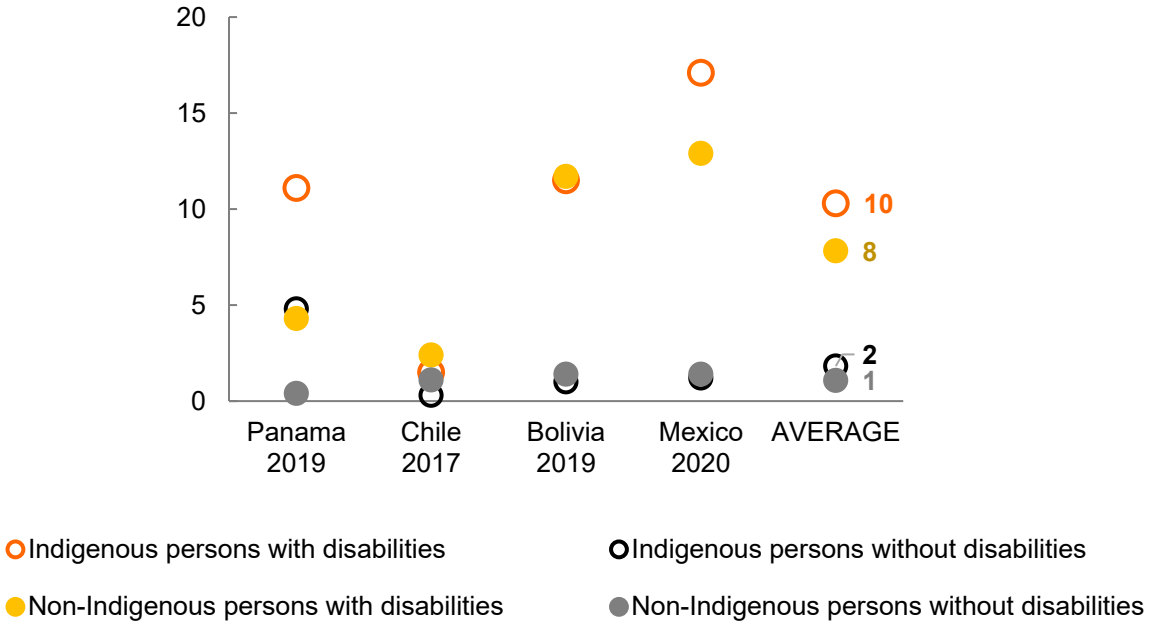
Figure 49. Percentage of children of primary school age who are out of school, by disability status, in 44 countries or areas, in 2020 or latest year available.



Note: Primary school age children are about 6 to 11 years old in the majority of the countries. (CF) identifies data produced using the Child Functioning Module. (WG) identifies data produced using the Washington Group short set of questions on functioning. Data on children with disabilities from Montenegro, Turkmenistan and Tuvalu are based on 25 to 49 observations and should be interpreted with caution. Source: ECLAC[13] and MICS.[227]

For children with disabilities of primary school age, the percentage who are out of school varies from 1 per cent in Belarus to 62 per cent in Chad. In Central African Republic, Democratic Republic of the Congo, Guinea-Bissau, Madagascar and Pakistan (Sindh), more than 20 per cent of children with disabilities of primary school age are out of school. Children with disabilities of primary school age are more likely to be out of school compared to their peers without disabilities – 11 per cent versus 9 per cent (Figure 49). The widest gaps – more than 7 per cent – are observed in Bangladesh, Chad, Guinea-Bissau and Mongolia. A few countries have already successfully reached very low percentages of primary school aged children out of school (less than 2 per cent), such as Argentina, Belarus, Costa Rica, Cuba, Georgia and Kyrgyzstan. Indigenous children with disabilities of primary school age are more likely to be out of school than their peers (Figure 50).

Figure 50. Percentage of children of primary school age who are out of school, by disability and Indigenous status, in 4 countries, in 2020 or latest year available.



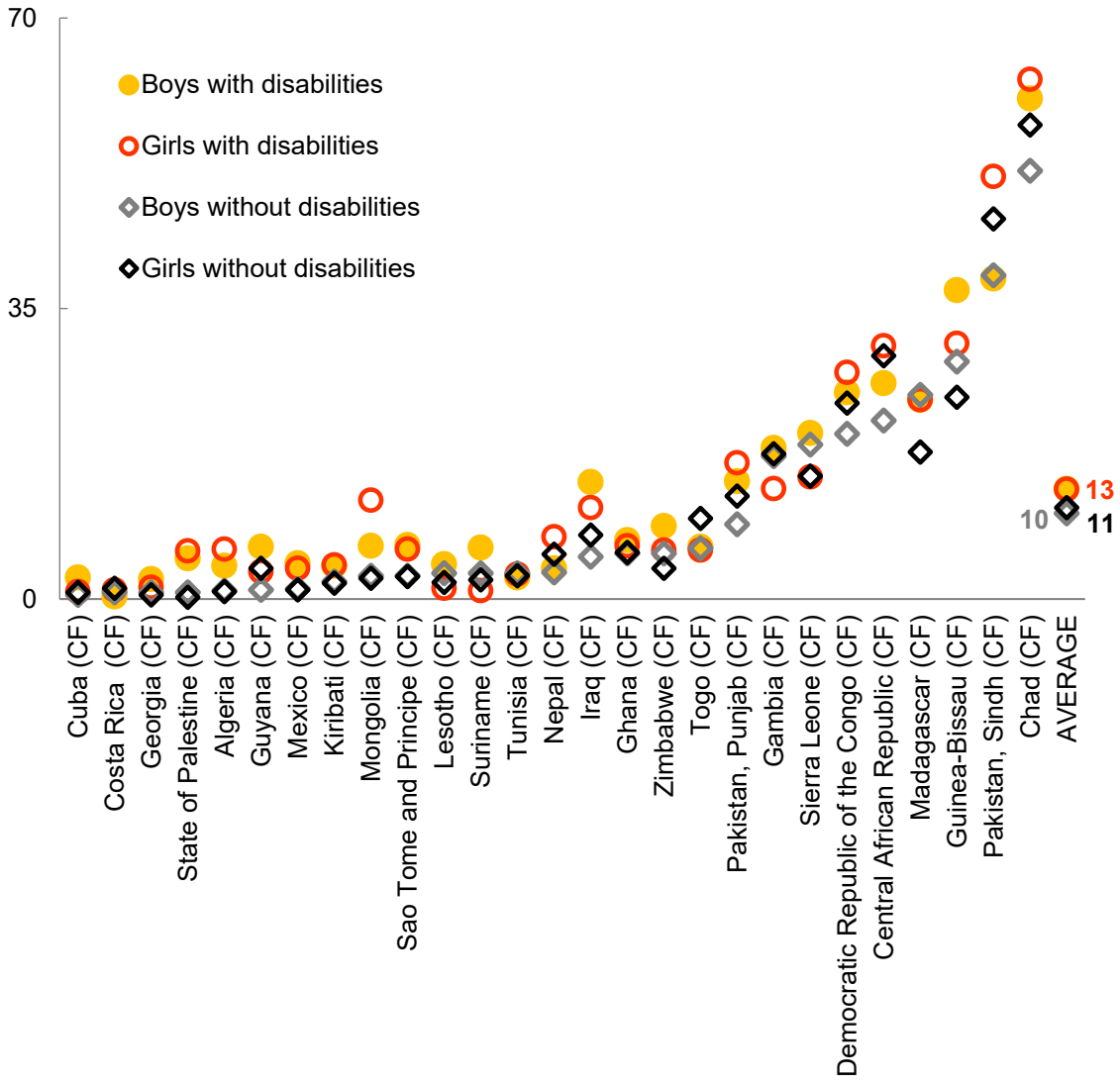
Note: Primary school age children are about 6 to 11 years old in the majority of the countries. Bolivia refers to the Plurinational State of Bolivia.
Source: ECLAC.[13]

Among 27 countries or areas, on average, 13 per cent of primary school age girls with disabilities are out of school, the same percentage as for boys with disabilities (Figure 51). For boys and girls of primary school age without disabilities, the levels are slightly lower (11 per cent and 10 per cent). In 12 out of these 27 countries or areas, the percentage of out-of-school girls with disabilities is higher than out-of-school boys with disabilities. The Sindh province in Pakistan shows the largest gap, with 51 per cent of girls with disabilities out of school compared to 39 per cent of boys with disabilities. In Mongolia, the percentage for girls with disabilities is double the percentage for boys with disabilities (12 per cent versus 6 per cent). In Chad, more than 60 percent of both boys and girls with disabilities are out of school.

Similar to children with disabilities of primary school age, adolescents with disabilities of lower secondary school age are more likely to be out of school than their peers without disabilities, in the majority of the countries. Across 38 countries or areas, for lower secondary school age adolescents, 16 per cent of adolescents with disabilities and 11 per cent of adolescents without disabilities are out of school (Figure 52), with the wider gaps in Bangladesh (22 per cent versus 12 per cent), Gambia (36 per cent versus 24 per cent), Kiribati (21 per cent versus 8 per cent) and Sao Tome and Principe (12 per cent versus 3 per cent). In nine countries or areas, more than a quarter of adolescents of lower secondary school age with disabilities are out of school: Central African Republic, Chad, Gambia, Guinea-Bissau, Honduras, Iraq, Madagascar, Pakistan (Sindh) and Zimbabwe. Low percentages of adolescents of lower secondary age

who are out of school, less than 5 per cent, have already been achieved in Argentina, Belarus, Guyana, Kyrgyzstan, Montenegro, Nepal, North Macedonia and Samoa. Indigenous adolescents with disabilities of lower secondary age are out of school at higher rates (19 per cent) than their peers without disabilities (6 per cent) – Figure 53.

Figure 51. Percentage of children of primary school age who are out of school, by disability status and sex, in 27 countries or areas, in 2020 or latest year available.



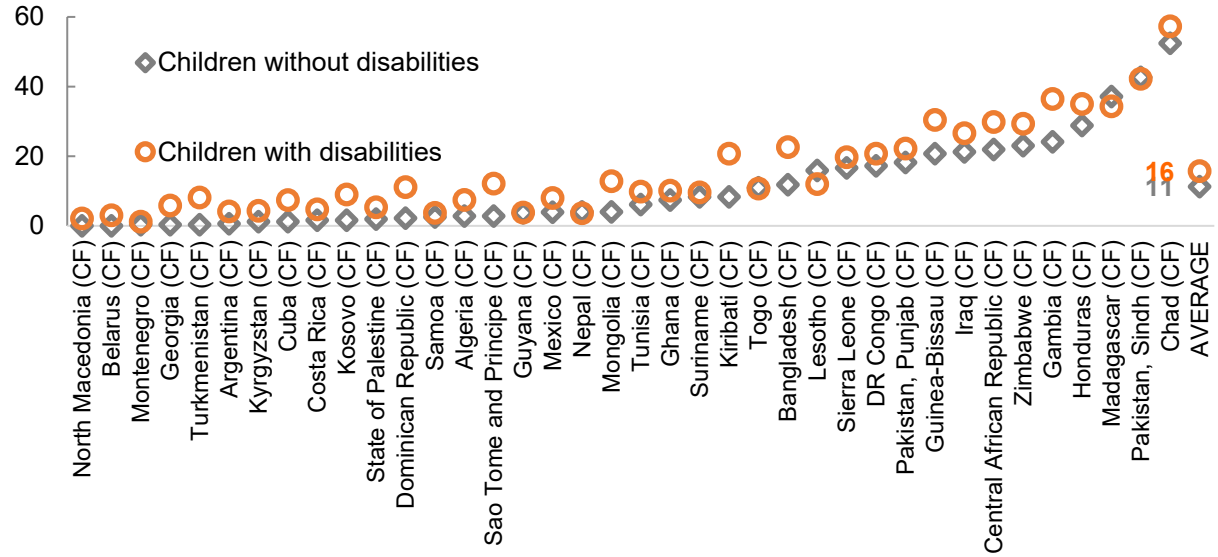
Note: (CF) identifies data produced using the Child Functioning Module.
Source: MICS.[227]

In 22 countries or areas, the average lower secondary out-of-school rate is higher for girls with disabilities than for boys without disabilities (20 per cent versus 14 per cent) – Figure 54. In 9 out of these 22

countries, this percentage is higher for girls with disabilities than for boys with disabilities. Pakistan's Sindh province shows the widest gap, with 52 per cent for girls with disabilities compared to 32 per cent for boys with disabilities. The gap is more than 10 percentage points in Central African Republic, Chad, Democratic Republic of the Congo, Guinea-Bissau and Iraq.

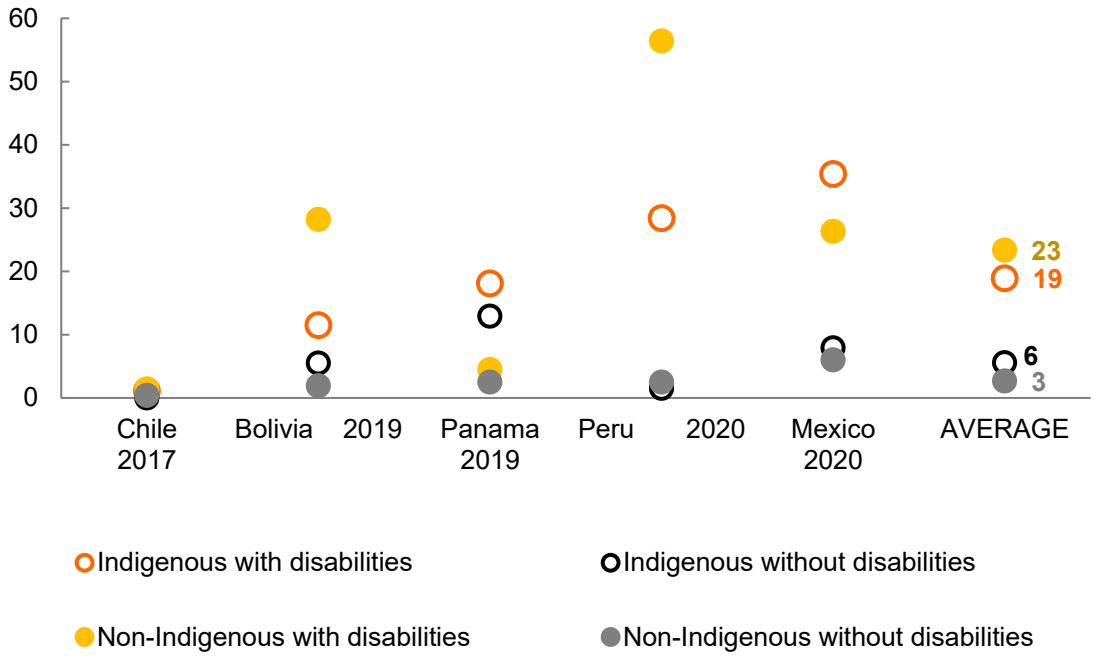
Although in some countries large percentages of children with disabilities of primary and lower secondary school age are out of school, it is among children with disabilities of upper secondary school age that the percentages of children out of school are highest, and noticeably so: 32 per cent of adolescents with disabilities of upper secondary school age are out of school (Figure 55). As seen in lower grades, adolescents with disabilities of upper secondary school age are more likely to be out of school compared to their peers without disabilities (32 per cent versus 24 per cent). In 10 countries or areas, more than 40 per cent of adolescents of upper secondary school age with disabilities are out of school: Bangladesh, Central African Republic, Chad, Cuba, Honduras, Iraq, Kiribati, Madagascar, Pakistan (Sindh) and Zimbabwe. The largest gap between the percentage of out-of-school adolescents with and without disabilities is recorded in Cuba with a 24 percentage point difference (41 per cent versus 17 per cent). This is followed by Kiribati and Tonga, where the gap is roughly 20 percentage points. In 12 countries, the gaps between the two groups are wider than 10 percentage points.

Figure 52. Percentage of adolescents of lower secondary school age who are out of school, by disability status, in 38 countries or areas, in 2020 or latest year available.



Note: Lower secondary school age adolescents are about 12 to 14 years old in the majority of the countries. (CF) identifies data produced using the Child Functioning Module. Data on children with disabilities from Belarus, Montenegro, North Macedonia, and Turkmenistan are based on 25 to 49 observations and should be interpreted with caution.
Source: MICS.[227]

Figure 53. Percentage of children of lower secondary school age who are out of school, by disability and Indigenous status, in 5 countries, in 2020 or latest year available.

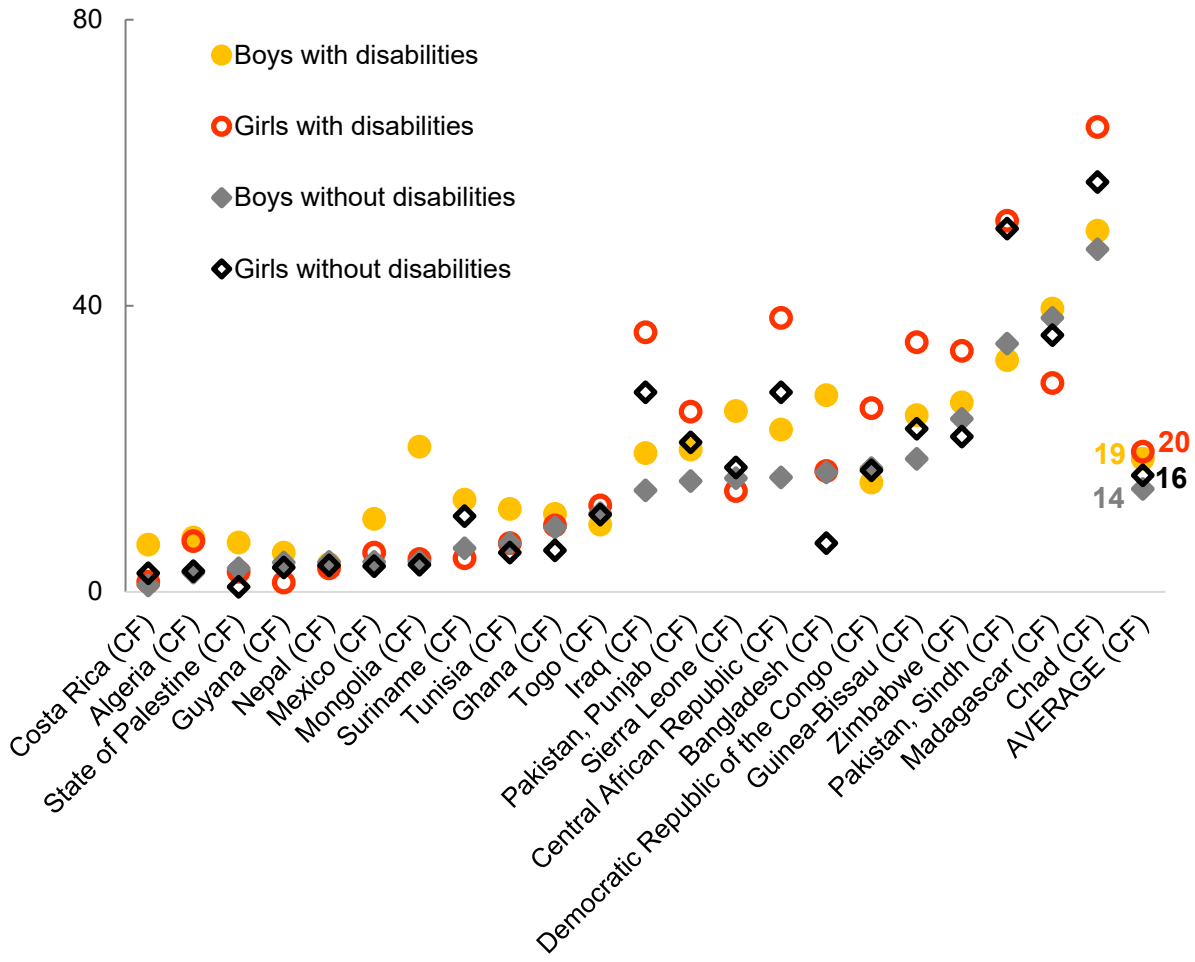


Note: Lower secondary school age adolescents are about 12 to 14 years old in the majority of the countries. Bolivia refers to the Plurinational State of Bolivia.
Source: ECLAC.[13]

In 15 countries or areas, on average, the out-of-school rate for both boys and girls with disabilities of upper secondary school age is the same (36 per cent) – Figure 56. In 7 out of these 15 countries, girls with disabilities are more likely to be out of school compared to boys with disabilities. Pakistan's Sindh province shows the largest gap between boys and girls with disabilities, with a 29 percentage point difference (37 per cent versus 66 per cent), followed by Chad (53 per cent versus 74 per cent). In Sierra Leone and Pakistan's Punjab province, the gap is more than 7 percentage points.

Persons with disabilities do not attend school due to many factors, including economic reasons, stigma, lack of accessibility of schools, lack of accessible transport to and from school and because of family pressure. In six countries or areas, among persons with disabilities who never attended school, 32 per cent did not attend because of economic reasons (Figure 57). In the Philippines and Sri Lanka, the majority did not attend for economic reasons, 66 per cent in the Philippines and 55 per cent in Sri Lanka. In seven countries or areas, among persons with disabilities who never attended school, 18 per cent did not attend because of barriers linked to their disability and 18 per cent because their parents did not want them to attend school (Figure 58). In Georgia, most persons with disabilities who never attended school, 90 per cent, did not attend because of barriers linked to their disability. In Pakistan, 60 per cent did not attend school because their parents did not want them to attend.

Figure 54. Percentage of children of lower secondary school age who are out of school, by disability status and sex, in 22 countries or areas, in 2020 or latest year available.

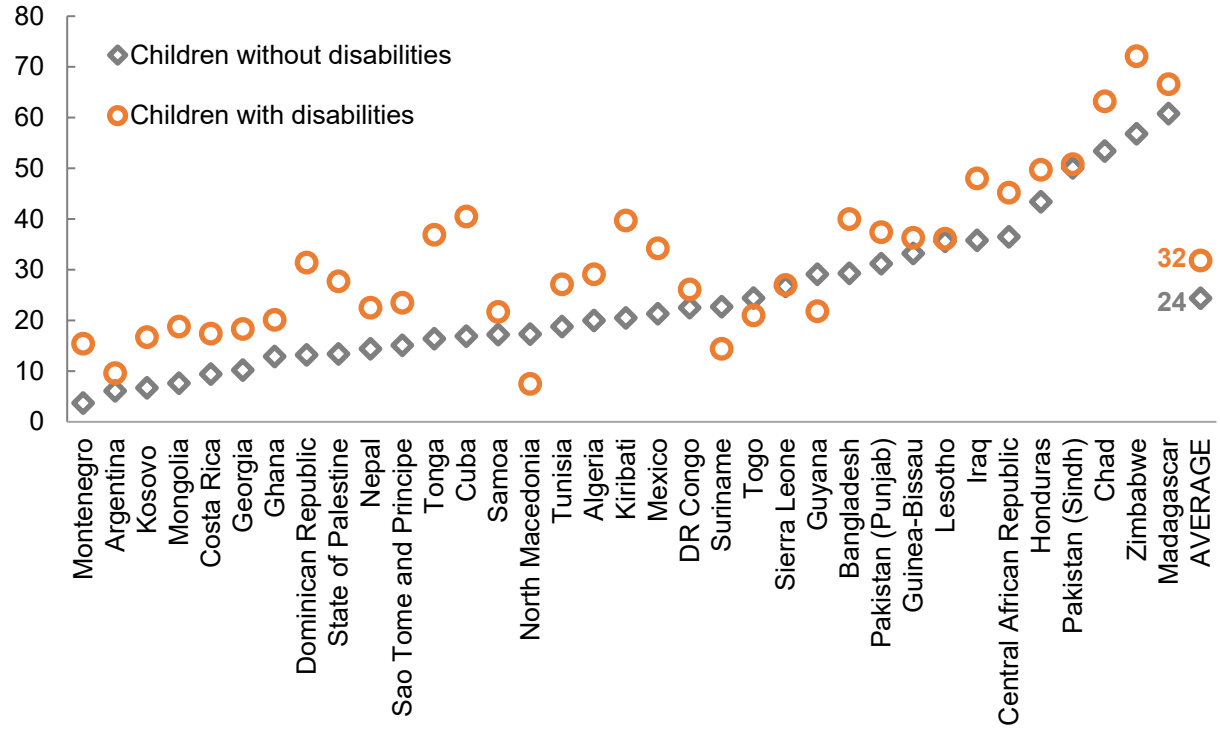


Note: (CF) identifies data produced using the Child Functioning Module.
Source: MICS.[227]

Attending school is only a part of the problem. Learners with disabilities who attend school also face barriers to completing their education. They are less likely to complete primary, secondary and tertiary education than persons without disabilities. Among 24 countries or areas, 69 per cent of children with disabilities compared to 75 per cent of children without disabilities completed primary education (Figure 59). The largest gap between children with and without disabilities in completing primary education is 17 percentage points in Iraq (62 versus 79 per cent). In Bangladesh, Central African Republic, Madagascar and Zimbabwe, the gap in primary school completion rates between children with and without disabilities is more than 10 percentage points. However, some countries have already achieved primary completion rates close to 100 per cent for both students with and without disabilities, with similar rates among the two groups: this is the case in Cuba, Georgia and Guyana. Adolescents with disabilities living in rural areas

are less likely to complete lower secondary education (37 per cent) than their peers without disabilities (52 per cent).[228]

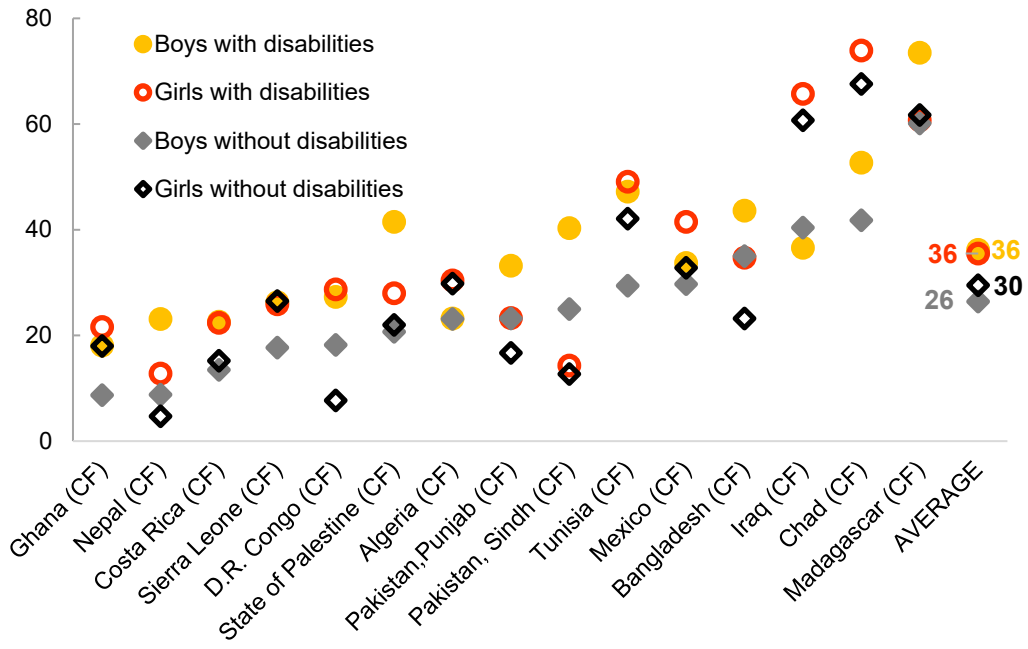
Figure 55. Percentage of adolescents of upper secondary school age who are out of school, by disability status, in 35 countries or areas, in 2020 or latest year available.



Note: Upper secondary school age is about 14 to 17 years in the majority of the countries. Data on children with disabilities from Kiribati, Kosovo, Lesotho, Montenegro, North Macedonia, Suriname, Tonga and Zimbabwe are based on 25 to 49 observations and should be interpreted with caution.
Source: MICS. [227]

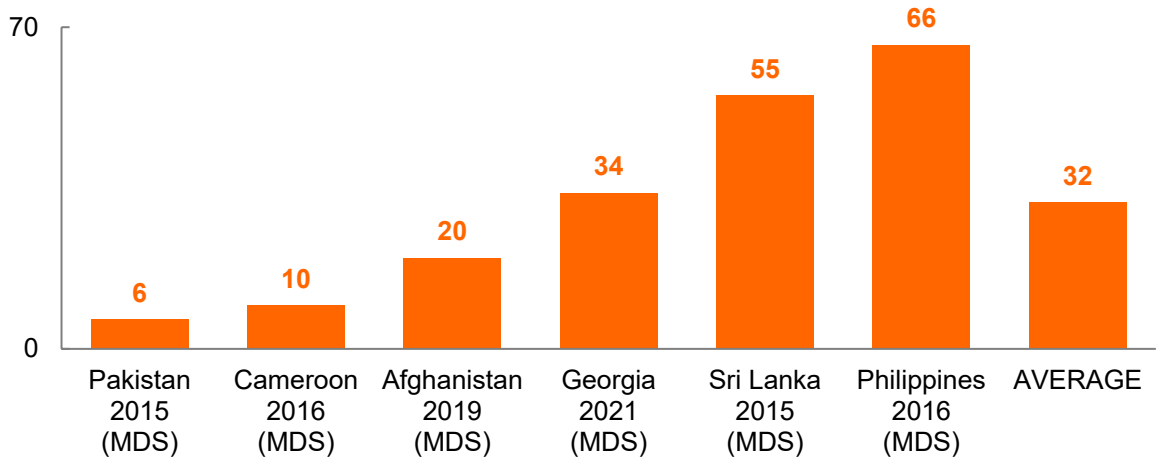
Girls and boys with disabilities are less likely to complete primary education than children without disabilities. In 18 countries or areas, boys and girls with disabilities are less likely to complete primary education than their peers without disabilities (Figure 60). Girls without disabilities have higher primary school completion rates compared to boys with disabilities in 12 of these countries or areas.

Figure 56. Percentage of adolescents of upper secondary school age who are out of school, by disability status and sex, in 15 countries or areas, in 2020 or latest year available.



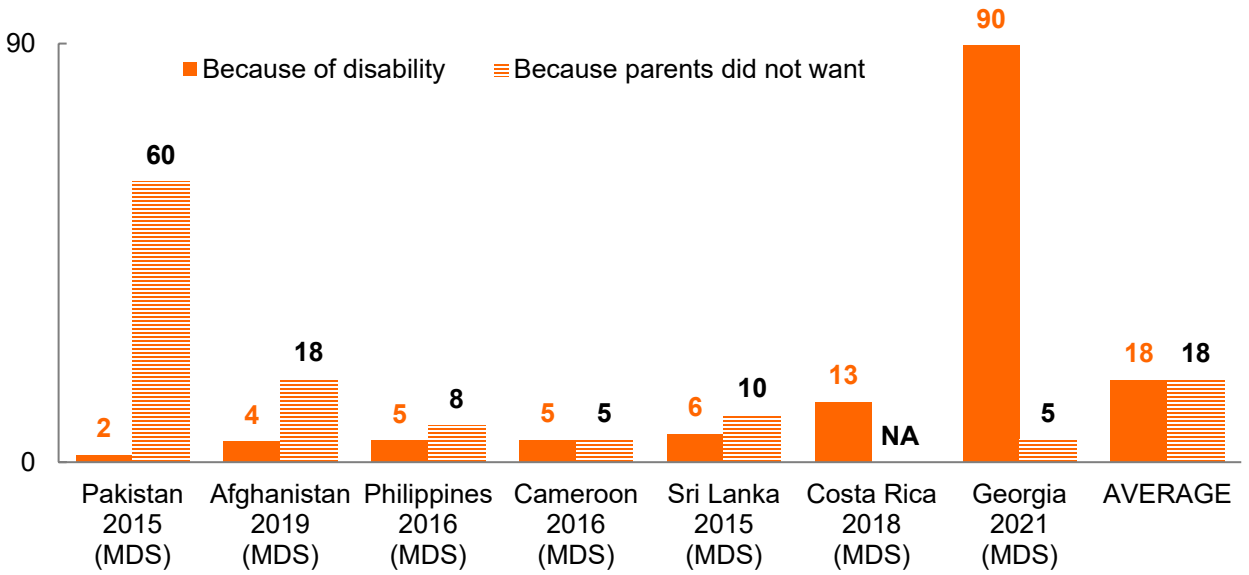
Note: (CF) identifies data produced using the Child Functioning Module. DR Congo refers to the Democratic Republic of the Congo.
Source: MICS.[227]

Figure 57. Percentage of persons with disabilities who never attended school because of economic reasons, in 6 countries or areas, in 2021 or latest year available.



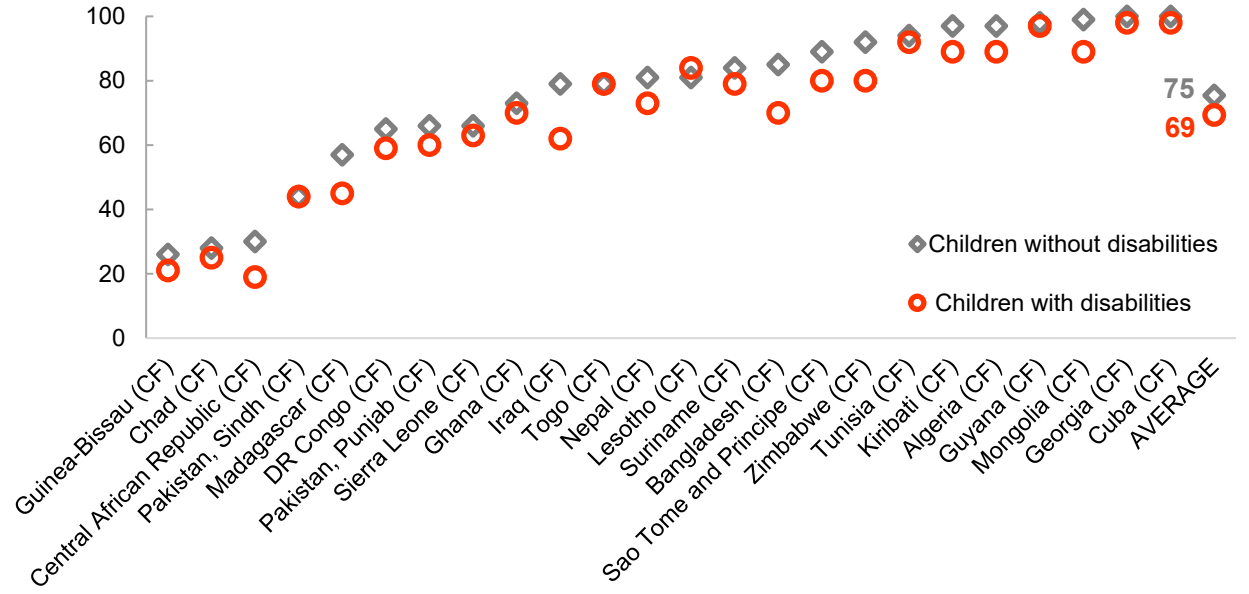
Note: (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from the Model Disability Surveys).

Figure 58. Percentage of persons with disabilities who never attended school because of disability or because parents did not want them to attend school, in 7 countries or areas, in 2021 or latest year available.



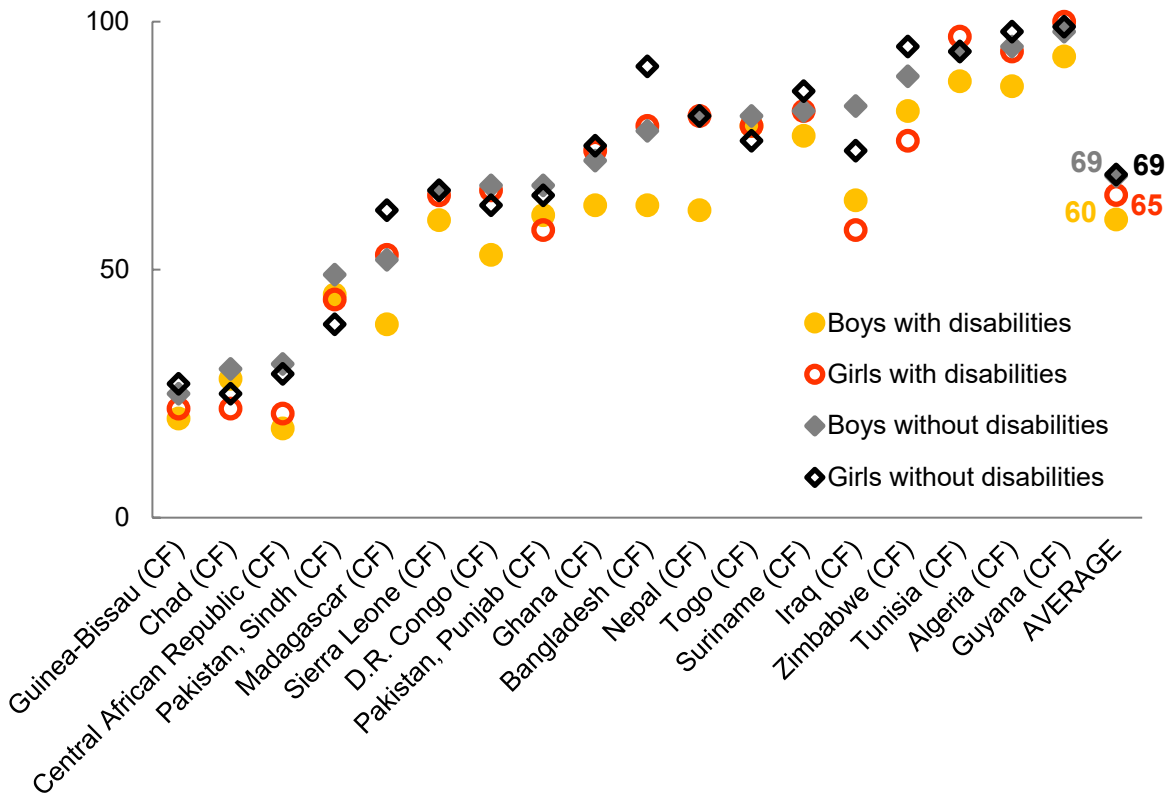
Note: (MDS) identifies data produced using the Model Disability Survey. NA indicated data not available.
Source: WHO (on the basis of data from the Model Disability Surveys).

Figure 59. Primary completion rate, by disability status, in 24 countries or areas, in 2020 or latest year available.



Note: (CF) identifies data produced using the Child Functioning Module. DR Congo refers to the Democratic Republic of the Congo.
Source: MICS.[227]

Figure 60. Primary completion rate, by disability status and sex, in 18 countries or areas, in 2020 or latest year available.



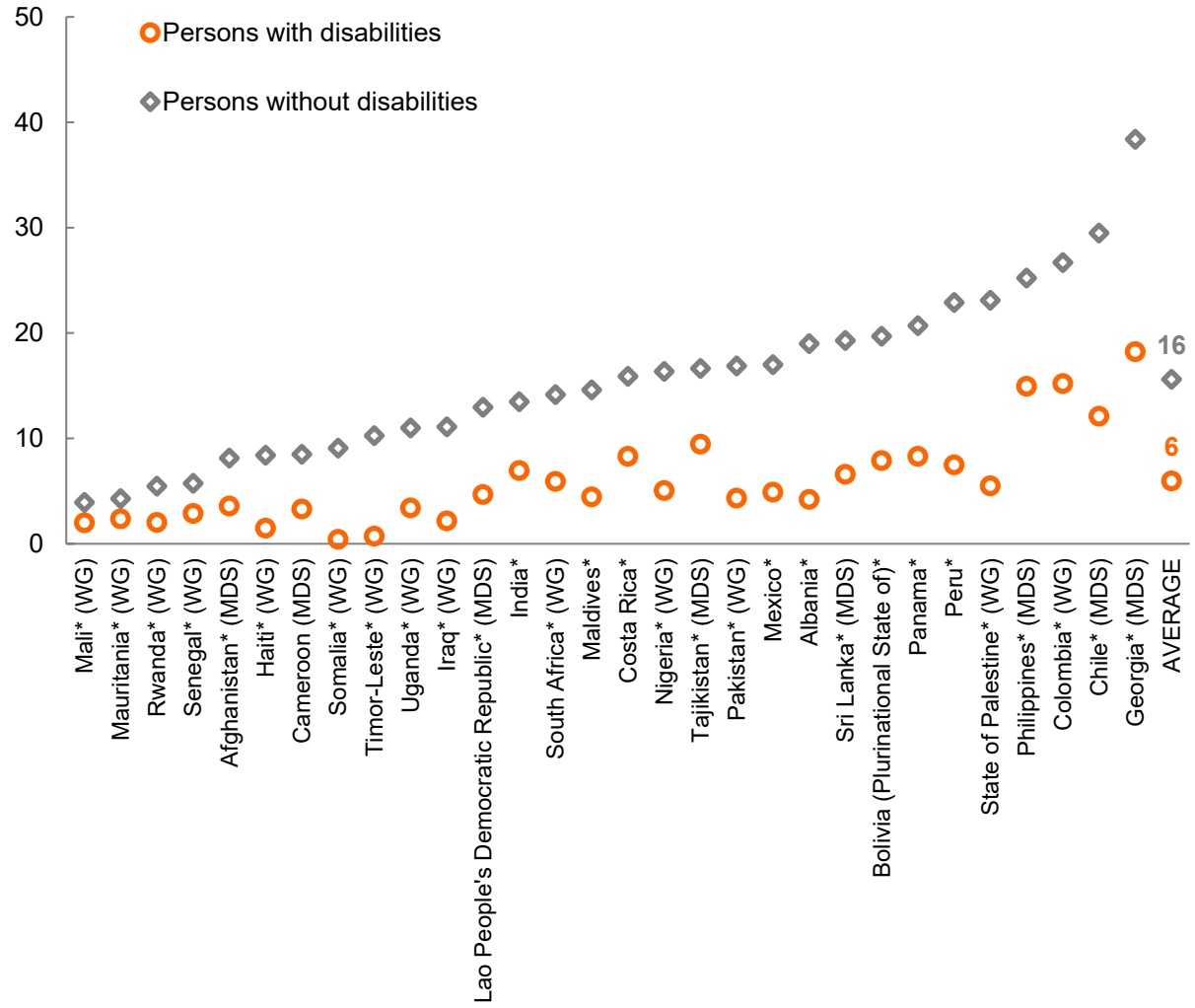
Note: (CF) identifies data produced using the Child Functioning Module. DR Congo refers to the Democratic Republic of the Congo.
Source: MICS.[227]

Persons with disabilities are less likely to complete tertiary education (Figure 61). Among 30 countries or areas, 16 per cent of persons without disabilities versus 6 per cent with disabilities completed tertiary education. The highest gaps between persons with and without disabilities is observed in Georgia (20 percentage points), State of Palestine (18 percentage points) and Chile (17 percentage points). In another 11 of these countries, the gap is higher than 10 percentage points. The percentage of persons with disabilities who completed tertiary education ranges from 0 per cent in Somalia to 18 per cent in Georgia.

Children with disabilities still face more barriers to achieve foundational reading and numeracy skills than children without disabilities. Among 24 countries or areas, children with disabilities have lower foundational reading skills compared to their peers without disabilities: 30 per cent versus 37 per cent (Figure 62). The largest gaps in foundational reading skills between children with and without disabilities are 64 per cent versus 82 per cent, in Turkmenistan, and 49 per cent versus 67 per cent in North

Macedonia. In the State of Palestine and Sao Tome and Principe, the gap also exceeds 15 percentage points. Less than 10 per cent of children 7 to 14 years old with disabilities in Chad, Central African Republic, Democratic Republic of the Congo, and the Gambia have acquired foundational reading skills.

Figure 61. Percentage of persons 25 years and older who completed tertiary education, by disability status, in 30 countries or areas, in 2021 or latest year available.

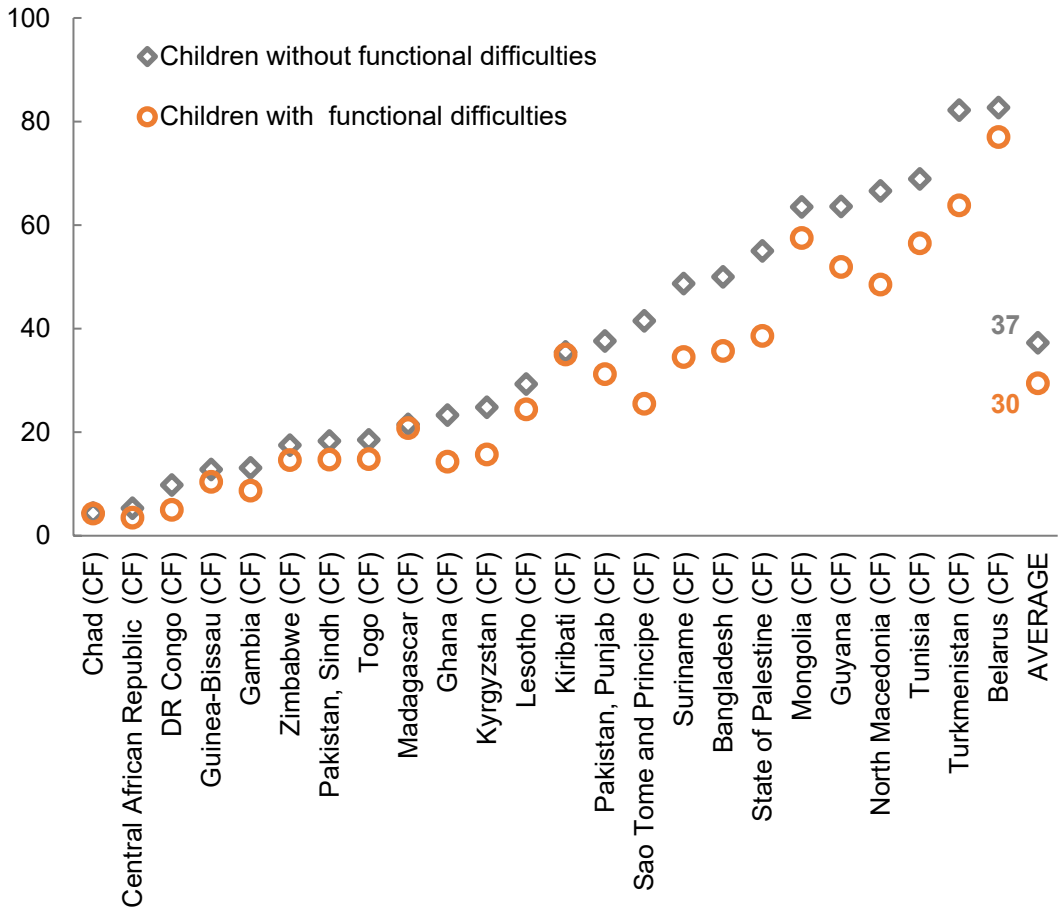


Note: (MDS) identifies data produced using the Model Disability Survey; (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent. Source: ESCAP,[14] ESCWA, UNDESA (on the basis of data from DHS[6]) and WHO (on the basis of data from the Model Disability Surveys).

Similarly, children with disabilities on average have lower foundational numeracy skills compared to their peers without disabilities: 23 per cent versus 27 per cent (Figure 63). The Democratic Republic of the

Congo has the lowest percentage of children with disabilities acquiring foundational numeracy skills – only 0.2 per cent. Less than 5 per cent of children with disabilities in Guinea-Bissau, Central African Republic, Madagascar and Pakistan (Sindh), have foundational numeracy skills. The largest gap in foundational numeracy skills between children with and without disabilities is 25 per cent versus 38 per cent in Sao Tome and Principe, followed by 39 per cent versus 53 per cent in Kyrgyzstan, 51 per cent versus 62 per cent in Guyana and 37 per cent versus 47 per cent in the State of Palestine.

Figure 62. Percentage of children aged 7 to 14 years with foundational reading skills, by disability status, in 24 countries or areas, in 2020 or latest year available.

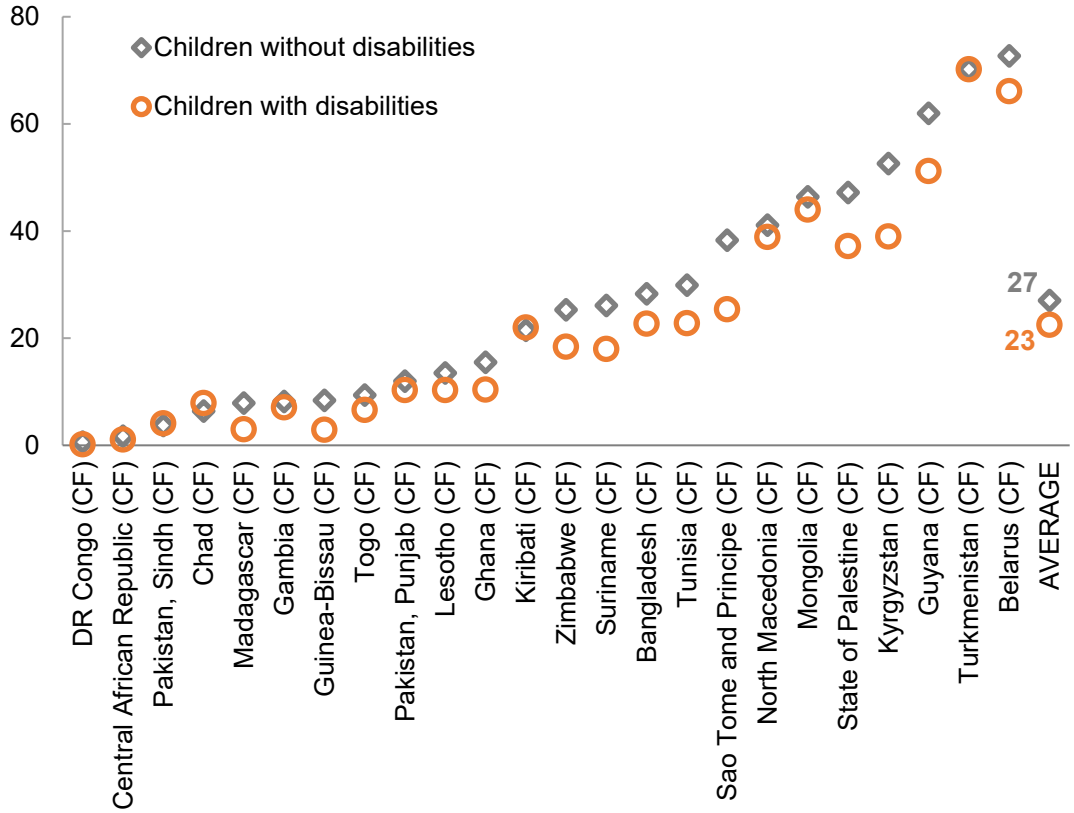


Note: Foundational reading skills are measured for grades 2/3, covering both in-school and out-of-school children. (CF) identifies data produced using the Child Functioning Module. Data on children with disabilities from Turkmenistan are based on 25 to 49 observations and should be interpreted with caution. DR Congo refers to the Democratic Republic of the Congo.
Source: MICS.[227]

Boys with disabilities are slightly less likely to achieve foundational reading and numeracy skills than girls with disabilities. In 24 countries or areas, 23 per cent of girls with disabilities and 22 per cent of boys with disabilities, on average, have foundational reading skills (Figure 64). Depending on the country, girls have

higher or lower foundational reading skills than boys, regardless of their disability status. In half of these countries, girls have lower foundational reading skills compared to boys; in the remaining countries girls with disabilities have higher foundational reading skills compared to boys with disabilities. The largest gaps between girls and boys with disabilities are observed in the Gambia (13 per cent versus 2 per cent) followed by Guinea-Bissau (13 per cent versus 8 per cent).

Figure 63. Percentage of children 7 to 14 years old with foundational numeracy skills, by disability status, in 24 countries or areas, in 2020 or latest year available.

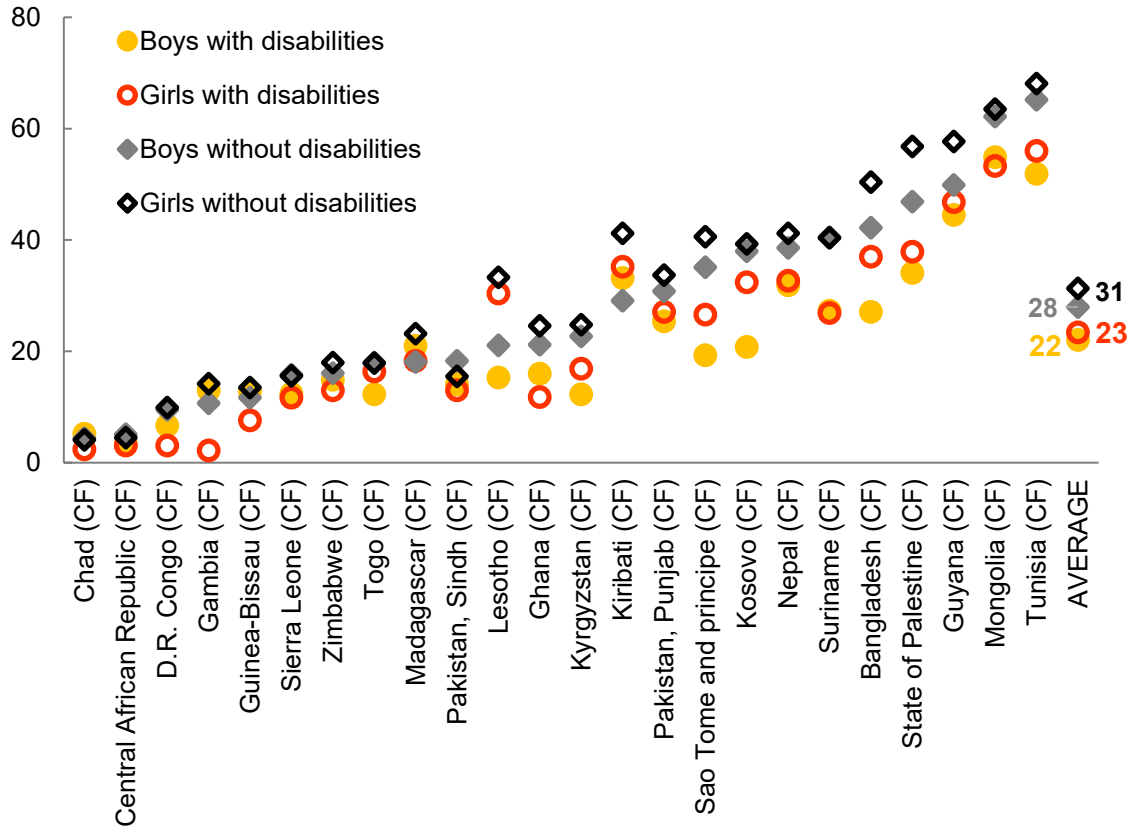


Note: Foundational numeracy skills are measured for grades 2/3, covering both in-school and out-of-school children. (CF) identifies data produced using the Child Functioning Module. Data on children with disabilities from Turkmenistan are based on 25 to 49 observations and should be interpreted with caution. DR Congo refers to the Democratic Republic of the Congo.
Source: MICS. [227]

Among 24 countries or areas, girls with disabilities on average have higher foundational numeracy skills compared to boys with disabilities (17 per cent versus 16 per cent) – Figure 65. Depending on the country, girls with disabilities have higher or lower foundational numeracy skills than boys with disabilities. In 14 out of 24 countries, girls with disabilities have higher foundational numeracy skills than boys with

disabilities. The largest gaps in foundational numeracy skills between girls and boys with disabilities are observed in Nepal (37 per cent versus 29 per cent), followed by Tunisia (25 per cent versus 18 per cent) and Ghana (14 per cent versus 7 per cent). In the Central African Republic, the Democratic Republic of the Congo, Guinea-Bissau, Madagascar, Pakistan's Sindh province and Sierra Leone, less than 5 per cent of boys and girls with disabilities achieve foundational numeracy skills.

Figure 64. Percentage of children aged 7 to 14 with foundational reading skills, by disability status and sex, in 24 countries or areas in 2020 or latest year available.



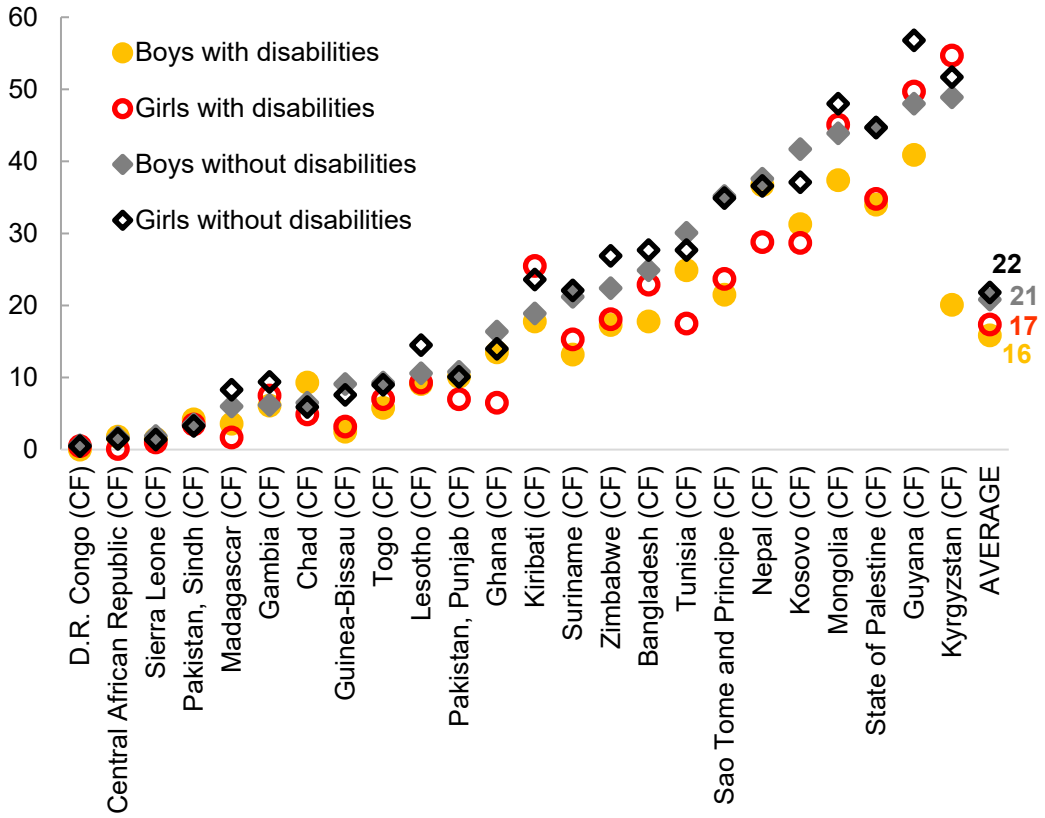
Note: (CF) identifies data produced using the Child Functioning Module. DR Congo refers to the Democratic Republic of the Congo.
Source: MICS.[227]

Youth and adults with disabilities tend to leave the educational system with lower information and communications technology (ICT) skills than youth and adults without disabilities (see the chapter on Goal 9.c), thus facing barriers to employment, decent jobs and entrepreneurship.

Physical and virtual barriers make it difficult for students with disabilities to participate. In seven countries, on average, 19 per cent of persons with disabilities reported that schools were not accessible or hindering (Figure 66). Percentages vary between 10 per cent in Nepal and 35 per cent in Zambia.

Countries have continued to formulate initiatives to make their educational systems more inclusive, eliminating obstacles and addressing discrimination against persons with disabilities. Since 2016, several countries have introduced laws and policies to protect the rights of persons with disabilities in line with the Convention on the Rights of Persons with Disabilities. In total, 37 countries guarantee in their constitutions the right to education for children with disabilities or protect against discrimination in education based on disability; 90 countries guarantee in their constitutions the right to education without a specific reference to disabilities.[229]

Figure 65. Percentage of children aged 7 to 14 with foundational numeracy skills by disability status and sex, in 24 countries or areas in 2020 or latest year available.

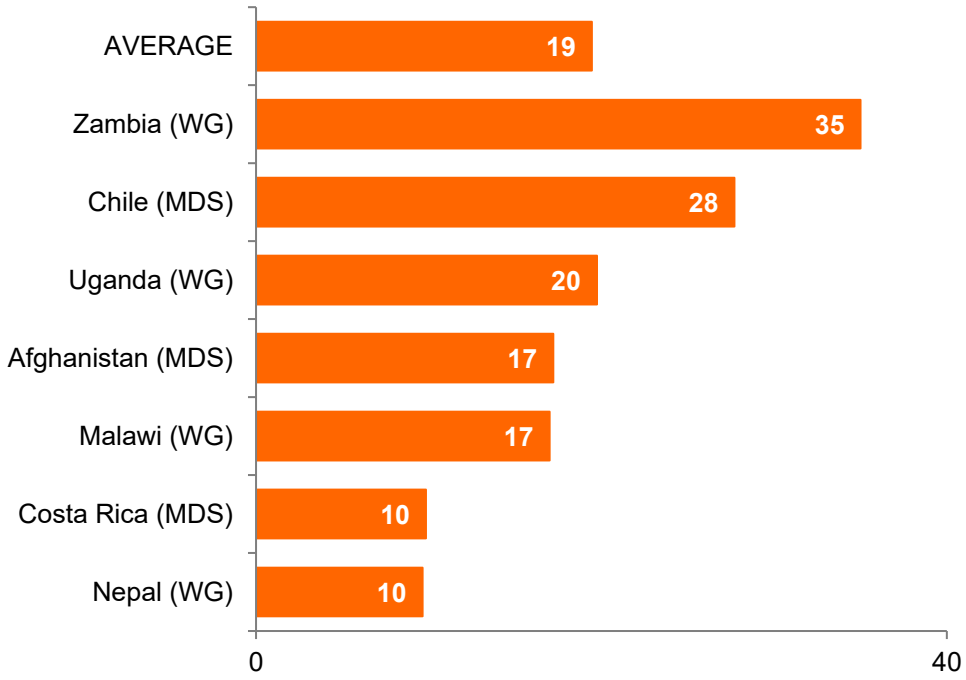


Note: (CF) identifies data produced using the Child Functioning Module. D.R. Congo refers to the Democratic Republic of the Congo.
Source: MICS.[227]

Apart from constitutions, there has been progress in other legal and policy measures to support inclusive education for persons with disabilities since 2016 (Figure 67). In 2021, 87 per cent of countries had laws or policies to support children with disabilities in education, up from 74 per cent in 2016. In 2021, a majority of countries, 74 per cent, were fostering positive attitudes from school staff in relation to children with disabilities as compared to 51 per cent in 2016. Countries also increased efforts to collect disability

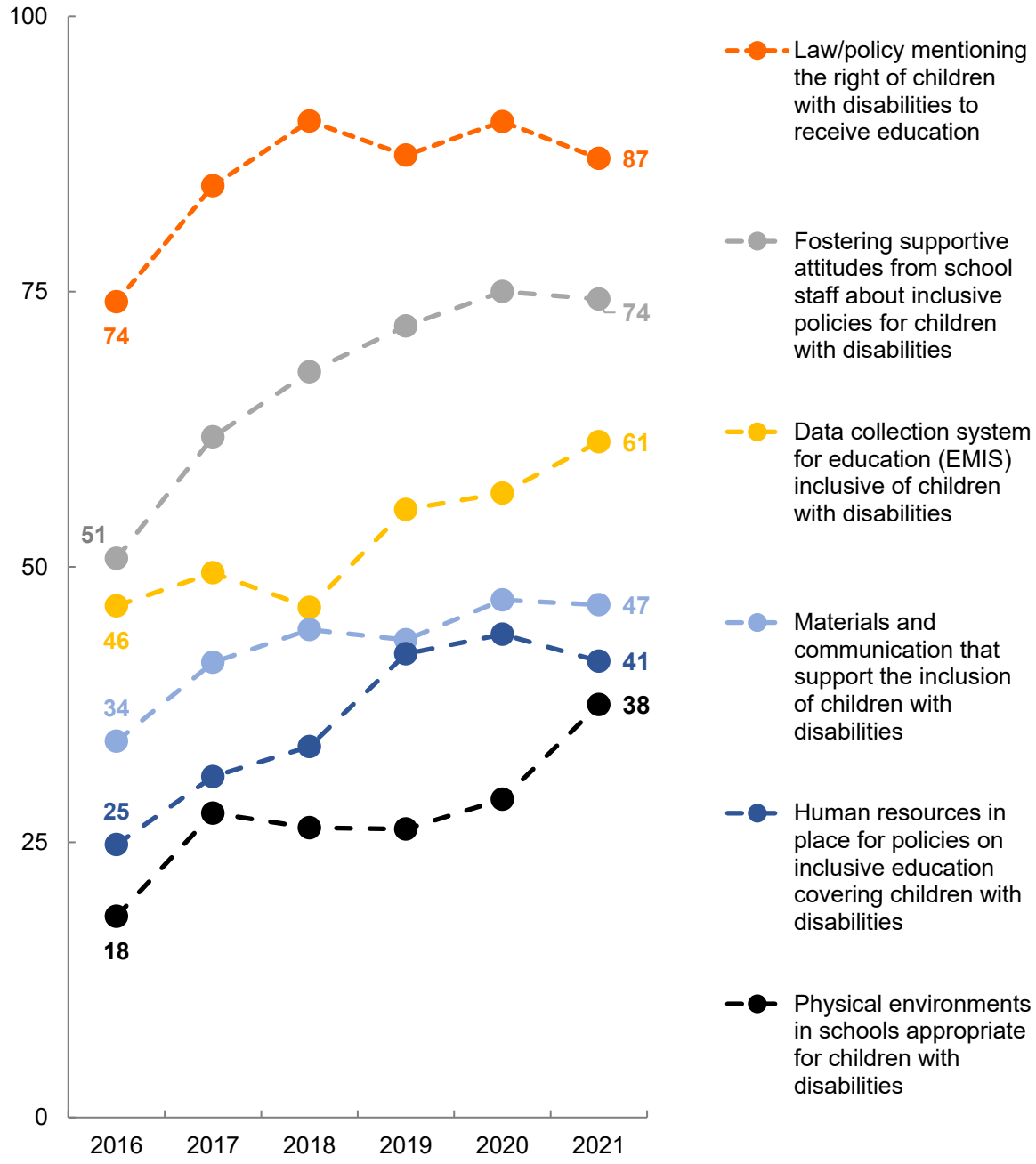
data through Education Management Information Systems (EMIS). In 2021, 61 per cent of 88 countries had a data collection system, up from 46 per cent in 2016, thus providing needed evidence for governments and policymakers to strengthen educational planning processes. In order to achieve inclusion in education, it is necessary to guarantee supportive and welcoming school environments for children with disabilities. In 2021, only 47 per cent of countries provided appropriate materials necessary for learning in their schools, up from 34 percent in 2016. Similarly, only 38 percent of countries in 2021 provided physically accessible environments appropriate for learners with disabilities, up from 18 percent in 2016. Finally, in 2021, 41 percent of countries provided human resources to implement policies on inclusive education covering children with disabilities, up from 25 percent in 2016.

Figure 66. Percentage of students with disabilities who found that schools were not accessible or hindering, in 7 countries, in 2019 or latest year available.



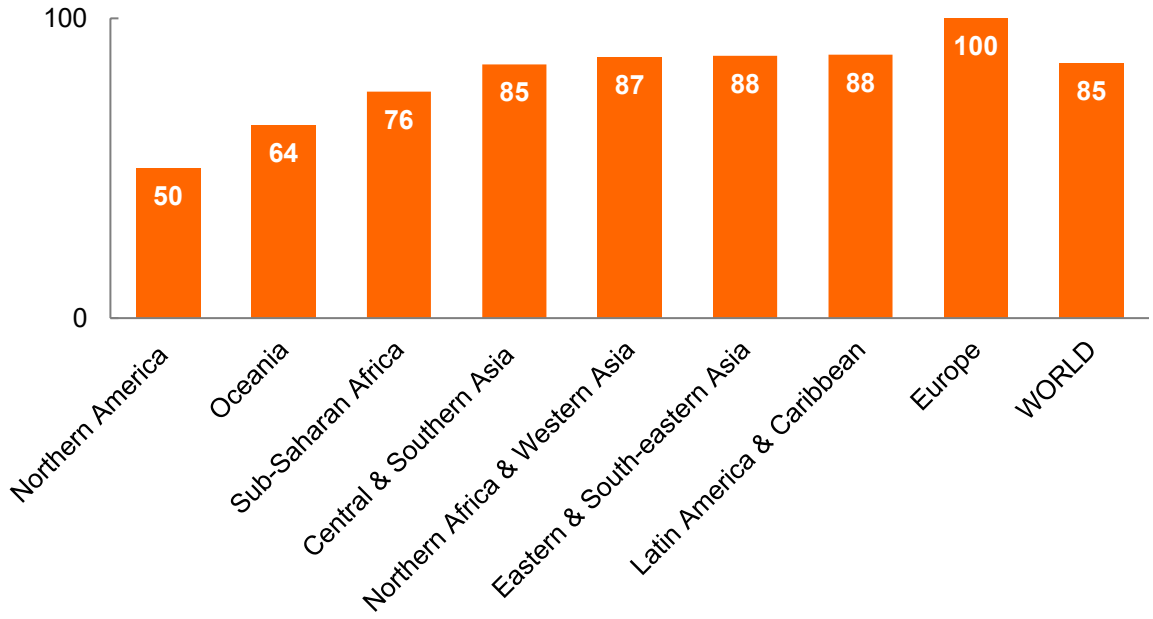
Note: (MDS) identifies data produced using the Model Disability Survey; (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO (on the basis of data from Model Disability Surveys).

Figure 67. Percentage of countries that implemented measures for the promotion of equitable education systems, in 75 to 135 countries, from 2016 to 2021.



Source: UNICEF.[230]

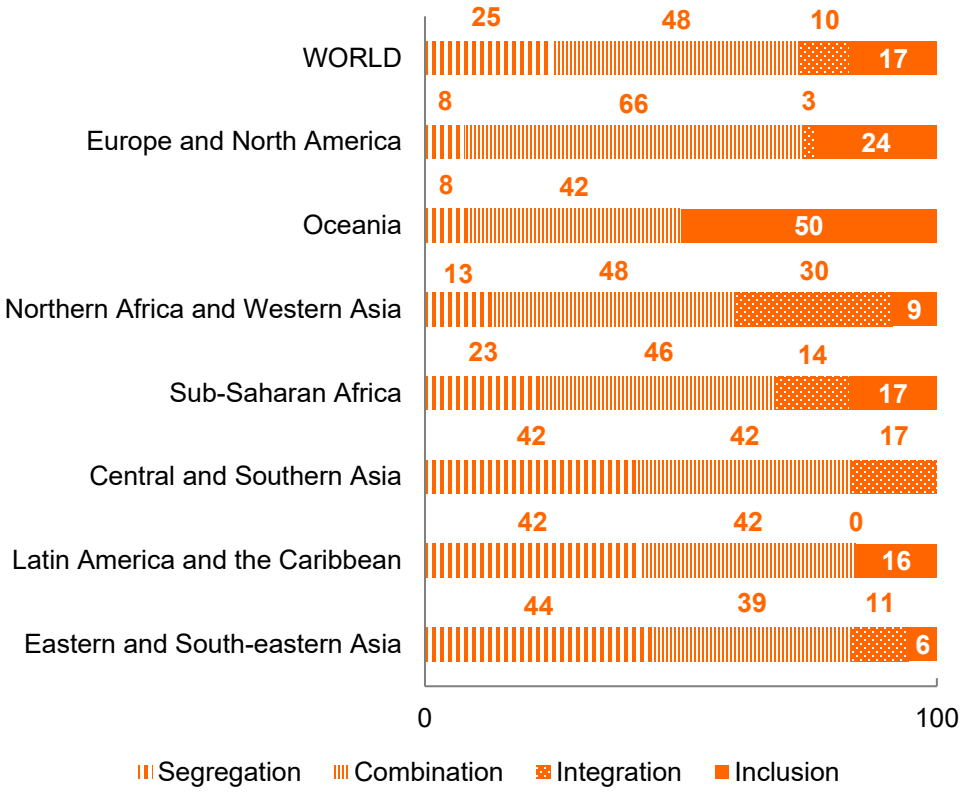
Figure 68. Percentage of countries that guarantee education for persons with disabilities in their laws regulating education, for the world and by region, in 2018.



Note: Based on 188 countries.
Source: World Policy Analysis Center (2022).[231]

The legal guarantees for education for persons with disabilities vary among regions (Figure 68). The percentage of countries providing such a guarantee is lowest in North America, Oceania and sub-Saharan Africa, and highest in Europe, Latin America and the Caribbean and Eastern and South-eastern Asia. Not all countries with a legal guarantee for education for persons with disabilities have provisions for ensuring inclusive education. Inclusive education involves teaching all students in the same age-appropriate general education classroom at their local school, but this is not yet the reality in many countries. Legally, the guarantees for inclusion of learners with disabilities in mainstream schools vary among countries and regions (Figure 68), ranging from segregated to integrated, combined and inclusive (Figure 69). Worldwide, 48 per cent of countries have laws that guarantee that learners with disabilities attend schools combining mainstreaming with separate settings, compared with 25 per cent of countries guaranteeing education in segregated schools and 17 per cent of countries in inclusive schools. The region with the highest percentage of countries providing legal guarantees of inclusive environments for learners with disabilities is Oceania, with 50 per cent of countries providing these legal guarantees; followed by Europe and North America, with 24 per cent of countries; and sub-Saharan Africa and Central and Southern Asia, with 17 per cent of countries. The region with the highest percentage of countries providing legal provisions for segregated environments for learners with disabilities is Eastern and South-eastern Asia with 44 per cent of countries, followed by Latin America and the Caribbean and Central and Southern Asia, both regions with 42 per cent of countries.

Figure 69. Percentage of countries by type of school organization for students with disabilities, as defined in their laws, for the world and by region, in 2020.



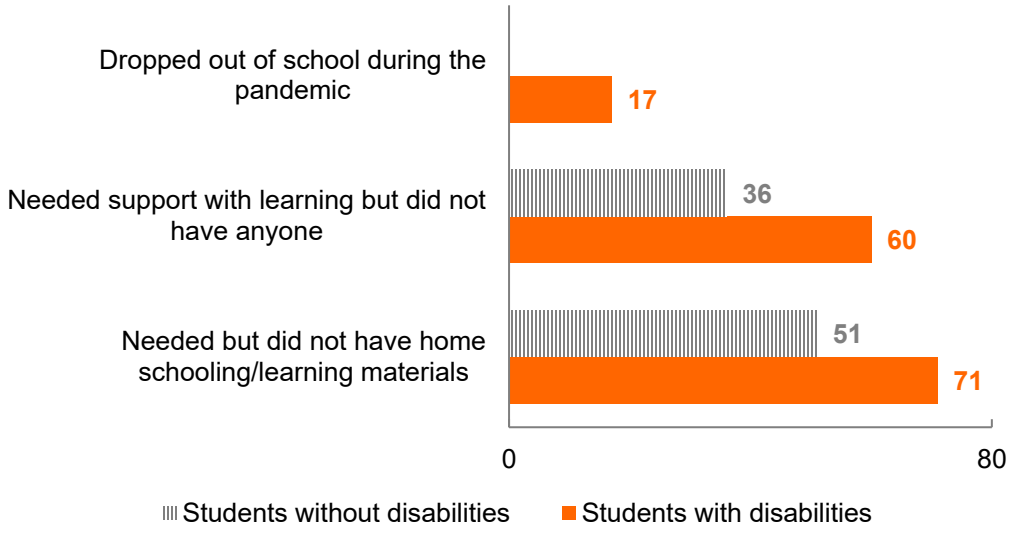
Note: Segregation means that learners with disabilities have access to separate schools designed to respond to learners with a particular impairment or various impairments. Combination means that learners with disabilities have access to schools combining mainstreaming with separate settings, that is, to schools where they are taught at times in the same classroom as their peers without disabilities, and at other times they are taught in separate classrooms away from their peers without disabilities. Integration means that learners with disabilities have access to mainstream schools as long as the learners can adjust to the standardized requirements of such institutions because individualized support and accommodation are not guaranteed for learners with disabilities. Inclusion means that learners with disabilities have access to mainstream schools and are taught in the same age-appropriate education classroom as learners without disabilities, with individualized support and accommodations to support their education.
Source: UNESCO (2020).[232]

Impact of the COVID-19 pandemic

The COVID-19 pandemic has created the worst crisis in education in recent years, disproportionally affecting children with disabilities. With school closures during the pandemic, many children and youth with disabilities fell behind, due to challenges in participating in online learning and lack of support (Figure 70). In developing countries, 17 per cent of respondents with disabilities who attended school before the pandemic, reported dropping out during the pandemic. Children with disabilities were also less likely than others to have access to learning materials and to receive learning support. A higher proportion of

children with disabilities (71 per cent) needed and did not have home schooling or learning materials, compared to children without disabilities (51 per cent); 60 per cent of children with disabilities needed but did not have someone to help them with learning, compared to 36 per cent of children without disabilities.

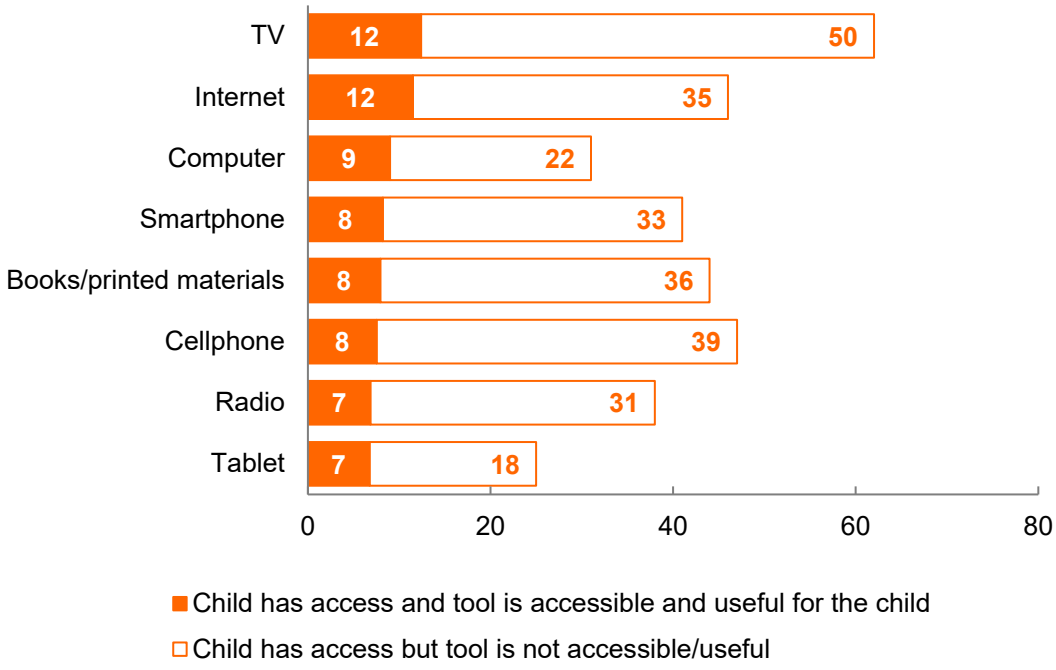
Figure 70. Percentage of students who dropped out during the COVID-19 pandemic, and who had an unmet need for learning support and for home schooling/learning materials, by disability status, in developing countries, in 2020.



Source: Save the Children (2020).[16]

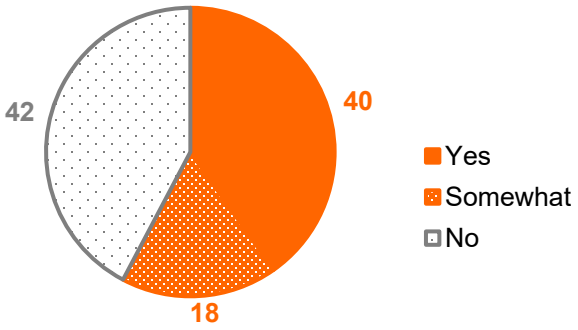
Students with disabilities faced additional challenges during the pandemic, including lack of access to the Internet and ICT for remote learning. During school closures due to the pandemic, only 62 per cent of children with disabilities worldwide had access to a television in their household and only 47 per cent had access to the Internet (Figure 71). Even among households with access to information and communication technologies, often these were not accessible and useful for students with disabilities. Only 7 per cent to 12 per cent of students with disabilities had access to accessible and useful ICT, from 7 per cent for radio and tablets to 12 per cent for TV and the Internet.

Figure 71. Percentage of children with disabilities with access to the Internet and other information and communication technology during school closures due to the COVID-19 pandemic, in 2020.



Source: World Bank and Inclusive Education Initiative 2020.[233]

Figure 72. Percentage of parents/caregivers of children with disabilities that had access to financial support during school closures due to the COVID-19 pandemic, in 2020.



Note: Data based on the responses of parents and caregivers of children with disabilities.
Source: World Bank and Inclusive Education Initiative 2020.[233]

Moreover, a majority of families did not have access to financial support to cope with the cost of additional devices, the Internet and personal support that remote learning requires. During the school closures due to the pandemic, 42 per cent of the parents and caregivers of children with disabilities did not have

access to financial support (Figure 72).

Students who were deaf and students with hearing impairments encountered barriers when their teachers and peers were wearing face masks.[234] Opaque masks became a major impediment for these students during the pandemic, both during in-person and online learning, as face masks inhibited lip reading, blocked muffling sound and interfered with audibility and intelligibility of speech. Although this barrier can be overcome by using transparent masks, research was not conducted on the efficacy of these masks to block the transmission of COVID-19 and thus prevented their wide usage during the pandemic.

To combat the unprecedented challenges to education for persons with disabilities, some countries developed approaches inclusive of all learners or targeting the needs of students with disabilities (Table 2). These approaches relied on inclusive guidelines for re-opening schools, partnering with organizations of persons with disabilities, investing in accessible learning platforms as well as low-tech distance learning solutions with accessibility features and conducting trials for remote learning materials for students with disabilities.

Table 2. Initiatives to support the education of students with disabilities during the COVID-19 pandemic.

Initiative	Examples of countries
Guidelines on re-opening schools in the COVID-19 environment	Bangladesh, [235] Cambodia,[236] Kenya,[237] Kiribati,[238] Myanmar,[239] Nigeria,[240] Papua New Guinea,[241] and Eastern Caribbean States[242]
Partnering with organizations of persons with disabilities	Paraguay[243]
Investing in accessible online learning platforms	Uganda,[244] Mauritius,[245] Colombia[246] and Guatemala[247]
Investing in low-tech distance learning solutions, like education broadcasts on TV or radio that include accessibility features	Bangladesh,[248] Portugal,[249] Cambodia[250] and Rwanda[251]
Teachers trialled remote learning materials and modalities for learners with disabilities	Bahamas[252] and Kiribati[253]
Therapy or psychological support for learners with disabilities during school closures	Martinique[254] and Turks and Caicos Islands [255]
Providing parents and caregivers with advice on disability-inclusive learning environments	Ireland, [256] Mozambique[257] and Nepal[258]

Since the COVID-19 pandemic, countries have been engaged in 'building back better'[259] and focusing on providing support to students with disabilities. Malawi and Ghana are expanding existing remedial

learning programmes to help children catch up on lost learning[260] and school grants are provided for similar programs in Rwanda.[261] In China, individualized learning plans aim to help with learning recovery among students with disabilities from disadvantaged backgrounds, while in the United States, emphasis is on accommodations, modifications, and assistance for children with disabilities.[262,263]

Summary of findings and the way forward

Children with disabilities continue to face barriers to access, progression, completion and learning outcomes, particularly in higher levels of education. Most children with disabilities are able to access primary education but this access drops at lower secondary education and even further for upper secondary education. While 11 per cent of children with disabilities of primary school age remain out of school, this percentages increases to 32 per cent for children with disabilities of upper secondary school age. Children with disabilities from vulnerable groups, such as Indigenous people, are particularly at a disadvantage. Although these gaps are found in most countries, a few countries have already succeeded in lowering out-of-school rates for children with disabilities of primary school age to very low levels, at par with levels for children without disabilities. Children with disabilities also face more barriers than children without disabilities to achieving reading skills (37 per cent versus 30 per cent) and numeracy skills (27 per cent versus 23 per cent).

Remarkable advances towards the inclusion of persons with disabilities in legislation, policies and school environments have been made since 2015. Almost all countries now have laws or policies protecting the right of persons with disabilities to education. The percentage of countries with physical school environments accessible and inclusive of persons with disabilities doubled from 2016 to 2021. However, despite these advances, less than half of all countries have educational materials and school environments designed to be accessible and inclusive of persons with disabilities.

In 2020, progress in policy and practice was abruptly disrupted by the COVID-19 pandemic. During the pandemic, education systems faced major challenges in providing continuous access to education for children and adolescents with disabilities. With nationwide school closures in effect and remote instruction becoming the only way for many to continue education, many students found themselves at home without the necessary personal and technological support to make learning possible and effective. One in five students with disabilities dropped out during the pandemic; nine in ten students with disabilities did not have a computer at home that was accessible and useful for their learning. Many families did not have the financial security to make the needed investments in support and ICT. Almost half of households with children with disabilities did not receive financial support during school closures to cover these additional costs.

If the rates of progress observed so far continue, all countries are expected to have adequate legislation or policies guaranteeing disability inclusion in education by 2030. To keep this momentum, legal revisions are particularly urgent in countries in Oceania and in sub-Saharan Africa.

For target 4.a, which calls for education facilities that are disability sensitive, progress, though noticeable, has not been enough. At the rate of progress observed since 2015 in making physical environments in schools appropriate for students with disabilities, the disability-related provisions of target 4.a. will only be achieved in slightly over half of all countries by 2030. The world needs to build and upgrade educational facilities appropriate for students with disabilities at a rate three times faster than the rates of progress observed so far, in order to achieve this target by 2030.

The following actions are recommended to achieve Goal 4 by, for and with persons with disabilities and to ensure that the right to an inclusive education for persons with disabilities is being upheld in legislation, policy and practice:

1. Establish inclusive education for persons with disabilities in legislation and policies. Governments should make sure national laws and policies are in line with the Convention on the Rights of Persons with Disabilities. Sectoral and cross-sectoral policies and legal systems need to protect against the discrimination of persons with disabilities and foster their right to receive equitable quality education, reasonable accommodation and individualized support, eliminating segregation and promoting diversity.

2. Expand inclusion in education to all levels of education. Adopting inclusive education practices to ensure quality education across all levels of education including preschool, primary and secondary education, technical and vocational education and training and higher education, with a lifelong learning perspective is crucial to ensure all learners have equal opportunities to realize their full potential. Expanding inclusive practices to preschool is essential to ensure the healthy growth and development of all children. Developing early screening and referral programmes to determine services and support needs for quality education should be a key element of the expansion together with the development of transition pathways from school to work.

3. Implement universal design principles and accessibility to ensure access to quality education for all. To ensure equal learning opportunities for all, the adoption and implementation of the principles of universal design in schools and other learning environments is crucial. This should include attention to educational infrastructure, transport, teaching and learning materials and pedagogical practices. Universal design for learning principles also needs to be applied in the context of distance learning with a focus on the availability of accessible infrastructure, connectivity and adapted content. Such initiatives should also include the development of flexible curricula that are adapted to the learning needs of all learners.

4. Provide access to assistive technologies in education. Ensure access points for assistive technologies in education, for both in-person and distance learning in urban and rural areas, supported by a dedicated workforce and support networks involving key development sectors, particularly health, rehabilitation and labour sectors and social services. Also, ensure training on the use of assistive technologies for learners, teachers and families.

5. Develop teacher capacities in inclusive education and build a diverse workforce in schools including teachers with disabilities. Make inclusive education an essential element of teacher training (pre- and in-service). Prepare teachers to develop learners' cognitive, emotional, social and creative skills and build welcoming, free from violence and safe face-to-face and online learning environments for all learners. Value a diverse education workforce, provide sufficient staffing levels to allow children with disabilities to thrive in all types of environments and foster motivation and readiness among teachers to commit to inclusive education. Peer support for inclusive education at local levels can play an important role in building both skills and confidence to develop inclusive teaching practices.

6. Engage multiple stakeholders to foster partnerships to advance inclusive policies and practices. Partner with non-governmental organizations, including organizations of persons with disabilities, communities, parents, caregivers, youth and the education workforce – including retired educators – to shape inclusive policies and practices. Empowering these stakeholders to engage with monitoring and evaluation processes can accelerate progress in making schools and other learning environments inclusive.

7. Foster cross-sectoral approaches to education, including access to health and social protection. Strengthen cross-sectoral approaches to education, including access to health, rehabilitation and social protection initiatives that address the additional costs learners with disabilities face in accessing education.

8. Continue to improve national collection and disaggregation of education data by disability as well as data collection on the learning environment. High-quality data are essential for the planning, budgeting, and implementation of inclusive education. Improving the quality of education for students with disabilities requires: (i) reliable data on access, progression and learning outcomes of children with disabilities; (ii) data monitoring the accessibility and inclusion of the learning environment, including facilities, materials and human resources; and (iii) data monitoring discrimination, exclusion, segregation, integration and inclusion of students with disabilities. In line with international guidelines for disability data collection, prioritize the standardization of data collection systems and foster collaboration among ministries and national agencies on the harmonization of administrative data collection processes.

9. Accelerate the implementation of inclusive recovery strategies to ensure the mitigation of learning losses caused by school closures during the global COVID-19 pandemic. The COVID-19 pandemic exacerbated pre-existing education disparities. In many countries, school closures have negatively impacted basic and foundational skills, thereby exacerbating an already serious learning gap between students with and without disabilities. To address these learning gaps, it is crucial to implement inclusive learning recovery strategies at scale with a focus on ongoing support and adaptations of instruction to children's learning levels.

10. Based on lessons from the COVID-19 pandemic, review and strengthen policies and practices related to the quality of education to ensure the needs of learners with disabilities are part of

future crisis readiness and response planning. It is important to take stock of the effects of the COVID-19 pandemic on the education system, in particular, on teachers, learners with disabilities and their families and caregivers. Developing mental health supports for teachers, learners and their families together with measures that foster wellbeing and a sense of belonging at school can promote healthy development and resilience to face future crises. Building positive learning environments that embrace diversity as a basic principle can play a key role in strengthening community resilience and addressing the adverse effects of crises on the education of persons with disabilities. The pandemic has revealed that, in times of crisis and beyond, it is important to provide training and support to families of persons with disabilities to ensure a stable support network. It is also important to provide virtual and physical spaces for teachers, families and students to share their experiences and learn from each other.

Achieving gender equality and empowering all women and girls (Goal 5)

Goal 5 calls for the empowerment of all women and girls and for gender equality. The Convention on the Rights of Persons with Disabilities (CRPD) includes a stand-alone article on women and girls with disabilities (article 6) and calls for women-focused legislation and gender-sensitive measures to protect women with disabilities from exploitation, violence and abuse (article 16); for their access to social protection and poverty reduction programmes (article 28); for measures to recognize their right to marry and found a family on the basis of free and full consent, to exercise their reproductive rights and to retain their fertility (article 23), thus protecting women with disabilities against forced or coerced sterilization or contraception.

Over the years, several resolutions of the United Nations General Assembly and the United Nations Economic and Social Council have been adopted on a wide range of issues making specific reference to women and girls with disabilities and calling for gender- and disability-inclusive actions. Recent resolutions have called for measures (i) to eliminate discrimination on any grounds,[264] including multiple and intersecting forms of discrimination against women and girls with disabilities through repealing discriminatory laws, policies and practices; (ii) and to remove any other barriers faced by women and girls with disabilities to the full and equal enjoyment of all rights stipulated in the Convention.[265] The resolutions have also called for mainstreaming a gender and disability perspective into (i) all relevant national and local institutions, including labour, economic and financial government agencies;[266] (ii) disaster risk reduction policies, plans, programmes and financing;[267] (iii) the design, implementation, monitoring and evaluating of social protection programmes and systems; [268] (iv) all interventions on digital technologies;[269] (v) policies and actions on ageing;[270] and (vi) actions addressing the needs of children with disabilities.[271]

In 2019, the United Nations Security Council adopted its first resolution on the protection of persons with disabilities in armed conflict, which underlined the benefit of providing inclusive and accessible assistance particularly to women and girls with disabilities affected by armed conflict, including reintegration, rehabilitation and psychosocial support, to ensure that their specific needs are effectively addressed.[272] A subsequent Security Council resolution called for the full, equal, and meaningful participation and inclusion of women with disabilities in missions related to peace operations.[273]

Other resolutions call for building disability- and gender-sensitive educational facilities,[274] increasing the employment of women with disabilities;[275] enhancing their participation in the labour market,[276] in the economy and in decision-making processes at all levels;[277] increasing their leadership in disaster risk reduction policies, plans, programmes and financing;[278] ensuring that no women with disabilities in rural areas are left behind;[279]and widening access to and ownership of natural and economic resources for women and girls with disabilities in rural areas, including access to financial services.[280]

Various resolutions also call for the elimination of all forms of violence against women and girls by addressing structural and underlying causes and risk factors, ensuring that services, programmes and facilities are accessible to and inclusive of women and girls with disabilities,[281] including in situations of risk, armed conflict, humanitarian emergencies and the occurrence of disasters caused by natural hazards.[282] They also call to enhance the reception and reintegration assistance for women migrant workers with disabilities who return to their countries of origin, with particular attention to the needs of victims of trafficking,[283] and to address the lack of data disaggregated by sex and disability to inform measures to reduce the vulnerability of women with disabilities to being trafficked.[284]

Based on available data and evidence, this chapter provides an overview of the situation of women with disabilities with a focus on targets 5.1 (end discrimination), 5.2 (eliminate violence), 5.3 (eliminate child marriage), 5.4 (value unpaid care and domestic work), 5.5 (participation and leadership in political, economic and public life), 5.a (economic resources, land ownership and financial services), 5.b (use of technology) and 5.c (policies and legislation). Target 5.6, which focuses on universal access to sexual and reproductive health and reproductive rights, is addressed in another chapter of this *Report* (see the chapter on targets 3.1, 3.7 and 5.6). The chapter concludes with recommendations on the way forward to achieve Goal 5 by 2030.

Current situation and progress so far

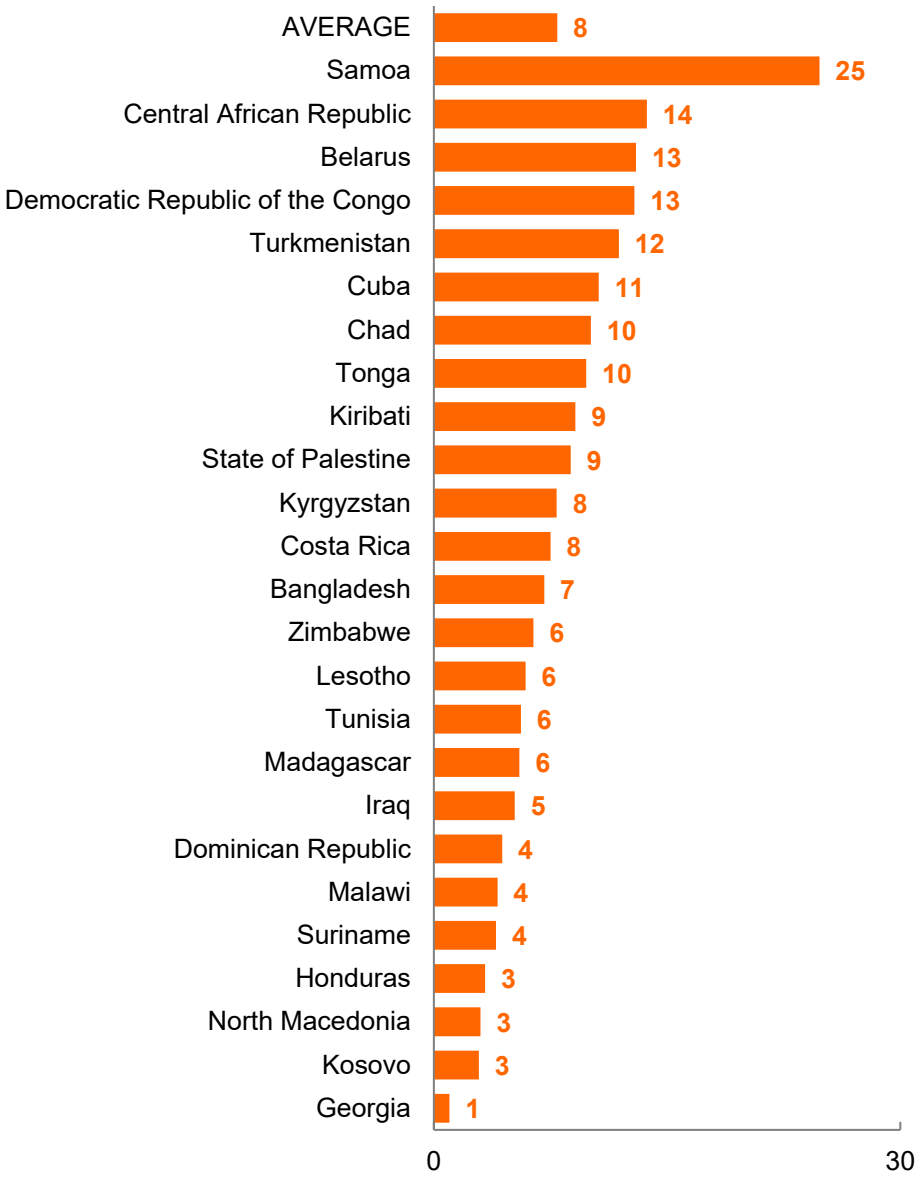
Major gaps and obstacles remain to the empowerment of women and girls with disabilities, including structural barriers and discriminatory practices. Evidence continues to show inequalities based on disability—when comparing women with and women without disabilities—and on gender, generally associated with the exclusion of women and girls with disabilities compared to men and boys with disabilities. As shown throughout this *Report*, women with disabilities face barriers to accessing education, employment, health services – including sexual and reproductive health – and water, sanitation and hygiene. There are also major data gaps on indicators to measure progress towards the SDGs for women and girls with disabilities.

On education, the primary completion rate for girls with disabilities is 65 per cent – higher than the primary completion rate for boys with disabilities (60 per cent), but lower than the rate of 69 per cent for both boys and girls without disabilities (see the chapter on Goal 4). On employment, only 23 per cent of women with disabilities are employed compared to 31 per cent of men with disabilities, 48 per cent of women without disabilities and 64 per cent of men without disabilities. In various countries, more than 50 per cent of women with disabilities do not have the births of their babies attended by skilled health personnel and do not receive a timely postnatal check (see the chapter on targets 3.1, 3.7 and 5.6). Due to a lack of accessible water, sanitation and hygiene facilities, 19 per cent of women and girls with disabilities compared to 13 per cent of women without disabilities do not participate in work, school and social activities during their menstrual period (see the chapter on Goal 6). Only three indicators in the

United Nations SDG Indicators Database have data disaggregated by both sex and disability – compared to seven indicators disaggregated by disability and 49 disaggregated by sex (see the chapter on target 17.18).

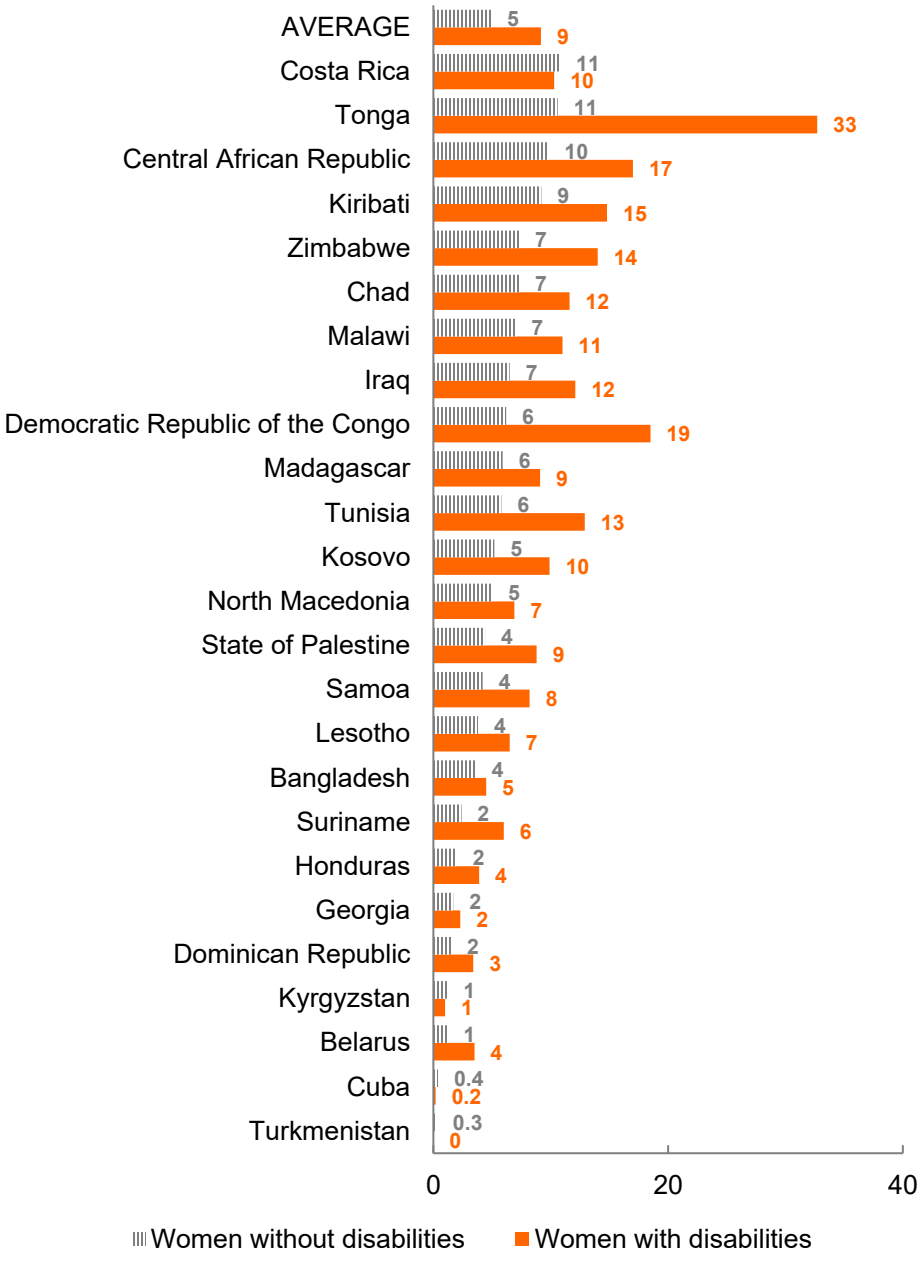
Limited evidence on progress suggests that the gap between women with disabilities and men without disabilities employed has slightly widened from 2015 to 2021 – from 38 percentage points[32] to 41 percentage points – as a result of a sharper decrease in the employment of women with disabilities triggered by the COVID-19 crisis.

Figure 73. Percentage of women with disabilities who felt discriminated against due to their disability, in 25 countries or areas, in 2020 or latest year available.



Source: UN SDG Indicators database.[285]

Figure 74. Percentage of women who felt discriminated against due to their gender, by disability status, in 25 countries or areas, in 2020 or latest year available.



Source: UN SDG Indicators database.[285]

End all forms of discrimination against all women and girls everywhere (Target 5.1)

Among 25 countries or areas, on average, 8 per cent of women with disabilities feel discriminated on the basis of disability, from 1 per cent in Georgia to 25 per cent in Samoa (Figure 73). Women with disabilities are also more likely to face gender discrimination than other women (Figure 74): 9 per cent of women

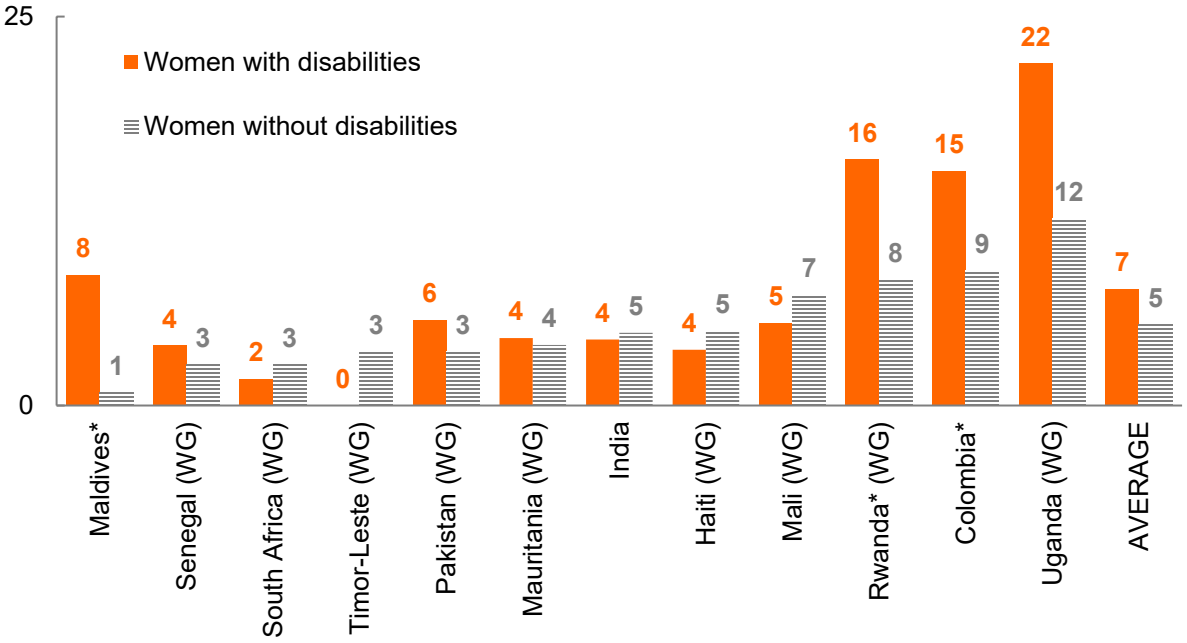
with disabilities report feeling discriminated against on the basis of gender compared to 5 per cent of women without disabilities. Many women with disabilities, like many persons with disabilities, also face discrimination in public services (see the chapter on targets 16.6 and 16.7).

Eliminate all forms of violence against all women and girls (Target 5.2)

Women and girls with disabilities are at particular risk of sexual violence, with 8 per cent of women with disabilities compared to 5 per cent of women without disabilities having suffered sexual violence in the last 12 months (Figure 75). During their lifetime, 13 per cent of women with disabilities compared to 10 per cent of women without disabilities experience sexual violence at least once (see the chapter on targets 16.1 and 16.2).

Women and girls with disabilities are particularly vulnerable to human trafficking and their trafficking for sexual exploitation has been reported on in various countries. In the United States, 12 per cent of girls with severe physical disabilities and 10 per cent of girls with cognitive disabilities have experienced sex trafficking. Girls with severe physical disabilities are six times more likely to experience sex trafficking than girls without disabilities and girls with cognitive disabilities are five times more likely to experience sex trafficking than girls without disabilities (see the chapter on targets 16.1 and 16.2).

Figure 75. Percentage of women aged 15 to 49 who have experienced sexual violence, at least once in the past 12 months, by disability status, in 12 countries, in 2021 or latest year available.



Note: An asterisk (*) indicates that the difference between girls with and without disabilities is statistically significant at the level of 5 per cent. (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from DHS[6]).

In addition to being subjected to the same violence, exploitation and abuse against women and harmful practices committed against women in general, women and girls with disabilities are also subject to specific manifestations of violence such as the denial of food or water, or threat of any of these acts; removing assistance dogs or assistive devices; restricting access to others; forced medical procedures or interventions without free and informed consent, including in the context of sexual and reproductive health such as forced or coerced sterilization or contraception; economic exploitation, neglect, humiliation, concealment, abandonment, abuse, including sexual abuse and sexual exploitation by state and non-state institutions, within the family or the community; and infanticide.[286]

While women and girls with disabilities are at a higher risk of violence than others, they have less access to both mainstream and support services and to justice (see the chapter on target 16.3) because of the denial of their privacy and obstacles to their freedom of movement; denial of decision-making and autonomy; obstacles to their access to information about available assistance; and a lack of recognition by national laws of their legal capacity.

Many programmes to eliminate violence against women and girls with disabilities and to provide support to survivors focus on raising awareness, providing training and education opportunities and empowering women with disabilities, providing shelters and safe homes, counselling, legal aid and training for family members. But targeted programmes for women and girls with disabilities are not always available and the programmes to address violence against women in general, regardless of disability status, often suffer from a lack of investment in specialist support services for victims with disabilities, placing significant limits on the types of services provided to them.[287] Shelters for victims of violence remain largely inaccessible for women with disabilities (see the chapter on targets 16.1 and 16.2) and women with disabilities may face barriers to accessing healthcare, including sexual and reproductive healthcare (see the chapter on targets 3.1, 3.7 and 5.6), after experiencing sexual violence.[288] Moreover, information, communication and services within the justice system as well as gender-based violence prevention and protection services are largely inaccessible to women and girls with disabilities, including information and communication on how to access these services.

Harmful stereotypes and stigma, including that disability may be a curse and that persons with disabilities are not sexual, limit the access of women with disabilities to gender-based violence services.[289] Often gender-based violence services do not reach women with disabilities in rural and remote areas or they may not be accessible for women with disabilities (for example, no sign language interpreters).[290] In countries that do not have a national sign language or when the national sign language is not widely learned by deaf women and women with hearing disabilities, these women may only communicate with family members through basic gestures and lip-reading, a situation that exacerbates their isolation from others, increases their risk of violence and prevents them from having autonomous access to basic information about their rights, to sexual reproductive health and to gender-based violence services.[290] Indigenous women with disabilities may also be at an increased risk of isolation, violence and lack of

access to support services.[291] There are reports of women in remote areas having to provide police with compensation to come and investigate claims of sexual violence, a major barrier for women and girls with disabilities who lack income.[292]

Many women and girls with disabilities rely on support persons such as family members, caregivers and community members in order to access gender-based violence services. But in many cases the perpetuators of sexual and gender-based violence are support persons, making it incredibly challenging for women and girls with disabilities to report violence or abuse and access gender-based violence services, especially if they are reliant on the perpetrator for income, housing and other support.

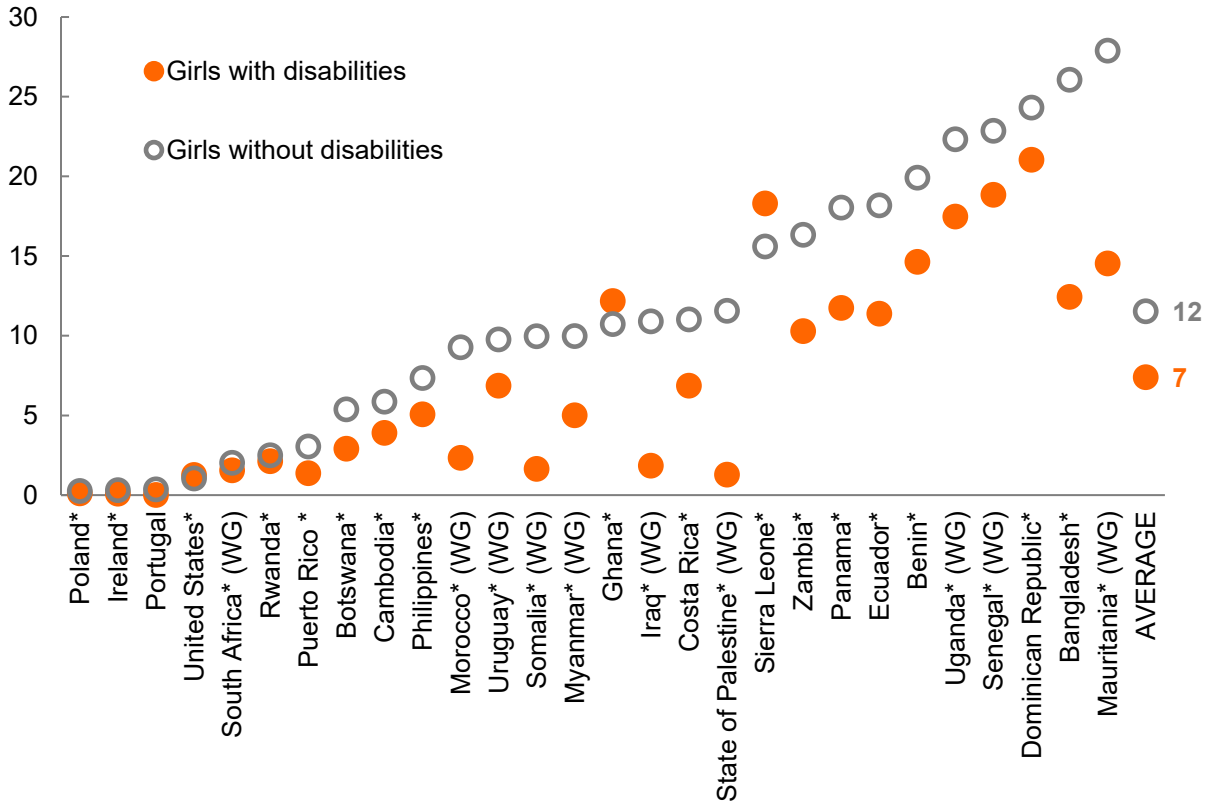
In some countries, legal frameworks continue to treat violence against women with disabilities differently than against other women, with sexual violence against women with disabilities prosecuted as a separate crime (sexual intercourse with a helpless person) rather than as rape.[293] Law enforcement officials are rarely trained to communicate with women with intellectual or hearing disabilities, limiting their opportunities to access justice in cases of violence.[294] In some countries, police encourage women with disabilities to engage with the perpetrators in informal “reconciliation” and sexual and gender-based violence cases against women with disabilities are seldom processed through formal justice systems.[295]

Eliminate child, early and forced marriage (Target 5.3)

Child marriage, that is, marriage under the age of 18, has been linked with negative reproductive and mental health outcomes as well as with intimate partner violence. Women and girls with disabilities continue to face risk factors for child, early and forced marriage, such as higher rates of poverty, lack of access to inclusive education and disability- and gender-based stigma within communities and families. Among 28 countries or areas, on average, 7 per cent of girls with disabilities aged 15 to 18 are or have been married, ranging from zero per cent in Portugal to 21 per cent in the Dominican Republic. In three of these countries or areas, girls with disabilities are more likely to be married than their peers without disabilities (Figure 76).

In fragile states (for example, countries characterized by poverty, conflict, political instability, insecurity and disaster), girls with disabilities are at higher risk of being coerced into early marriage. Among four fragile states, 54 per cent of women with disabilities aged 20 to 24 were under 18 years of age at the time of their first marriage of cohabitation, compared to 44 per cent of women without disabilities.[296] Although most of these marriages and cohabitations happened when these women were between 15 and 17 years old, a staggering 12 per cent of women with disabilities aged 20 to 24 were under 15 years of age at the time of their first marriage of cohabitation, compared to 9 per cent of women without disabilities. Women with disabilities that married or cohabitated before their 18th birthday were more likely than others to suffer intimate partner violence: 50 per cent of them compared to 44 per cent of women without disabilities who were married or in cohabitation as children.

Figure 76. Percentage of girls aged 15 to 18 who are or have been previously married, by disability status, in 28 countries, in 2021 or latest year available.

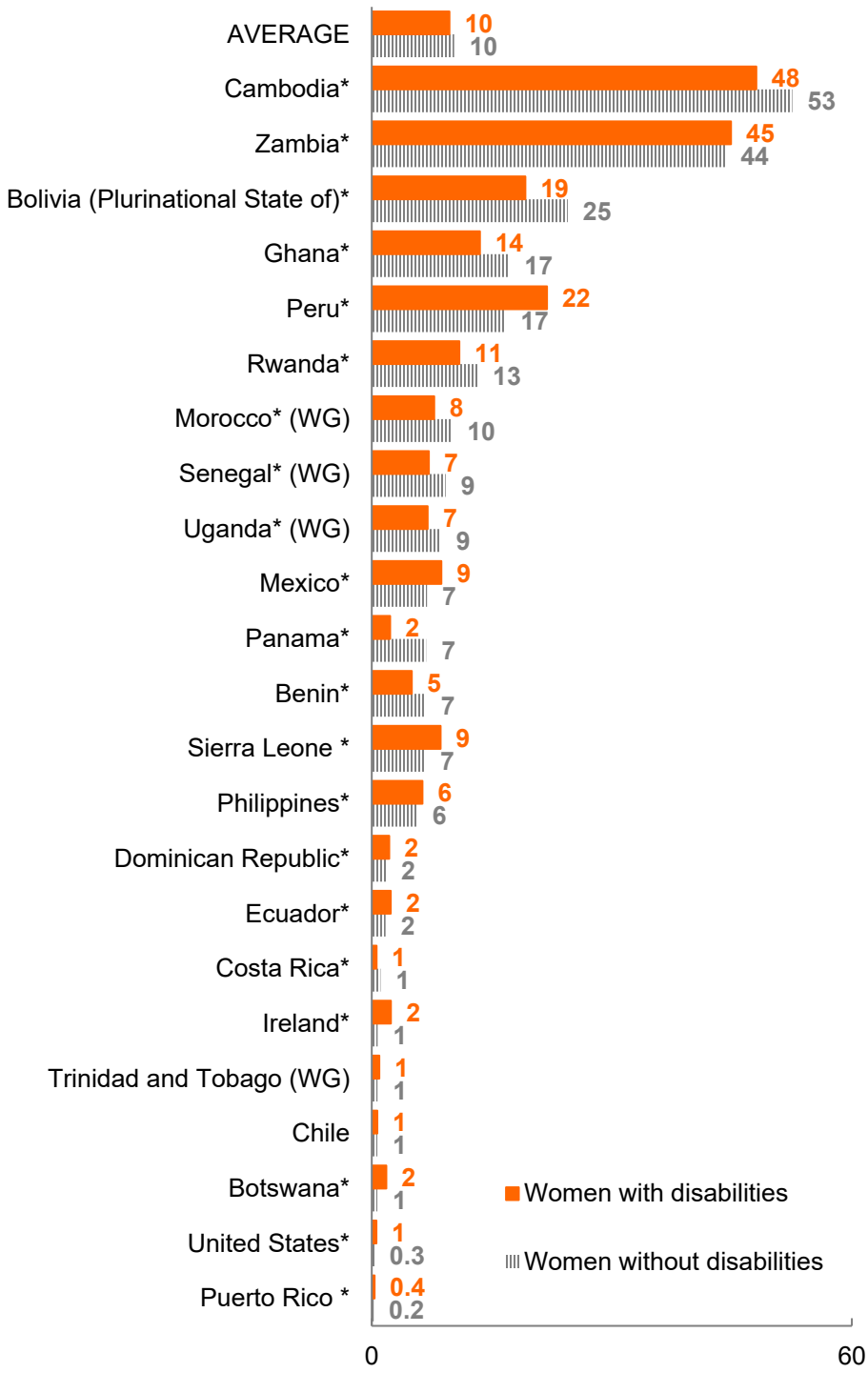


Note: An asterisk (*) indicates that the difference between girls with and without disabilities is statistically significant at the level of 5 per cent. (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: ESCWA and UNDESA (on the basis of data from IPUMS).

Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection (Target 5.4)

Unpaid domestic and care work refers to activities such as the management and preparation of food and meals; cleaning and maintaining of own dwelling and surroundings; do-it-yourself decoration; maintenance and repair of personal and household goods; care and maintenance of clothing and other textiles and footwear; household management; pet care; shopping for own household and family member; childcare and instruction; care of the sick, older persons or household and family members with disabilities; and travel related to these services.

Figure 77. Percentage of employed women aged 15 and over in unpaid work, by disability status, in 23 countries or areas, in 2021 or latest year available.



Note: An asterisk (*) indicates that the difference between girls with and without disabilities is statistically significant at the level of 5 per cent. (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: ECLAC[13] and UNDESA (on the basis of data from IPUMS).

Contrary to paid work in which women with disabilities participate less than women without disabilities, women with disabilities are engaged in unpaid work at levels that are similar to women without disabilities (Figure 77). In 23 countries or areas, on average, 10 percent of women with disabilities are engaged in unpaid work, the same percentage as that observed for women without disabilities. The percentages of women with disabilities in unpaid work vary from 0.4 per cent in Puerto Rico to 48 per cent in Cambodia. Since women with disabilities have more difficulty finding paid employment in formal or informal sectors than those without disabilities, they may be left with unpaid work as their only option, especially within the household. Women with disabilities, similarly to other women involved in unpaid work, do not receive the services, social protection and basic infrastructure to support, recognize and value this work.

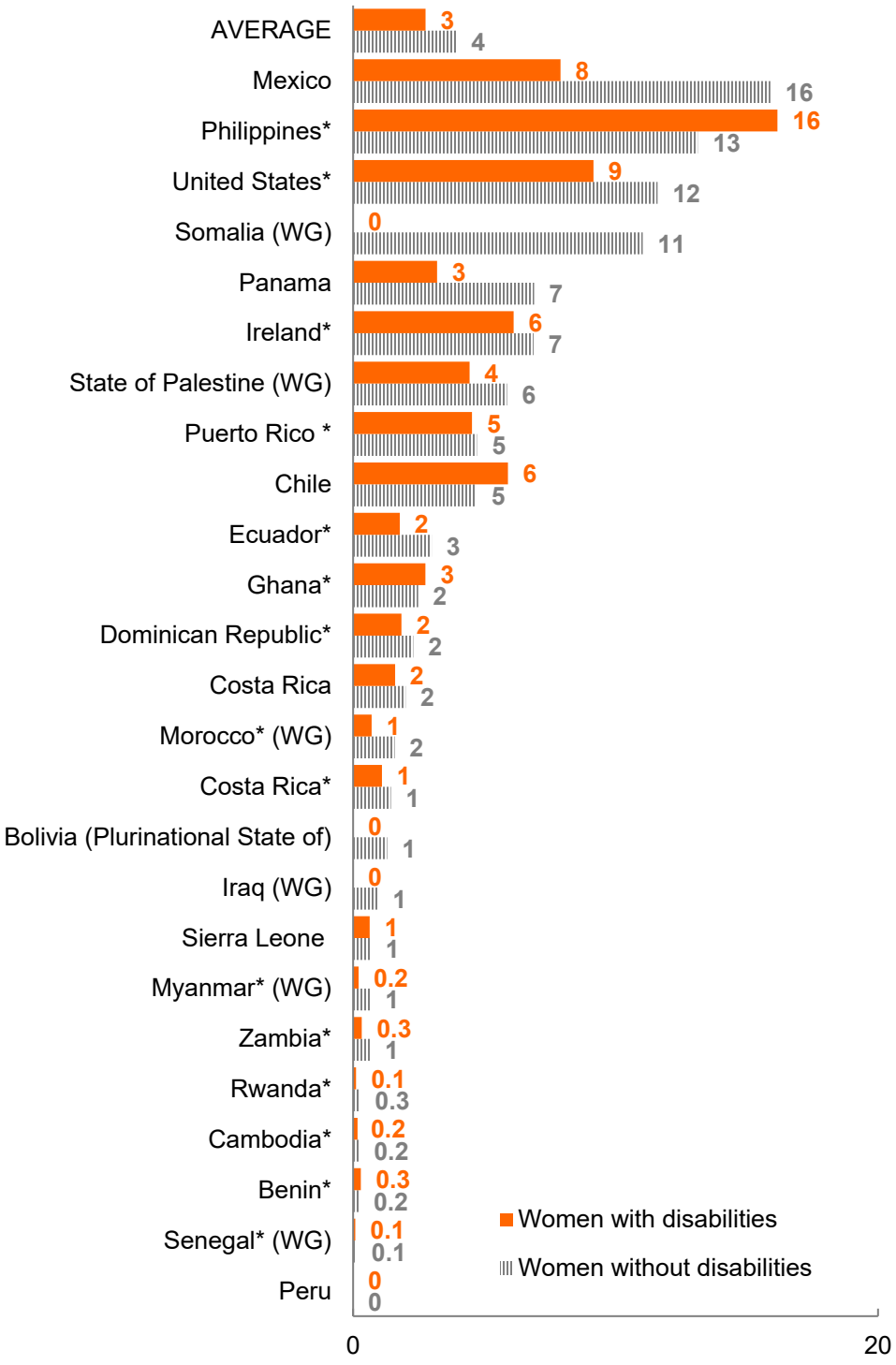
Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life (Target 5.5)

Cultural norms and legal systems that discriminate based on gender and disability often prevent the participation of women with disabilities in leadership and decision-making positions. In 25 countries or areas, on average, women with disabilities are slightly less likely to assume a position as a legislator, senior official or manager than women without disabilities: 3 per cent of women with disabilities hold these positions compared to 4 per cent of women without disabilities (Figure 78). Women with disabilities are less likely to hold these positions than women without disabilities in 20 out of these 25 countries. In some countries, the gap between women with and without disabilities exceeds 5 percentage points.

There is limited data available on women with disabilities in political leadership roles. The data available suggest that representation remains low. For example, in 2022, only two out of nine countries or areas in the Asia and Pacific region had women parliamentarians with disabilities in the national legislative body – compared to four out of nine for men parliamentarians with disabilities.[14] In the two countries, the percentages of women parliamentarians with disabilities were 4 per cent and 8 per cent, a considerable improvement from 0 and 4 per cent in 2017 (Figure 79). In 2022, of a total 1,896 parliamentarians in the 9 countries or areas, members of parliament with disabilities represented 0.7 per cent, with three times more men with disabilities than women with disabilities (10 men and 4 women).[14]

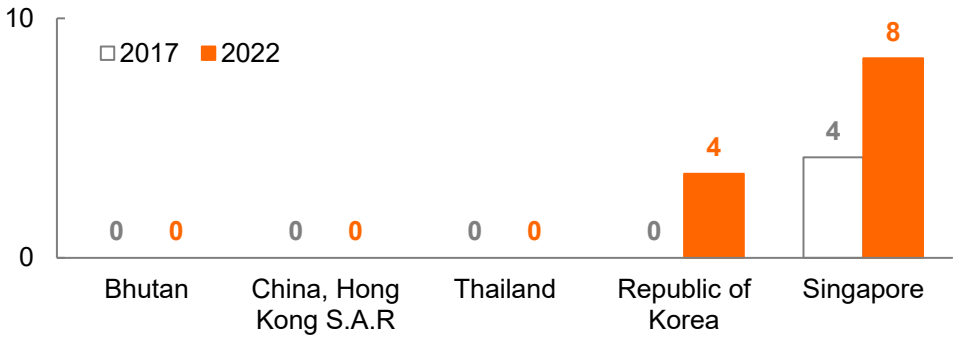
Countries using legislated quotas tend to have a higher representation of women in local government. However, only 44 per cent of 160 countries with elected local deliberative bodies have legislated gender quotas for local elections; [297] of those, only Uganda and Zimbabwe specifically require that women with disabilities are included in the electoral lists or in the composition of the elected local deliberative bodies.[298]

Figure 78. Percentage of employed women aged 15 and over who work as legislators, senior officials, and managers, by disability status, in 25 countries or areas, in 2021 or latest year available.



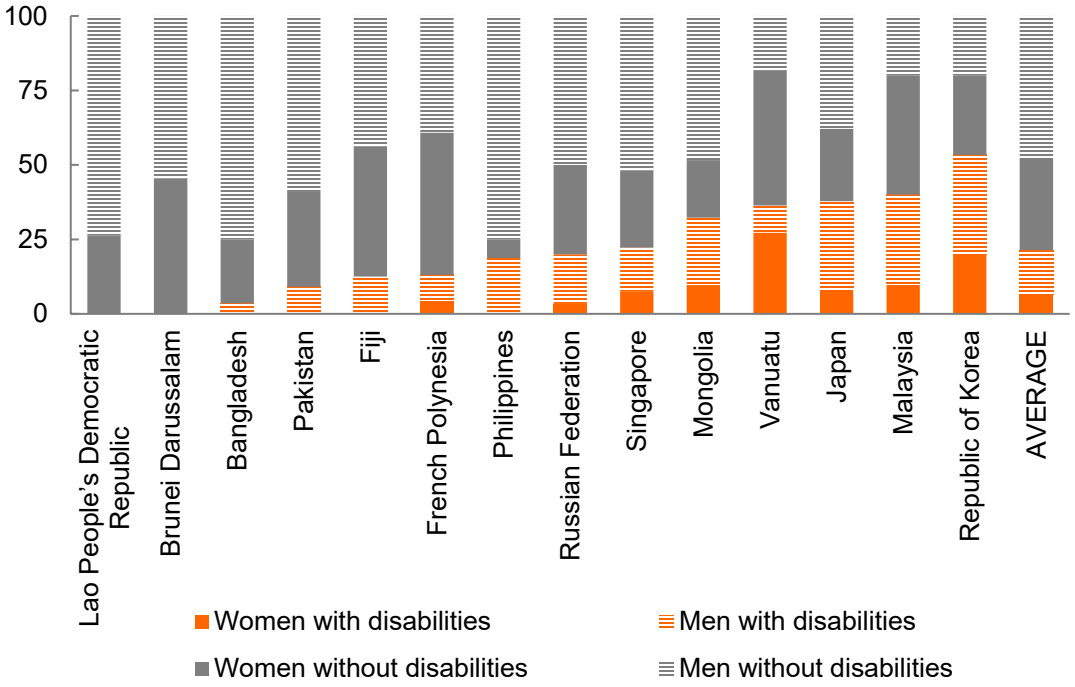
Source: ECLAC,[13] ESCWA, and UNDESA (on the basis of data from IPUMS).

Figure 79. Percentage of seats held by women with disabilities in the national parliament or similar legislative body, in 5 countries or areas in Asia, in 2017 and 2022.



Note: S.A.R. refers to Special Administrative Region.
Source: 2022 data provided by ESCAP;[14] 2017 data from ESCAP (2018).[299]

Figure 80. Percentage of members of national coordination mechanisms on disability, by disability status and sex, in 14 countries or areas, in 2022.

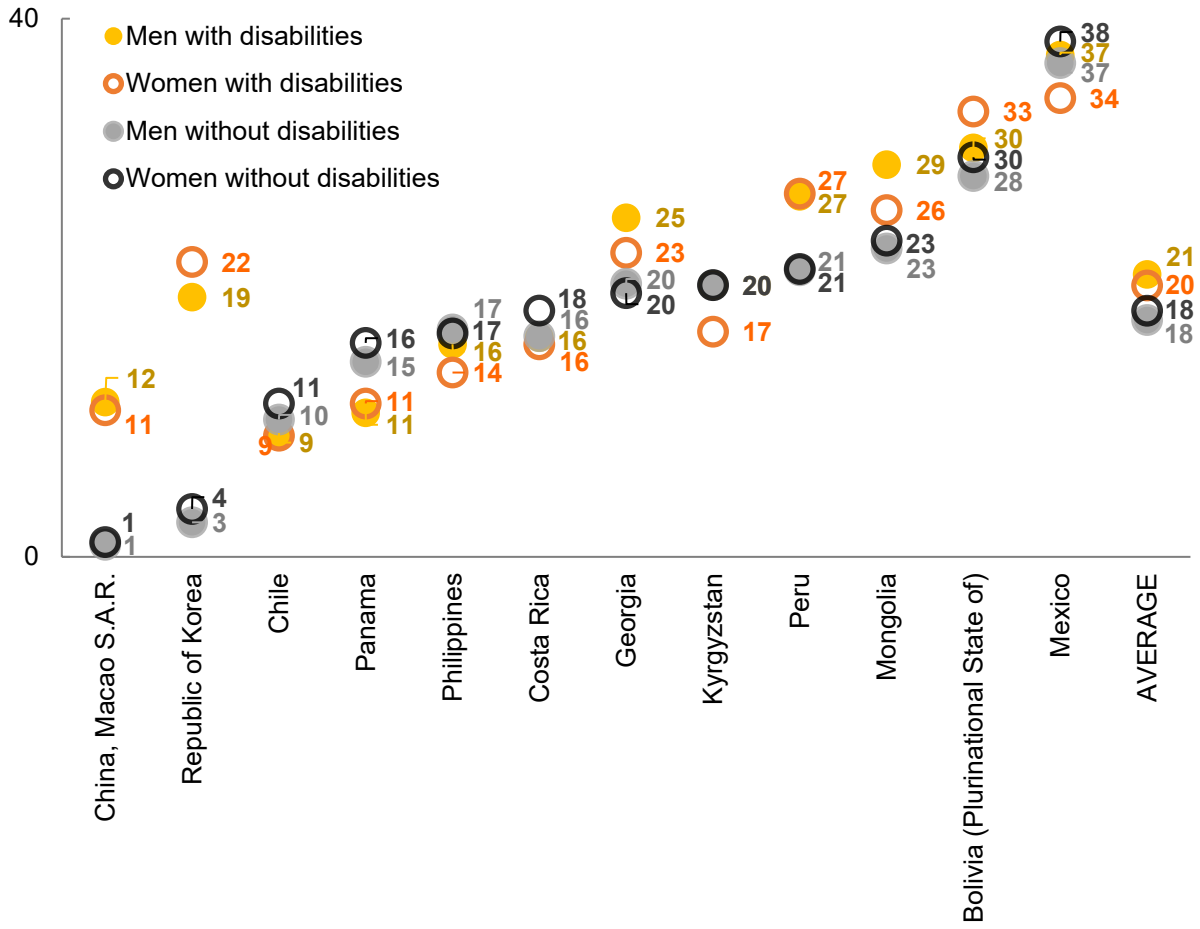


Source: ESCAP.[14]

The representation of women with disabilities tends also to be low in national coordination mechanisms on disability matters, the consultative and coordination bodies that oversee national disability policies and programmes and that usually consist of representatives of relevant government ministries, representative organizations of persons with disabilities and other stakeholders. For instance, among 14 countries or

areas from the Asia and Pacific region, the percentage of women with disabilities is on average 6 per cent, compared to 15 per cent for men with disabilities, 31 per cent for women without disabilities and 48 per cent for men without disabilities (Figure 80). In six of these countries, there are no women with disabilities represented. Vanuatu has the highest representation of women with disabilities (27 per cent) and is also the only country where the percentage of women with disabilities in these mechanisms is higher than men with disabilities.

Figure 81. Percentage of persons living under the national poverty line, by disability status and sex, in 12 countries or areas, in 2021 or latest year available.



Note: S.A.R. refers to Special Administrative Region.
Source: ECLAC[13] and ESCAP.[14]

The participation and leadership of women with disabilities is essential in development, peacebuilding and humanitarian action. During conflicts, women with disabilities face multiple and intersecting forms of discrimination related to their gender and disability, which significantly increases their risk of gender-based violence. The loss of community support and protection mechanisms exacerbates the risk of

violence against women and girls with disabilities and hinders their access to critical protections and essential services, including sexual and reproductive healthcare. However, interventions during and after conflict situations and humanitarian emergencies often fail to recognize the needs and perspectives of women with disabilities. Among six countries in conflict and post-conflict situations, only 41 per cent of local interventions by international agencies, governments or civil society addressed both gender and disability together. [300]

The provision of services for persons with disabilities is not always informed from a gender perspective. The leadership of formal care and support systems for persons with disabilities tends to be occupied by men which may pose barriers to integrating a gender perspective and the perspectives of women with disabilities in particular. An analysis of social media data in 2022 indicated that the percentage of women directors or managers in services for persons with disabilities was 37 per cent compared to 63 per cent of directors or managers who are men (see the chapter on target 10.2).

To promote equality and the empowerment of women and girls with disabilities, trainings provided by United Nations country teams on disability-inclusive development, gender equality and the rights of women and girls with disabilities have been actively encouraging the participation of women with disabilities. In such a training in the United Republic of Tanzania in 2021, 28 per cent of participants were women with disabilities.[300]

Give women with disabilities equal rights to economic resources and access to financial services (target 5.a)

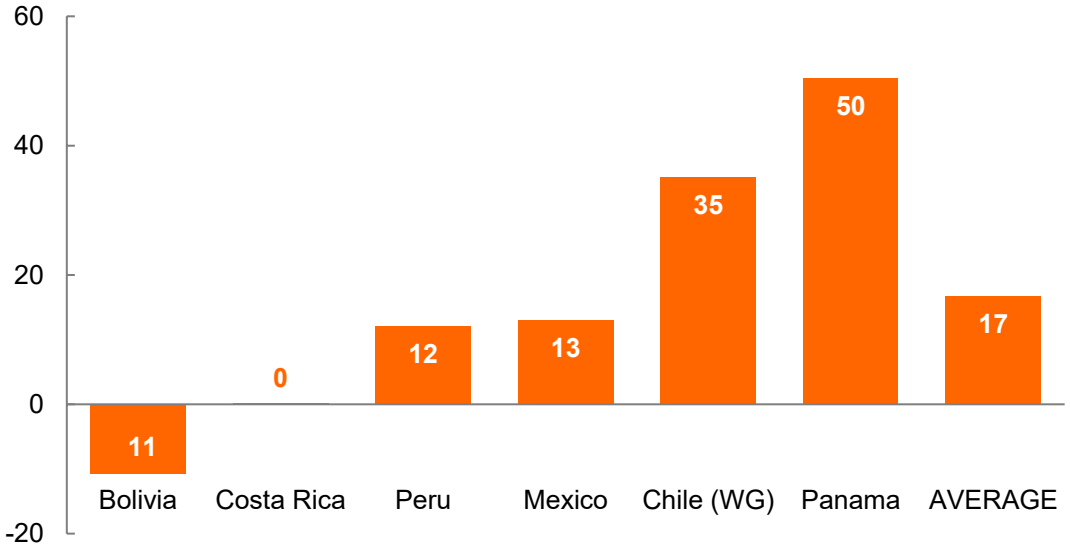
Women with disabilities face barriers to accessing economic resources. Among 12 countries or areas, 20 per cent of women with disabilities live in poverty, compared to 21 per cent of men with disabilities and 18 per cent of both women and men without disabilities (Figure 81). In some countries, such as the Plurinational State of Bolivia and the Republic of Korea, the poverty rates for women with disabilities are higher than the poverty rates for men with disabilities.

Women with disabilities often have lower wages than men with disabilities and both women and men without disabilities. Among six countries, the wages for men with disabilities are on average 17 per cent higher than the wages for women with disabilities (Figure 82). In Costa Rica and Peru, progress has been made in reducing this wage gap (Figure 83). In 2015, in Costa Rica, wages for men with disabilities were 9 per cent higher than wages for women with disabilities, and in Peru they were 20 per cent higher. In 2021, there was no difference between the wages for women and men with disabilities in Costa Rica, and in Peru the wages for men with disabilities were only 12 per cent higher.

Online banking has become an essential tool for accessing financial services. Yet, women with disabilities face barriers to access these services. Among nine countries, 15 per cent of women with disabilities compared to 20 per cent of men with disabilities conduct financial transactions with a mobile phone

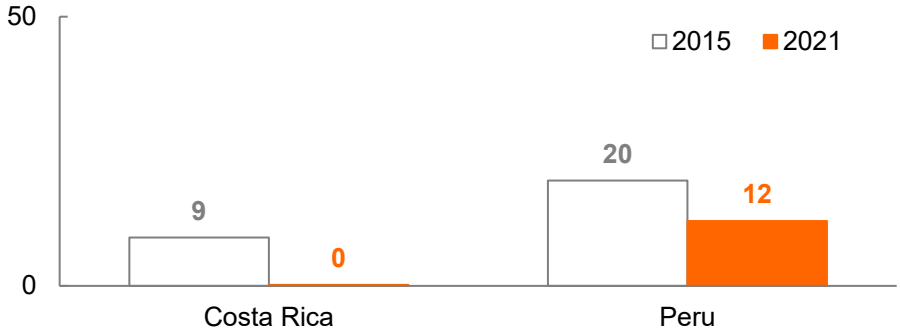
(Figure 84). In some countries, the gap between women and men with disabilities is larger than 10 percentage points.

Figure 82. Wage gaps between women and men with disabilities, in percentage, in 6 countries, in 2021 or latest year available.



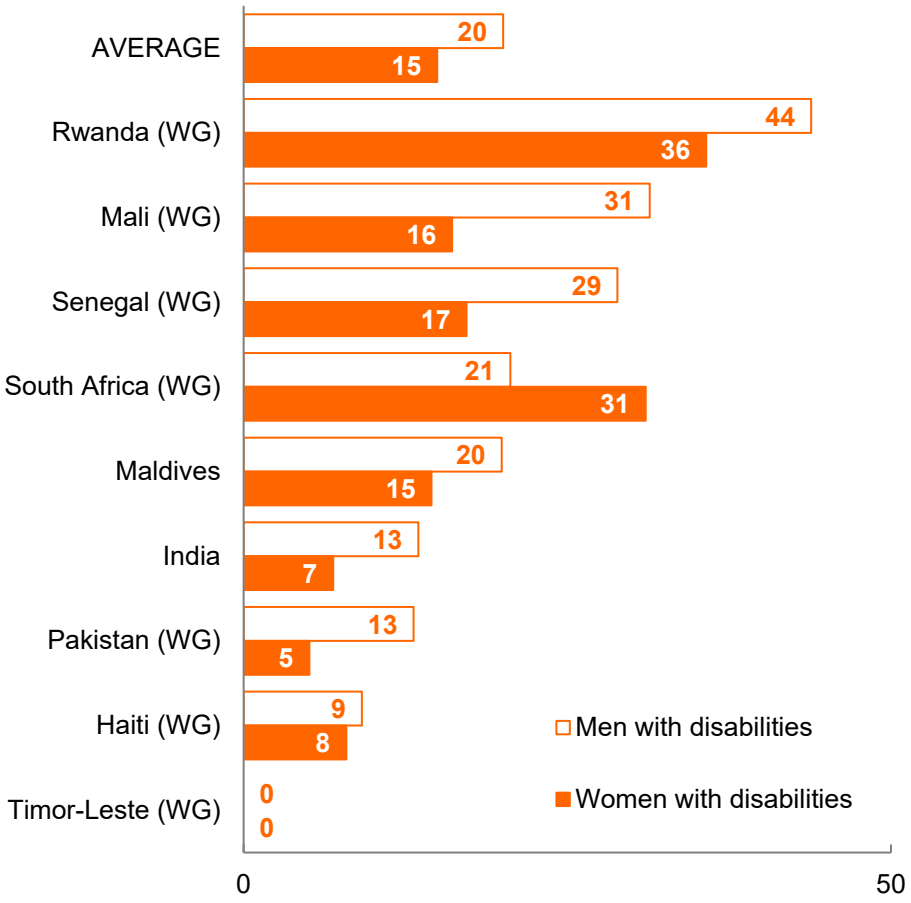
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. Bolivia refers to the Plurinational State of Bolivia.
Source: ECLAC.[13]

Figure 83. Progress in wage gaps between women and men with disabilities, in percentage, in 2 countries, from 2015 to 2021.



Source: ECLAC.[13]

Figure 84. Percentage of persons with disabilities who use a mobile phone for financial transactions, by sex, in 9 countries, in 2021 or latest year available.

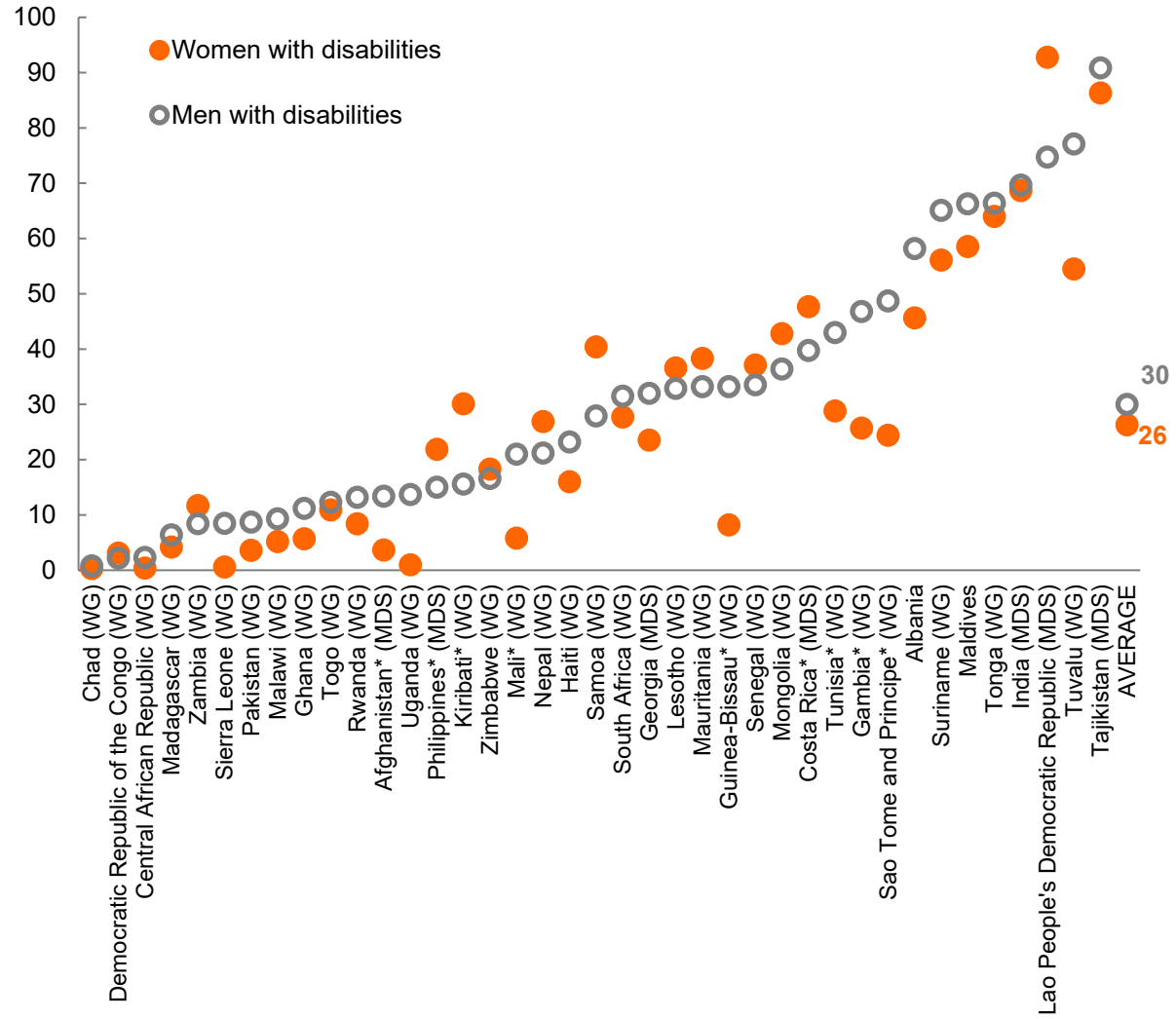


Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from DHS[6]).

Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women with disabilities (target 5.b)

Women with disabilities on average have slightly lower rates of Internet use than men with disabilities, with 26 per cent of women with disabilities and 30 per cent of men with disabilities using the Internet (Figure 85). Gaps in Internet use between women and men depend on the country, with use among women with disabilities being higher than among men with disabilities in some countries and lower in others. In Gambia, Sao Tome and Principe and Tuvalu, Internet use among women with disabilities is considerably lower than among men with disabilities, with gaps of over 20 percentage points.

Figure 85. Percentage of persons with disabilities who use the Internet, by sex, in 39 countries, in 2021 or latest year available.

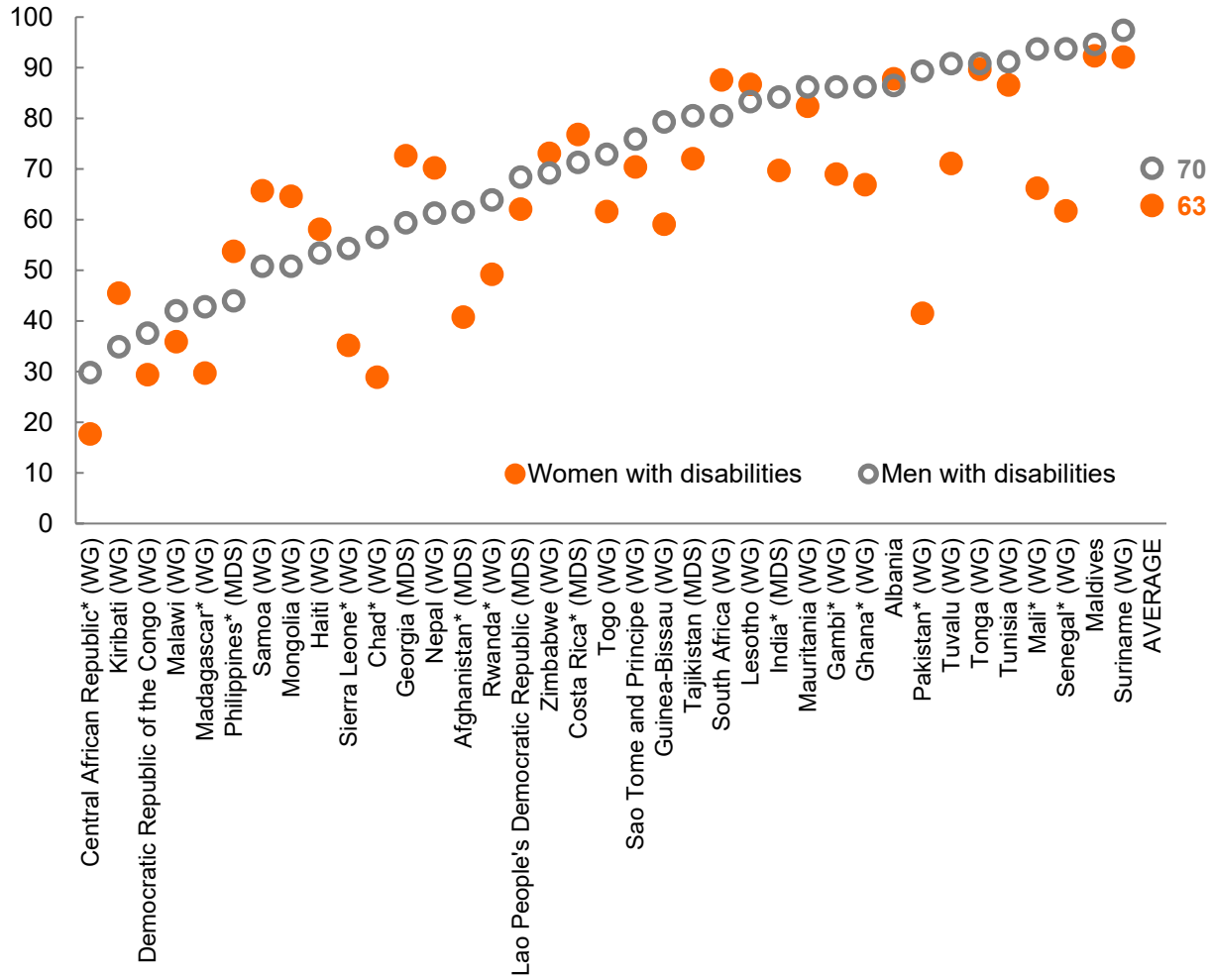


Note: (MDS) identifies data produced with the Model Disability Survey. (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between men and women with disabilities is statistically significant at the level of 5 per cent. Data on men with disabilities from Senegal are based on 25 to 49 observations and should be interpreted with caution. Source: ECLAC,[13] UNDESA (on the basis of data from DHS[6] and SINTEF[9]) and World Bank (on the basis of data from DHS[6] and MICS).

Women with disabilities are the least likely to own a mobile phone, lagging behind women and men without disabilities and men with disabilities. Among 37 countries, 63 per cent of women with disabilities and 70 per cent of men with disabilities own a mobile phone (Figure 86). Gender gaps in mobile phone ownership vary across countries, with ownership being more common among women with disabilities in some countries and less common in others. In Afghanistan, Chad, Mali, Pakistan and Senegal, mobile

phone ownership among women with disabilities is considerably lower than among men with disabilities, with gaps of over 20 percentage points.

Figure 86. Percentage of persons with disabilities who own a mobile phone, by sex, in 37 countries, in 2021 or latest year available.

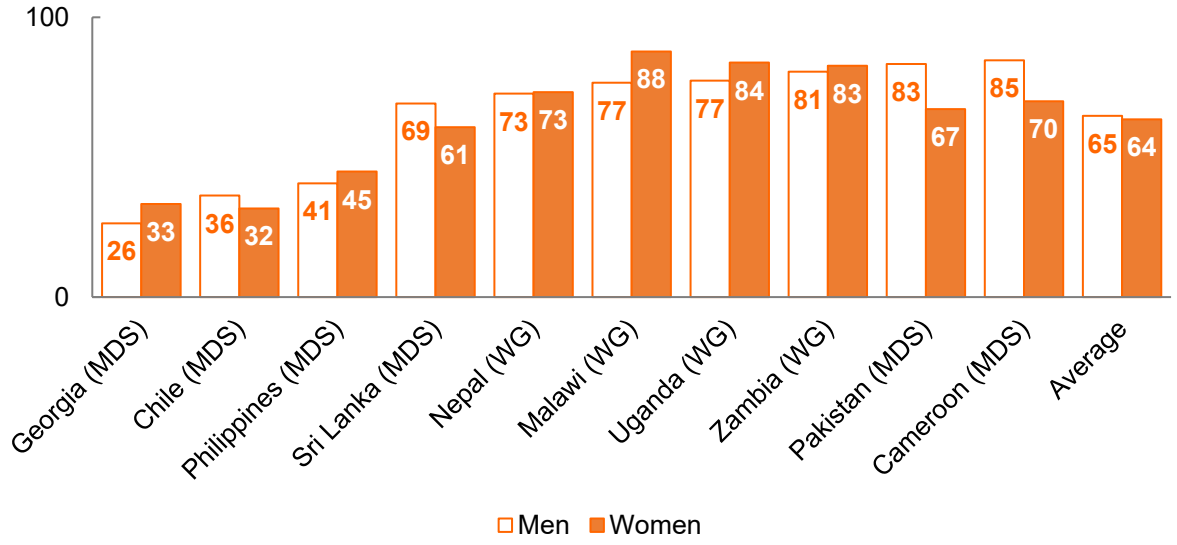


Note: (MDS) identifies data produced with the Model Disability Survey. (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between men and women with disabilities is statistically significant at the level of 5 per cent.
Source: UNDESA (on the basis of data from DHS[6]), WHO (on the basis of data from MDS) and World Bank (on the basis of data from DHS[6] and MICS).

Among 10 countries or areas, 64 per cent of women with disabilities report not having the assistive technology they need, similar to the level observed among men with disabilities (Figure 87), but there are variations among countries. Depending on the country, women with disabilities are more or less likely than men with disabilities to access the assistive products they need. The highest gap between women and men with disabilities is observed in Malawi, with 88 per cent of women and 77 per cent of men with

disabilities not having the assistive technology they need. Assistive technology is not always gender-friendly and women with disabilities may also face other barriers accessing assistive technology because of financial and cultural factors.[301]

Figure 87. Percentage of persons with disabilities who need but do not have assistive products (e.g., sign language interpreter, wheelchair, hearing/visual aids, braille), by sex, in 10 countries or areas, in 2021 or latest year available.



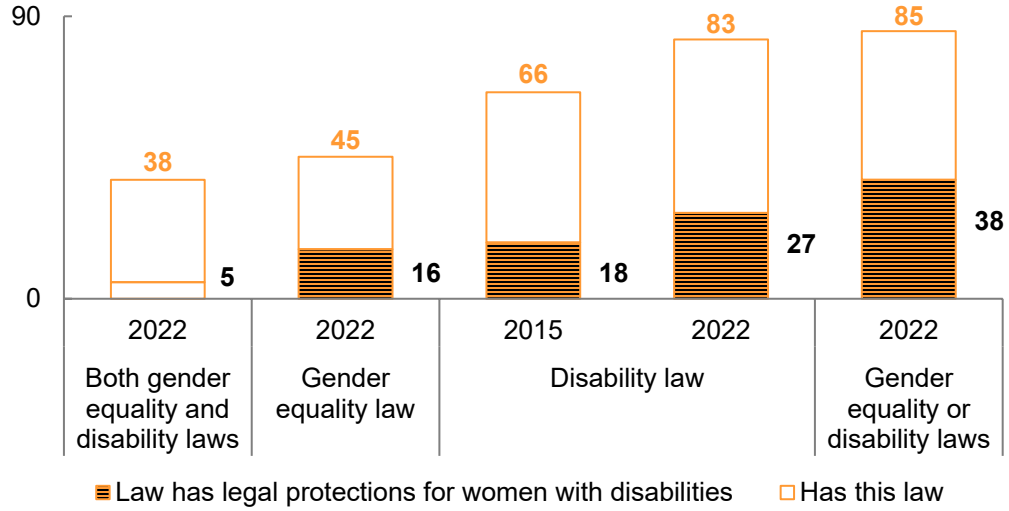
Note: (MDS) identifies data produced with the Model Disability Survey. (WG) identifies data produced with the Washington Group Short Set of Questions.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO (on the basis of data from MDS).

Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls with disabilities at all levels (target 5.c)

Specific recognitions and protections of the rights of women with disabilities exist in various national laws but not in constitutions. Among 176 countries, while some countries have a constitutional provision that guarantees equal rights for persons with disabilities, none of these constitutions mentions women with disabilities.[302] Legal guarantees for women with disabilities appear in gender equality laws and in disability laws in various countries (Figure 88). Among 190 countries, 16 per cent have gender equality laws with specific legal protections for women with disabilities, and 27 per cent have disability laws that specifically promote and protect the rights of women with disabilities. In only 5 per cent of these countries, both gender equality laws and disability laws exist and mention women with disabilities. Overall, in 38 per cent of countries there is either a gender equality law or a disability law with specific legal protections for women with disabilities. Since 2015, there has been progress in the percentage of countries with specific

legal protections for women with disabilities in their disability laws, from 18 per cent in 2015 to 27 per cent in 2022.

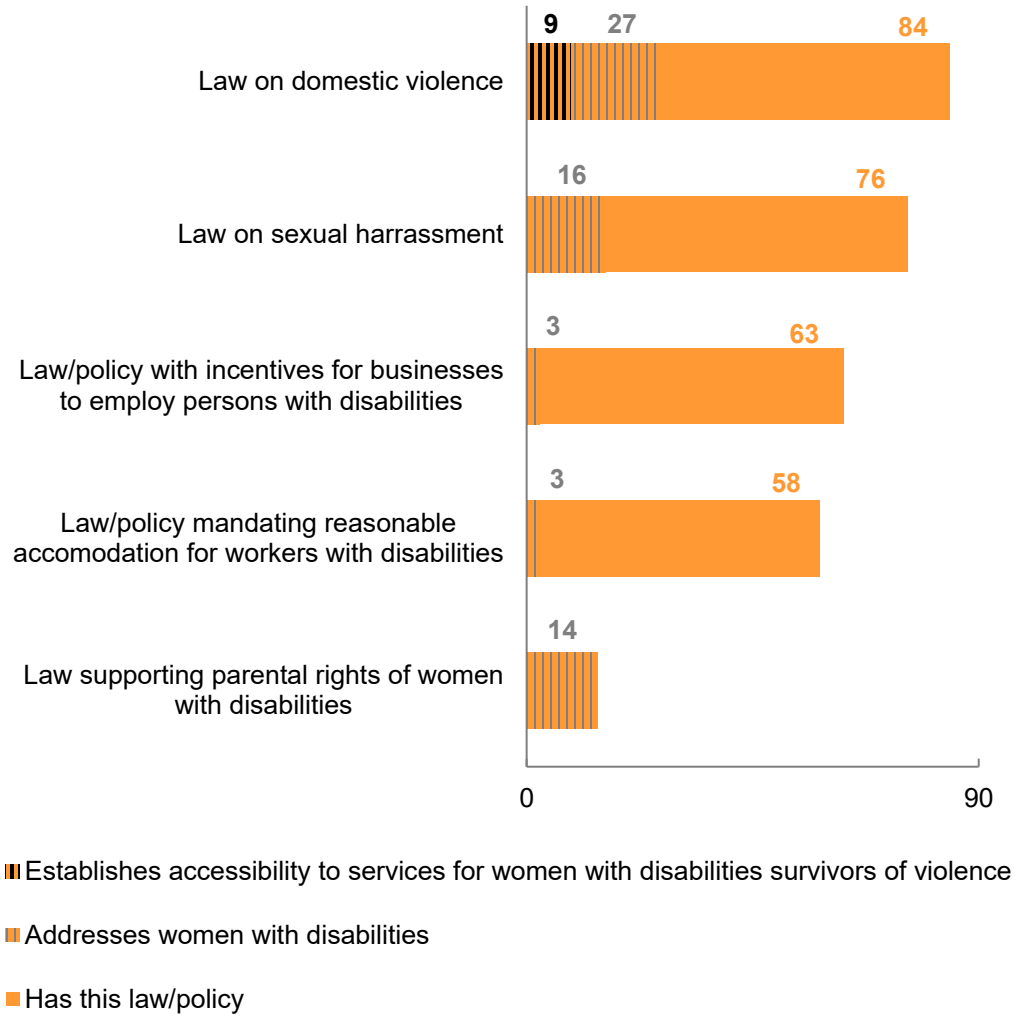
Figure 88. Percentage of countries that have legal protections specifically for women with disabilities in their gender equality or disability laws, in 190 countries, in 2015 and 2022.



Source: Braunmiller and Dry (2022)[303] and UNDESA (on the basis of data from the World Bank Group[304]).

Several countries have laws or policies to specifically protect the rights of women with disabilities with regard to family life, labour inclusion and a life free from violence (Figure 89). Among 190 countries, 27 per cent explicitly address women with disabilities in their domestic violence law and 9 per cent of countries have domestic violence laws that establish accessibility to services for women with disabilities who are survivors of violence; 16 per cent of countries have specific legislation on sexual harassment against women with disabilities. Fewer countries have specific laws or policies for women with disabilities in regard to labour inclusion. While 63 per cent of countries have laws or policies on incentives to promote the employment of persons with disabilities (such as quotas, tax breaks and wage replacement), only 3 per cent mention women with disabilities in these laws or policies. The same percentage of countries, 3 per cent, has a law or policy on reasonable accommodation for workers with disabilities that mentions women with disabilities. In 14 per cent of the 190 countries, the law provides specific support to women with disabilities in the exercise of their parental rights and responsibilities (such as extension of maternity leave, financial aid and legal protection to keep custody of their children).

Figure 89. Percentage of countries that have legislation or policies specifically addressing women with disabilities, by type of legislation/policy, in 190 countries, in 2022.



Source: Braunmiller and Dry (2022).[305]

Impact of the COVID-19 pandemic

The COVID-19 pandemic has increased gender inequality, discrimination and violence against women with disabilities. During the pandemic, women with disabilities were more likely to lose earnings than women without disabilities: 74 per cent of women with disabilities compared to 68 per cent of women without disabilities lost their earnings – a 6 percentage point gap *(*Figure 90*)*. This gap was even more pronounced for younger women with disabilities, reaching 11 percentage points: 79 per cent of women with disabilities aged 25 to 59 lost earnings compared to 68 per cent of women without disabilities of the same age group.[306] Working-aged women with disabilities aged 25 to 59 were slightly more likely to lose

their jobs (33 per cent) than women without disabilities (31 per cent). In the European Union in particular, the COVID-19 crisis had a profound impact on the employment of women with disabilities, as 32 per cent of women with disabilities who were employed before the pandemic lost their jobs during the pandemic (Figure 91). The impact was much bigger on women with disabilities than on men with disabilities (16 per cent lost their jobs), on women without disabilities (15 per cent) and on men without disabilities (8 per cent).

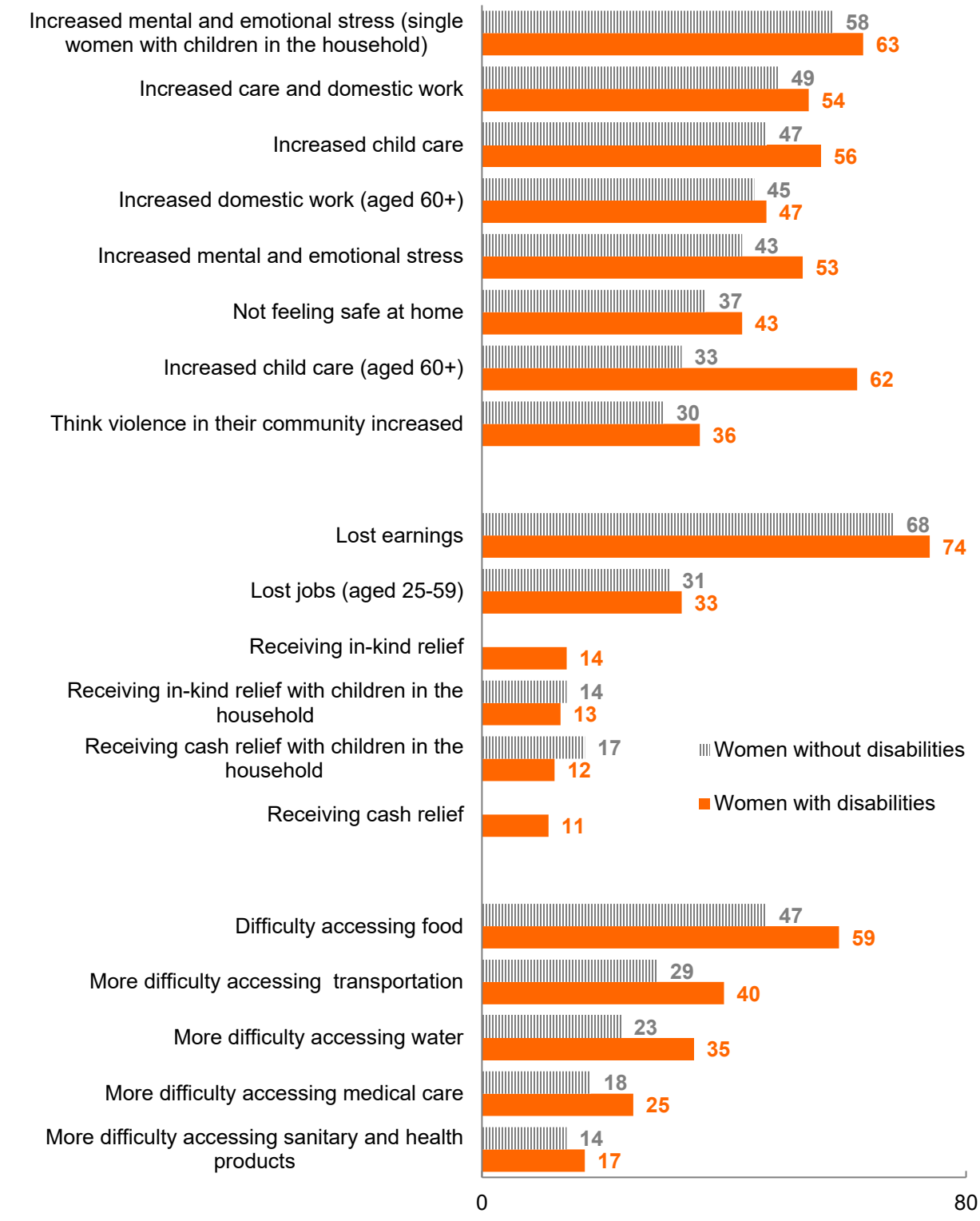
Yet, women with disabilities received less cash or in-kind relief than women without disabilities (Figure 90). For women with children in the household, 12 per cent of women with disabilities versus 17 per cent of women without disabilities received cash relief; and 13 per cent of women with disabilities versus 14 per cent of women without disabilities received in-kind relief. Overall, for all women with disabilities, with or without children, only 11 per cent received cash relief and only 14 per cent received in-kind relief.

Additionally, during the pandemic, more women with disabilities saw an increase in their care and domestic work (54 per cent) compared to women without disabilities (49 per cent), men with disabilities (47 per cent) and men without disabilities (44 per cent). This held true also for childcare (56 per cent of women with disabilities, 50 per cent of men with disabilities, 47 per cent of women without disabilities, and 45 per cent of men without disabilities).[306] The impact of additional childcare responsibilities particularly impacted older women with disabilities aged 60 and over: 62 per cent of them reported an increase in childcare compared to 33 per cent of their peers without disabilities.

The pandemic had a disproportionate impact on the mental health of women with disabilities and their access to health services, sanitation and transportation. A higher percentage of women with disabilities of all ages reported increased mental and emotional stress compared to women without disabilities (53 per cent versus 43 per cent), as did single women with disabilities with children in the household compared to their peers without disabilities (63 per cent versus 58 per cent). Compared to women without disabilities, women with disabilities reported more difficulty accessing medical care (25 per cent versus 18 per cent), sanitary and health products (17 per cent versus 14 per cent), water (35 per cent versus 23 per cent), food (59 per cent versus 47 per cent) and transportation (40 per cent versus 29 per cent).

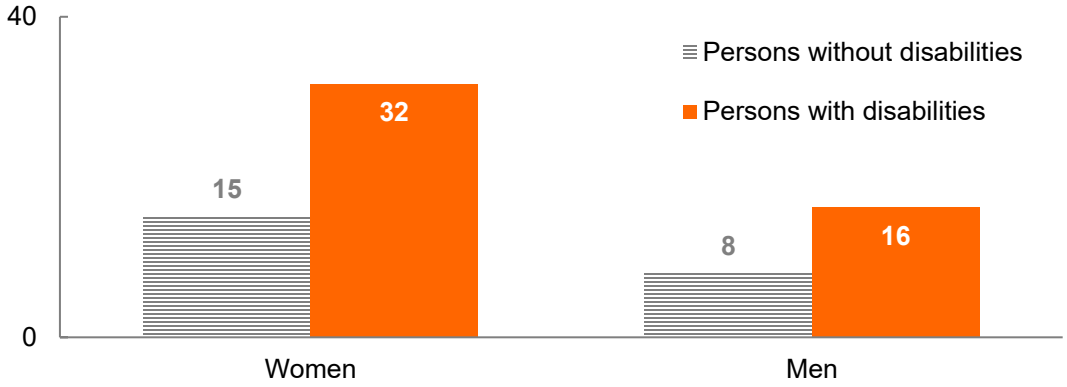
The pandemic also compromised the safety of women with disabilities. They were more likely than women without disabilities to not feel safe at home (43 per cent versus 37 per cent) and to think that violence in their community had increased (36 per cent versus 30 per cent). Some women with disabilities reported additional challenges in protecting themselves during the pandemic. Lockdowns lead to a lack of the usual support services, the perception by the perpetrators that women with disabilities would not have the power to leave and resist abuse[307] or that police would not pursue their allegations of violence, as police were reallocated towards enforcing social distancing measures.[308] During the pandemic, female parents and caregivers with disabilities were more likely to report an unmet need to access domestic violence services (14 per cent), compared to male caregivers with disabilities (11 per cent).[16]

Figure 90. Percentage of women impacted by the COVID-19 pandemic, by area impacted and disability status, in 26 countries, between March 2020 and March 2021.



Source: UN Women (2022).[306]

Figure 91. Percentage of persons who were employed before the start of the COVID-19 pandemic and unemployed in March 2021, by disability status and sex, in the European Union.



Source: ILO (on the basis of data from EUROFOUND Living, working and COVID-19 e-survey).

Summary of findings and the way forward

Major gaps and obstacles remain to the achievement of Goal 5 for women with disabilities, including discrimination, violence and early marriage: 8 per cent of women with disabilities feel discriminated against due to their disabilities and 9 per cent due to their gender; 8 per cent of women with disabilities experienced sexual violence in the past 12 months; and 7 per cent of girls with disabilities aged 15 to 18 are or have been married. While women and girls with disabilities are at a higher risk of violence than others, they tend to lack access to victim support services and to justice.

Women with disabilities are often pushed into unpaid work and barred from leadership positions. Although women with disabilities are much less likely than others to be given paid work (23 per cent of women with disabilities compared to 31 per cent of men with disabilities, 48 per cent of women without disabilities and 64 per cent of men without disabilities), they are engaged in unpaid work at levels similar to women without disabilities (10 per cent of both women with and without disabilities). For this unpaid work, women with disabilities receive no infrastructure support, no pay and no social protection. Moreover, women with disabilities are less often given opportunities to work as legislators, senior officials or managers: 3 per cent of women with disabilities versus 4 per cent of women without disabilities. And they are severely underrepresented in national parliaments, local governments and national coordination mechanisms on disability. For example, in Asia and the Pacific, women with disabilities constitute only 0.7 per cent of all parliamentarians and 6 per cent of the representatives in national coordination mechanisms on disability. Worldwide, only two countries specifically require that women with disabilities are included in electoral lists or in the composition of elected local deliberative bodies.

Women with disabilities also face more barriers than others in accessing economic resources, with 20 per cent of women with disabilities living in poverty. They also receive lower wages for their work than others, with the wages of men with disabilities being 17 per cent higher than the wages of women with

disabilities. They face obstacles to accessing financial services and technology. Only 15 per cent of women with disabilities compared to 20 per cent of men with disabilities conduct financial transactions with a mobile phone; only 26 per cent of women with disabilities compared to 30 per cent of men with disabilities use the Internet; only 63 per cent of women with disabilities and 70 per cent of men with disabilities own a mobile phone; and 64 per cent of women with disabilities do not have access to the assistive technology that they need.

Legislation and policies to address these gaps are still inexistent in many countries. Only 38 per cent of countries have a gender equality law or a disability law with specific legal protections for women with disabilities; only 27 per cent address women with disabilities in their domestic violence laws and 16 per cent in their sexual harassment laws; only 9 per cent of countries have legal requirements for accessibility to services for women with disabilities who are survivors of violence; and only 14 per cent legally protect the parental rights of women with disabilities, their right to keep the custody of their children and provide support through inter-alia the extension of maternity leave and financial aid. Fewer countries have specific laws or policies for women with disabilities regarding labour: only 3 per cent mention women with disabilities in their laws on incentives to promote the employment of persons with disabilities and on reasonable accommodation for workers with disabilities.

The COVID-19 pandemic exacerbated these gaps, as 74 per cent of women with disabilities lost their earnings, 59 per cent had difficulties accessing food, 55 per cent had additional unpaid care and domestic work, 43 per cent did not feel safe at home and 33 per cent lost their jobs. These drawbacks took a toll on the wellbeing of women with disabilities: 53 per cent of women with disabilities reported increased mental and emotional stress during the pandemic. Yet, only 11 per cent of women with disabilities received cash relief and 14 per cent received in-kind relief.

Limited evidence to assess progress since 2015 suggests improvements in some countries in increasing the representation of women with disabilities in parliament and decreasing wage gaps between women and men with disabilities. Worldwide, the gap between women with disabilities and men without disabilities who are employed has slightly widened from 2015 to 2021 – from 38 percentage points to 41 percentage points – as a result of a sharper decrease in the employment of women with disabilities triggered by the COVID-19 crisis. This trend needs to be reserved in order to close the gap by 2030. There has been progress in the percentage of countries with specific legal protections for women with disabilities in their disability laws, from 18 per cent in 2015 to 27 per cent in 2022. If the same rate of progress continues, only 38 per cent of countries will have these legal protections by 2030. Progress should be four times faster in order to reach all countries by 2030.

There are major gaps in research and data on women with disabilities: only three indicators in the United Nations SDG Indicators Database have data disaggregated by both sex and disability – compared to seven indicators disaggregated by disability and 49 disaggregated by sex.

To fully achieve Goal 5 for women and girls with disabilities, the following actions should be considered:

1. Develop legislation and policy responses that protect the rights and promote the inclusion of women and girls with disabilities. Ensure that laws and policies on disability inclusion are gender responsive. Amend existing laws and policies to promote equality for women and girls with disabilities and prohibit discrimination on the basis of gender and disability. Mainstream the rights of women and girls with disabilities as a cross-cutting issue in national laws, policies, programmes and services. In particular, address and target women and girls with disabilities in policies that relate to aging, gender, health, poverty, work, access to ICT, child marriage, political participation, discrimination and violence. Laws, policies and systems must ensure women and girls with disabilities have access to services and support to ensure their rights to participation on an equal basis. Use a gender-sensitive approach in all initiatives on disability inclusion. Involve women with disabilities with diverse experiences and perspectives as well as representative organizations of women with disabilities in the development of laws, policies and other interventions about them. Develop both mainstream and targeted interventions for the equality, participation and empowerment of women and girls with disabilities.

2. Amend laws, policies and regulatory provisions to prohibit forced or coerced reproductive health interventions and to guarantee free and informed consent in accessing health services. Replace laws that place women and girls with disabilities under guardianship or other substituted decision-making schemes with laws and policies that prohibit forced reproductive health interventions and provide support to women and girls with disabilities to receive quality healthcare and make decisions for themselves in sexual and reproductive health contexts.

3. Fund interventions to support the equality and empowerment of women and girls with disabilities and recognize and empower women and girls with disabilities as experts and leaders. Provide dedicated funding and resources to promote the empowerment of women and girls with disabilities. Invest in activities that make visible the diversity of perspectives, knowledge and leadership of women and girls with disabilities. Provide grants targeted to the inclusion and empowerment of women and girls with disabilities. Use gender-responsive and disability-inclusive budgeting. Build the capacity of girls and women with disabilities at local levels and ensure their access to information. Undertake and increase awareness-raising campaigns with and about women and girls with disabilities and their rights to equality and to not be discriminated against. Remove barriers to the full and effective participation of women and girls with disabilities in the planning, implementation, monitoring, evaluation and reporting on of policies and programs. Promote gender equality for persons with disabilities and establish gender- and disability-sensitive organizational policies in all national bodies and in official communication materials.

4. Build the capacity of non-governmental organizations to promote the equality and empowerment of women and girls with disabilities. Strength the capacity of organizations of women, organizations of persons with disabilities and other relevant organizations to address the intersectionality between gender and disability, to be inclusive and to support the leadership of women with disabilities. Support the creation of organizations of women with disabilities and their inclusion in wider networks to

influence political frameworks for the inclusion and effective participation of women and girls with disabilities. Strengthen partnerships between representative organizations of women with disabilities and mainstream rights organizations. Encourage development organizations to mainstream the experience and analysis of women with disabilities into their programmes, including by making it a requirement to receive funding.

5. Increase women with disabilities' leadership, recognition and participation in decision-making in the context of peace and humanitarian actions. Given that participation and protection are intertwined, establish mechanisms of protection for women with disabilities during and after conflicts or humanitarian emergencies. Involve representative organizations of women with disabilities and women-led organizations of persons with disabilities in peace, security and humanitarian actions. Promote the leadership of women with disabilities in peace and humanitarian actions.

6. Guarantee women with disabilities' access to vote and their right to participate as candidates, electoral observers and to be elected or designated to office. Ensure that women with disabilities have access to information and mechanisms related to political participation and that these are provided in disability-accessible formats. Ensure that women with disabilities can exercise their capacity to make choices.

7. Put in place mechanisms to eliminate violence against women with disabilities and ensure that women and girls with disabilities have access to gender- and disability-responsive services and support. Make sexual and reproductive healthcare, gender-based violence prevention and response services accessible, inclusive, affordable and designed to meet the specific needs of women and girls with disabilities. Ensure that legal frameworks treat violence against women with disabilities as equal in status to other gender-based violence. Adopt guidelines for the accessibility of justice mechanisms and gender-based violence support services for women and girls with disabilities who are victims of violence. Develop these guidelines in conjunction with women with disabilities and their representative organizations. Make the guidelines available in accessible formats for persons with disabilities and widely distribute these guidelines among women with disabilities, including within institutions. Monitor the implementation of these guidelines.

8. Address the data and knowledge gap on women and girls with disabilities. Facilitate innovative practices, such as the use of big data, and increase investments for the collection of statistics and data on issues faced by women and girls with disabilities, including simultaneous disaggregation of data by gender and disability as well as other dimensions relevant to national contexts such as race, ethnicity, migratory status and geographic location. In order to inform urgently needed policies to tackle the discrimination and violence experienced by women and girls with disabilities, produce data on women and girls with disabilities and their experiences of discrimination, violence, child marriage, female genital mutilation, health including sexual and reproductive health, access to land ownership and access to justice. Encourage national coordination mechanisms on disability and on gender to establish

accountability frameworks, with goals and indicators, to monitor the rights, participation and empowerment of women and girls with disabilities. Support research on the situation of women and girls with disabilities.

Ensuring the availability of water, sanitation and hygiene (Goal 6)

The 2030 Agenda includes Goal 6, which calls for ensuring the availability and sustainable management of water and sanitation for all and establishes ambitious targets for universal access to safe drinking water, sanitation and hygiene services. In particular, target 6.1 calls for achieving universal and equitable access to safe and affordable drinking water for all; and target 6.2 calls for achieving access to adequate and equitable sanitation and hygiene for all. This chapter will focus on these two targets. Universal coverage implies providing access to services in all settings – homes, schools, healthcare facilities, workplaces and public spaces, among others – and for all people, to ensure that no one is left behind.

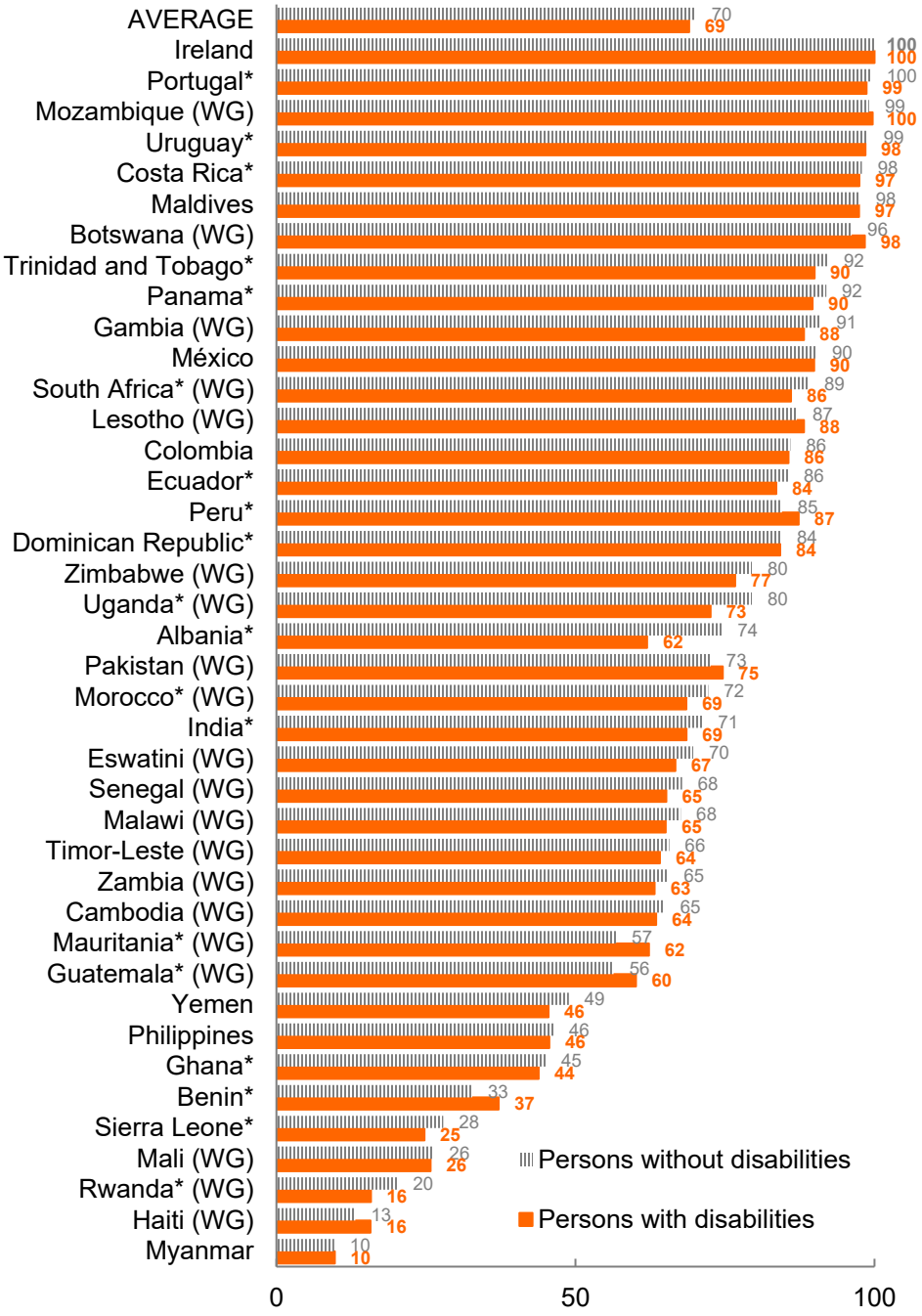
Access to safe drinking water and sanitation are internationally recognized human rights, derived from the right to an adequate standard of living under Article 11 of the International Covenant on Economic, Social and Cultural Rights. Access to safe and clean drinking water and access to sanitation were further recognized as human rights in United Nations General Assembly Resolution 64/292, adopted in 2010. Moreover, the Convention on the Rights of Persons with Disabilities (CRPD) calls on States Parties to take measures to ensure equal access by persons with disabilities to clean water services.

This chapter presents an overview of the availability and accessibility of water, sanitation and hygiene for persons with disabilities. The chapter also offers recommendations for improving the current situation of persons with disabilities regarding access to water, sanitation and hygiene and to achieve the related targets of Goal 6 by, for and with persons with disabilities.

Current situation and progress so far

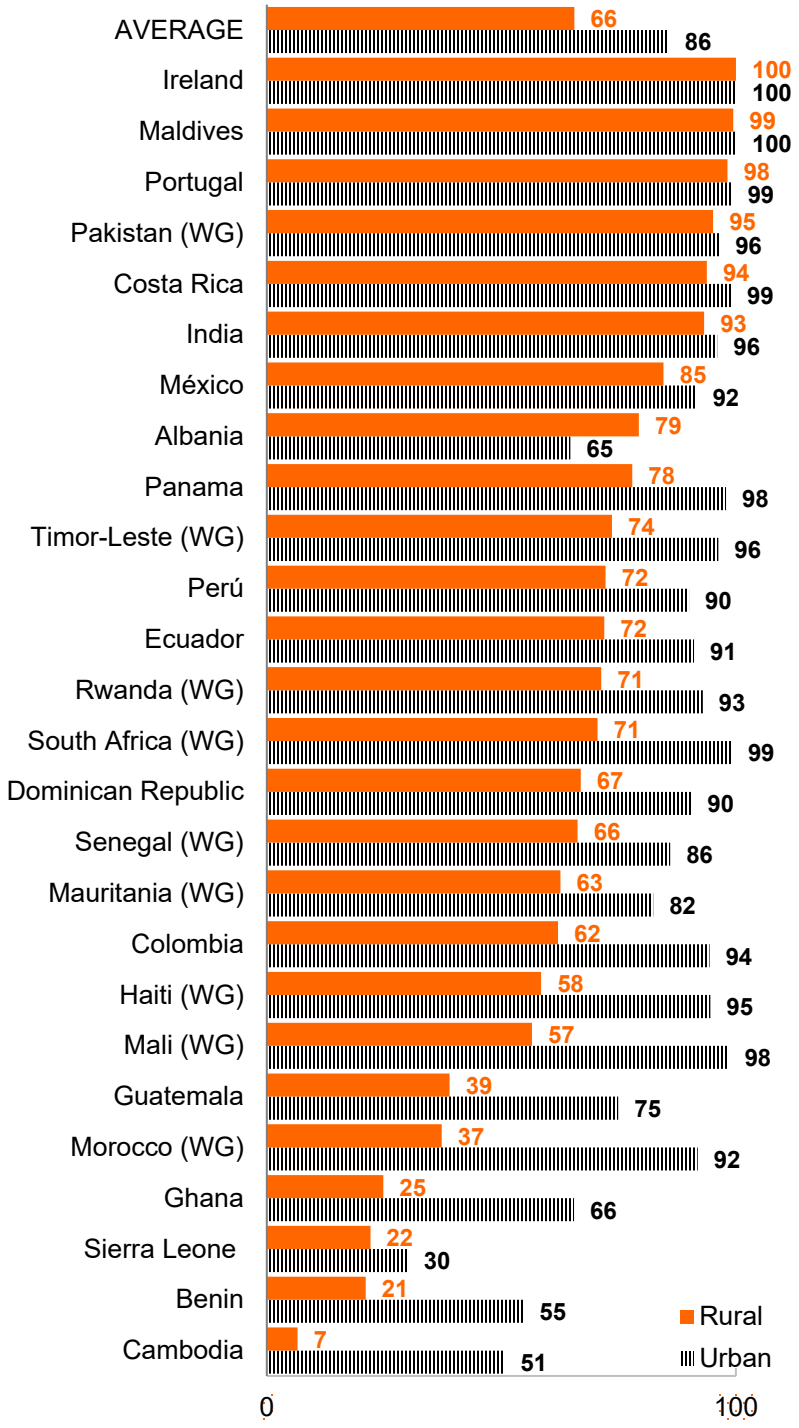
Access to safe drinking water, sanitation and hygiene is essential for good health, welfare and productivity. Inadequate water, sanitation and hygiene are primarily responsible for the transmission of a wide range of communicable diseases including cholera, diarrhoea, dysentery, hepatitis A, typhoid and polio. Diarrhoeal diseases exacerbate malnutrition and remain a leading global cause of death among children under five. Persons with disabilities continue to experience barriers in access to adequate water, sanitation and hygiene. In particular, persons with disabilities are less likely to live in households with this access. Data from 40 countries show that persons with disabilities are, on average, slightly less likely than persons without disabilities to live in households with access to adequate water, 69 per cent versus 70 per cent (Figure 92). The largest gap reaches 12 percentage points in Albania, in which 62 per cent of persons with disabilities compared to 74 per cent of persons without disabilities have access to an improved drinking water source in their dwelling. Persons with disabilities in rural areas are less likely than persons with disabilities in urban areas to live in a dwelling with access to improved drinking water (Figure 93).

Figure 92. Percentage of persons who live in a household with an improved/safe source of drinking water on premises, by disability status, in 40 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. Data for Botswana, Cambodia, Eswatini, Gambia, Lesotho, Malawi, Mozambique, Uganda, Yemen and Zimbabwe refer to households with and without persons with disabilities.
Source: UNDESA (on the basis of data from DHS,[6] IPUMS and SINTEF[9]) and ECLAC.[13]

Figure 93. Percentage of persons with disabilities with access to an improved/safe source of drinking water on or off the premises, by area of residence, in 26 countries, in 2021 or latest year available.



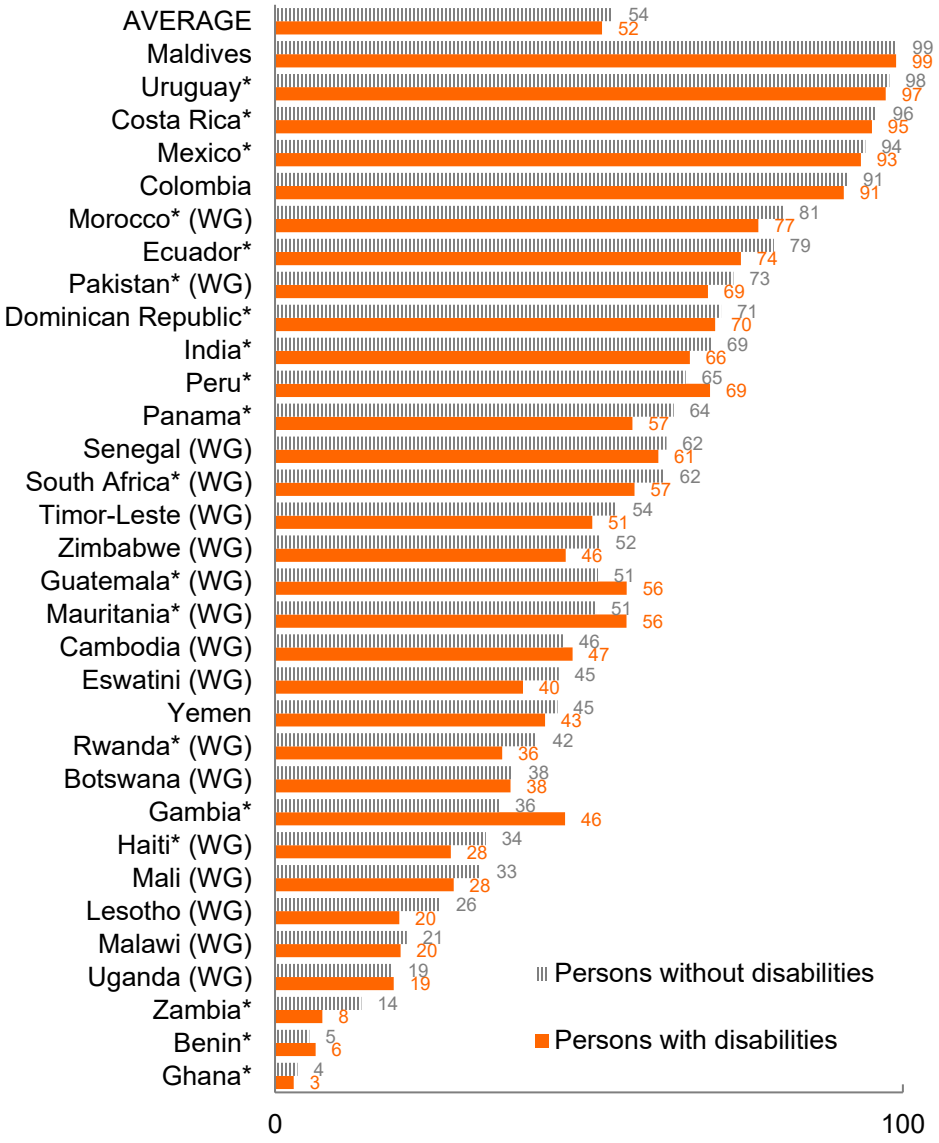
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. Data for Cambodia refer to households with persons with disabilities.
Source: UNDESA (on the basis of data from DHS[6] and IPUMS) and ECLAC.[13]

Persons with disabilities are less likely to live in households with sanitation facilities on their own premises, that is, in their own dwelling or in their own yard or plot. Among 32 developing countries, persons with disabilities are slightly more often confronted with this challenge, as 52 per cent of persons with disabilities compared to 54 per cent of persons without disabilities have improved sanitation on their premises (Figure 94). A distant, shared bathroom can create additional difficulties for persons with disabilities, who may experience difficulties, for example, in mobility, locating the bathroom, and waiting in line. Yet, in 15 countries, less than 50 per cent of persons with disabilities have improved sanitation on their premises. Persons with disabilities in rural areas are less likely than persons with disabilities in urban areas to live in a dwelling with access to improved sanitation (Figure 95).

In European countries, on average, the percentage of persons who live in households with a toilet on the premises is slightly lower for persons with disabilities, 97 per cent, than for persons without disabilities, 98 per cent (Figure 96). For many of these countries, the population without a toilet on the premises is small, both for persons with and without disabilities and the gaps between persons with and without disabilities, albeit often disfavouring persons with disabilities, are also small. However, in countries where the presence of a toilet in the dwelling is not close to universal, persons with disabilities tend to have a significant disadvantage. In four European countries, more than 1 in 10 persons with disabilities still lacked a private indoor flush toilet in 2020. In these countries, the gaps between persons with and without disabilities are between 4 percentage points and 8 percentage points. On a positive note, these countries have made considerable progress since 2015 (Figure 97).

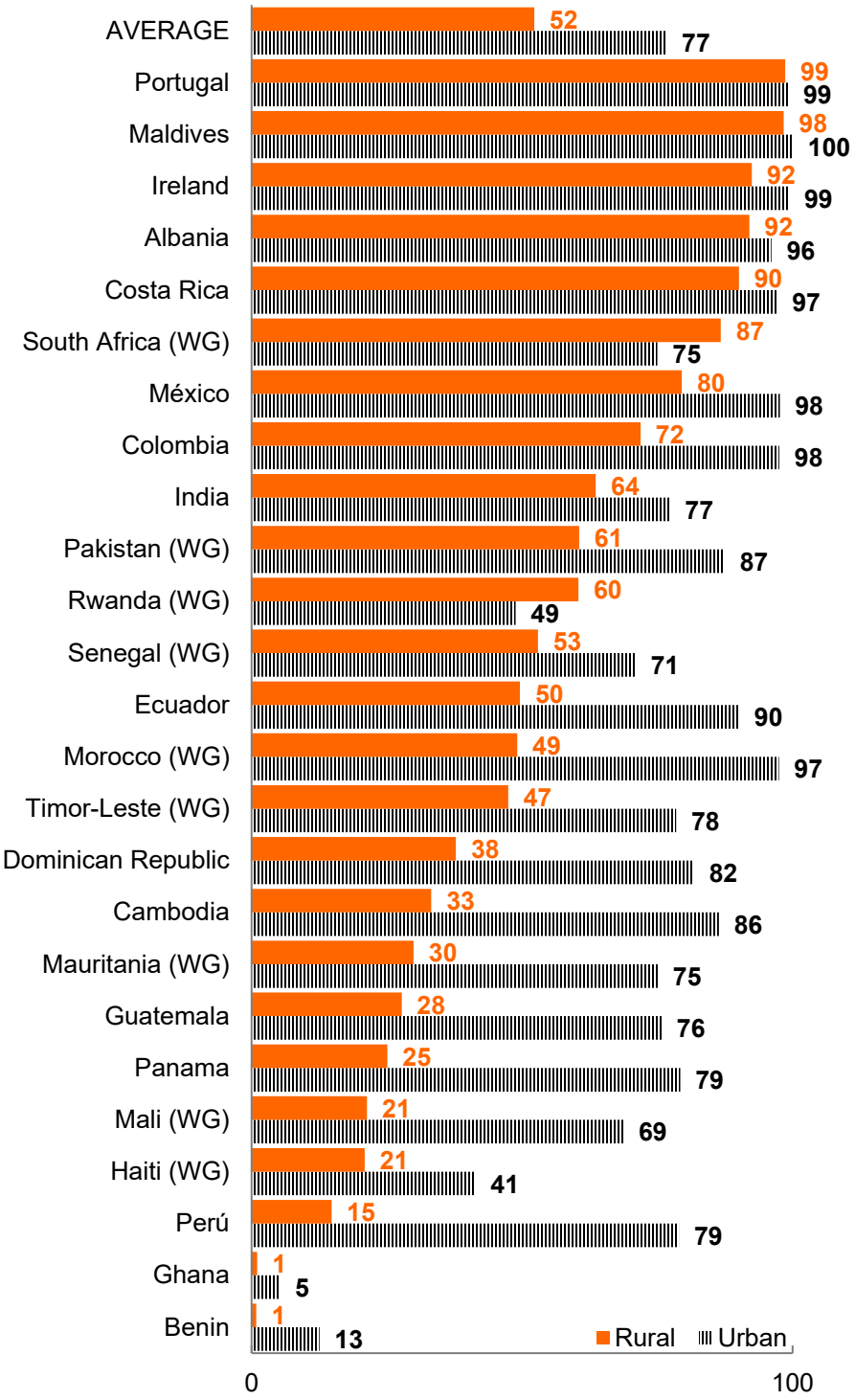
Similarly, it is slightly more common for persons with disabilities to not have a bath or shower in their home (Figure 98). Data from 34 countries mostly in Europe, indicate that the average percentage of persons with disabilities without a bath or shower in their dwelling was slightly higher (3 per cent) compared to persons without disabilities (2 per cent). In five of these countries, more than 1 in 10 persons with disabilities lives in a dwelling with no bath or shower. For both toilets and bath or shower, the gap between persons with and without disabilities is wider in countries where the overall lack of these facilities in dwellings is higher. Since 2015, almost all these countries have made progress in decreasing the percentage of persons with disabilities who do not have a bath or shower in their home (Figure 99).

Figure 94. Percentage of persons who live in a household with improved sanitation on premises, by disability status, in 32 developing countries, in 2021 or latest year available.



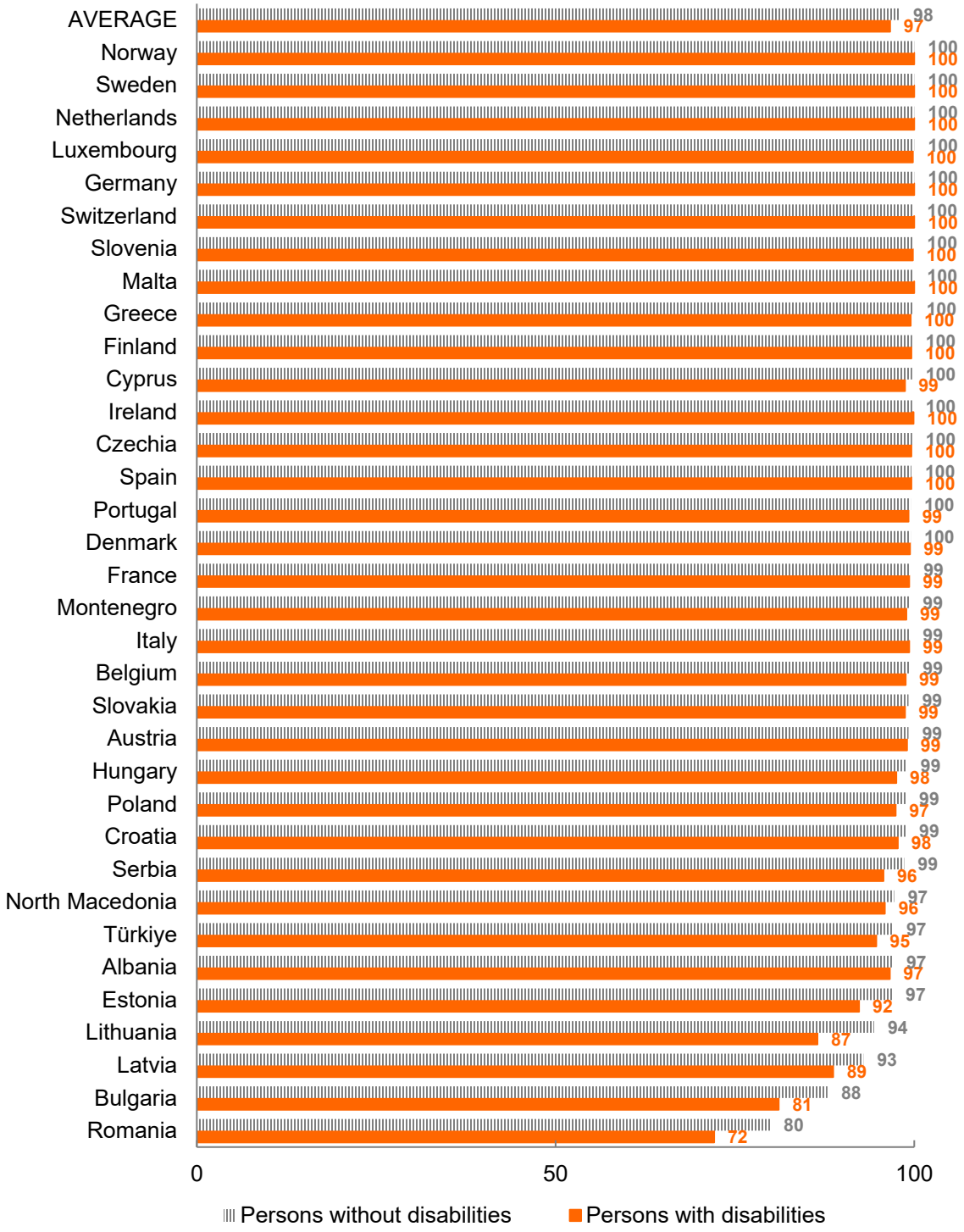
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. Data for Botswana, Cambodia, Eswatini, Gambia, Lesotho, Malawi, Uganda, Yemen and Zimbabwe refer to households with and without persons with disabilities.
Source: UNDESA (on the basis of data from DHS,[6] IPUMS[8] and SINTEF[9]) and ECLAC.[13]

Figure 95. Percentage of persons with disabilities with access to improved sanitation on or off the premises, by area of residence, in 25 countries, in 2021 or latest year available.



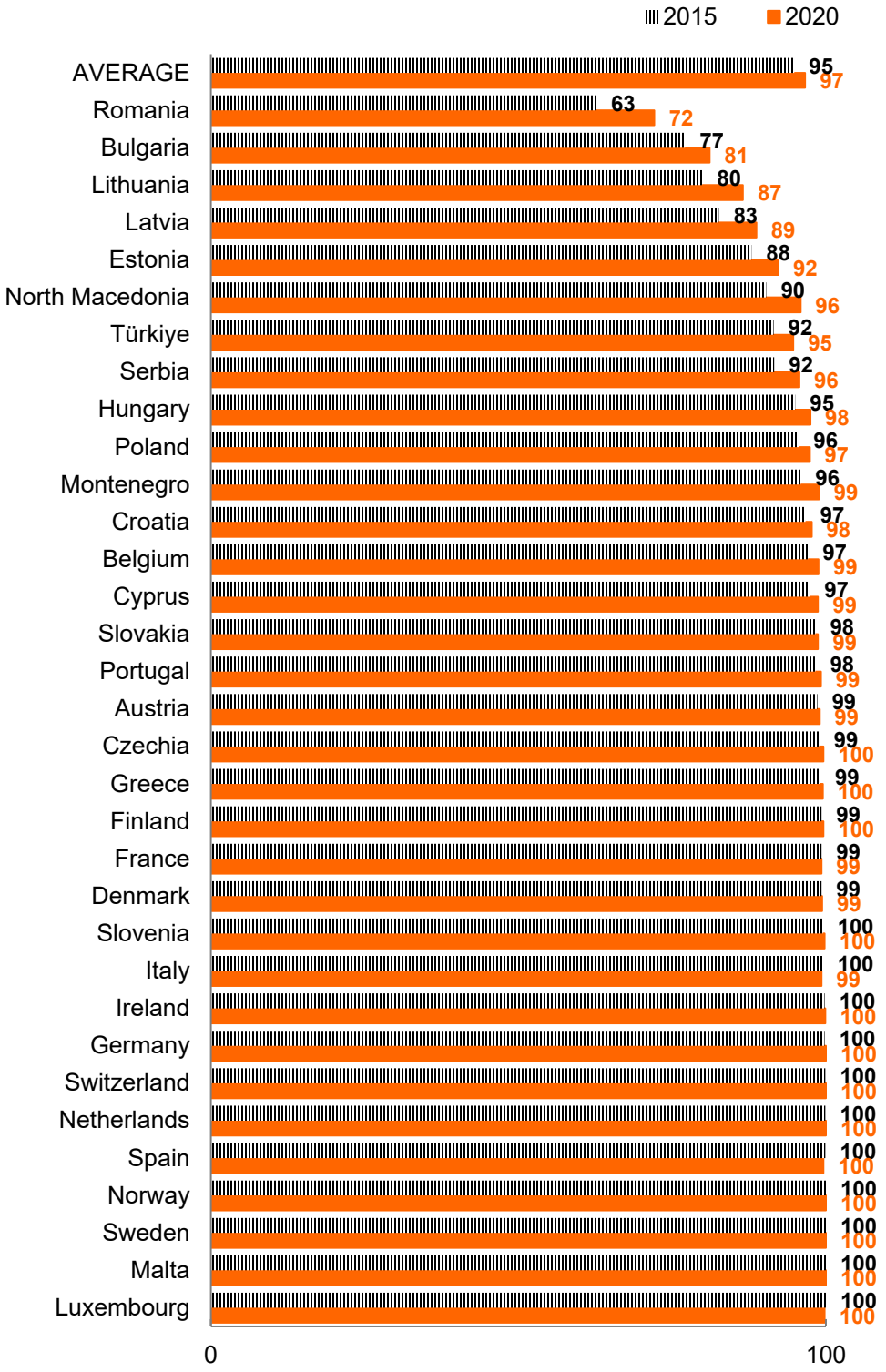
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. Data for Cambodia refer to households with and without persons with disabilities.
Source: UNDESA (on the basis of data from DHS[6] and IPUMS) and ECLAC.[13]

Figure 96. Percentage of persons aged 16 and over with a toilet in their dwelling, by disability status, in 34 European countries, in 2020.



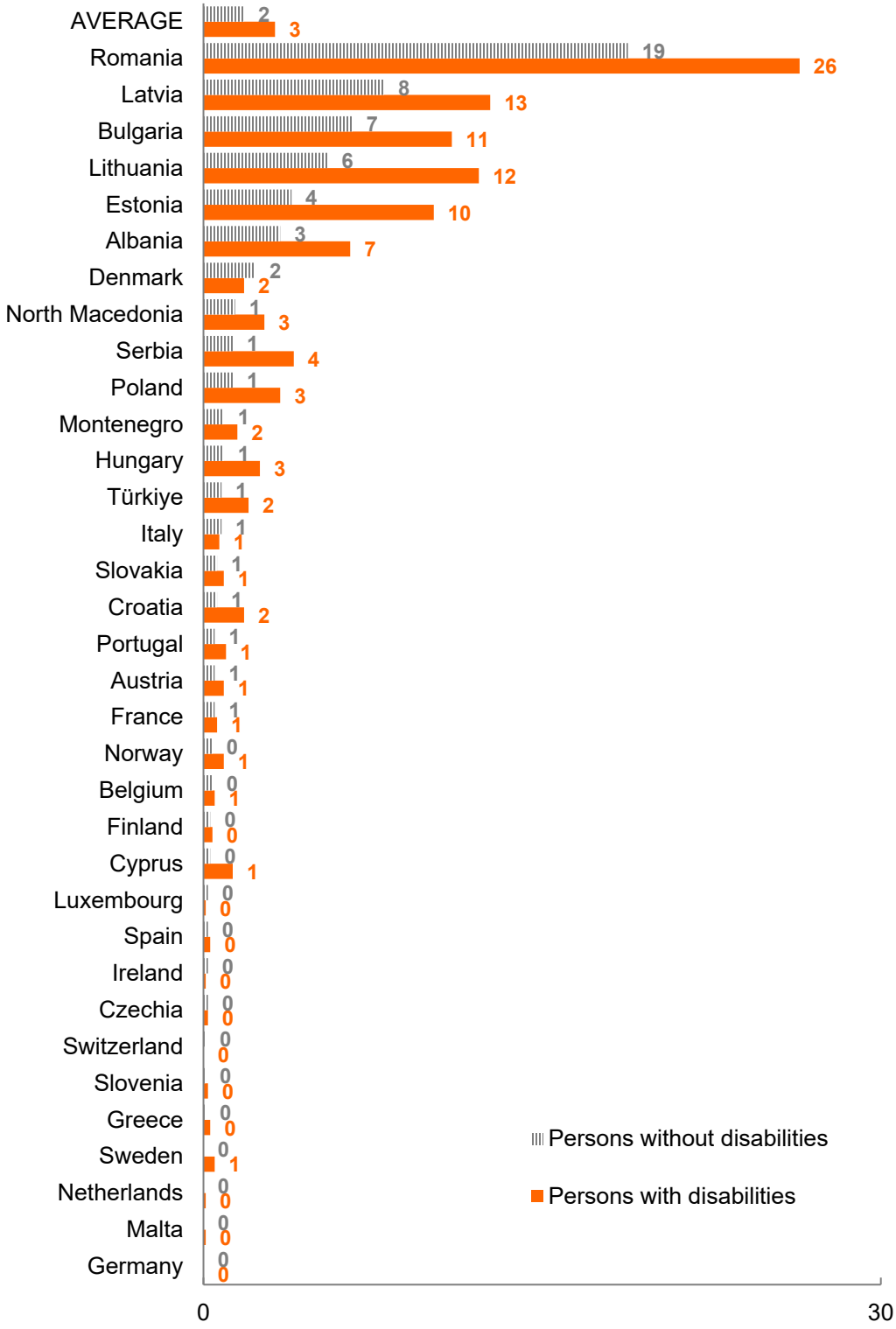
Source: Eurostat.[7]

Figure 97. Percentage of persons with a toilet in their dwelling, by disability status, in 33 countries, 2015 and 2020.



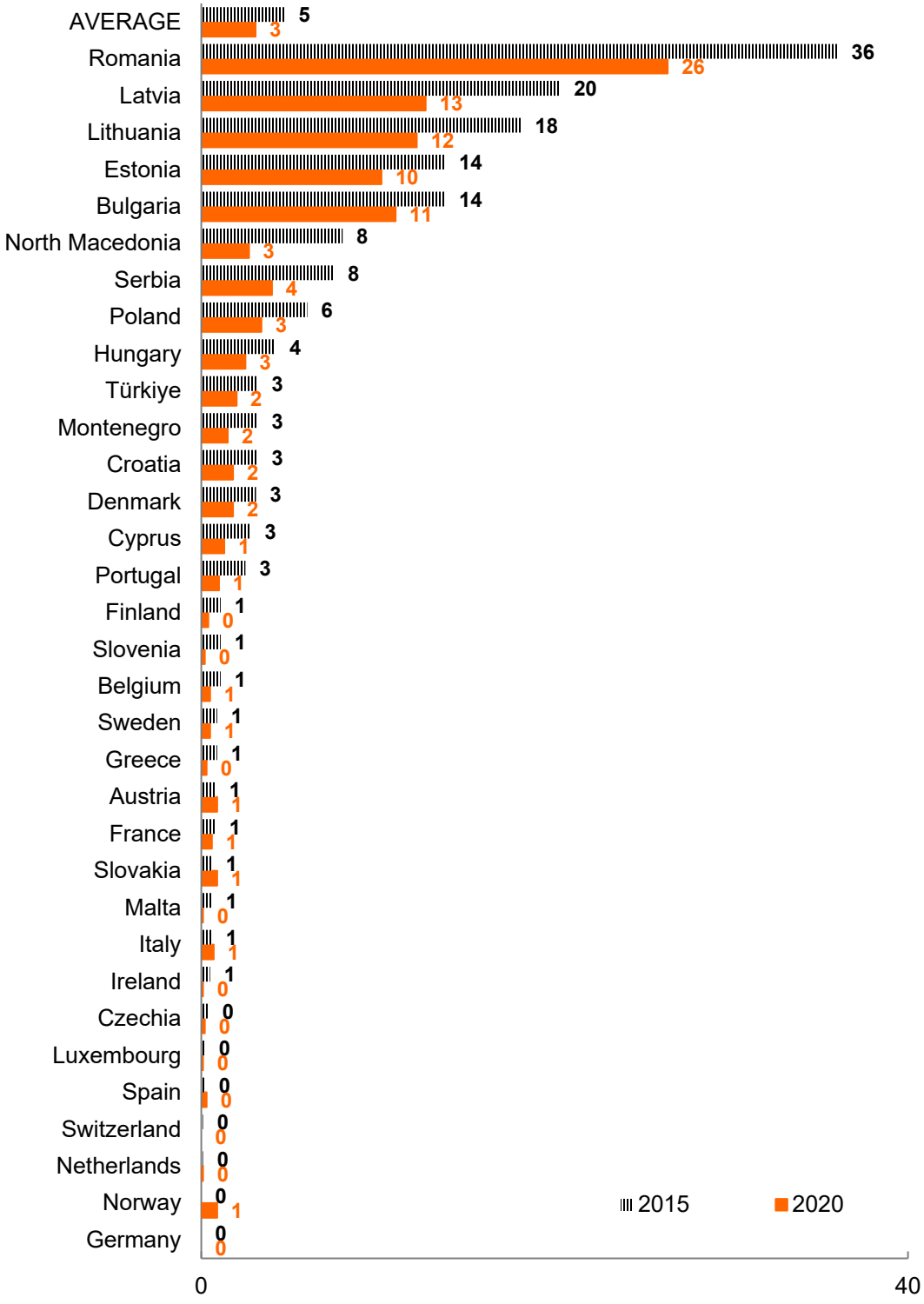
Source: Eurostat.[7]

Figure 98. Percentage of persons aged 16 and over without a bath or shower in their dwelling, by disability status, in 34 countries, in 2020.



Source: Eurostat.[7]

Figure 99. Percentage of persons with disabilities aged 16 and over with no bath or shower in their dwelling, in 33 countries, 2015 and 2020.



Source: Eurostat.[7]

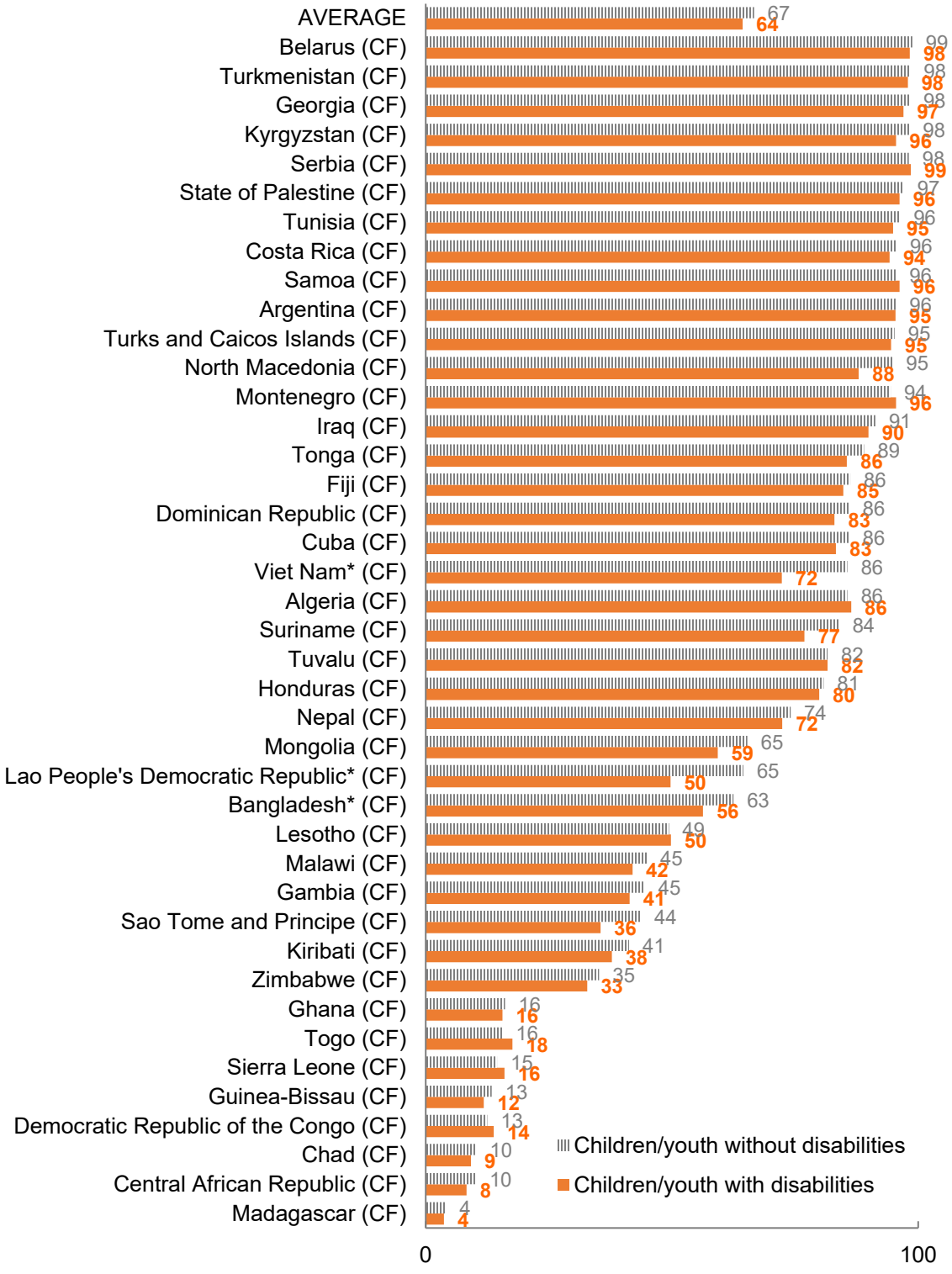
Extending access is especially important for children with disabilities. However, children with disabilities are less likely to live in a dwelling with improved sanitation facilities, with 64 per cent of children with disabilities versus 67 per cent of children without disabilities living in such a dwelling (**Error! Not a valid bookmark self-reference.**). The highest gaps are observed in Viet Nam (72 per cent of children with disabilities versus 86 per cent of children without disabilities) and Lao People's Democratic Republic (50 per cent of children with disabilities versus 65 per cent of children without disabilities). In addition, compared to others, children with disabilities are less likely to have handwashing facilities with soap and water at home (63 per cent of children with disabilities versus 69 per cent of children without disabilities); and less likely to have all three basic water, sanitation and hygiene services accessible within their dwelling, yard or plot (27 per cent of children with disabilities versus 32 per cent of children without disabilities).[46]

While access at home is important for persons with disabilities, this basic access may not be sufficient. Many persons with disabilities need water, sanitation and hygiene facilities with accessible features to meet their needs and ensure their privacy, dignity and safety. Moreover, inaccessible water, sanitation and hygiene facilities can cause accidents and injuries as well as increasing stigma and impeding persons with disabilities from using these facilities independently. They can also increase the risk of children and women with disabilities being abused or exploited while collecting water, defecating or managing their menstrual periods.

Implementation of inclusive design and of accessibility features in sanitation are increasingly common but barriers to sanitation still persist, particularly for persons with disabilities living in developing countries. Frequently mentioned structural barriers include lack of support bars in latrines for people who have difficulties holding themselves in a sitting or squatting position, and lack of accessible sinks and washing points. Among 10 countries or areas, on average 30 per cent of persons with disabilities reported their toilet at home was hindering or not accessible (Figure 101). In six of these countries, more than one out of five persons with a severe disability considered the toilet in their dwelling hindering or very hindering.

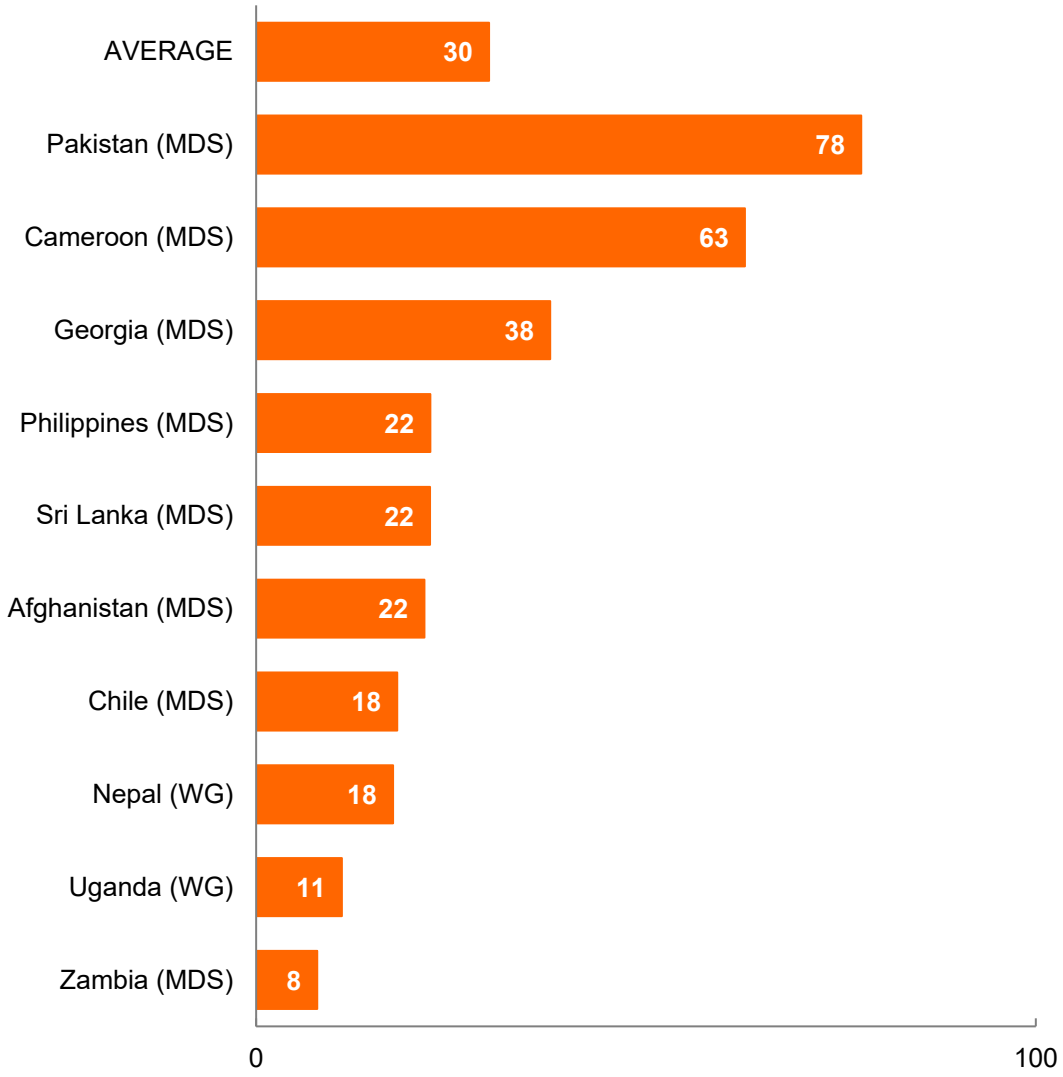
Lack of accessible water, sanitation and hygiene facilities can be particularly harmful for girls and women with disabilities. To effectively manage their menstrual periods, girls and women with disabilities require access to water, sanitation and hygiene facilities, access to affordable and appropriate menstrual hygiene materials, information on good practices, and a supportive environment in which they can manage menstruation without embarrassment or stigma. Yet, among 30 countries or areas, on average 19 per cent of women with disabilities compared to 13 per cent of women without disabilities did not participate in work, school and social activities during their last menstrual period (Figure 102). In many countries, women with disabilities are twice as likely to not participate in work, school and social activities during menstruation than women without disabilities. In North Macedonia, women with disabilities were five times more likely to not participate.

Figure 100. Percentage of children/youth aged 2 to 17 years living in a dwelling with improved sanitation facilities, by disability status, in 41 countries or areas, in 2017-2021.



Note: (CF) identifies data produced using the Child Functioning Module.
Source: UNICEF (on the basis of data from MICS[6]).

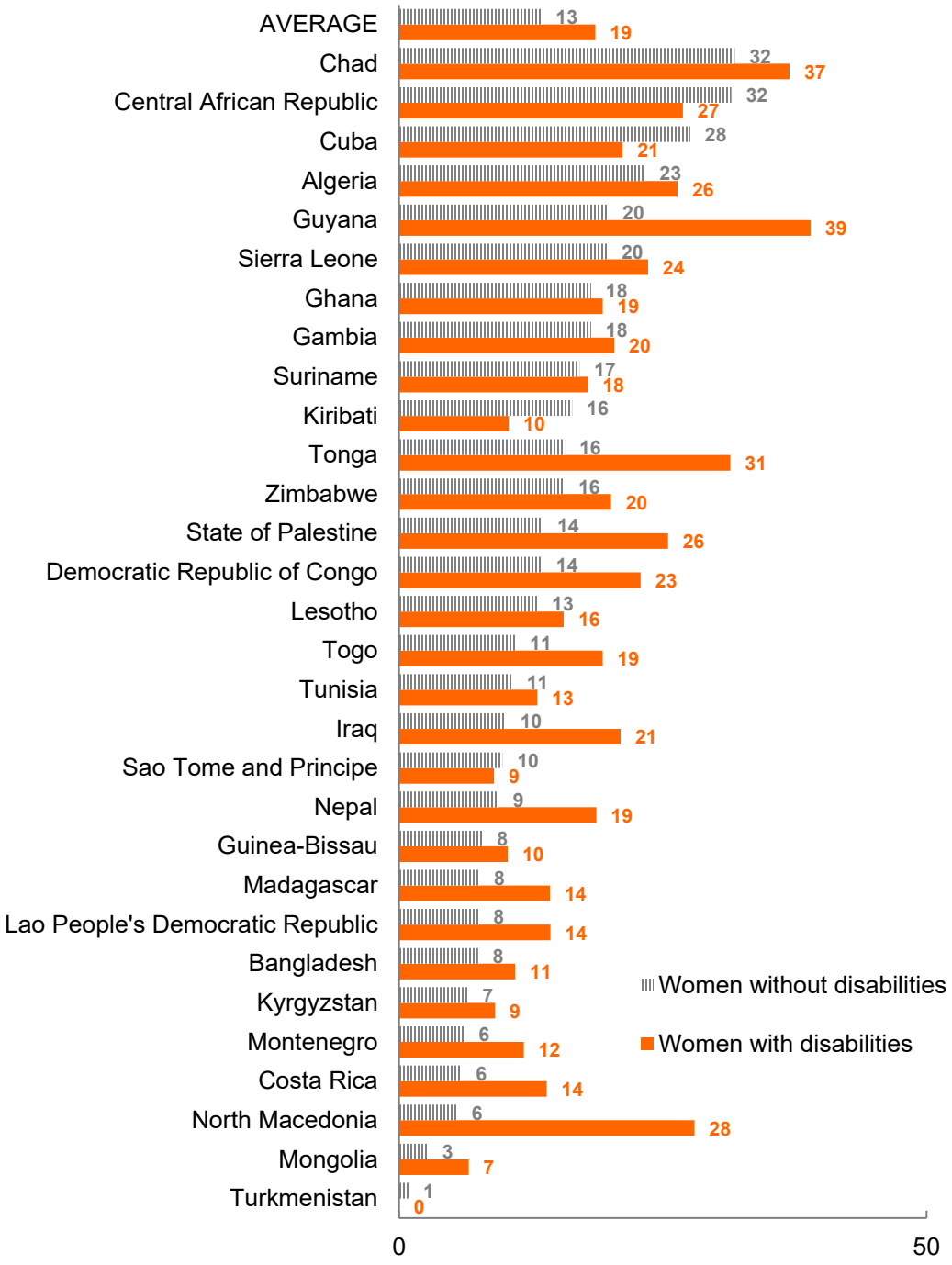
Figure 101. Percentage of persons with disabilities who reported their toilet at home is hindering or not accessible, in 10 countries or areas, in 2015-2021.



Source: UNDESA (on the basis of data from SINTEF[9]) and WHO.

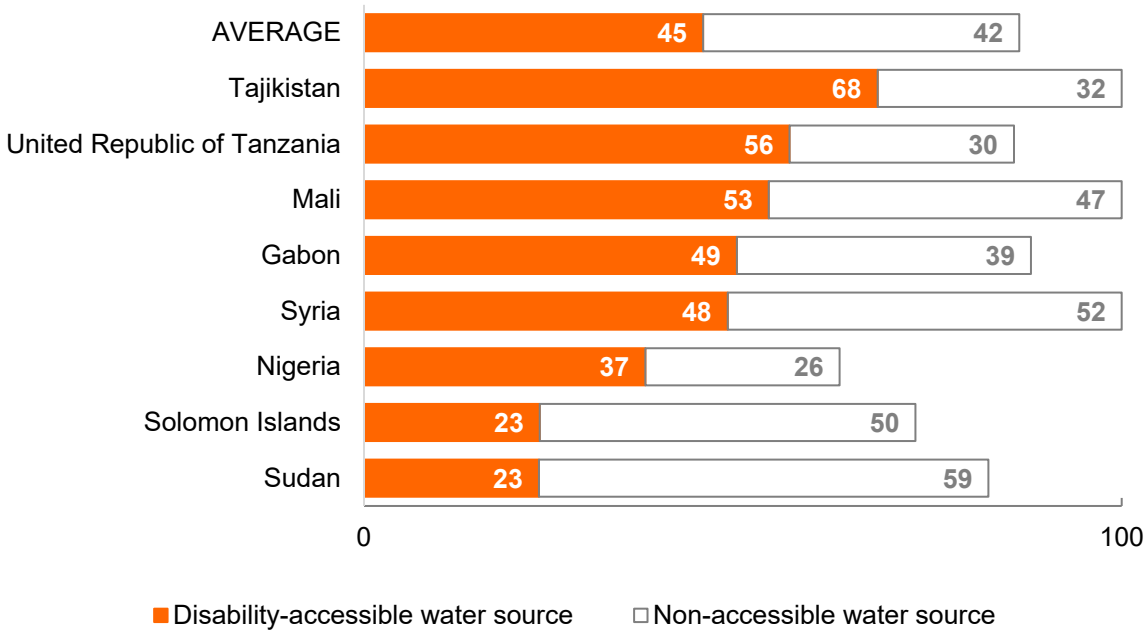
Disability-inclusive water, sanitation and hygiene services in schools are widely recognized as a critical component of a safe and inclusive learning environment for all. Children with disabilities will face additional barriers to education if water, sanitation and hygiene facilities in schools are not accessible.

Figure 102. Percentage of women and girls aged 15 to 49 who did not participate in school, work or social activities during their last menstrual period, by disability status, in 30 countries or areas, in 2020 or latest year available.



Source: UNICEF (on the basis of data from MICS[6]).

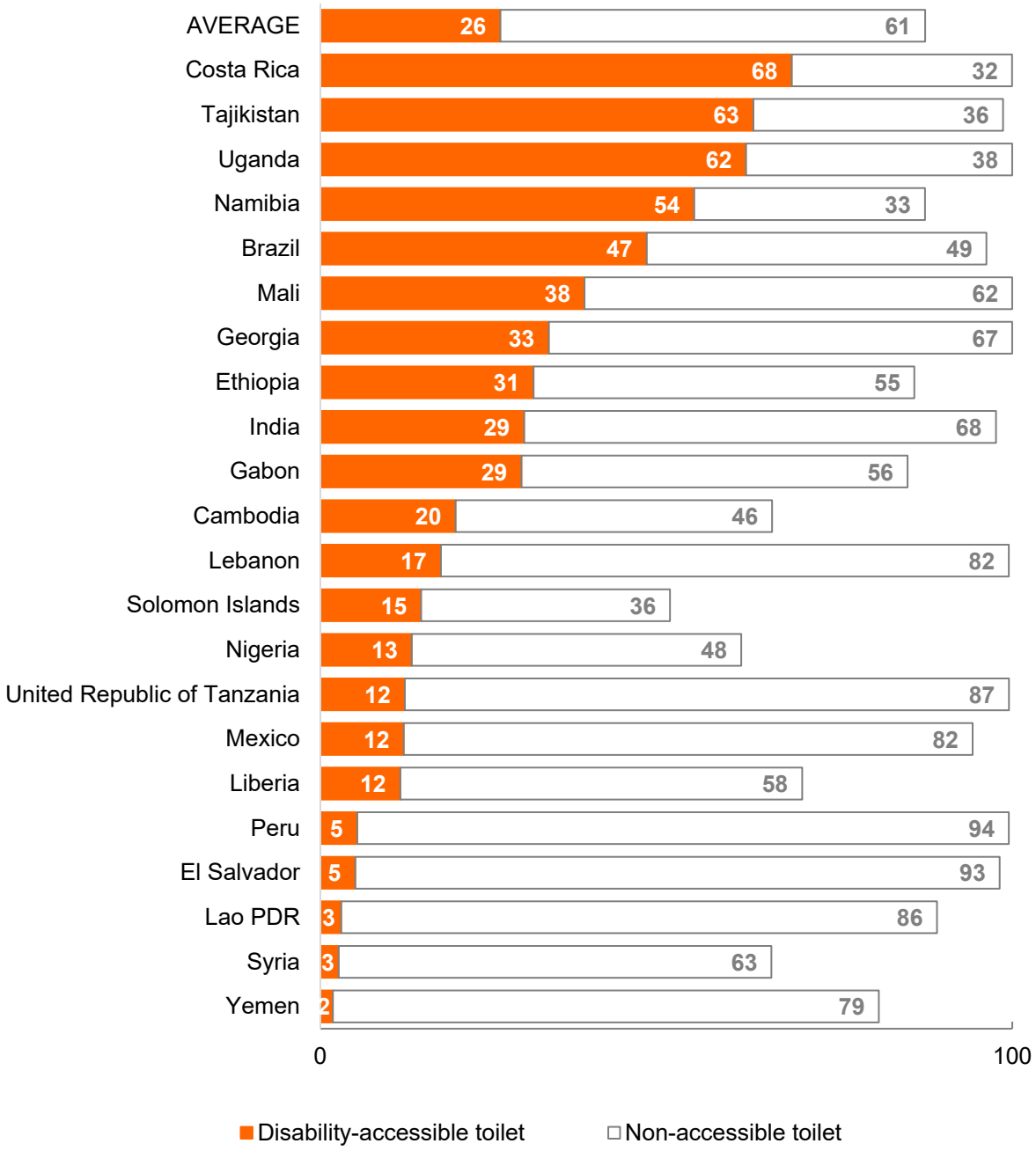
Figure 103. Percentage of schools with accessible and non-accessible drinking water sources, in 8 countries, in 2021 or latest year available.



Note: National definitions of "disability-accessible" vary among countries. Some countries consider accessibility to all students, others accessibility to those with limited mobility or vision, others use specific accessibility criteria like presence of railings, and others focus on whether students are able to use the facilities without assistance.
Source: JMP Report (2022).[309]

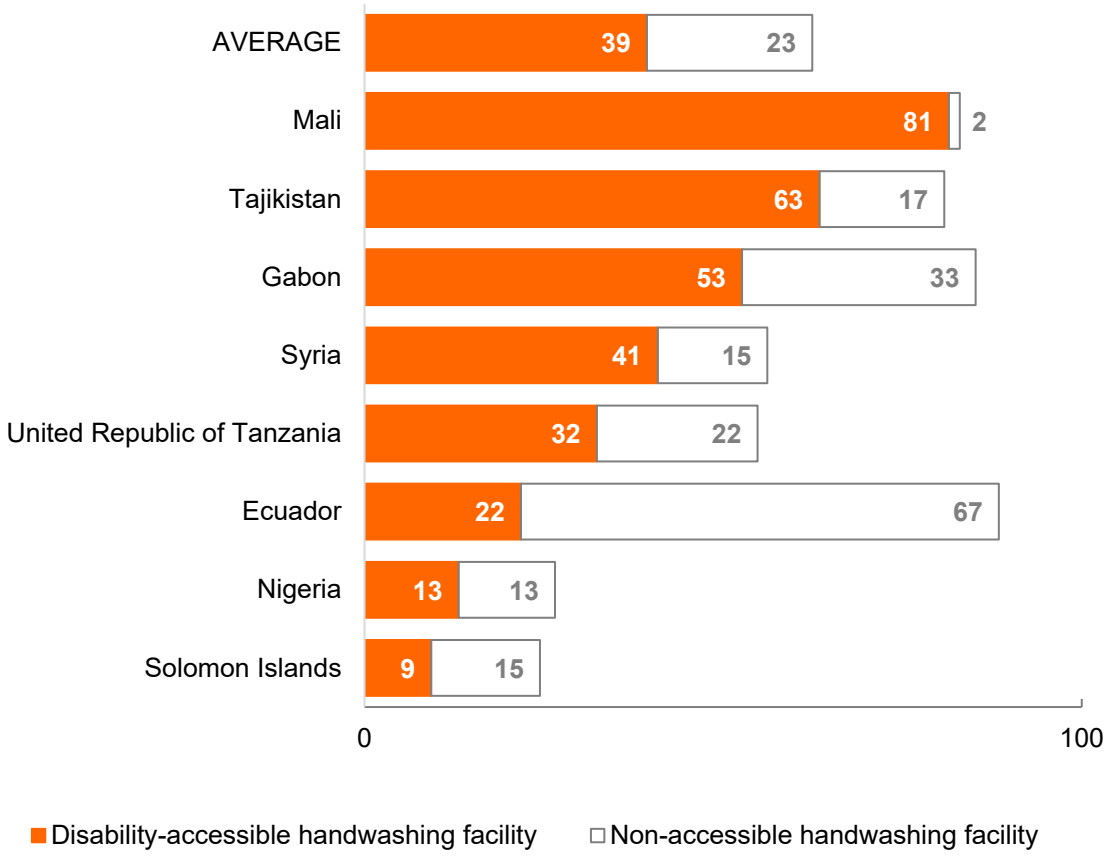
In many countries, most schools have some kind of water, sanitation and hygiene facility, but in far fewer schools this facility is disability-accessible (Figure 103). In Syria and Mali, all schools have some kind of water source but only about half have disability-accessible water sources. In Sudan, more than 80 per cent of schools have a water source, but only 23 per cent have disability-accessible sources. Regarding sanitation, in over half the countries, the percentage of schools with non-accessible toilets exceeds 50 per cent (Figure 104). In Yemen, about 80 per cent of schools have toilets, but only 2 per cent of schools have disability-accessible toilets. Schools in Costa Rica and Peru universally (>99 per cent) have some kind of sanitation facility, but while 68 per cent of schools in Costa Rica have disability-accessible toilets, only 5 per cent of schools in Peru have disability-accessible toilets. The accessibility gap for hygiene services is smaller but still significant (Figure 105). In five out of eight countries or areas, less than 50 per cent of schools have handwashing facilities which are accessible. Mali reports the smallest gap: 81 per cent of schools have a disability-accessible handwashing facility and only 2 per cent have non-accessible handwashing facilities.

Figure 104. Percentage of schools with accessible and non-accessible sanitation, in 22 countries or areas, in 2021 or latest year available.



Note: National definitions of "disability-accessible" vary among countries. Some countries consider accessibility to all students, others accessibility to those with limited mobility or vision, others use specific accessibility criteria like presence of railings, and others focus on whether students are able to use the facilities without assistance.
Source: JMP Report (2022).[309]

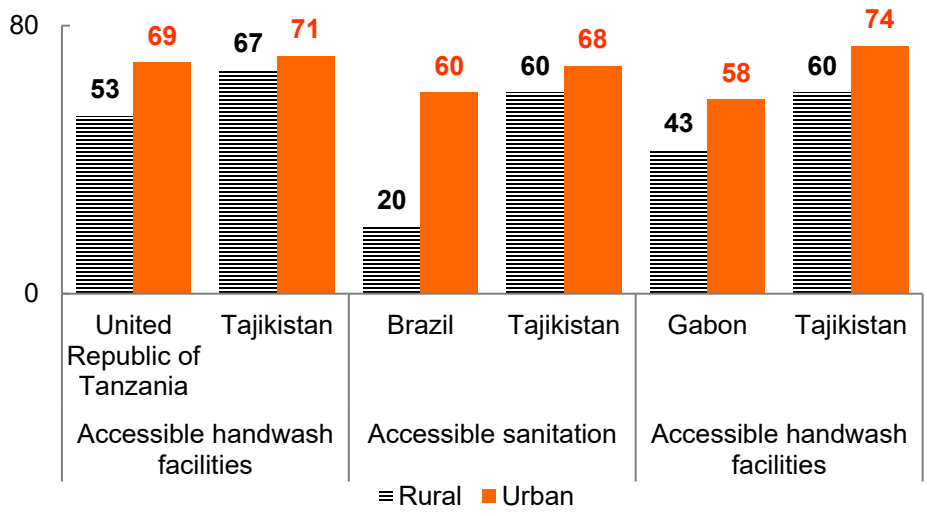
Figure 105. Percentage of schools with accessible and non-accessible handwashing facilities, in 8 countries or areas, in 2021 or latest year available.



Note: National definitions of "disability-accessible" vary among countries. Some countries consider accessibility to all students, others accessibility to those with limited mobility or vision, others use specific accessibility criteria like presence of railings, and others focus on whether students are able to use the facilities without assistance.
Source: JMP Report (2022).[309]

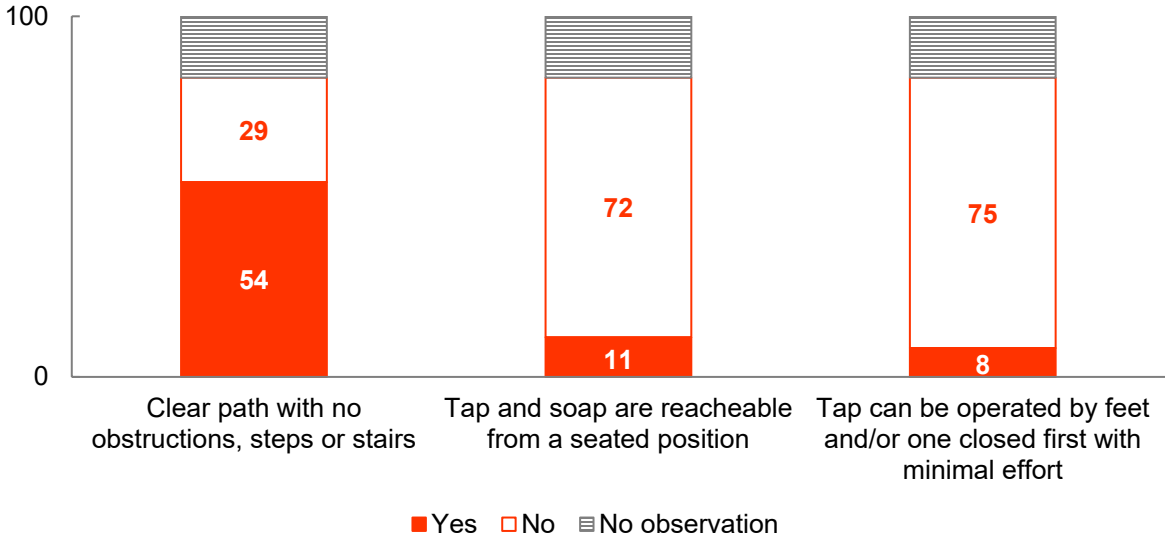
Accessible water, sanitation and hygiene tends to be less common in schools in rural areas than in schools in urban areas (Figure 106). Some accessible features tend to be lacking in handwashing facilities in schools in rural areas. For example, in Tajikistan, 54 per cent of schools in rural areas have a clear path with no obstructions, steps or stairs to the handwashing facilities, but persons with disabilities can reach the tap and soap from a seated position in only 11 per cent of the schools and persons with disabilities can operate the tap by foot or by a closed fist in only 8 per cent of the schools. (Figure 107).

Figure 106. Percentage of schools with accessible water, sanitation and hygiene, in urban and rural areas, in 4 countries, in 2020-2021.



Source: JMP Report (2022).[309]

Figure 107. Percentage of handwashing facilities in schools with accessibility features, by type of feature, in rural areas, in Tajikistan in 2020.

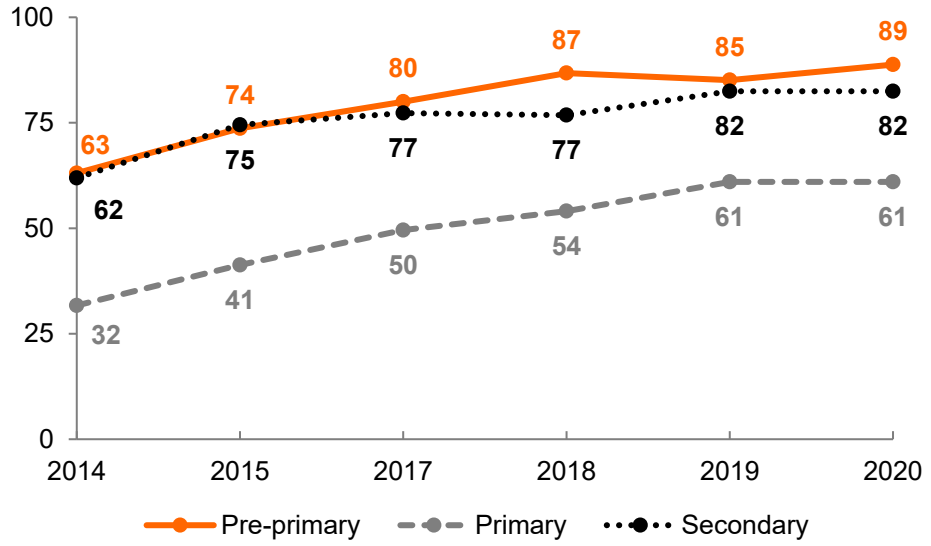


Source: JMP Report (2022).[309]

Legal provisions can trigger positive action in making water, sanitation and hygiene facilities in schools accessible to all. For example, in Costa Rica, Act 7600 on Equal Opportunities for Persons with Disabilities was amended in 2014 to bring the definition of persons with disabilities and of accessibility in

line with the CRPD. The Law stresses the need to 'incorporate an inclusive approach and take into account the special needs of different types of people so that they are not excluded due to their disability. Since the 2014 amendment of this Act, there has been a steady increase in the number of pre-primary, primary and secondary schools with toilets that are accessible for persons with disabilities (Figure 108). By 2020, coverage was higher in pre-primary schools and secondary schools than in primary schools, but since 2014 primary school coverage has nearly doubled from 32 per cent to 61 per cent.

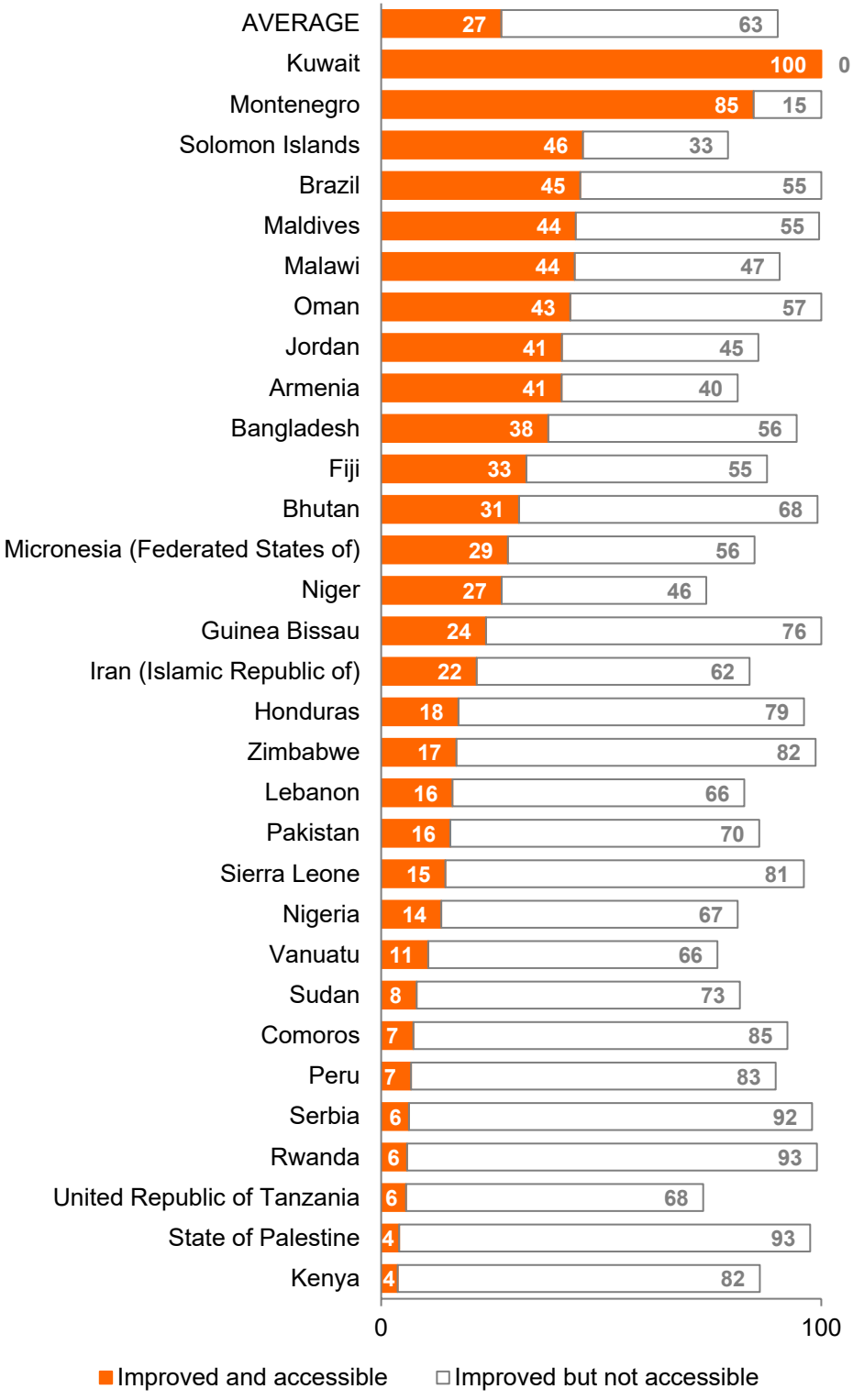
Figure 108. Percentage of pre-primary, primary and secondary schools with at least one accessible toilet, in Costa Rica, from 2014 to 2020.



Source: Ministry of Public Education and Infrastructure of Costa Rica.

In health facilities, toilets are also not always accessible for persons with disabilities. Persons with disabilities will face additional barriers to healthcare if water, sanitation and hygiene facilities in hospitals and clinics are not accessible. Among 31 countries or areas, on average, only 27 per cent of healthcare facilities have improved sanitation facilities accessible to persons with limited mobility (Figure 109). Furthermore, in almost all of these countries, healthcare facilities are much more likely to have a non-accessible improved sanitation facility than to have an improved sanitation facility accessible to those with limited mobility. In Brazil, Guinea Bissau, Maldives and Oman, all healthcare facilities have improved sanitation but fewer than half meet the criterion for accessibility. In Rwanda and the State of Palestine, the gap between healthcare facilities with non-accessible and accessible toilets is more than 85 percentage points. Kuwait is the only country where all healthcare facilities have sanitation facilities that are both improved and accessible to persons with limited mobility.

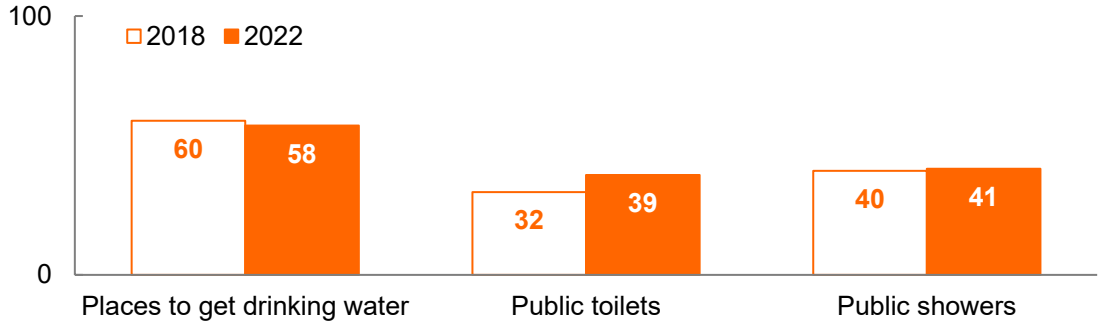
Figure 109. Percentage of healthcare facilities with accessible and non-accessible improved sanitation for those with limited mobility, in 31 countries or areas, in 2021.



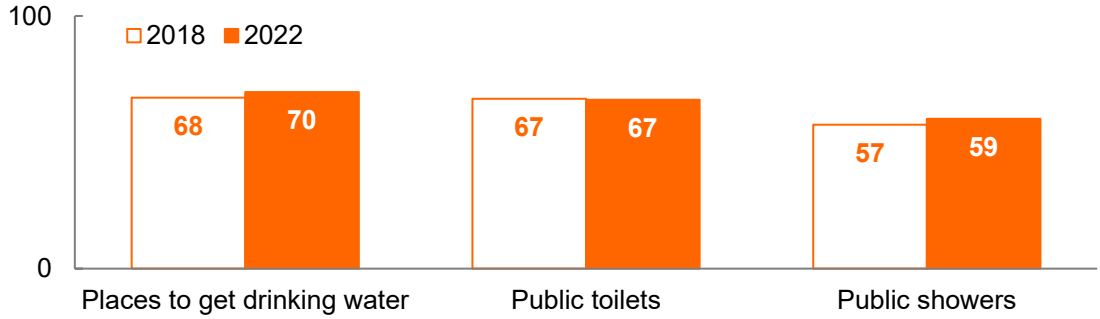
Source: JMP Report (2022).[309]

Figure 110. Percentage of places to get drinking water, and that have public toilets and public showers that are accessible for wheelchair users, in developing and developed countries, in 2018 and 2022.

(a) Developing countries



(b) Developed countries



Source: UNDESA (on the basis of data from Sozialhelden[10]).

Accessible public water, sanitation and hygiene in outdoor settings is key for persons with disabilities to participate in society. Moreover, in settings in which safe drinking water and showers are not available in their homes, accessible places to get drinking water, accessible toilets and accessible public showers are essential for ensuring the independent living of persons with disabilities. However, many of these premises remain non-accessible for persons with disabilities. Crowdsourced data in developing countries in 2022 found that only 58 per cent of places to get drinking water, 39 per cent of public toilets and 41 per cent of public showers were accessible for wheelchair users (Figure 110). These premises were more accessible in developed countries, with 70 per cent of places to get drinking water, 67 per cent of public toilets and 59 per cent of public showers accessible for wheelchair users in 2022. Apart from public toilets in developing countries, which saw an increase in accessibility for wheelchair users from 32 per cent to 39 per cent from 2018 to 2022, the progress for other premises in developing countries and for all these premises in developed countries has been minimal or lacking since 2018.

Disaggregating water, sanitation and hygiene data by disability and collecting information on the specific

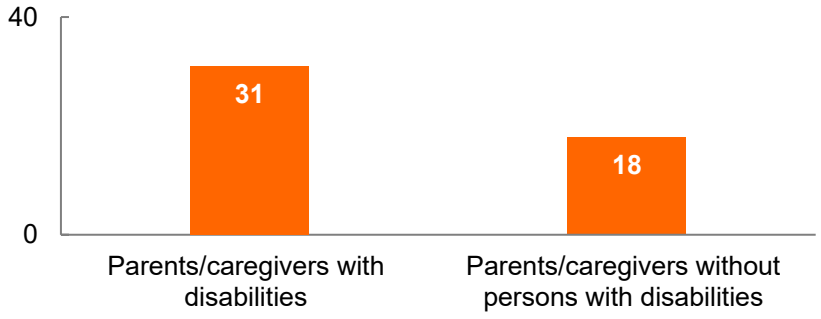
issues faced by persons with disabilities is important in order to design water, sanitation and hygiene programmes that effectively meet the needs of persons with disabilities and overcome barriers to access. However, data over time are still largely missing and prevent the assessment of progress towards SDG 6 for persons with disabilities. Moreover, in both household and institutional settings, the emphasis on data collection remains focused on a list of water, sanitation and hygiene accessibility features and is rarely complemented with data collection on the experience of users with disabilities and the barriers they encounter in using these facilities independently.

Impact of the COVID-19 pandemic

The COVID-19 pandemic brought challenges to affording basic services, such as water and hygiene products. Moreover, with social restrictions, it affected delivery and the support that many persons with disabilities needed to acquire water and hygiene products. Although data on access to water, sanitation and hygiene during the pandemic is limited, the available data suggest that persons with disabilities faced more barriers to access water, sanitation and hygiene than persons without disabilities during the COVID-19 pandemic.

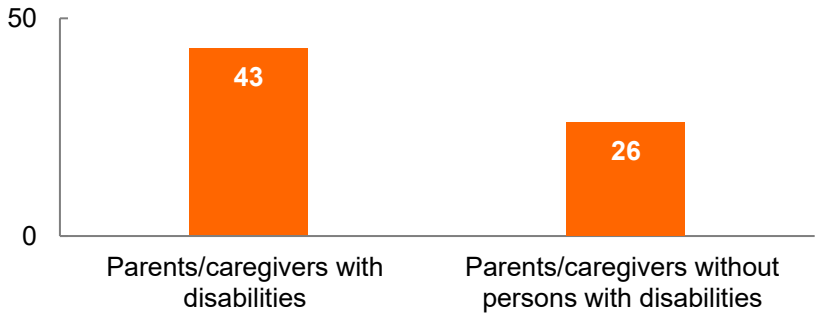
In 2020, a higher proportion of parents and caregivers with disabilities (31 per cent), compared to parents and caregivers without disabilities (18 per cent), reported needing and not having access to water delivery (Figure 111). Similarly, a higher proportion of parents and caregivers with disabilities (43 per cent), compared to parents and caregivers without disabilities (26 per cent), needed but did not have access to sanitary products (Figure 112). A higher proportion of households with persons with disabilities, compared to those without, reported difficulties paying for utility bills (31 per cent versus 24 per cent) – see Figure 122 of the chapter on Goal 7.

Figure 111. Percentage of parents/caregivers who needed but did not have access to water delivery during the COVID-19 pandemic, by disability status, in 2020.



Source: Save the Children (2020).[16]

Figure 112. Percentage of parents/caregivers who needed but did not have access to sanitary products during the COVID-19 pandemic, by disability status, in 2020.



Source: Save the Children (2020).[16]

Summary of findings and the way forward

Persons with disabilities have the same rights as others to safe drinking water and sanitation but have often been overlooked in water, sanitation and hygiene sector policies and programmes. In many countries, persons with disabilities are less likely than persons without disabilities to live in a dwelling with a safe drinking water source, improved sanitation and a bath or shower on the premises. Moreover, even when these services are available, they are often not accessible for persons with disabilities, thus compromising independent use with privacy, dignity and safety. A third of persons with disabilities in developing countries indicate that the toilets at their home are not accessible for them.

In many countries, a third or more of water, sanitation and hygiene services in institutional settings, like schools and healthcare facilities, and in public settings are not accessible for persons with disabilities. Lack of accessible water, sanitation and hygiene services impact particularly women and girls with disabilities, who are more likely than women and girls without disabilities to miss school, work or social activities during their menstrual periods.

Available data suggest increased barriers to water, sanitation and hygiene for persons with disabilities than for persons without disabilities during the COVID-19 pandemic, with higher percentages of persons with disabilities not having access to water delivery, sanitary products and not being able to pay water bills.

The availability of data has increased since the *Disability and Development Report 2018*, with a larger number of countries with recent data disaggregated by disability on the availability of water, sanitation and hygiene facilities at home and with data on the accessibility of water, sanitation and hygiene services at home, in schools and in healthcare facilities. However, the available data remains insufficient to draw a global picture of the current situation, to assess progress since 2015, and to understand the experiences

of users with disabilities and the barriers they encounter in using water, sanitation and hygiene facilities independently.

The limited data available over time indicate that progress has been insufficient, and that increased and accelerated efforts are needed to achieve targets 6.1 and 6.2 for persons with disabilities. To achieve universal accessible water, sanitation and hygiene facilities in public settings, in developing countries, public toilets need to be made accessible for persons with disabilities three times faster than the progress rates observed so far and public showers 25 times faster; the percentage of public places to get drinking water that are accessible has been decreasing and this trend needs to be inverted – about 40 per cent of these water sources remain not accessible. In developed countries, public places to get drinking water need to be made accessible for persons with disabilities at a rate five times faster than the progress rates observed so far and public showers six times faster; the percentage of public toilets that are accessible has stagnated – about 30 per cent remain not accessible for persons with disabilities. In European countries, consistent progress has been made since 2015 on the availability of toilets and baths or showers in the dwellings of persons with disabilities. At current rates of progress, the availability of a toilet in the dwelling of all persons with disabilities is expected to be achieved in 31 out of 33 countries in this region by 2030; and the availability of a bath or shower in the dwelling of all persons with disabilities is expected to be achieved in about two thirds of these countries by 2030. In the countries that have lagged behind since 2015, the rates of progress need to increase about 1.2 times faster than current rates and in some countries the trend needs to be inverted as the lack of toilets and baths or showers on premises is increasing.

To achieve targets 6.1 and 6.2 by, for and with persons with disabilities, accelerated efforts from all relevant stakeholders will be needed, focusing on the following actions:

1. Mainstream disability in water, sanitation and hygiene policies and programmes. Ensure that all water, sanitation and hygiene policies and programmes are designed and implemented to be disability inclusive, meeting the rights and needs of persons with disabilities and overcoming barriers to access. Build the capacity of government and non-government stakeholders involved in water, sanitation and hygiene service provision to identify and respond to the needs of persons with disabilities. Document and disseminate good practices and lessons learned in the inclusion of persons with disabilities in the design, implementation and monitoring of water, sanitation and hygiene services. Promote innovative approaches and technologies to support the development of such services that address the needs and priorities of persons with disabilities.

2. Include persons with disabilities in all stages of water, sanitation and hygiene policy and programme implementation. Strengthen partnerships between organizations working on water, sanitation and hygiene and representative organizations of persons with disabilities and promote collaboration across sectors and stakeholders involved in the delivery of such services.

3. Allocate financial resources and budgets to promote and support access to disability-inclusive water, sanitation and hygiene services in households and in institutional settings, including schools and healthcare facilities. This allocation should be informed by gaps identified though the monitoring of access to water, sanitation and hygiene for persons with disabilities in households, institutional settings like schools and healthcare facilities, and in public places. Financial support to families can also help with the additional costs related to accessible water, sanitation and hygiene facilities.

4. Improve the monitoring, including the availability of high-quality data, on water, sanitation and hygiene access for persons with disabilities. Define targets, indicators and sources of data for monitoring progress towards disability-inclusive water, sanitation and hygiene in households, schools and healthcare facilities. Support the routine collection and reporting of disaggregated data on persons with disabilities to inform policy and programmes and to strengthen accountability for progress towards disability-inclusive water, sanitation and hygiene services. Further work is also required to develop international standards for measuring the accessibility and use of water, sanitation and hygiene facilities by children with disabilities; and to harmonize definitions and indicators for the data on disability-inclusive services in schools. While a growing number of countries monitors these services, national definitions and indicators vary widely, which makes cross-country comparison difficult.

Ensuring access to energy (Goal 7)

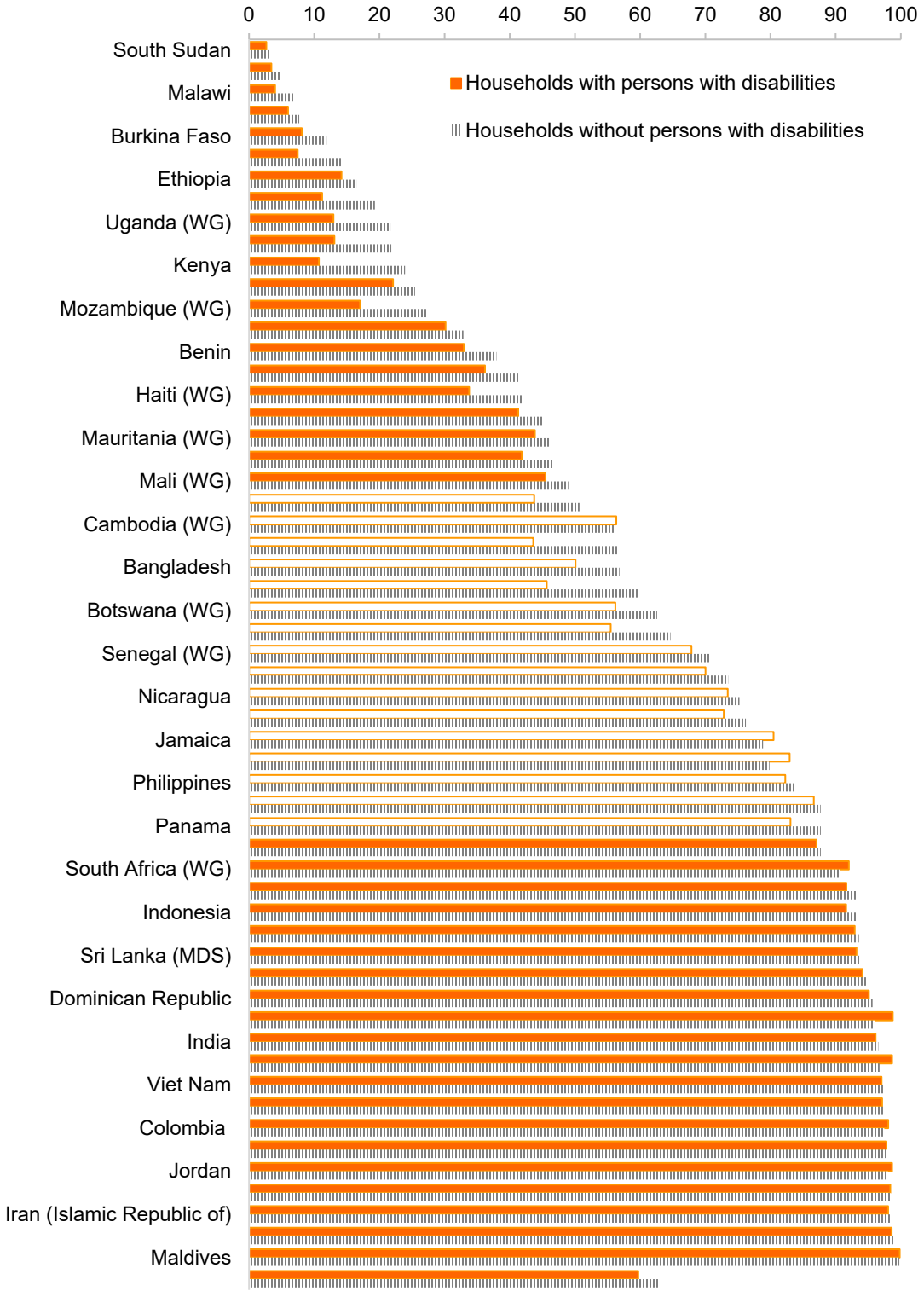
This chapter discusses the current status and progress towards access to energy for persons with disabilities. The 2030 Agenda for Sustainable Development in its Goal 7 calls for access to affordable, reliable, sustainable and modern energy for all, implicitly establishing the goal for persons with disabilities. 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 require access to energy for persons with disabilities. Moreover, for many persons with disabilities access to electricity is crucial as they need to use electricity-run assistive technology to live independently or for survival.

Despite this need, the link between energy and the well-being of persons with disabilities has been absent in major international frameworks on energy.[32] Recent outcomes have increasingly drawn attention to the need to leave no one behind, focusing on vulnerable groups in energy access but did not address persons with disabilities explicitly. For example, in June 2021, the Executive Note for the G20 Energy Transition Working Group and the G20 Climate Sustainability Working Group, entitled “Energy Poverty: addressing the intersection of Goal 7, development and resilience” recognized that to prepare for a future emergency, either a public health pandemic or a climate-related emergency, governments need to put in place programs that can target populations that will be vulnerable to risks. The Note further stressed the need to ensure that vulnerable lower-income households are protected against financial risk, particularly in the context of the liberalization of energy markets. In addition, the Global Roadmap towards Attainment of Goal 7 – one of the main outcomes of the High-level Dialogue on Energy held in September 2021 – called for leaving no one behind, especially the most vulnerable, on the path to a net zero future, by stressing the need for a global energy transition which is just, inclusive and equitable.

Current situation and progress so far

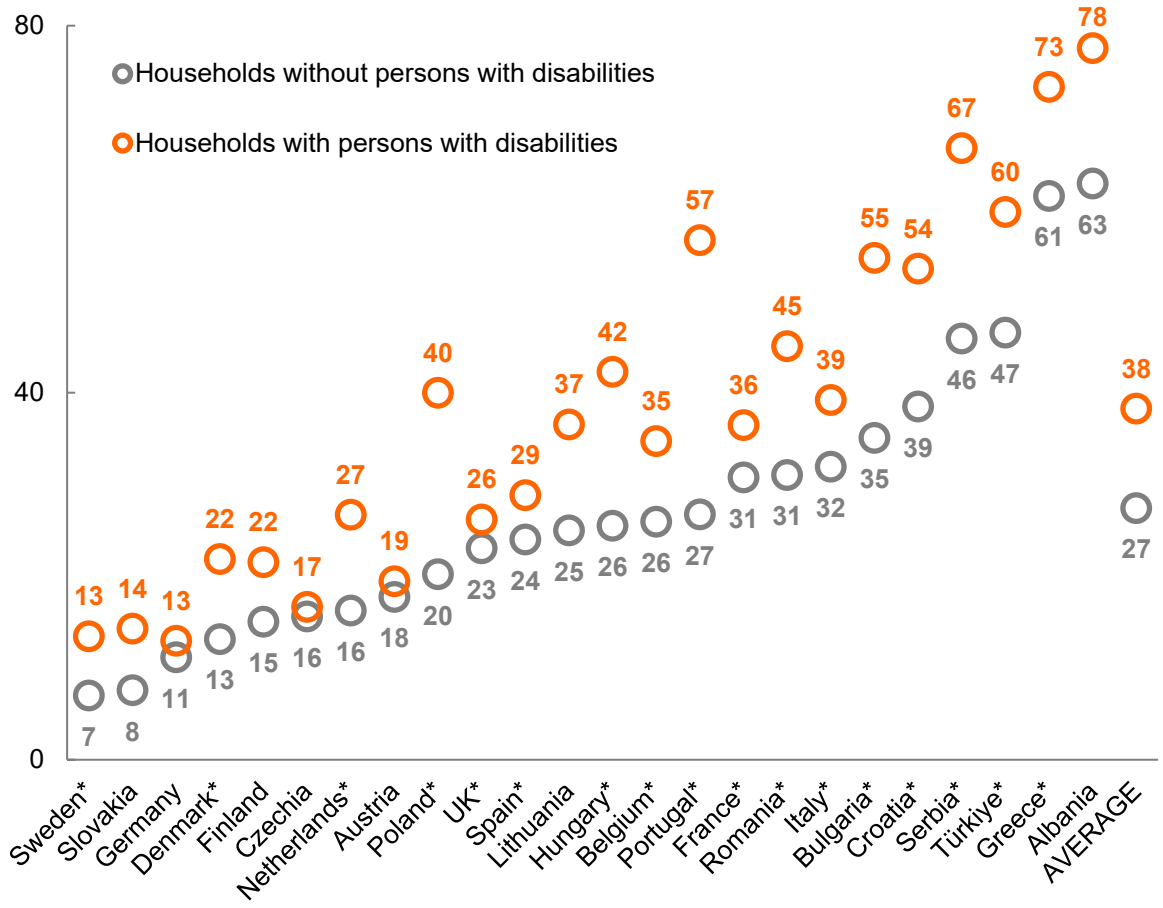
Persons with disabilities are less likely to have access to electricity and may find electricity less affordable than persons without disabilities. In developing regions, on average, 60 per cent of households with persons with disabilities compared to 63 per cent of households without persons with disabilities have access to electricity (Figure 113). In 30 out of 33 countries, access to electricity is lower for households with persons with disabilities than for households without persons with disabilities. The largest gaps between households with and without persons with disabilities are found in Cameroon and the United Republic of Tanzania (13 percentage points) and Mozambique (10 percentage points). Countries with almost universal access tend to have small or no gaps in electricity access between households with and without persons with disabilities; while countries in which electricity access is far from universal tend to show higher gaps in access.

Figure 113. Percentage of households, with and without persons with disabilities, with access to electricity, in 57 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from DHS,[6] IPUMS, SINTEF[9] and WHO).

Figure 114. Percentage of households that are energy poor, by disability status, in 24 countries, in 2016.

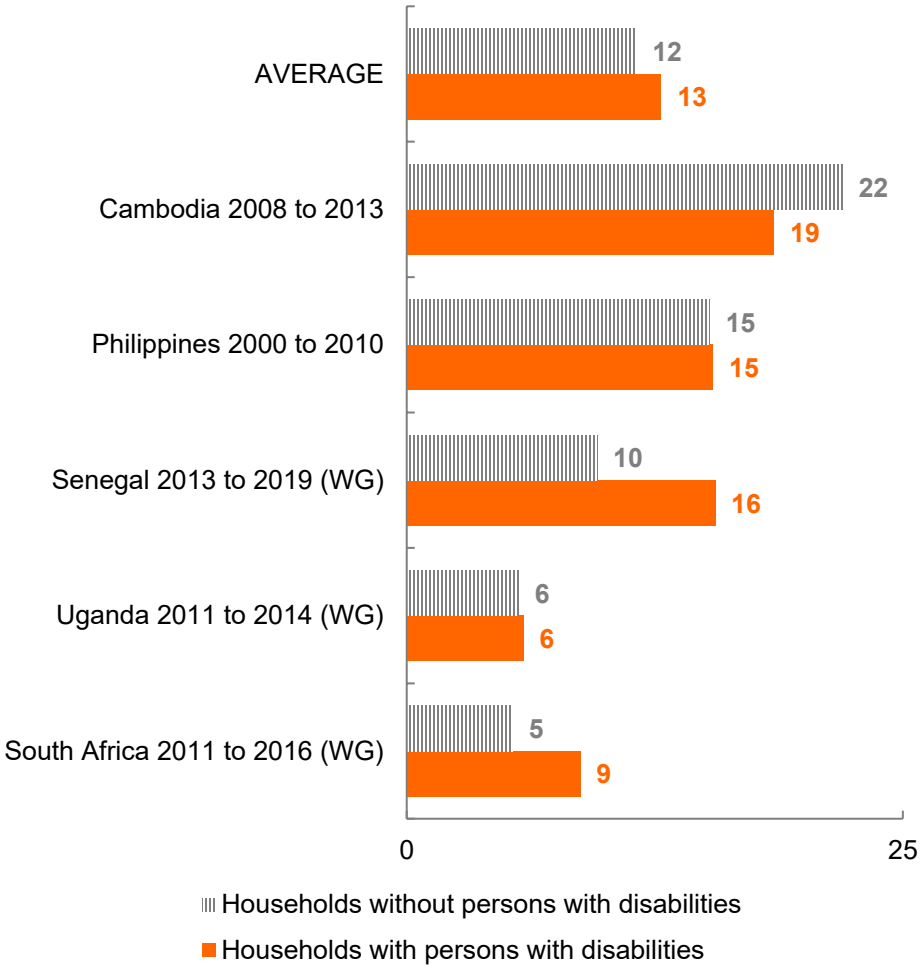


Note: Households that are energy poor refer to households that experience one or more of the following: have rot in windows, doors or floors; have damp or leaks in walls or roof; cannot afford to keep home adequately warm; or have arrears during the past 12 months on utility bills, such as electricity, water or gas. Persons with disabilities in this figure also include persons with chronic illnesses. An asterisk (*) indicates that the difference between households with and without persons with disabilities is statistically significant at the 5 per cent level.
Source: Authors' elaboration (on the basis of data from the European Quality of Life Survey 2016).

In European countries, households with persons with disabilities are more likely to be energy poor than households without persons with disabilities (Figure 114), that is, they are more likely to experience one of the following characteristics: have rot in windows, doors or floors; have damp or leaks in walls or roof; cannot afford to keep home adequately warm; or have arrears during the past 12 months on utility bills, such as electricity or gas. In 24 countries in Europe, on average, 38 per cent of households with persons with disabilities compared to 27 per cent of households without persons with disabilities are energy poor. In 10 countries, the gap between households with and without persons with disabilities is higher than 10 percentage points, with the highest gap being 30 percentage points, in Portugal.

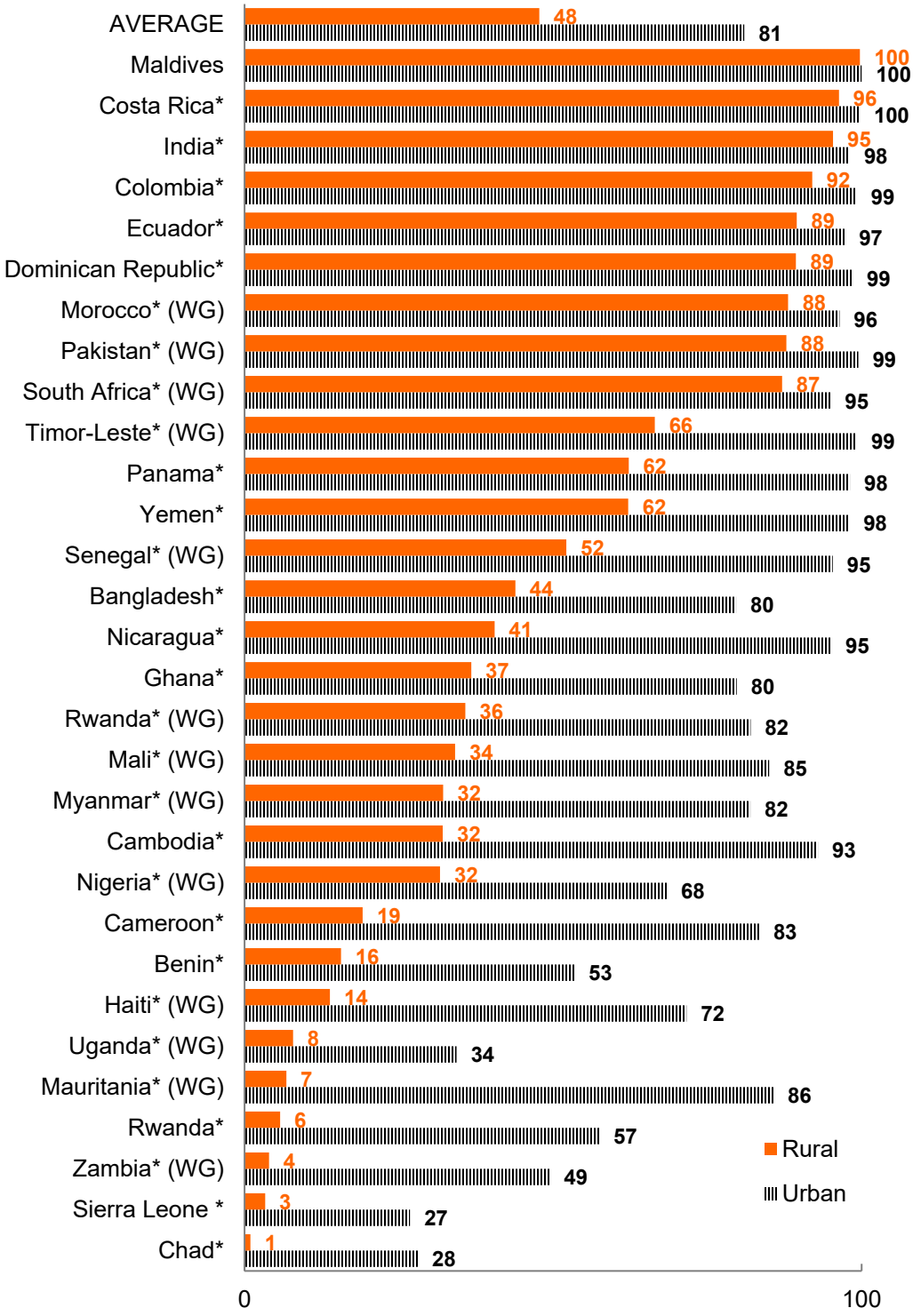
Countries have been making progress in providing access to electricity, including for persons with disabilities (Figure 115). For instance, among five countries, access to electricity increased by 12 percentage points for households without persons with disabilities and by 13 percentage points for households with persons with disabilities. In four countries – Philippines, Senegal, South Africa and Uganda – progress for households with persons with disabilities has been similar to or higher than for households without persons with disabilities.

Figure 115. Progress made by countries in access to electricity, in percentage points, by disability status, in 5 countries, in 2000-2019.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from DHS[6] and IPUMS[8]).

Figure 116. Percentage of households with persons with disabilities with access to electricity, by area of residence, in 30 countries, in 2021 or latest year available.

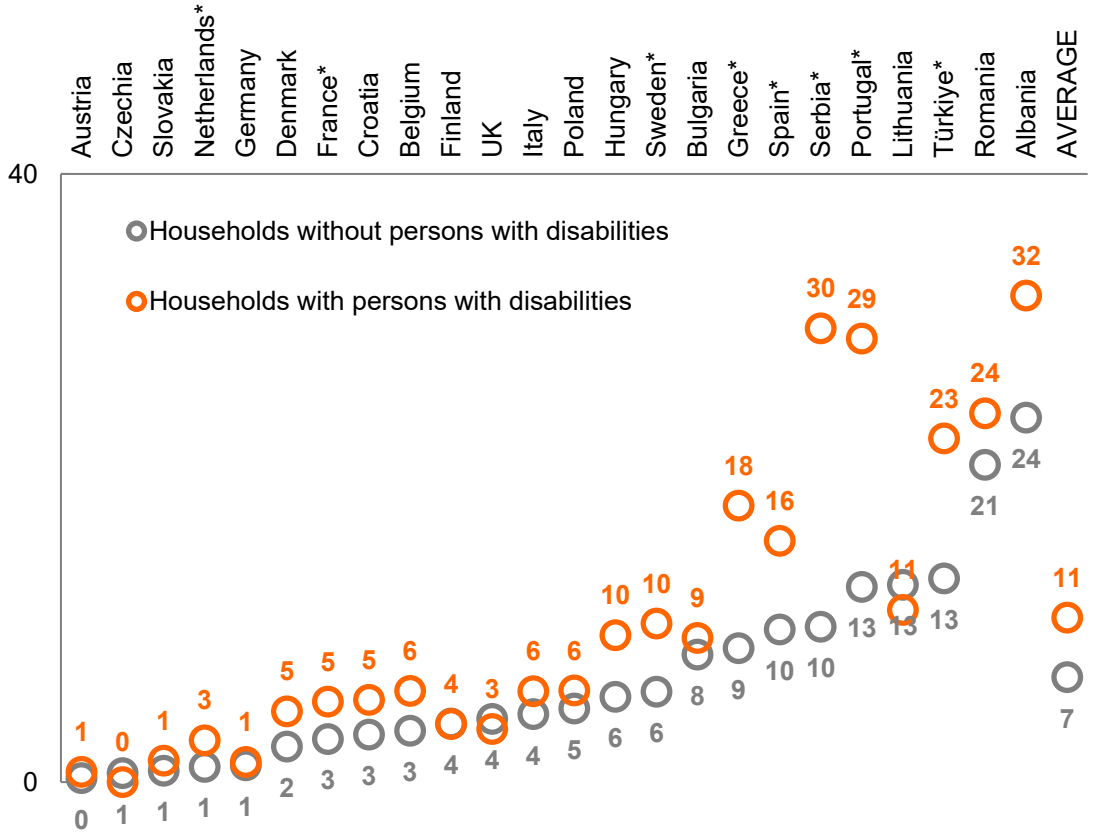


Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from DHS,[6] IPUMS and SINTEF[9]).

There is a clear rural/urban divide for persons with disabilities and access to electricity (Figure 116). Among 30 countries, there is a higher rate of access to electricity for persons with disabilities living in urban areas than for those in rural locations: 81 per cent of households with persons with disabilities in urban areas have access to electricity compared to 48 per cent in rural areas. In seven countries, the difference in access to electricity for persons with disabilities in urban and rural areas exceeds 50 percentage points, with the highest difference recorded in Mauritania (79 percentage points).

Across Europe, a lack of adequate heating or cooling facilities is highest among households with persons with disabilities (Figure 117). The largest gaps in lack of heating or cooling facilities between households with and without persons with disabilities occur in Serbia (20 percentage points), Portugal (16 percentage points) and Greece (9 percentage points).

Figure 117. Percentage of households lacking heating or cooling facilities, by disability status, in 24 countries, in 2016.



Note: Persons with disabilities also include persons with chronic illnesses. An asterisk (*) indicates that the difference between households with and without persons with disabilities is statistically significant at the 5 per cent level.
Source: Authors' elaboration (based on European Quality of Life Survey 2016).

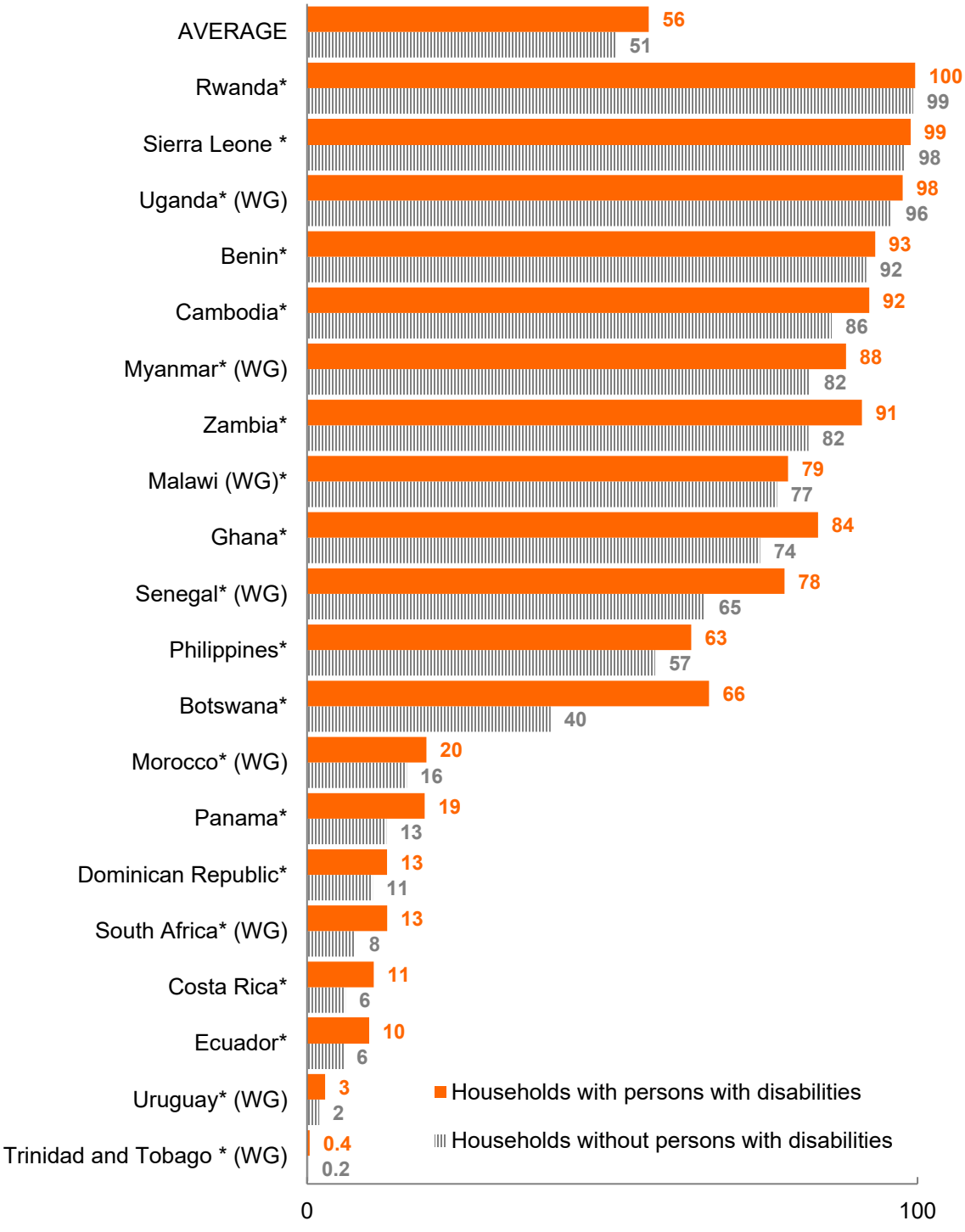
Within the home, indoor air pollution remains an issue in many countries due to cooking and heating using open fires and inefficient stoves burning kerosene, biomass (wood, animal dung or crop waste) and coal in poorly ventilated conditions. Many persons with disabilities spend more time at home, and thus are more exposed to this indoor air pollution. This exposure is linked to cardiovascular disease, chronic obstructive pulmonary disease and lung cancer. Among 20 developing countries, a higher percentage of households with persons with disabilities than households without persons with disabilities use wood or coal for cooking instead of a clean cooking fuel. On average, 56 per cent of households with persons with disabilities versus 51 per cent of households without persons with disabilities use wood and coal (Figure 118). The largest gaps are found in Botswana (26 percentage points) and Senegal (13 percentage points).

Across 14 countries, use of wood and coal for cooking is higher in rural areas (Figure 119). On average, 66 per cent of households with persons with disabilities in rural areas, compared to 32 per cent in urban areas use wood or coal for cooking. In all countries, the use of wood and coal is higher in rural areas than in urban areas, with the largest gaps in Zimbabwe, in which 96 per cent of households with persons with disabilities in rural areas use wood or coal while only 20 per cent of households with persons with disabilities in urban areas use wood or coal.

Persons with disabilities often have higher energy needs, including additional heating/cooling, (de) humidifiers, increased personal cleaning, increased laundry, breathing apparatus, home-based mobility aids, hoists, lifts and assistive technology. Energy needs are vastly different between and even within types of disability, and also sit within the wider context of the household itself, and what other energy needs may exist. Energy needs are not fixed and can fluctuate seasonally – some types of disabilities may result in higher energy needs for heating or cooling. As persons with disabilities are at higher risk of experiencing poverty (see the chapter on Goal 1), these increased energy costs can place greater pressure on them, and they may not be able to afford energy bills.

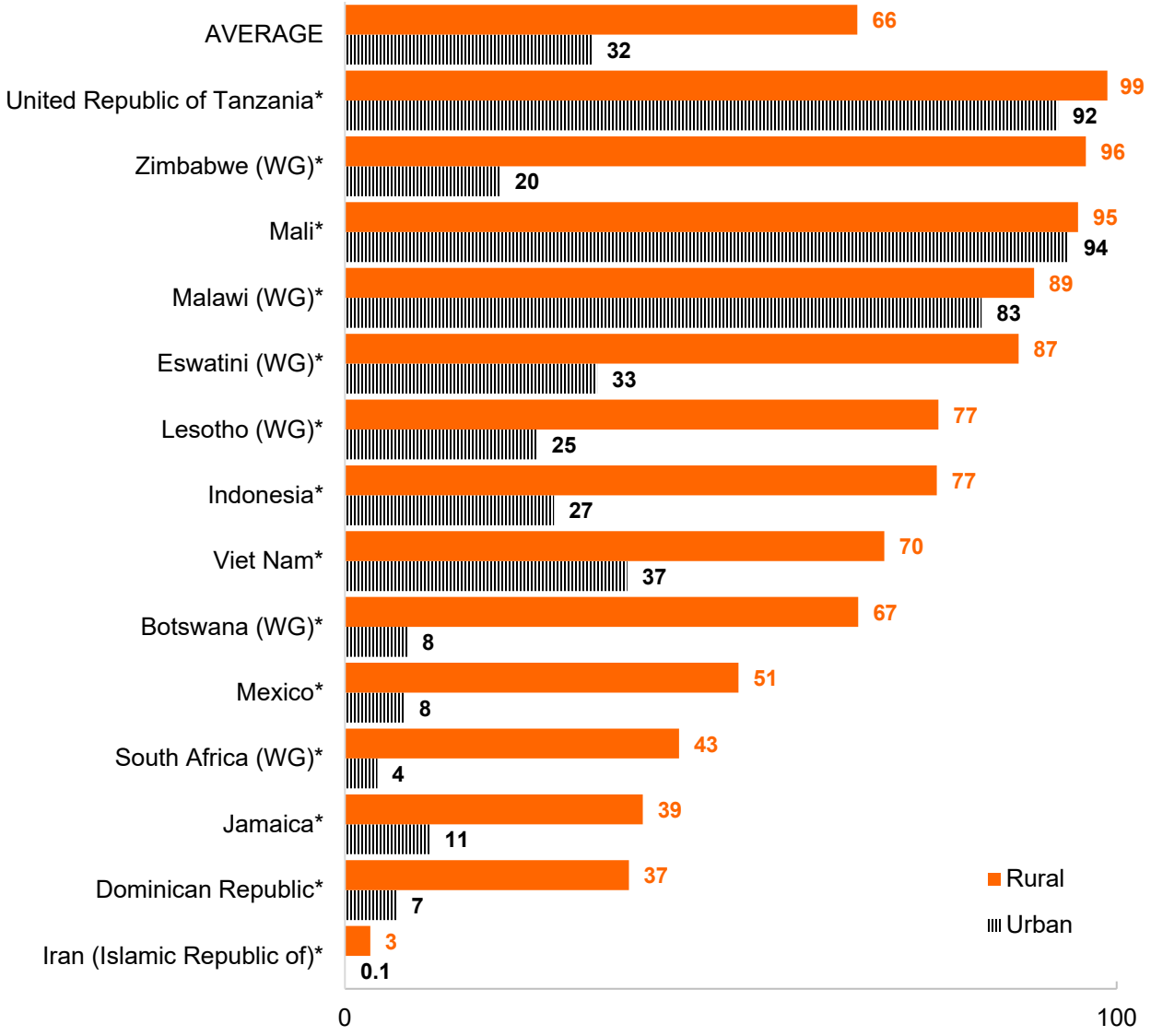
A number of other factors may also exacerbate lower access to energy among persons with disabilities. Accessing the cheapest forms of energy often requires a bank account and regular income, whereas the most expensive forms of energy are offered on a pay-as-you-go basis. As many banks worldwide remain not accessible for persons with disabilities (see the chapter on Goal 1) and persons with disabilities face barriers to accessing the job market and receiving regular income (see the chapter on Goal 8), they may not have access to the cheaper energy tariffs. Moreover, there may be additional barriers that prevent persons with disabilities from implementing features in their home that might reduce energy bills, including a lack of space, being unable to pack or move items around the home, and the potential disruption of having home improvements or people in the home.

Figure 118. Percentage of households cooking with wood or coal, by disability status, in 20 countries, in 2017 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between households with and without persons with disabilities is statistically significant at the 5 per cent level.
Source: UNDESA (on the basis of data from IPUMS).

Figure 119. Percentage of households with persons with disabilities cooking with wood or coal, by area of residence, in 14 countries, in 2017 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from IPUMS).

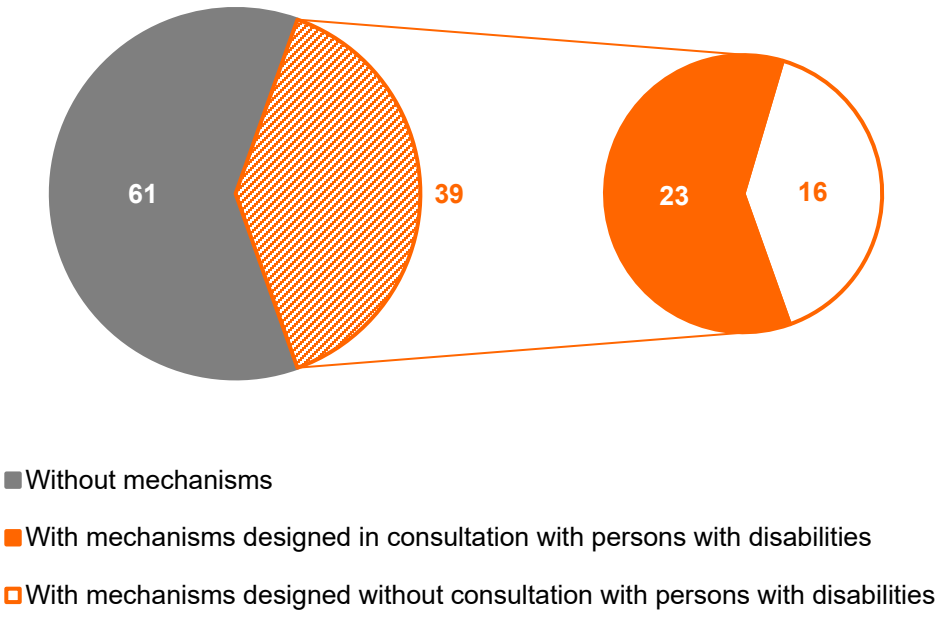
The governance of domestic energy at the national, regional, local and community levels can also impact energy access for persons with disabilities. For instance, the extent to which energy markets are regulated, the way in which energy is provided to the home, charging systems and pricing structures all affect access. In terms of markets, regulating the energy power market through government subsidies and price limits can significantly protect vulnerable populations, including persons with disabilities, from gas and electricity price increases, while free market approaches can lead to sharp increases in energy poverty rates. Persons with disabilities face more barriers to managing and dealing with financial shocks[32]

and may be more affected by unregulated energy markets.

Energy infrastructure issues can significantly improve or worsen access to energy for persons with disabilities. Persons with disabilities may face more barriers to energy access in rural and coastal areas as well as small islands as these areas tend to be less often connected to electricity grids. Moreover, persons with disabilities living in small island developing States may also face more barriers to accessing affordable uninterrupted energy access as these States are often highly reliant on expensive fossil fuel imports, are more vulnerable to energy price shocks and also experience interrupted supply.

Black-outs can compromise the use of electricity-run assistive technology; more than a quarter of priority assistive products require electricity to run.[32] Yet, in 2023, among 23 countries, only 39 per cent of countries had mechanisms to assist persons with disabilities using electricity-run assistive devices during a power outage; only two-thirds of these mechanisms were designed in consultation with persons with disabilities (Figure 120).

Figure 120. Percentage of countries with mechanisms to assist persons with disabilities using electricity-run assistive devices during a power outage, among 23 countries, in 2023.



Source: UNDESA. [310]

Lack of affordable and reliable access to energy can push persons with disabilities to rely on alternative forms of energy such as bottled liquefied petroleum gas and heating oil (which are often more expensive and less convenient), indoor fires, candles, gas burners or cutting peat to burn for warmth (which come with a range of risks caused by the indoor air pollution they create). Lack of access to affordable energy

can also lead to practices such as energy rationing and self-disconnection as a result of tight budgets that are under pressure, something that is especially harmful for persons with disabilities who rely on energy services for their independent living, including through the use of electricity-run assistive technology.

Moreover, there can be a range of other adverse consequences for persons with disabilities when their energy needs are not met. Inadequate ambient temperatures can cause both physical and mental health problems that can turn into long-term health conditions, can exacerbate existing physical and mental health conditions and can compromise the achievement of Goal 7 and Goal 3 (see the chapter on Goal 3). In countries with colder temperatures, there tends to be a focus on poor housing conditions such as damp and mould and low ambient temperatures. Existing heart and circulatory diseases and respiratory conditions can be exacerbated by poor housing conditions associated with energy poverty, and new health conditions may be brought on. Higher ambient temperatures, and longer periods of warmth may be necessary in order to maintain a person's existing health status. For example, Parkinson's disease restricts physical activity, which slows body heat generation and conservation, whereas someone with chronic obstructive pulmonary disease might require a heating regime that is higher than the standard in order to prevent both short-term and longer-term health consequences – in both cases there are likely to be higher energy costs, with negative health consequences at stake if energy needs are not met.[311]

While cold and damp both drive and exacerbate long-term health conditions, so too does excess heat. Increased temperatures (for example, heatwaves) have the potential to negatively affect the mental status of persons with mental and psychosocial disabilities.[312] Mitigating the effects of heat may require running electrical equipment such as air conditioners, fans and other cooling devices, which require suitable infrastructure, and without policy intervention, will add to household energy costs.

Apart from health consequences, the cost of energy may also create financial pressures elsewhere, exacerbating poverty, deprivation and exclusion: persons with disabilities may decide to go without other essential goods and services; miss out on other key areas of life such as education or employment in order to meet energy needs.

Policy, regulation and administrative arrangements can exacerbate or improve the circumstances of persons with disabilities, both directly through energy policy, and indirectly through the interaction of broader social security policies with energy services. Policy measures that act to reduce energy costs or to raise incomes (for example, through disability-related social security payments) are usually the most successful, as they provide financial compensation for the additional energy costs associated with disabilities. There are various national examples of support being provided for persons with disabilities to mitigate the effects of high energy costs, such as social energy tariffs, rebates, caps on bills, one off payments, discounts, subsidies and financial top ups (Box 5). This support is sometimes provided through social protection schemes or through direct support for energy bills.

Many of the schemes in place have limitations in terms of eligibility, leaving out persons with disabilities who may need assistance to afford enough energy to cover their needs. Determining eligibility for support

for energy needs for persons with disabilities can be costly and time consuming, especially given the broad range of disabilities and the variation of energy needs across types of disabilities. A tailored energy support intervention might require numerous home visits and follow up. Given these challenges, many schemes use blunt eligibility criteria. Some schemes only cover persons with disabilities of retirement age, others only cover working age persons with disabilities if they meet the criteria for low income or receive disability benefits. In some cases, schemes do not cover all potential beneficiaries and coverage is only guaranteed while there are sufficient funds.

Box 5. Supporting energy costs for persons with disabilities

Social tariffs in Belgium: Since the completion of the market for gas and electricity in 2007, a federal law defines the concept of protected residential consumers with low incomes or in precarious situations. Those protected consumers have the right to access electricity and gas at a reduced rate. The status of protected consumer is granted to a household, if one of its members belongs to certain social categories: people receiving minimum income benefits from public social welfare centres; or people receiving an income replacing benefit or a disability benefit.

Discounted bills in Croatia: The Croatian Energy Act, adopted in 2012 and amended in 2018, affirms that persons with disabilities have the right to a supply of energy, guarantees a supply of electricity for persons with disabilities in crisis situations and entitles persons who receive disability benefits to a monthly reduction in their electricity bills.

Discounted bills in the United Kingdom: The Warm Home Discount Scheme provides a discount on energy bills, paid between October and March, and persons receiving disability benefits are eligible for this scheme.[313]

One off payment in the Republic of Moldova: During the 2022 energy crisis, the European Union provided funding for direct financial assistance to support persons during the winter through the energy crisis. Support was targeted based on vulnerability criteria, including the number of persons with disabilities in the household.[314]

One off payment in the United Kingdom: A one off payment is made to persons of working age who are in receipt of low-income benefits and: (i) receive a disability benefit, or (ii) have a child with disabilities. This support consists of a payment for each seven day period of very cold weather (zero degrees Celsius or lower) between 1 November and 31 March.[315]

To counter these challenges and provide more tailored support, an emergent trend in policies supporting the energy needs of persons with disabilities is *social prescribing*, in which support to energy bills or energy bill discounts as well as home energy efficiency systems and improvements can be prescribed by health or social care practitioners. For example, in the United Kingdom, persons with respiratory

conditions that are exacerbated by the cold, such as Chronic Obstructive Pulmonary Disease, received improvements to their home such as new energy efficient boilers, double glazing and insulation.[316] After these interventions, the beneficiaries needed fewer medical appointments, had improved mental health and reduced energy poverty.

Structural issues often exist at the national level that impede the development of effective policies on access to clean energy for persons with disabilities. Ministries and national entities that work on policies for persons with disabilities, housing, climate change, social security and energy tend to operate separately, and often there is an insufficient understanding about the intersection of these issues at the household level. In particular, an emergent issue that affects energy access for persons with disabilities is climate change and climate policies. Many climate policies focus on mitigation (reducing carbon emissions). Mitigation policies are likely to have direct impacts on persons with disabilities as they are likely to affect household energy the most. Countries pursuing a net zero agenda are likely to see a range of changes that affect domestic energy use including housing retrofit to improve energy efficiency, changes in the types of energy used in the home – for example, hydrogen, micro-generation and a switch to home car charging. In countries with lower energy access, mitigation strategies may include any of the above, but often also include a development angle, such as rural electrification using renewable energy. Household-level, low-carbon policies may bring about a period of rapid change. If not well planned to consider and address the rights, perspectives and needs of persons with disabilities, these changes to the physical energy infrastructure of the home and the energy services provided can have a harmful impact on persons with disabilities.

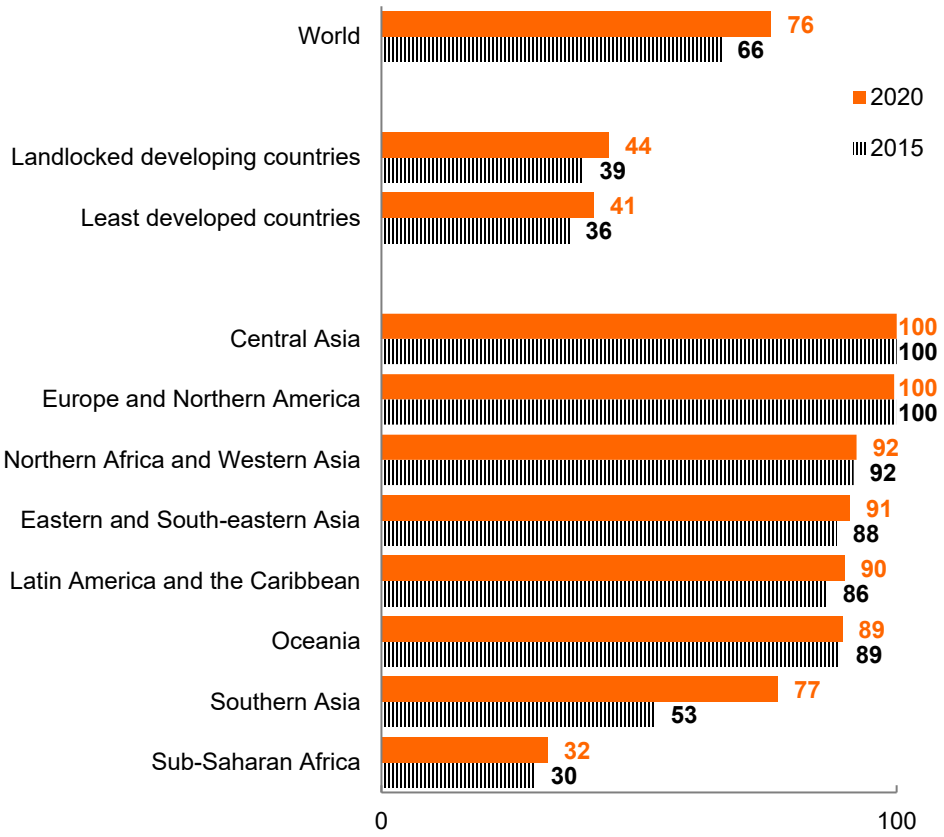
Persons with disabilities may need adjustments when undergoing changes to their heating system or home insulation. Adjustments may include the provision of physical support help such as moving items of furniture and clearing space. Adjustments may also be needed to avoid disruption to carefully planned home layouts and routines that some persons with disabilities may need. Moreover, interventions need to be planned around the energy needs of persons with disabilities. For instance, if a member of the household uses assistive technology reliant on energy, this needs to be taken into account whilst any work on energy infrastructure and services is being undertaken to avoid disruptions in energy access and ultimately in access to assistive technology. A one-size-fits-all approach to energy improvements tends to miss the needs of many persons with disabilities. Furthermore, any interventions should also be designed for all, including persons with disabilities, or adapted to persons with disabilities; for example, ensuring that smart home technology is accessible to persons with visual impairments. Without considering the needs and perspectives of persons with disabilities, persons with disabilities either (i) cannot carry on with the improvements and are left with outdated and increasingly expensive home energy systems or (ii) endure the improvements and end up with energy systems that are not fit for them.

Moreover, the requirement for a household with persons with disabilities to make a financial contribution to a new intervention can be prohibitive, especially for poorer households, even if there is a medium- to

long-term financial benefit. Persons with disabilities may not be able to take the financial risk.

There are several ways in which these potential risks can be mitigated. In terms of policy design, engagement with persons with disabilities and the organizations that represent them has been found to improve policy settings, reduce the unintended consequences of policies, and improve access to support, for example, by removing barriers that prevent access to measures such as restrictive eligibility criteria and additional costs. In terms of policy implementation, ensuring that where persons with disabilities have specific needs in terms of applying for measures, their installation or their function, these are addressed. Positive examples of this working well include: a single point of contact throughout the installation process, support with the application process including eligibility checks and other paperwork, and the provision of adapted measures that are tailored towards the needs of persons with disabilities.

Figure 121. Percentage of primary schools with access to electricity, by region, in 2015 and 2020.



Note: For Central Asia, 2015 data are from 2016; for Latin America and the Caribbean, 2020 data are from 2019; and for Oceania, 2020 data are from 2017.
Source: UN SDG indicators database.[285]

Despite the challenges, the acceleration of changes in household energy systems to more efficient and less polluting systems has the potential to have positive effects for persons with disabilities. Indoor living

conditions without energy access, energy efficiency or using polluting energy sources are especially dangerous for persons with disabilities. Improvements to these provide multiple benefits in terms of health and well-being. The increasing use of smart technology in household energy systems can also be enabling for many persons with disabilities.

Lack of electricity in schools prevents students with disabilities from accessing and using electricity-run technology, including assistive technology, that would enhance inclusive education and allow them to participate in education independently. Many schools, particularly in developing countries, still lack electricity – a barrier to operating ICT and assistive technologies to ensure the inclusion of students with disabilities and also a barrier to ensure the school environment is accessible (for example, with good lighting). In 2020, 76 per cent of primary schools worldwide had access to electricity up from 66 per cent in 2015 (Figure 121). Primary schools in sub-Saharan Africa had the lowest level of access: 32 per cent in 2020, showing barely any progress from 2015 (30 per cent); followed by Southern Asia, where 77 per cent of primary schools had access in 2020, a remarkable improvement from 53 per cent in 2015. In other regions, the percentages are higher. Both least developed countries and landlocked developing countries show low levels of access to electricity in primary schools (less than half the schools have access) and little progress since 2015.

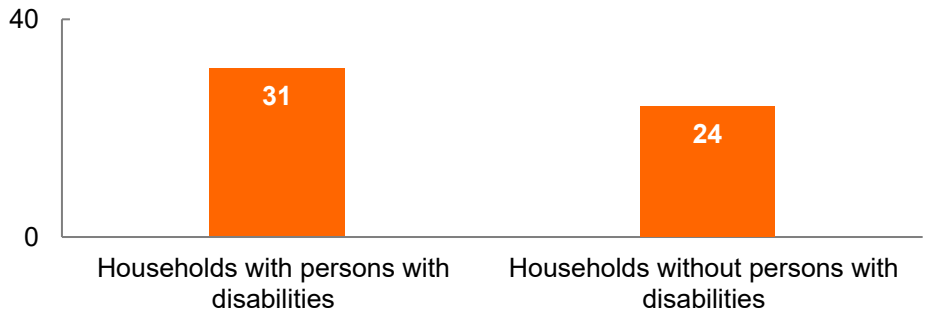
Impact of the COVID-19 pandemic

The COVID-19 pandemic brought challenges to affording access to energy, especially for persons with disabilities. In 2020, worldwide, a higher proportion of households with persons with disabilities, compared to those without, reported difficulties paying for utility bills: 31 per cent versus 24 per cent (Figure 122). Decreases in income during the pandemic as well as higher energy prices[317] continued to make it difficult for many persons with disabilities to pay for energy bills well past the year of onset of the pandemic. For example, in the United Kingdom, in 2022, 30 per cent of households with persons with disabilities reported a constant struggle to pay bills, compared to 13 per cent of households without persons with disabilities; persons with disabilities cut back on other necessities in order to manage these rising costs of energy, with 43 per cent of households with persons with disabilities reporting eating lower quality food than usual and 48 per cent struggling to keep their home warm and comfortable.[318]

Several governments, regulators and utility companies responded to the pandemic by putting in place additional protective measures to ensure continuous access to affordable energy during the pandemic.[319] Six countries developed targeted measures for persons with disabilities. The measures developed for persons with disabilities focused on forbidding energy disconnections or providing financial support for energy bills. For example, the Jamaica Public Service electricity utility applied disconnection suspensions for all essential services, including electricity, for persons with disabilities. Moreover, it put in place payment flexibility for persons with disabilities, as well as a fund for bill relief and other forms of assistance to vulnerable consumers, including customers with disabilities. In Greece, financial assistance

was offered in the form of additional discounts of 8 per cent on the energy bill for persons with disabilities, while in the Mexicali municipality in Mexico, payment support was provided to persons with disabilities. In certain areas in the United Kingdom, a COVID-19 Heating Payment Scheme entitled persons receiving certain disability benefits to a one-time assistance for payment. In the state of Virginia, in the United States, energy assistance programmes were available for heating, cooling, weatherization and other energy needs for persons with disabilities.

Figure 122. Percentage of households that reported difficulties paying utility bills, by disability status, in 2020.



Source: Save the Children (2020).[16]

In other countries, protective measures, such as disconnection bans, tariff adjustments and financial assistance, were put in place either for the general population or for certain categories of low-income groups. These measures would have benefitted low-income persons with disabilities as well. For example, in Spain, energy disconnections were forbidden for beneficiaries of the social bonus for energy, including persons with disabilities.

Summary of findings and the way forward

Since 2018, many countries succeeded in expanding access to electricity and this trend also benefited persons with disabilities. Several countries have now reached close to universal access for both persons with and without disabilities. However, for countries that remain with mid to low levels of electricity access, persons with disabilities experience more challenges in accessing electricity than persons without disabilities; and many of the barriers and inequalities identified in the *Disability and Development Report 2018* remain.

Disability continues to be largely absent from the international energy discourse and more political commitment to highlight the nexus between energy poverty and disability is needed. Persons with disabilities face more barriers to accessing the financial means to pay for energy, they often have higher energy needs and many persons with disabilities rely on electricity-run assistive technology for

independent living or survival. Yet, in 2023, only 39 per cent of countries had mechanisms to assist persons with disabilities using electricity-run assistive devices during a power outage; and only two-thirds of these mechanisms were designed in consultation with persons with disabilities.

In developing countries, gaps in electricity access between households with and without persons with disabilities reach 10 percentage points or more in several countries with low to medium access to electricity. Persons with disabilities living in rural areas have even lower access. In many countries, the percentage of households with persons with disabilities in rural areas that have access to electricity is less than half that of urban areas. Moreover, households with persons with disabilities in rural areas are twice as likely to use polluting forms of energy like wood and coal, thus endangering the health of persons with disabilities and their household members. In European countries, households with persons with disabilities are more likely to be energy poor than households without persons with disabilities, with gaps reaching 10 percentage points or more in several countries.

Access to electricity is crucial in schools to allow the use of electricity-run assistive technology by students with disabilities. Worldwide, the percentage of primary schools with access to electricity has increased from 66 per cent in 2015 to 76 per cent in 2020, with most regions in the world having now universal or close to universal access to electricity. An exception to this progress is sub-Saharan Africa where only about a third of primary schools have electricity access and little progress has been made since 2015. Worldwide, with current rates of progress, 95 per cent of primary schools are expected to have electricity by 2030. To reach 100 per cent of primary schools by 2030, the rates of progress need to accelerate to 1.2 times faster than the rates of progress observed since 2015.

The COVID-19 pandemic brought additional challenges. Energy prices soared and many persons with disabilities lost jobs, income and other financial means, leading to about one third of households with persons with disabilities facing difficulties paying for utility bills. Ad hoc measures were adopted in a few countries to support energy access for persons with disabilities during the COVID-19 pandemic – continuing these measures in the post-COVID-19 world will provide relief for persons with disabilities who need them. Several countries have been using various forms of assistance such as disconnection bans, tariff adjustments and financial assistance. Furthermore, an emerging positive trend in energy-disability policy is *social prescribing*, in which the support is tailored by considering the individual energy needs of the person with disabilities as these needs can vary by type and severity of disability.

With the cascading crises of the COVID-19 pandemic, conflict and climate change, interruptions in energy access could become more frequent. Devastating disasters caused by natural hazards are on the rise and can cause interruptions in electricity access lasting for days. Current conflicts are also affecting energy availability. Energy costs have been on the rise and may increase further. This energy crisis, compounded by historical inequalities in energy access for persons with disabilities, can cause further

barriers for independent living for persons with disabilities and, for those who depend on electricity-run assistive technology for survival, it can lead to death.

Changes in household energy systems to make them more efficient and less polluting have the potential to benefit persons with disabilities in terms of affordability, health and well-being. However, these changes are still often planned without a meaningful consultation with persons with disabilities and their representative organizations and without considering the perspectives and needs of persons with disabilities. Improvements in energy systems can lead to disruptions in the use of electricity, disruptions in the use of life-saving assistive technology and disruptions to carefully planned layouts and routines that persons with disabilities may need. Many persons with disabilities would not be able to go through such disruptions. As a result, persons with disabilities may end up with inefficient and polluting forms of energy.

To improve energy access for persons with disabilities in line with Goal 7, suggested actions are outlined below:

1. Take into consideration the extra energy costs which persons with disabilities are faced with and the co-benefits of including support to energy access in determining social protection measures for persons with disabilities. Persons with disabilities tend to have higher energy consumption and, therefore, 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. These programmes should be accessible for persons with disabilities and should be developed in consultation with persons with disabilities to take their perspectives into account.

2. Include special measures for persons with disabilities in energy programmes. Initiatives and programmes launched by countries, local governments, 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 pay attention to the energy needs of persons with disabilities to secure their access to affordable and reliable energy. Special measures can include direct support for energy, for example, through mechanisms such as social tariffs, grants and discounts. Supporting affordable energy equipment and technology, such as batteries, is also key.

3. Close the gap in energy access between persons with and without disabilities and close the rural-urban gap in energy access for persons with disabilities. This will require a focus on countries with lower electricity access, because in these countries the energy access gap between households with and without persons with disabilities tends to be wider. Rural areas 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 survival, independent living and for participation in society. Electricity services should reach persons with disabilities who require electricity-run assistive technology. In the absence of household electricity, charging at public facilities or off-grid systems (that is, stand-alone and mini-grid systems), 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. Establish mechanisms for ensuring electricity access during electricity service disruptions and blackouts to persons with disabilities who use life-saving electricity-run assistive technologies.

5. Reduce use of solid fuels and promote modern and clean forms of energy in the households of persons with disabilities. Initiatives and programmes to reduce the use of solid fuels and to promote the use of energy efficient stoves using modern forms of energy should reach households with persons with disabilities as a priority, as many persons with disabilities tend to spend longer periods at home than persons without disabilities and therefore have higher risks of exposure to indoor pollution. It will also save persons with disabilities, particularly women and girls with disabilities, from exposure to violence while collecting firewood. Targeted actions should be developed for rural areas, as the use of solid fuels is particularly high in households with persons with disabilities in these areas.

6. Invest in providing access to 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 students 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. Efforts to provide access to electricity are particularly needed in primary schools in sub-Saharan Africa, in least developed countries and in landlocked developing countries.

7. Include persons with disabilities in national governing bodies working on energy access. The inclusion of persons with disabilities in these bodies, such as national energy committees, energy advisory boards and energy dispute tribunals, could play a vital role in addressing the energy needs of persons with disabilities in the implementation of energy policies. Advisory committees on electricity typically provide advice to policymakers in the implementation of energy acts or policies, on electricity reliability, security and policy issues, review electricity programmes and initiatives and identify emerging issues. Persons with disabilities must be engaged in these decision-making processes to ensure that their needs are adequately addressed in acts, policies and programmes.

8. Raise awareness within ministries and promote coordination among ministries to address energy poverty among persons with disabilities. At the national level, the bodies with mandates relating to disability, assistive technology, social protection and energy are usually different. But these

areas are interlinked, and more inter-ministerial coordination will be needed to address this nexus. Discussions on the energy poverty of persons with disabilities will need to be linked to discourses around assistive technology and vice-versa, because being energy poor impacts the use of assistive technology, which in turn impacts the independent living of persons with disabilities and their enjoyment of human rights.

9. Increase the availability of high-quality data on energy access for persons with disabilities, especially in developing countries. Routinely collect data disaggregated by disability on access to electricity (SDG indicator 7.1.1) and on primary reliance on clean fuels and technology (SDG indicator 7.1.2). Further disaggregate these data by gender and area of residence (rural and urban).

10. Make clean energy transition and climate mitigation policies inclusive of persons with disabilities. Climate policy agendas are likely to lead to changes in energy infrastructure, the provision of energy, associated policy and regulation. This is likely to affect how households use energy both within the home and beyond. There are many opportunities to make this a positive, enabling and inclusive transition. However, there is also the risk that persons with disabilities may be left behind and, as a result, further marginalized and excluded. Policymakers should engage with civil society, especially representative organizations of persons with disabilities, and relevant stakeholders to ensure that the needs of persons with disabilities are considered throughout policy design and implementation.

Promoting full and productive employment and decent work (Goal 8)

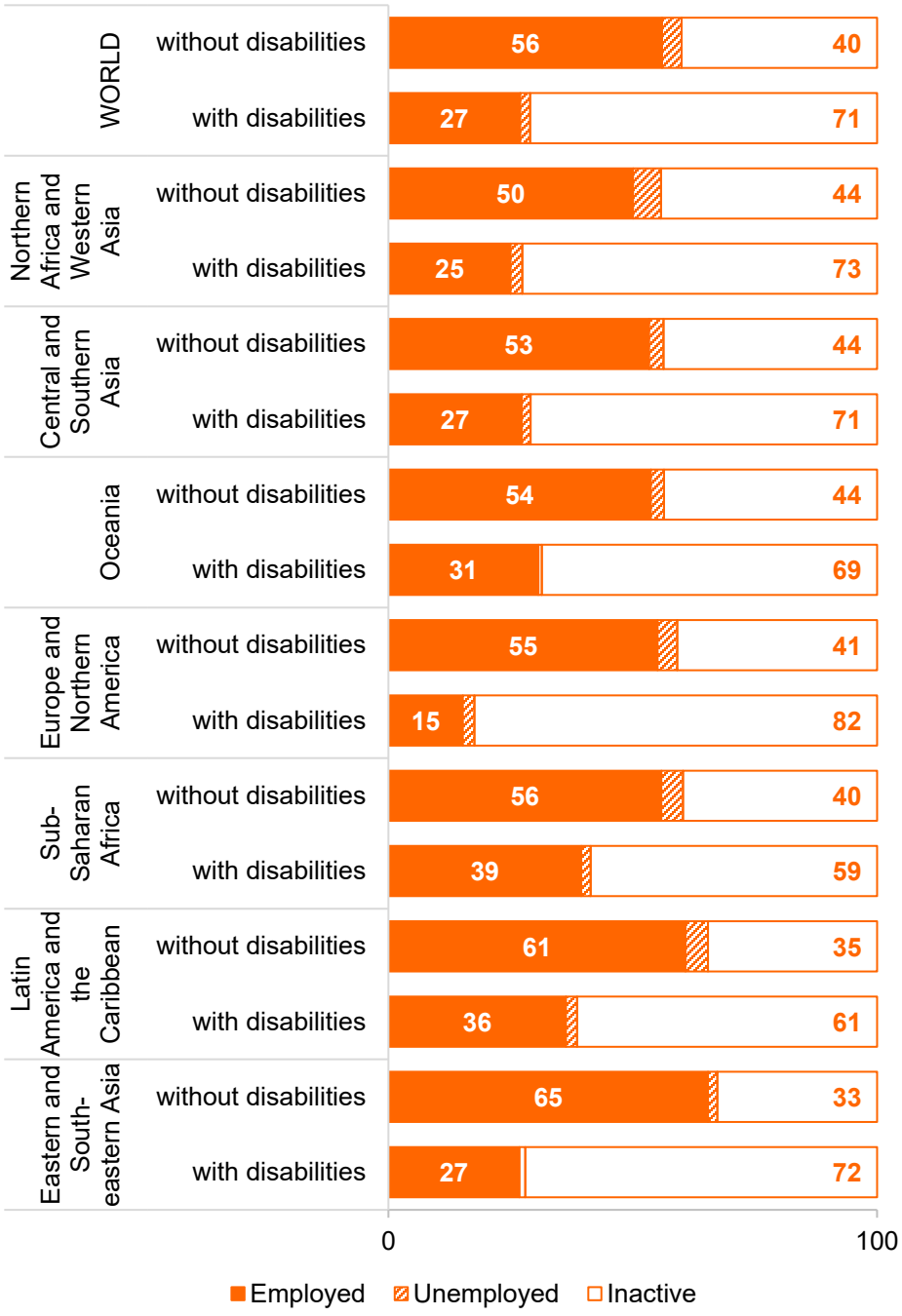
This chapter discusses the current situation and progress made so far for persons with disabilities vis-à-vis Goal 8 and reflects on new opportunities and ongoing challenges faced by persons with disabilities in the labour market, including in the transition to green and digital economies. Goal 8 calls for promoting sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. Goal 8 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. The right to work is explicitly enshrined in article 27 of the Convention on the Rights of Persons with Disabilities, which focuses on work and employment. The United Nations Committee on the Rights of Persons with Disabilities in its General Comment Number 8 provides guidance to States Parties and other stakeholders on Article 27 of the Convention.

Current situation and progress so far

As many persons with disabilities of working age are often not registered as job seekers, they are usually not reflected in unemployment rates. Consequently, the best way of assessing the labour market participation of persons with disabilities is by measuring the percentage of the working age population that is employed and comparing these measures between persons with and without disabilities. Globally, the percentages of the working age population that are employed currently stand at 27 per cent for persons with disabilities and 56 per cent for persons without disabilities (Figure 123) – not very different from five years ago. The level of economic development has a significant impact, with the largest gap being found in the high-income regions of Europe and North America (40 points) and the lowest in sub-Saharan Africa (17 points).

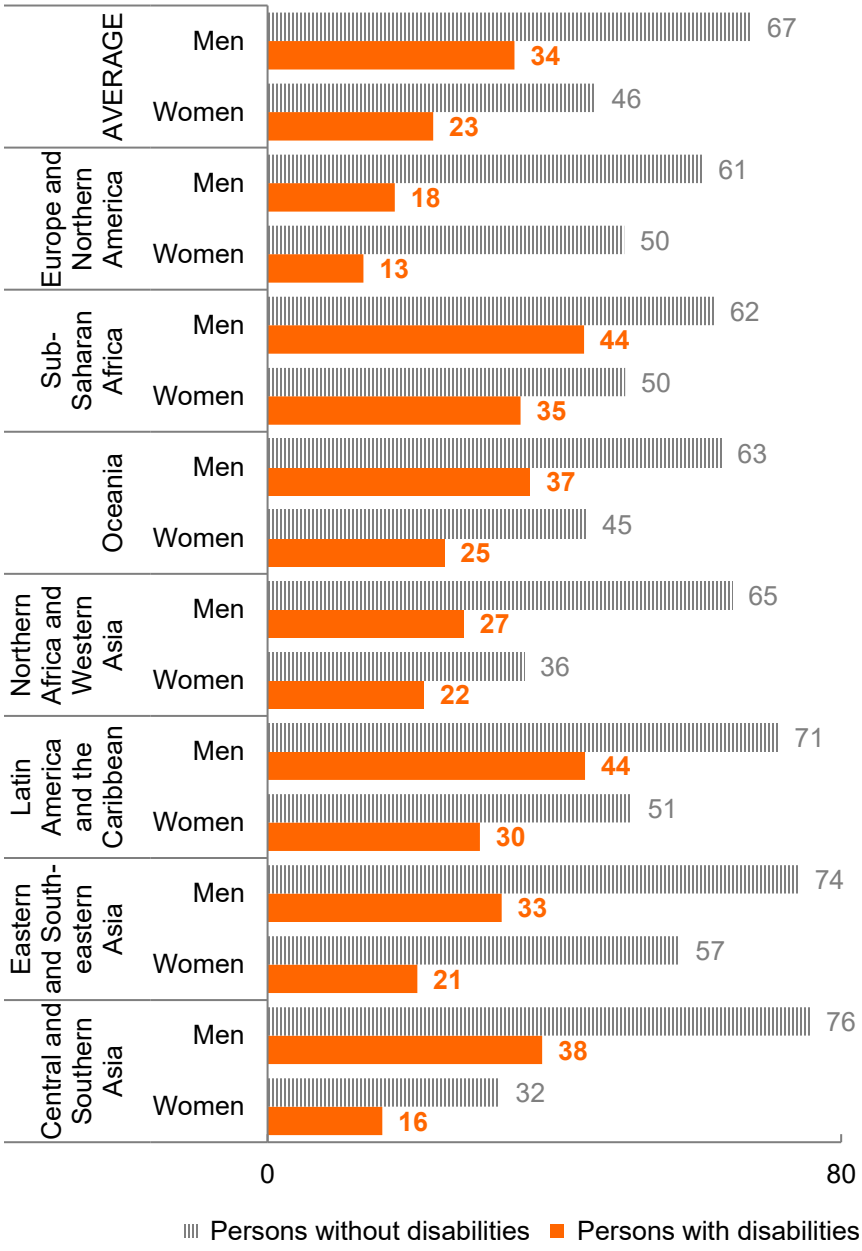
Persons with disabilities are more likely to be outside the labour force, that is, they are not employed nor looking for a job, than persons without disabilities. Gaps between persons with and without disabilities in inactivity rates – that is, the percentage of persons outside the labour force – are wide: there is an overall gap of 30 points in the inactivity rates between persons with and without disabilities, with significant gaps present in every region (Figure 123). The inactivity among persons with disabilities is much higher than unemployment in all regions, with Europe and Northern America witnessing the largest inactivity figures. This indicates that many barriers persist for persons with disabilities in the labour market as a majority of persons with disabilities in all regions does not have a job and is not encouraged to look for a job. From a policy perspective, the low percentage of persons with disabilities employed, particularly in high-income countries, presents significant challenges. These challenges include reducing inactivity, which is a lot more challenging than reducing unemployment, as it entails combating stigma and negative attitudes among employers and the general population, as well as providing accessible and inclusive workplaces.

Figure 123. Percentage of the population aged 15 years and over by labour force status (employed, unemployed and outside the labour force), by disability status, for the world and in 7 regions, in 2021 or latest year available.



Note: Persons outside the labour force, also referred to as inactive persons, refer to persons who are not employed and are not looking for a job. Regional and global estimates are calculated as arithmetic averages of country data. Estimates based on data from 90 countries.
Source: ILO.[320]

Figure 124. Employment to population ratios for persons aged 15 years and over, by disability status and sex, in 7 regions, in 2021 or latest year available.



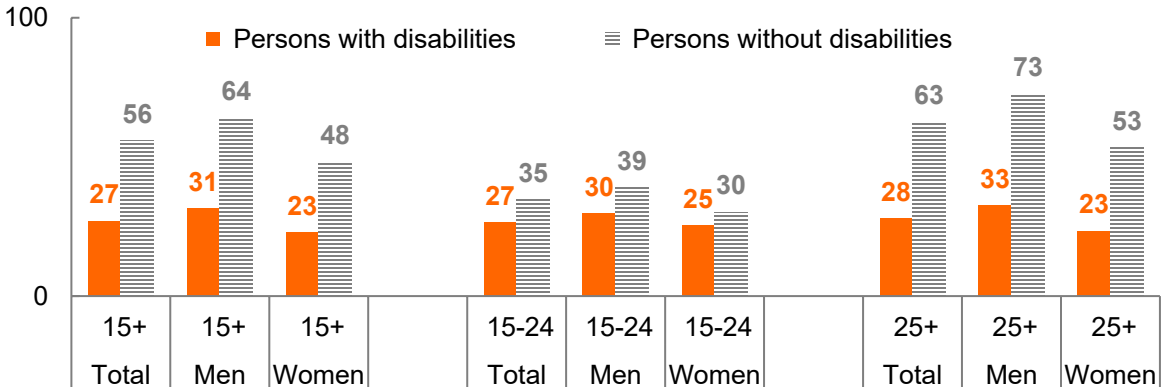
Note: Estimates based on data from 90 countries.
Source: ILO.[320]

Persons with disabilities experience additional barriers and discrimination depending on their gender, age and type of disability. Women with disabilities face more barriers than men with disabilities, with employment to population ratios lower for women with disabilities than for men with disabilities. The

average employment to population ratio is 23 per cent for women with disabilities and 34 per cent for men with disabilities (Figure 124). In all regions, women with disabilities are the least likely to be employed, with their employment to population ratios substantially lower than for men with disabilities, women without disabilities and men without disabilities. The gap between women with disabilities and men without disabilities is largest in Central and Southern Asia and in Eastern and South-eastern Asia. The employment to population ratio of women with disabilities is lowest in Europe and Northern America and in Central and Southern Asia. The employment gap between persons with and without disabilities is higher for older people and the gap between women and men with disabilities is also higher in this age group (Figure 125). Persons with psychosocial or mental disabilities are further left behind than other persons with disabilities in the labour market in many countries (Figure 126).

In terms of unemployment rates (SDG indicator 8.5.2), in Europe and North America, the rate for persons with disabilities is much higher than that of persons without disabilities and slightly higher in Asia, Latin America and the Caribbean and Northern Africa, but the reverse is true in sub-Saharan Africa and Oceania (Figure 127). However, these statistics are misleading as many persons with disabilities are not counted in unemployment rates because they are discouraged from looking for a job due to stigma and negative attitudes.

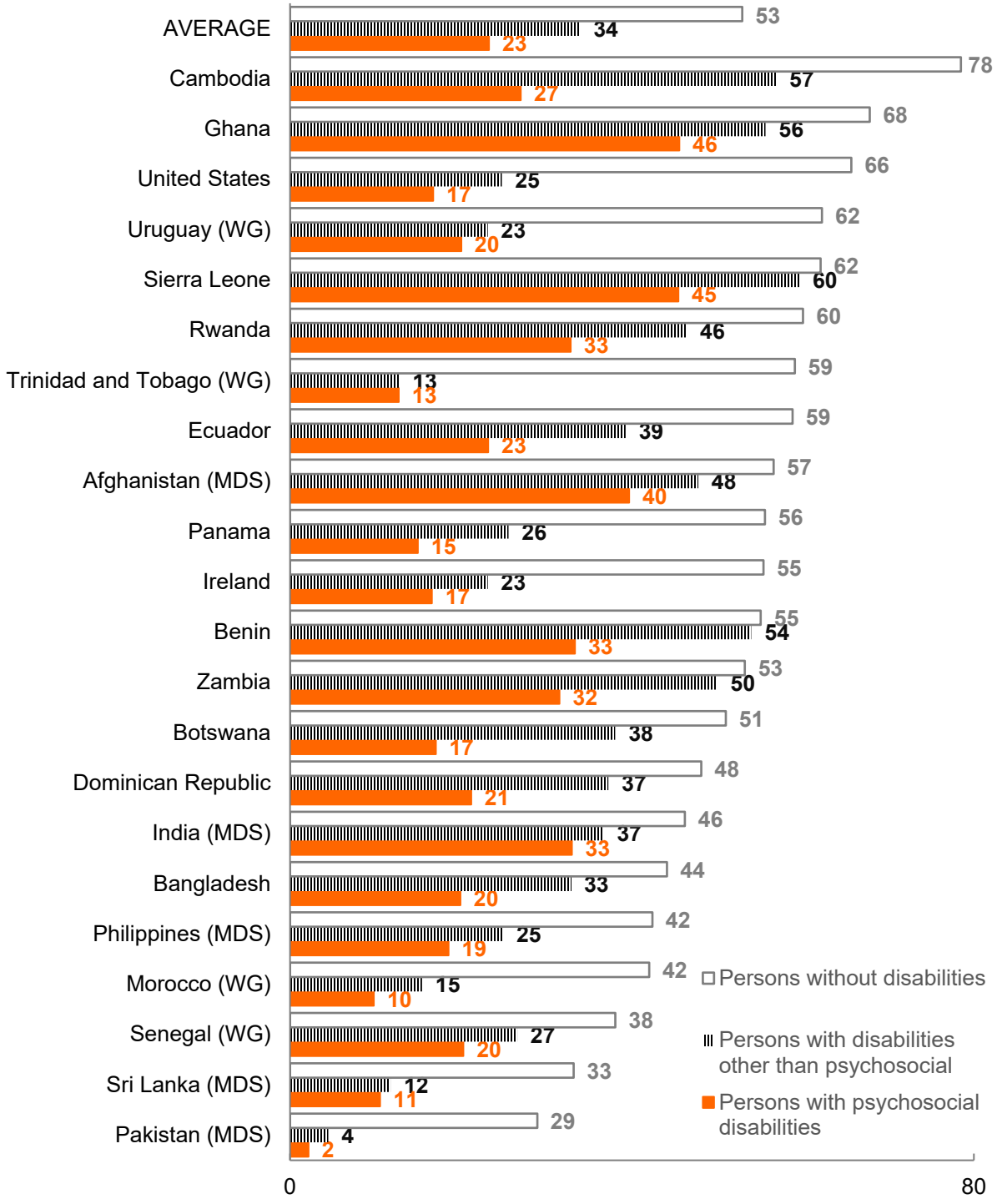
Figure 125. Employment to population ratios for persons aged 15 years and over, by disability status, age group and sex, global estimates, in 2021 or latest year available.



Note: Global estimates calculated as arithmetic averages of country level data. Estimates based on data from 90 countries.
Source: ILO. [320]

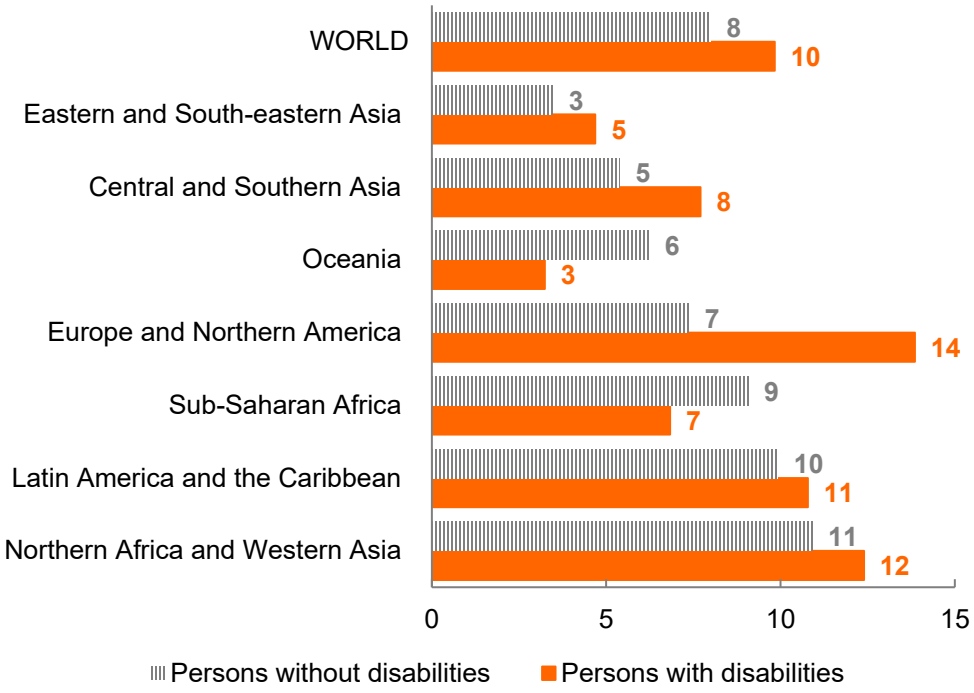
In many countries, laws regulating labour still lack protections against discrimination on the grounds of disability, including in recruitment (see the chapter on Goal 10). An emerging challenge in this area, is securing accessible and inclusive environments as new technologies are introduced in recruitment processes.[321] Artificial intelligence (AI) is increasingly being used for recruiting candidates for a job. These AI systems are trained to identify which job candidates will be successful workers, based on a remote video interview.

Figure 126. Percentage of persons aged 15 and over who are employed, by psychosocial disability and disability status, in 22 countries, in 2019 or latest year available.



Note: For Afghanistan, India, Pakistan, Philippines and Sri Lanka, "persons with disabilities other than psychosocial" reflects all persons with disabilities. (MDS) identifies data produced using the Model Disability Survey.
Source: UNDESA (on the basis of data from IPUMS[8]) and WHO (on the basis of data from Model Disability Surveys).

Figure 127. Unemployment rates for persons aged 15 and over, by disability status, for the world and in 7 regions, in 2021 or latest year available.

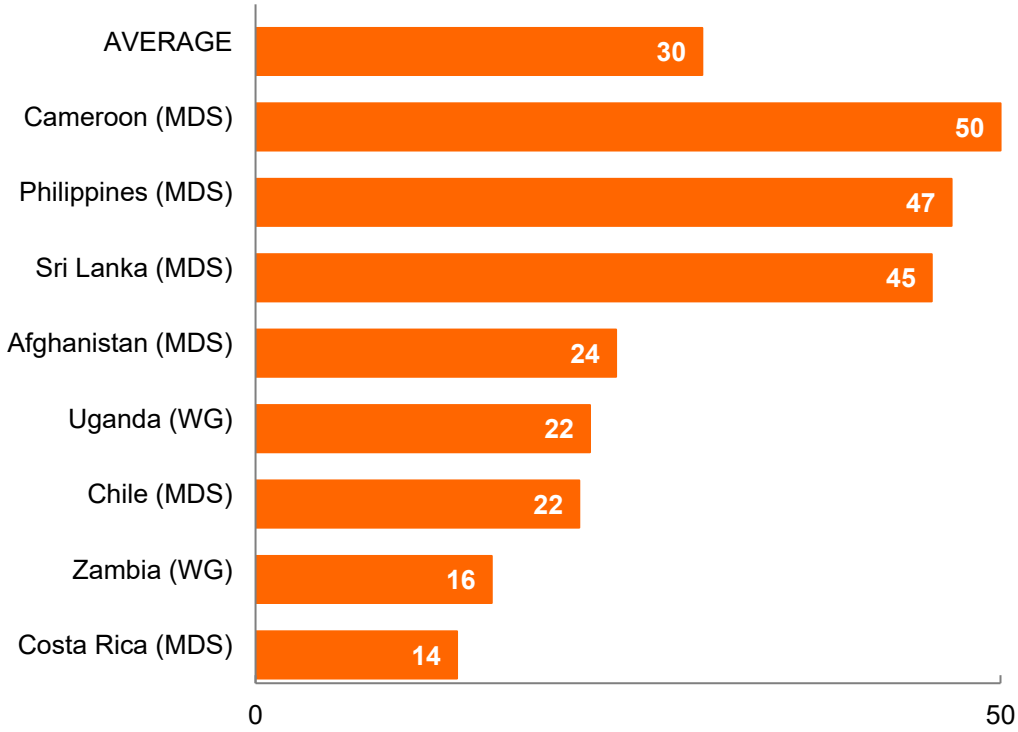


Note: Regional and global estimates calculated as arithmetic averages of 97 countries.
Source: ILO.[320]

However, these AI systems are often not designed to include the perspectives and presence of persons with disabilities. These systems examine speech patterns, tone of voice, facial movements, and other indicators, and make recommendations about who should be scheduled for a follow-up interview and who should not get the job. As persons with disabilities are not sufficiently included in training these systems, the systems tend to discriminate against many persons with disabilities, whose impairments significantly affect facial expression and voice: disabilities such as deafness, blindness, speech disorders and surviving a stroke; or candidates with disabilities who require reasonable accommodations.[322]

These concerns extend to the use of AI in employee surveillance and performance management. The AI debates rarely bring disability into their agenda, while those advocating for disability rights remain to a large extent unaware of the potential impact of these emerging technologies. Developers of AI human resources technology are still often not required to prove that their products are safe and inclusive for job seekers or employees with disabilities.

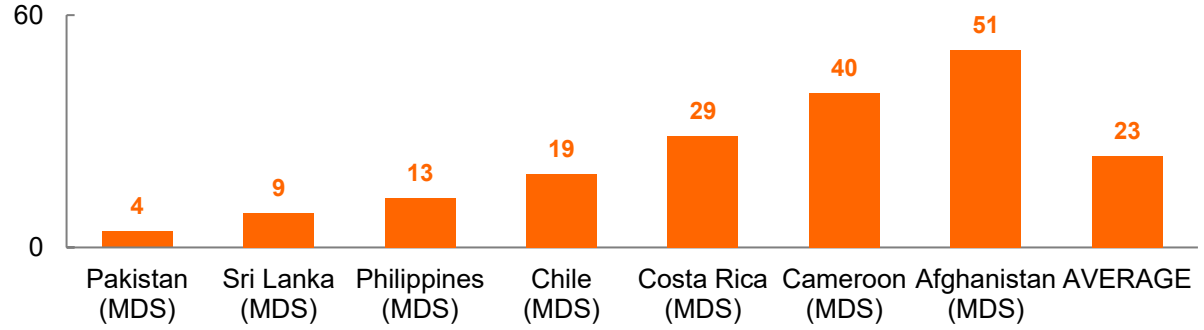
Figure 128. Percentage of persons with disabilities who reported that their workplace is hindering or not accessible, in 8 countries, in 2015-2019.



Note: (MDS) identifies data produced using the Model Disability Survey. (WG) identifies data produced using the Washington Group short set of questions on functioning. Data from Cameroon were collected in selected regions of these countries and are not nationally representative.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO (on the basis of data from Model Disability Surveys).

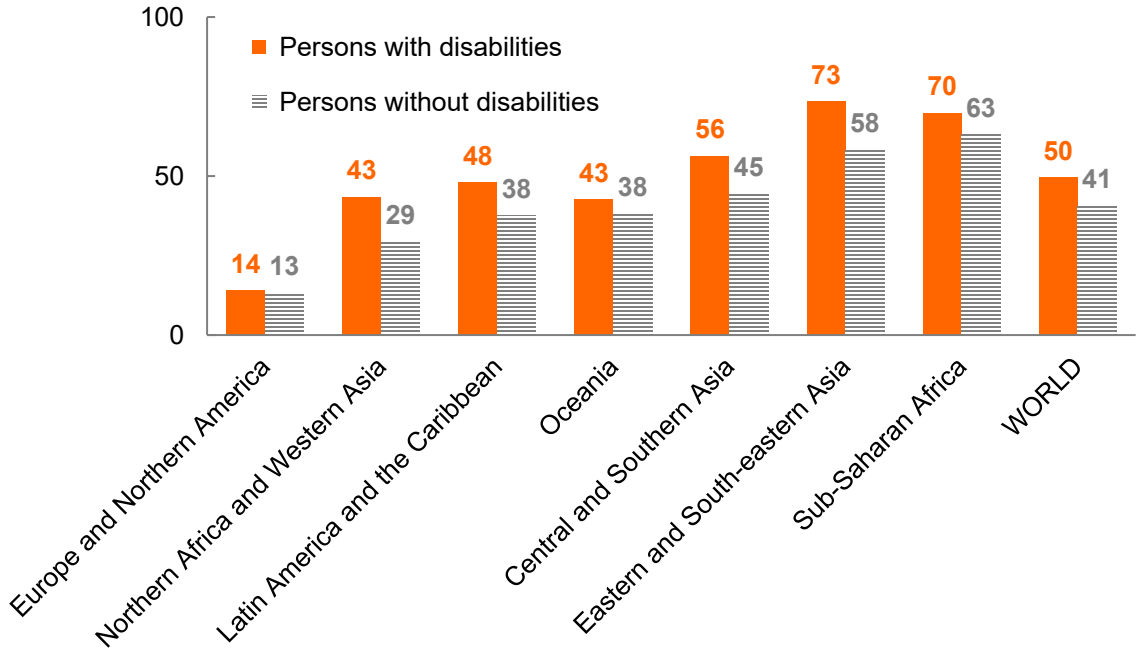
While legislation in many countries includes the provision of reasonable accommodation,[323] its practical implementation tends to fall short. Technical assistance and (when there are cost implications) financial assistance to employers to provide reasonable accommodation and make the workplace accessible is generally lacking. In eight developing countries, an average of 30 per cent of persons with disabilities reported that their workplace is hindering or not accessible (Figure 128). Worldwide, as of 2022, only 62 per cent of employment agencies were accessible for users of wheelchairs, 12 per cent were partially accessible and 26 per cent were not accessible at all (Figure 139). Assistive technology can be costly and is often not available. In seven countries, 23 per cent of adults with disabilities need but do not have assistive products for work, from 4 per cent in Pakistan to 51 per cent in Afghanistan (Figure 129). Due to these obstacles, many persons with disabilities who are capable of working are not able to secure a job and remain an underutilized segment in the labour force.

Figure 129. Percentage of persons with disabilities who need but do not have assistive products at work, in 7 countries, in 2015-2019.



Note: (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon and Pakistan were collected in selected regions of these countries and are not nationally representative.
Source: WHO (on the basis of data from Model Disability Surveys).

Figure 130. Percentage of employed persons who are self-employed, by disability status, for the world and in 7 regions, in 2021 or latest year available.

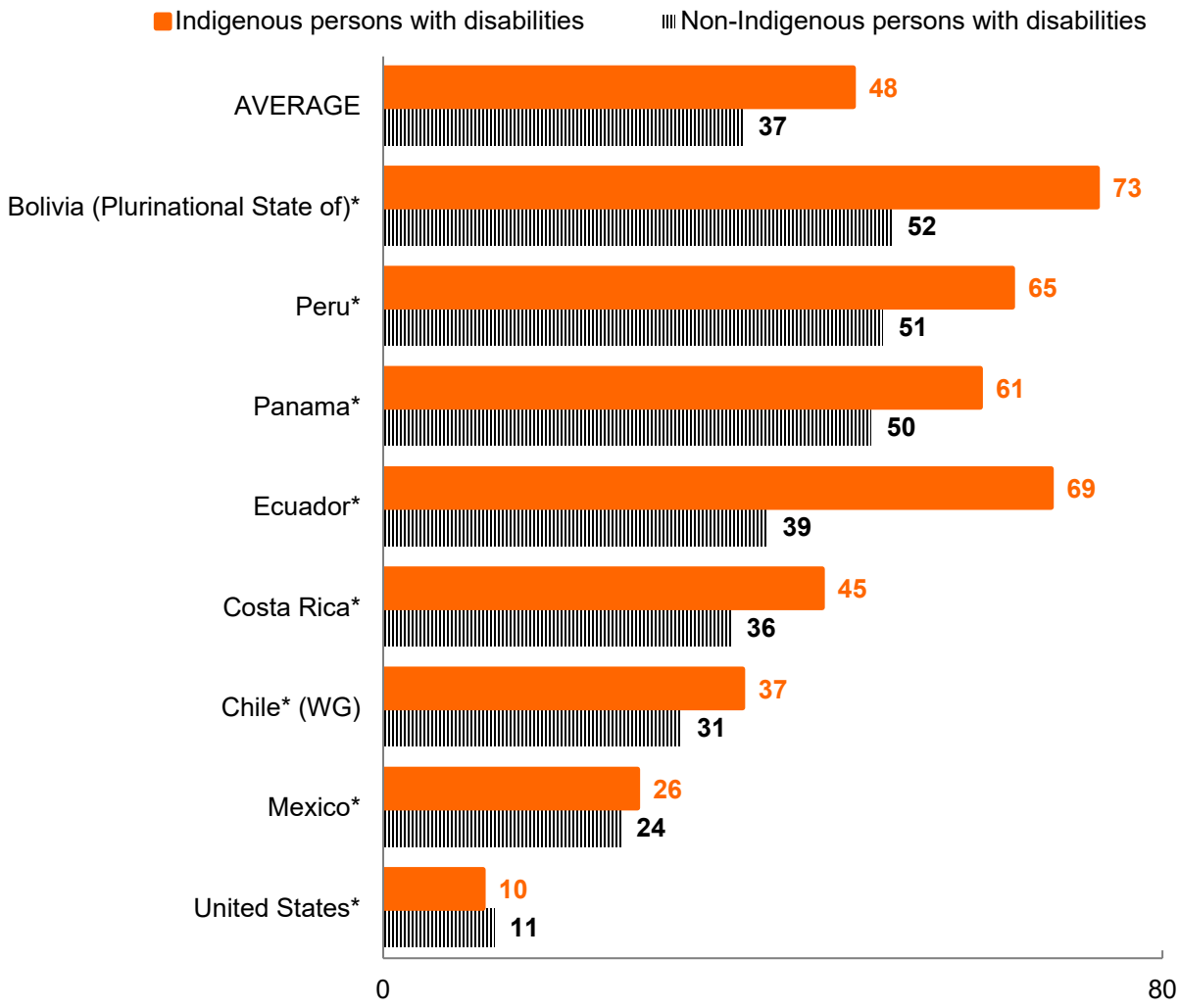


Note: Regional and global estimates calculated as arithmetic averages of country data. Estimates based on data from 90 countries.
Source: ILO.[320]

Persons with disabilities are overrepresented in self-employment and more likely to be working in informal employment. Globally, 50 percent of employed persons with disabilities compared to 41 per cent of employed persons without disabilities are self-employed (Figure 130). Indigenous persons with disabilities

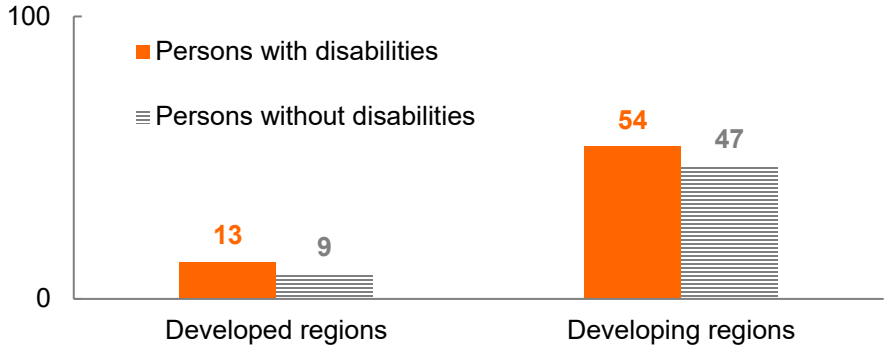
are more likely to be self-employed than non-Indigenous persons with disabilities: among the employed population in eight countries in the Americas, 48 per cent of Indigenous persons with disabilities are self-employed but only 37 per cent non-Indigenous persons with disabilities are self-employed (Figure 131).

Figure 131. Percentage of employed persons with disabilities aged 15 and over who are self-employed, for Indigenous and non-Indigenous people, in 8 countries, in 2021 or latest year available.



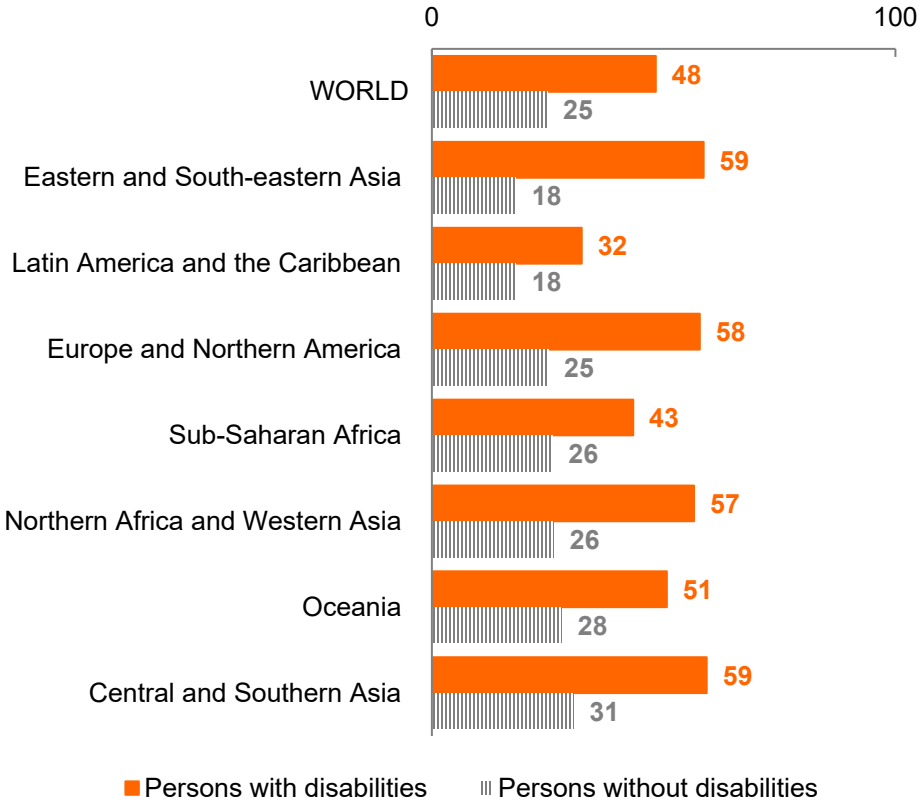
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. Data for non-Indigenous people for Panama and Peru refer to not Indigenous and not Afro-descendants. Source: ECLAC[13] (on the basis of data from national household surveys) and UNDESA (on the basis of data from IPUMS).

Figure 132. Percentage of employed persons who work in the informal sector, by disability status, in developed and developing regions, in 2021 or latest year available.



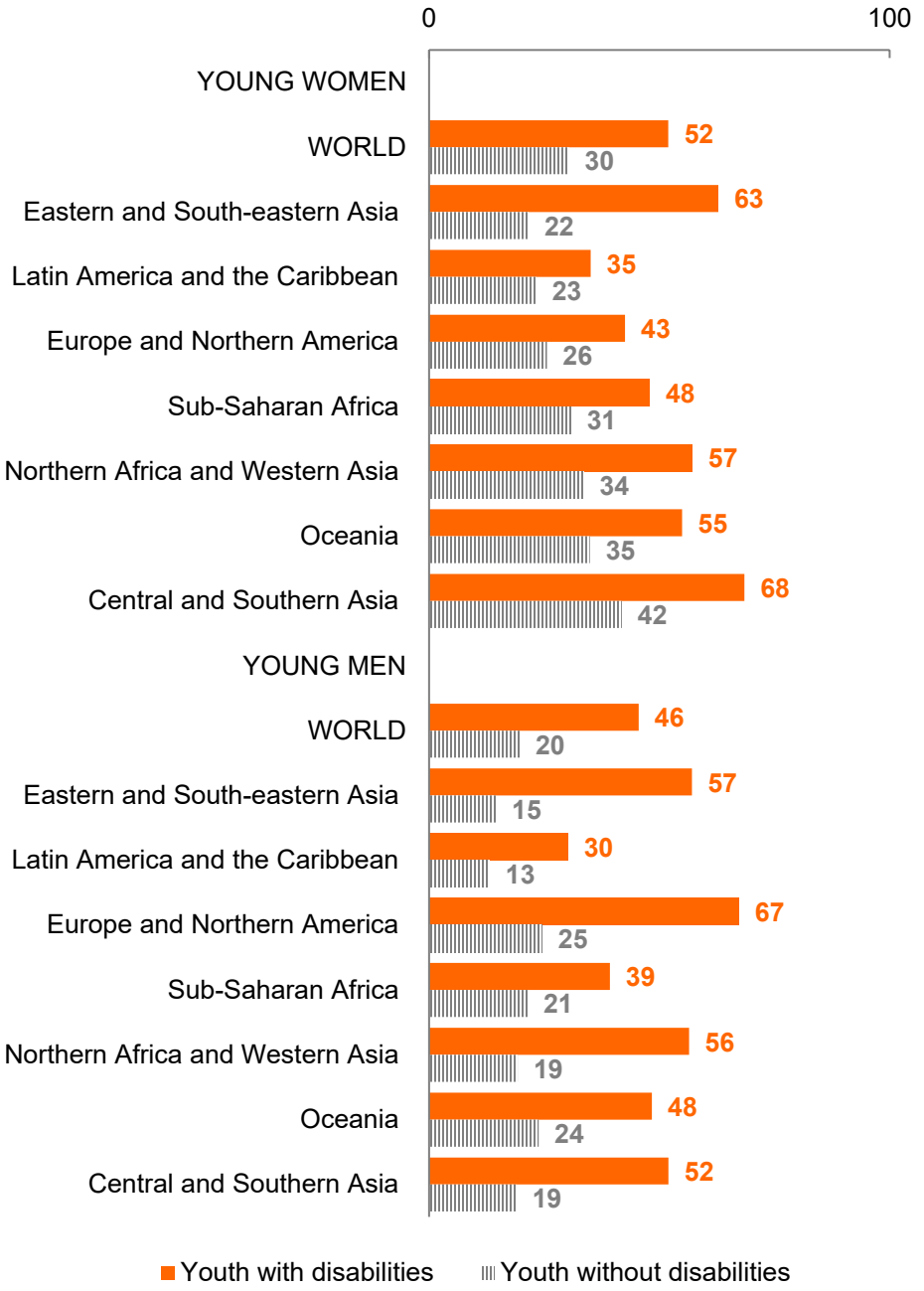
Note: Regional estimates calculated as arithmetic averages of 27 developed countries and 43 developing countries with data for 2021 or most recent year after 2015.
Source: ILO.[320]

Figure 133. Percentage of youth aged 15 to 24 not in employment, education or training (NEET), by disability status, for the world and in 7 regions, in 2021 or most recent year with data.



Note: Regional estimates calculated as arithmetic averages of country data. Estimates based on data from 61 countries.
Source: ILO.[320]

Figure 134. Percentage of youth aged 15 to 24 not in employment, education or training (NEET), by disability status and sex, in 7 regions, in 2021 or latest year available.



Note: Estimates based on data from 61 countries.
Source: ILO.[320]

There is a significant overlap between self-employment and informal employment, especially in regions with a high level of informal employment such as sub-Saharan Africa, as most persons working in the informal economy run micro businesses, often on their own or with a family member as the only workers.

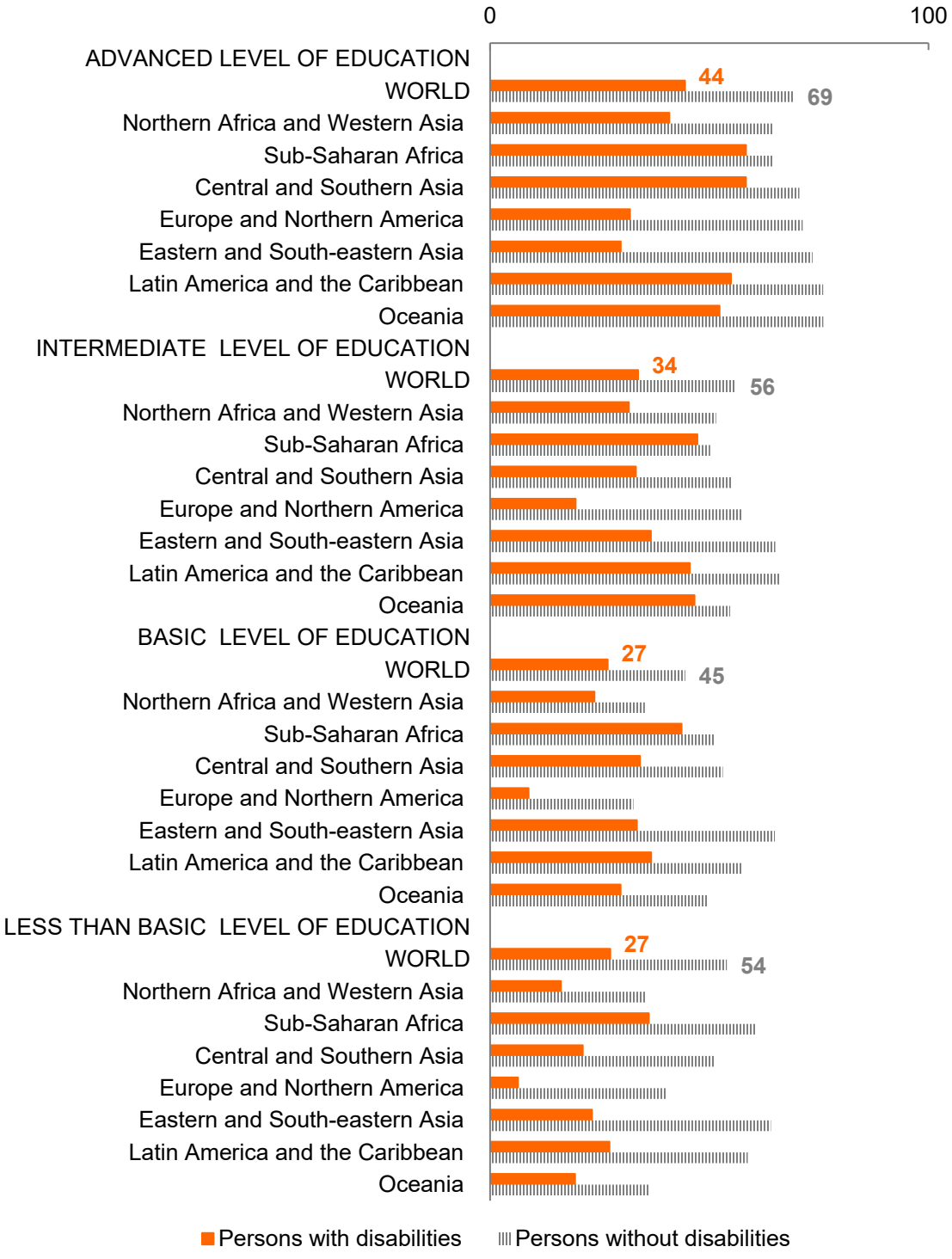
While the size of the informal economy varies enormously between developed and developing regions, with informal employment being much more common in developing regions, there is a similar gap between persons with and without disabilities in informal work in both developed and developing regions (Figure 132). Most employed persons with disabilities living in developing countries, 54 per cent, work in the informal economy, while 13 per cent of employed persons with disabilities living in developed countries work in the informal economy.

Youth with disabilities are strikingly overrepresented among the youth who are not in employment, education or training (NEET). In 2021, youth with disabilities were almost twice as likely to be NEET than youth without disabilities - close to 50 per cent of youth with disabilities compared to 25 per cent of youth without disabilities, with the gap being most extreme in Central and Southern Asia and Eastern and South-eastern Asia (Figure 133). Overall young women with disabilities have higher rates of NEET, albeit in some regions, in particular Europe and Northern America, the figures are worse for young men with disabilities (Figure 134). Young women with disabilities are almost twice as likely to be NEET than young women without disabilities – 52 per cent of young women with disabilities compared to 30 per cent of young women without disabilities, with the gap being most extreme in Eastern and South-eastern Asia.

Among persons with disabilities, education and training are important for securing employment, but not enough. On one hand, education makes a difference, as the percentages of persons with disabilities who are employed increases with the level of education; on the other hand, lower levels of education among persons with disabilities do not fully explain the gaps in access to employment, as the employment gaps between persons with and without disabilities persist at higher levels of education (Figure 135). While having a higher level of education increases the opportunities of finding a job for all workers, workers with disabilities retain their disadvantage at all levels of education.

Since 2015, there has been a significant increase in interest among the private sector in employing persons with disabilities. This is reflected in the establishment of national business and disability networks in different countries (for example, Argentina, Kenya, Nigeria, Uganda and Uruguay) as well as the establishment of global organizations of businesses that make commitments to concrete actions for disability inclusion.[324] The employment of persons with disabilities is also starting to get more attention in corporate sustainability reporting. An example of this is the new Corporate Sustainability Reporting Directive in the European Union.[325] There is also an increased focus by trade unions on the employment of persons with disabilities. This ought, over time, to contribute to more persons with disabilities entering the labour market, and to better working conditions for those already working.[326] However, disability inclusion still remains largely invisible in the environment, social and governance frameworks used by investors to assess how businesses are performing,[327] despite the quantified benefits of disability inclusion in the workforce, in terms of business growth and innovation.[328,329] These frameworks typically include measures such as investments in employees, but generally disability parameters are not included.

Figure 135. Employment to population ratios, by level of education and by disability status, for the world and in 7 regions, in 2021 or latest year available.



Note: Regional estimates calculated as arithmetic averages of country data. World estimates are averages of regional data. Estimates based on data from 90 countries.
Source: ILO.[320]

Table 3. Examples of initiatives taken by countries to promote inclusive employment, 2016-2022.

Initiatives taken by countries to promote the employment of persons with disabilities	Examples of countries where the initiative has been implemented
Matchmaking services that connect persons with disabilities and employers	Austria,[330] Cambodia,[331] Canada,[332] Chile,[333] Denmark,[334] Egypt,[335] Israel,[336] Malaysia,[337] Mexico,[338] Peru,[339] South Africa,[340] Tanzania[341]
Inclusive and accessible job search platforms for persons with disabilities	Australia,[342] Bulgaria,[343] Finland,[344] Hong Kong (Special Administrative Region of China),[345] India[346]
Providing job coaches to help persons with disabilities fill out job applications	Austria,[347] Cambodia,[348] Chile,[349] Finland,[350] Ireland,[351] Israel,[352] Paraguay[353]
Transforming sheltered workshops into gainful employment of persons with disabilities	Austria,[354] United States of America[355]
Promoting the employment of persons with disabilities in the public sector	Canada,[356] Spain[357]
Work placement programs for persons with intellectual disabilities	Brazil,[358] Chile,[359] Egypt,[360] Romania[361]
Individualized support for persons with autism in the labour market, including in recruitment, job coaching and career development	Belgium,[362] Israel,[363] United States[364]
Creating workplace simulations for persons with disabilities	Italy[365]
Supporting employment for persons with psychosocial disabilities, through internships and training programs	Israel,[366] Spain[367]
Vocational training programs for persons with and without disabilities together, using Universal Design principles in curriculum and online platforms	Philippines[368]
Providing training and financial support for persons with disabilities to establish their own micro-enterprises or self-employment	Afghanistan,[369] Bangladesh,[370;371] Ecuador[372]
Creation of accessible online tools, open to all, for national dialogues on employment and disability issues and policies	United States[373]
Disability awareness training to remove barriers to inclusive employment	Turkey,[374] Uganda[375]
Creating self-assessment tools for companies to assess their readiness to hire persons with disabilities	India[376]
Incentive employment programs for the private sector, including subsidies and technical support to identify candidates with disabilities that meet the job description	Colombia,[377] Egypt,[378] India,[379] Saudi Arabia,[380] Spain[381]

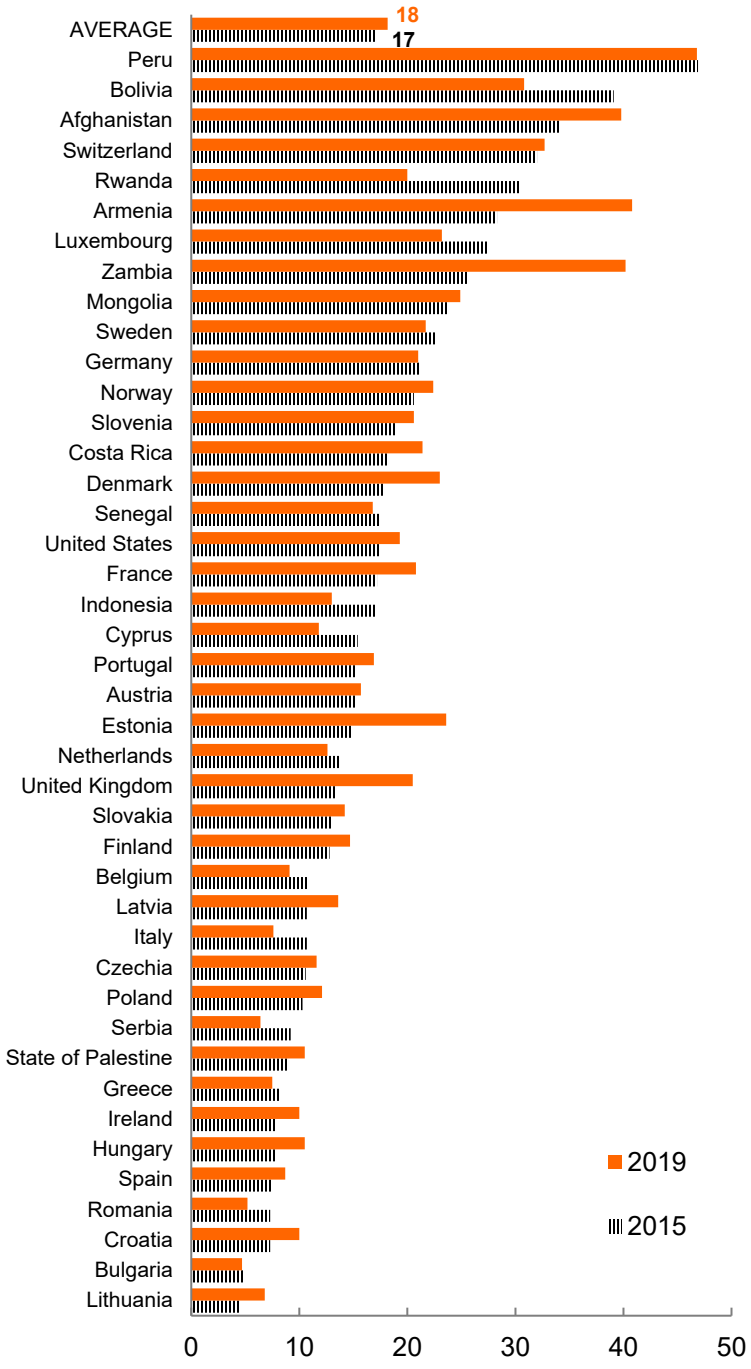
Initiatives taken by countries to promote the employment of persons with disabilities	Examples of countries where the initiative has been implemented
Businesses investing in training and creating job positions for persons with disabilities, including in hospitality, information technology and pharmaceutical industries	Austria,[382] Germany,[383] Hungary,[384] India,[385] Jamaica,[386] Kazakhstan,[387] Moldova,[388] South Africa[389]

In various countries worldwide, initiatives have been taken to promote the employment of persons with disabilities, including employment quotas,[32] awareness campaigns among employers, vocational training programs for persons with disabilities, support in job searches and applications, providing incentives and support to employers to hire persons with disabilities, providing technical and financial support to persons with disabilities who want to start their own business and engaging with persons with disabilities and the general public on policies to promote the employment of persons with disabilities (Table 3). However, in many countries, vocational training (TVET) institutions still provide skills not in line with labour maker demands and promote exclusion rather than inclusion. In particular, there are still many disability-specific segregated institutions providing skills that are not demanded; and the mainstream institutions are often not accessible and inclusive to trainees with disabilities.

Despite these initiatives, overall, progress in the employment of persons with disabilities has remained stagnant since 2015. Before the pandemic, from 2015 to 2019, gains in employment for persons with disabilities were small (**Error! Not a valid bookmark self-reference.**). Among 42 countries or areas, the percentage of persons with disabilities who were employed increased from 17 per cent in 2015 to 18 per cent in 2019. Results at the country level are mixed. Some countries managed to successfully increase the percentage of persons with disabilities who are employed during this period. In two countries, Armenia and Zambia, this percentage increased more than 10 percentage points from 2015 to 2019; in Estonia the percentage increased by 9 percentage points; and in the United Kingdom it increased by 7 percentage points. But in other countries the percentage of persons with disabilities who were employed decreased. Rwanda showed the highest decrease of 10 percentage points, followed by Bolivia (Plurinational State of), with 8 percentage points.

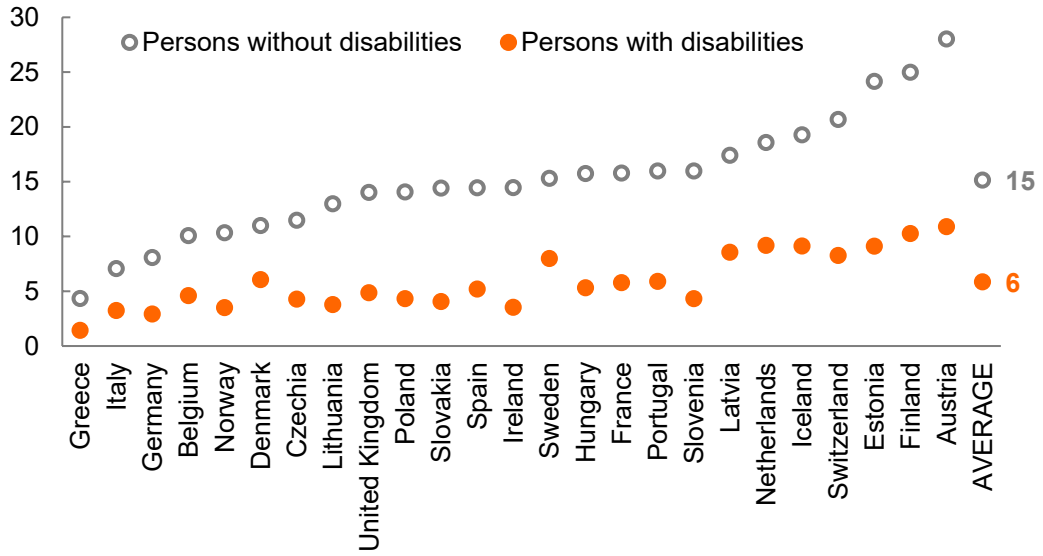
Moreover, job entry and job exit rates are much less favourable for persons with disabilities than others. Persons with disabilities tend to be the last to enter the labour market when the economic situation improves (Figure 137). If they are unemployed, they are more likely to remain unemployed in the future, than unemployed persons without disabilities. Persons with disabilities are the first to lose their jobs when the economic situation deteriorates (Figure 138). Employed persons with disabilities are more likely to become unemployed in the future than employed persons without disabilities.

Figure 136. Progress in percentage of persons with disabilities employed, in 42 countries or areas, from 2015 to 2019.



Note: Percentage of persons employed refers to employment to population ratios; 2019 data point for Afghanistan reflects data from 2021; 2015 data points refer to a different year for Afghanistan (2017), Indonesia (2016), State of Palestine (2018) and Zambia (2018). Bolivia refers to the Plurinational State of Bolivia.
Source: ILO.[320]

Figure 137. Percentage of persons who were employed at the time of the survey, among all persons not employed in the previous year, by disability status, in 25 countries, average over 2016-2019.



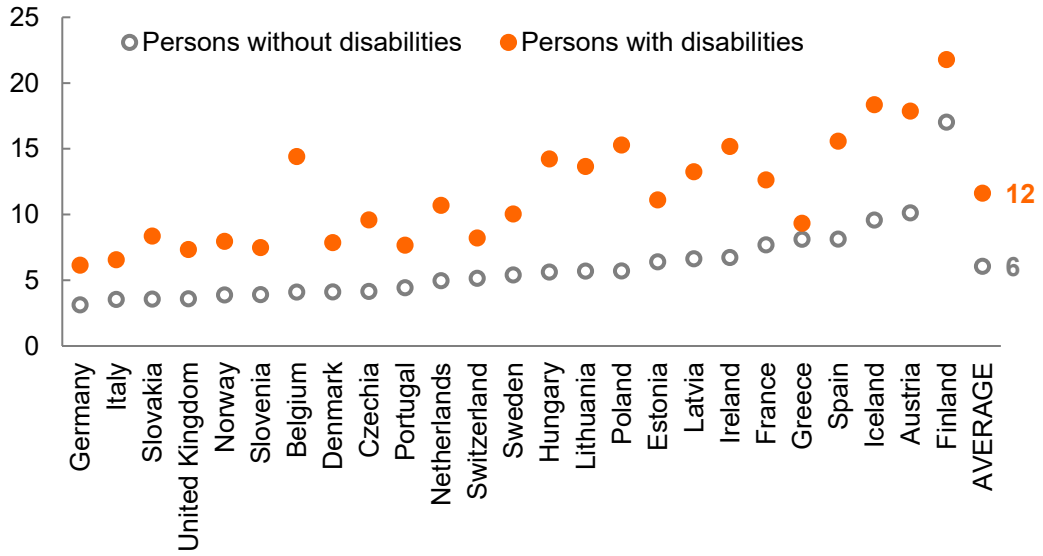
Source: OECD (2022).[390]

Many businesses have made progress in making workplaces more inclusive of persons with disabilities, but gaps remain. In May 2022, a survey undertaken around the world among 111 private sector companies committed to disability inclusion indicated that 68 per cent of them had implemented changes in business operations and services, of which 70 per cent were considered to have been inclusive of persons with disabilities.[391] But many businesses continue to struggle to provide digital accessibility in the workplace: 32 per cent of these companies reported a need for more capacity building in providing workplace adjustments for inclusive remote work.[392] Regarding accessible employment agencies for persons with disabilities, there has been some progress since 2018. The percentage of employment agencies that are accessible for wheelchair users increased from 56 per cent in 2018 to 62 per cent in 2022 (Figure 139).

New and emerging challenges are expected to impact the labour market for persons with disabilities: the green economy,[393] the digital economy and remote working. All are likely to generate many jobs in the coming years, thereby providing important job opportunities for persons with disabilities. However, if not managed with disability inclusion in mind, they could turn into lost opportunities. Currently, there is an increasing attention to disability inclusion in the context of creating green jobs. But these efforts remain insufficient. Persons with disabilities are not always included in the measures taken by countries to transition towards greener, more resilient and climate-neutral economies and societies and that impact employment. Moreover, statistics on persons working in the green sector disaggregated by disability are

particularly lacking, and it remains almost impossible to understand the participation of persons with disabilities in the green sector and the barriers they face.

Figure 138. Percentage of persons who were unemployed or outside the labour force at the time of the survey, among all persons employed in the previous year, by disability status, in 25 countries, average over 2016-2019.



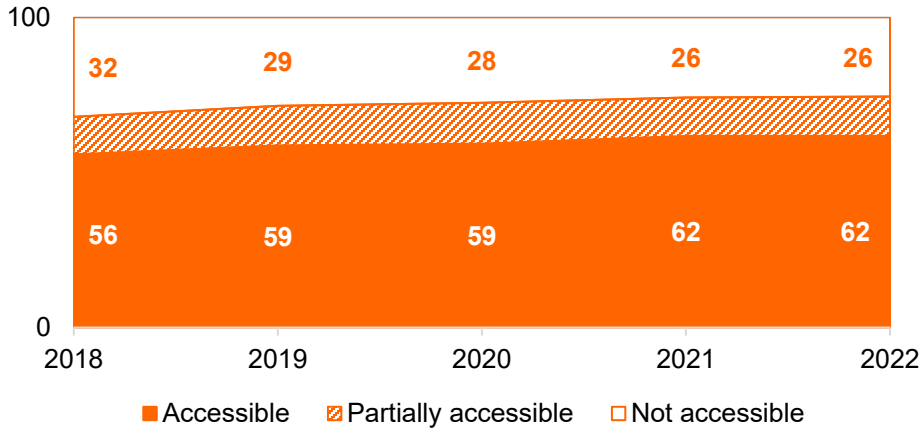
Note: Persons outside the labour force, also referred to as inactive persons, refer to persons who are not employed and are not looking for a job.
Source: OECD (2022).[390]

Regarding the digital economy, the unmet demand for information technology (IT) professionals in many countries provides a great opportunity for persons with disabilities to enter or re-enter the labour force. Ensuring that persons with disabilities have the capacity to take advantage of these opportunities will however require a concerted effort from all stakeholders.[394] The main challenge is to ensure that mainstream online and in-person training in IT and digitization skills are inclusive of persons with disabilities. It is also important to ensure that, during the training phase, companies commit to providing job opportunities for the trainees with disabilities graduating from these trainings. Workplace-based learning, either as part of the training or immediately after its completion, can play a key role in ensuring that the training leads to actual employment. While some targeted interventions are already promoting digital skills and jobs for persons with disabilities,[395] there is a lack of data to fully understand the participation of persons with disabilities in the digital economy and the barriers they encounter.

Given the trends already underway, it is likely that remote work will continue to grow in the future. Many persons with disabilities prefer to work remotely. As of March 2021, in the European Union, persons with disabilities were more likely to prefer to work from home than persons without disabilities: 27 per cent of

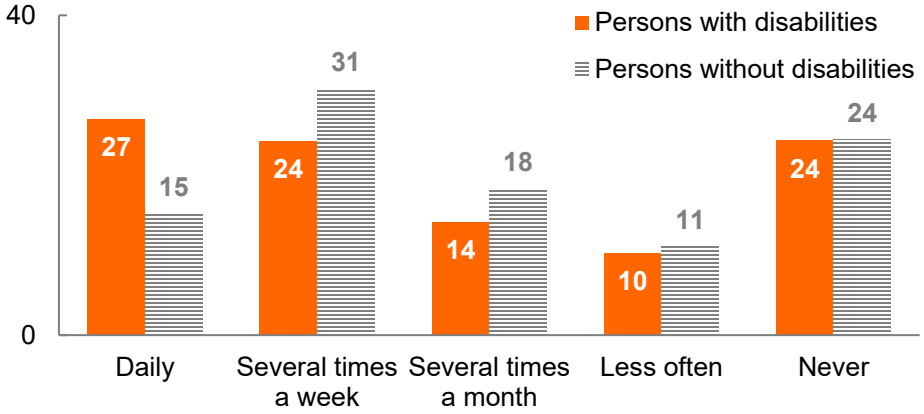
persons with disabilities versus 15 per cent of persons without disabilities prefer to work from home daily (Figure 140). Yet, persons with disabilities were less likely to have a job amenable to being performed remotely: 34 per cent of jobs held by persons with disabilities in European countries can be done remotely compared to 39 per cent of jobs held by persons without disabilities (Figure 141). Also, while remote work is a good option for many persons with disabilities, it is unsuitable for others. Apart from the fact that many persons with disabilities work in jobs that cannot be done remotely, when remote work is done on a full-time basis, it can lead to isolation and social exclusion. The support required for persons with intellectual disabilities through job coaches is often available at the workplace but would not be available when they are working from home.

Figure 139. Percentage of employment agencies that are accessible for wheelchair users, worldwide, yearly from 2018 to 2022.



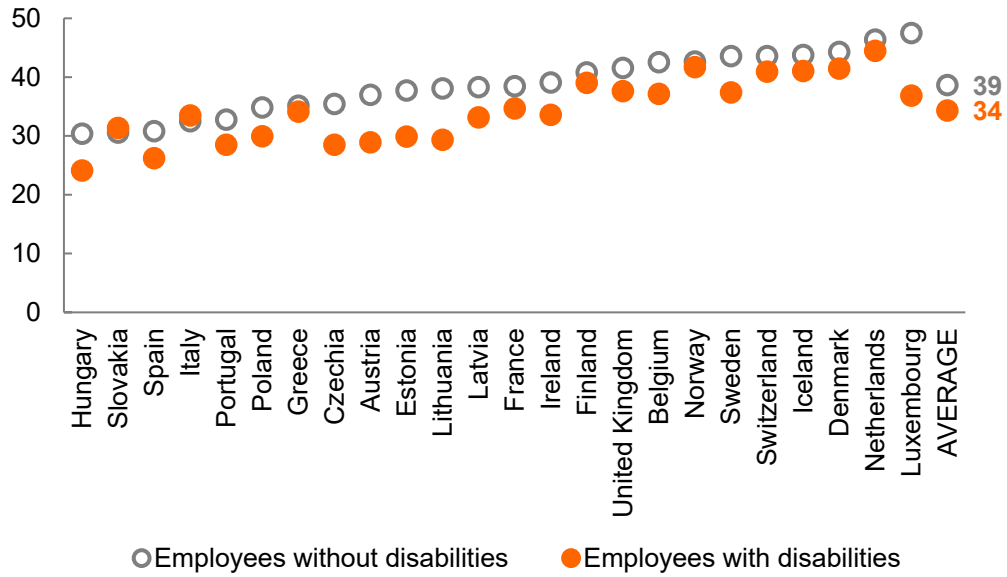
Source: UNDESA (on the basis of data from Sozialhelden[10]).

Figure 140. Percentage of persons who prefer to work from home, by disability status, in the European Union, in March 2021.



Source: ILO (on the basis of data from EUROFOUND Living, working and COVID-19 e-survey).

Figure 141. Percentage of jobs held by employees aged 15 to 69 that can be performed remotely, by disability status of the employee, in 24 countries, in 2019.



Note: Jobs are considered to be able to be performed remotely on the basis of the types of tasks performed in different occupations. Data from Iceland, Ireland and Italy are from 2018 and data from the United Kingdom are from 2016. The average is an unweighted average of the countries shown.
Source: OECD[396] (on the basis of data from European Union Statistics on Income and Living Conditions).

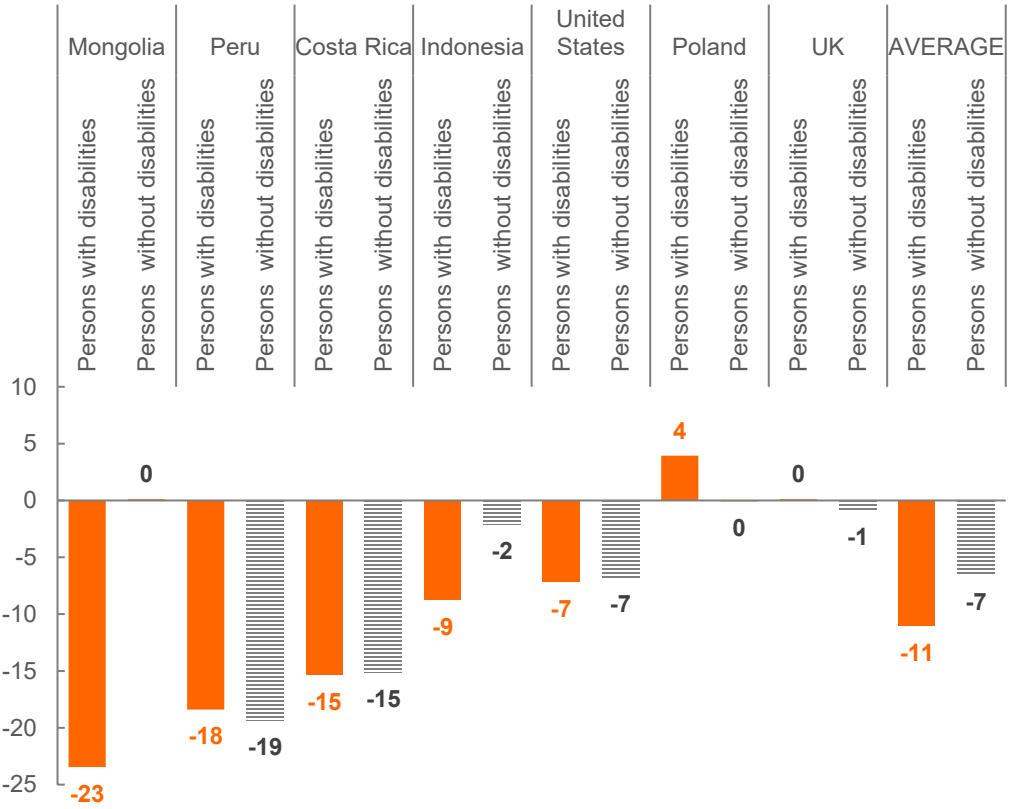
Impact of the COVID-19 pandemic

The COVID-19 crisis had a profound impact on the employment of persons with disabilities as many who were employed before the pandemic lost their jobs. Due to the over-representation of workers with disabilities in the informal economy (Figure 132), the impacts of the pandemic on the informal economy were felt heavily among persons with disabilities. For many people working in the informal economy, lockdowns meant stopping their economic activities and losing their jobs. Moreover, for persons with hearing impairments who rely on lip-reading, face masks hindered speech comprehension at work: 31 per cent of persons with disabilities who had a job in 2021 said that they encountered barriers trying to communicate with others at work because of face masks.[397] Although transparent face masks exist and can eliminate this barrier, they were not produced and disseminated in large scale during the COVID-19 pandemic. A major challenge has been the lack of research on their efficacy in preventing the transmission of disease.[398]

Among seven countries, on average, the percentage of persons who were employed decreased by 11 per cent for persons with disabilities and 7 per cent for persons without disabilities, from 2019 to 2020 (Figure 142). In Indonesia and Mongolia, for instance, persons with disabilities were particularly affected. In the European Union, this impact was particularly high on young persons with disabilities and on those with

only primary school education (Figure 143). Among persons with tertiary education, persons with disabilities lost jobs at much higher rates than persons without disabilities. The negative impact was also greater on women with disabilities than on men with disabilities.

Figure 142. Percentage loss in the percentage of persons employed (employment to population ratios) from 2019 to 2020, in 7 countries, by disability status.



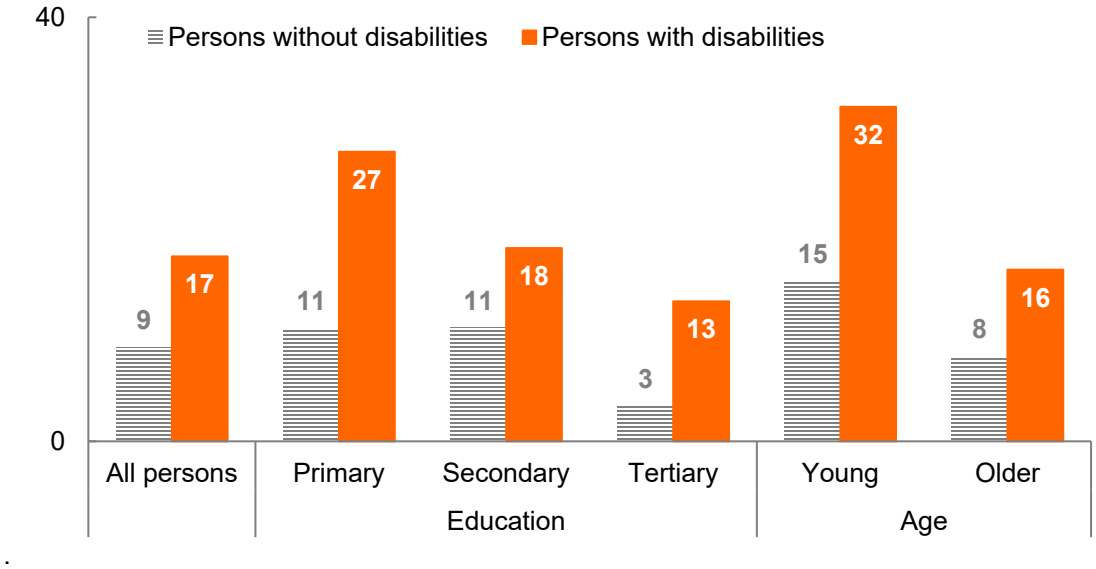
Source: ILO.[320]

The COVID-19 pandemic accelerated an already evident trend towards more people working remotely and, consequently, a higher emphasis on digital skills. The COVID-19 pandemic has also accelerated the process of digitization of the economy and the world-of-work. This could present an opportunity for persons with disabilities: in recovering and building back better from the COVID-19 pandemic, digital labour platforms can offer income-generating opportunities to workers and their flexible work arrangements may be more convenient for many persons with disabilities.[399] But the shift to remote work can also deepen inequalities. During the COVID-19 pandemic, 49 per cent of workers with disabilities faced barriers to working online or by telephone (see the chapter on target 9.c).

There has also been a marked shift towards self-employment, with more people aspiring to run their own businesses. The COVID-19 pandemic caused a significant shock to labour markets, with many

companies pausing recruitment or restructuring existing workforces. This may help explain the shift towards a greater focus on self-employment. However, the pandemic also seems to have been a catalyst for persons with disabilities to focus more on self-employment as a route to self-determination and to address the barriers and vulnerabilities they face in formal, wage-earning employment.

Figure 143. Percentage of persons who were employed before the start of the COVID-19 pandemic and unemployed in March 2021, by disability status, level of education and age, in the European Union.



Note: Employment status before the start of the COVID-19 pandemic refers to 2019.
Source: ILO (on the basis of data from EUROFOUND Living, working and COVID-19 e-survey).

Summary of findings and the way forward

Persons with disabilities, and in particular women with disabilities, persons with psychosocial disabilities and those with lower levels of education, face higher rates of unemployment and inactivity. The situation is also stark for young persons with disabilities: they are twice as likely as youth without disabilities to not be in employment, education or training. Persons with disabilities in general face lower wages (see the chapter on Goal 1), and overrepresentation in the informal economy and in self-employment, with Indigenous persons with disabilities more likely to be self-employed than non-Indigenous persons with disabilities. Globally, the percentage of persons with disabilities in employment would have to increase by at least 2 percentage points per year until 2030 in order to close the gap between persons with and without disabilities.

In recent years, more countries have adopted labour laws prohibiting discrimination on the basis of disability. However, despite this positive trend, current rates of expansion are too slow to ensure that

persons with disabilities in all countries are legally protected against discrimination in the workplace by 2030. To ensure protection in all countries by 2030, countries should adopt provisions prohibiting discrimination on the basis of disability in hiring, terminations, promotions and training at a rate twice as fast as current trends (see the chapter on Goal 10). For indirect discrimination in the workplace, legal provisions are particularly lacking. These provisions will need to be adopted at a rate eight times faster than current rates of progress to guarantee that all persons with disabilities are legally protected against indirect discrimination in the workplace by 2030. Efforts to expand legal protections against discrimination of persons with disabilities are particularly needed in Eastern and South-eastern Asia, Oceania and sub-Saharan Africa.

Many countries have laws to support accessible working places. But many working places are not accessible and lack reasonable accommodations as well as access to assistive technologies. The accessibility of employment agencies to wheelchair users has been increasing and reached 62 per cent in 2022, up from 56 per cent in 2018. However, these gains have been slow. Progress in accessibility for these spaces should be twice as fast in order to achieve universally accessible employment agencies by 2030.

Moreover, the employment of persons with disabilities was particularly adversely affected by the COVID-19 pandemic. In some countries, they lost jobs at a much higher rate than persons without disabilities. Persons with disabilities were less likely to have jobs that were amenable to remote working and were more likely to work in the informal sector. As lockdowns spread, they were the first to lose their jobs.

Challenges also remain in offering job opportunities for persons with disabilities in the green and digital economy, and data remain insufficient to provide a sound assessment of the participation of persons with disabilities in these sectors and the barriers they face.

On a positive note, there has been significant progress in the availability of statistics pertaining to the labour market participation of persons with disabilities in recent years, allowing global and regional estimates for various employment indicators, a major improvement compared to five years ago.

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

1. Adopt national legislation that protects persons with disabilities against discrimination on the basis of disability in all matters of employment. National laws more commonly protect against discrimination in recruitment, but discrimination does not end once a person gets a job. Protections in career development opportunities are as important as protections to ensure equal access to the labour market. Employers should be encouraged to develop disability-inclusive human resource policies consistent with these laws and that mention the right to reasonable accommodation and career development and promotions.

2. Promote the inclusion of persons with disabilities in green jobs and in the digital economy. In particular, (i) ensure that legislation and policies dealing with remote working and digital platforms address the specific challenges faced by persons with disabilities and prohibit any discriminatory and harmful uses or impacts of artificial intelligence in relation to persons with disabilities; (ii) ensure persons with disabilities and their representative organizations take part in the relevant bodies that address the digital and green economies; (iii) promote the effective inclusion of persons with disabilities, and youth with disabilities, in all mainstream digital and green job creation and skills development initiatives, including those resulting from measures addressing recovery from the COVID-19 pandemic, in particular the Global Accelerator on Jobs and Social Protection launched by the United Nations Secretary General's One Common Agenda; (iv) include persons with disabilities in the Climate Action for Jobs initiative, the Green Jobs for Youth initiative launched at COP27 and in national just transition plans; (v) foster reskilling and upskilling of persons with disabilities affected by technological changes and therefore at risk of losing their jobs; and (vi) ensure that data on employment in the digital and in the green economy are disaggregated by disability.

3. Improve the situation of persons with disabilities working in the informal economy. Governments should include and consult with persons with disabilities in the formulation of measures to formalize working situations and measures to promote better working conditions among informal workers. Trade unions and other organizations working to promote the rights of informal workers should include informal workers with disabilities in their advocacy and information campaigns.

4. Make all pathways to employment disability inclusive. More efforts are needed to ensure equal access for persons with disabilities in education, complemented with measures to ensure a solid transition from school to work. Technical and Vocational Education Training, apprenticeship schemes, public employment services, public employment programmes, universities, work-based training and business development services must all work to promote the employment of persons with disabilities, with a particular focus on the transition from school to work of youth with disabilities. Special attention should be provided to promote the employment of persons with disabilities by small and medium enterprises and organizations of the social and solidarity economy who often lack targeted support to become more disability-confident and inclusive. More efforts need to be made to include persons with disabilities in all measures promoting decent work in the rural economy.

5. Promote employment among underrepresented groups of persons with disabilities. Governments should consult with and include underrepresented groups of persons with disabilities in their interventions and policies to ensure no one is left behind. Data should be collected and analysed to assess intersectionality on gender and disability, but also other relevant grounds (age, Indigenous origin and minorities, among others).

6. Continue to improve disability disaggregated employment data, in regular times and during crises. While it is encouraging that more and more countries are producing disability disaggregated

employment data, this effort needs to be upscaled and done systematically to improve employment statistics for persons with disabilities. For instance, the Washington Group/ILO module on the employment of persons with disabilities (see the chapter on Goal 17) can provide information on the gaps between persons with and without disabilities and also information on the root causes of these gaps. Information and data are also needed by type of impairment, to better guide policies to promote the employment of persons with disabilities. Efforts should be made to collect employment data on persons with disabilities during crises, such as pandemics, to guide responses and mitigate negative impacts.

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

This chapter offers an overview of access to and usage of information and communication technologies (ICT) among persons with disabilities, within the context of target 9.c. This target commits to significantly increase access to ICT and to provide universal and affordable access to the Internet in least developed countries by 2020. The Convention on the Rights of Persons with Disabilities recognizes the critical role that ICT plays in empowering persons with disabilities and in ensuring that they fully enjoy their human rights and fundamental freedoms. The preamble stresses the importance of ICT, and article 9 obliges States to undertake and promote research and development and enhance the availability and use of ICT. Article 9 also stresses the need to provide equitable access and to remove barriers to ICT access. Article 21 urges private entities and the mass media that provide services and information through the Internet to make these accessible to persons with disabilities. In 2018, the International Telecommunication Union resolution 191 defined a strategy for the coordination of efforts to bridge the digital divide and the standardization gap for persons with disabilities; and resolution 196 called for ensuring that access to telecommunications/ICT is open, affordable and inclusive, paying special attention to persons with disabilities.

ICT includes any information and communication device or application and its content, such as radio, television, satellite, mobile phones, fixed lines, computers, network hardware and software. In today's digital age, ICT plays a central role in nearly all aspects of life. ICT affects how people work, learn, buy products and services, approach entertainment opportunities, vote, search and receive information, and interact with each other. ICT can offer persons with disabilities opportunities for education, work, leisure, social interaction and political participation as well as provide access to public services and information. At the same time, digital technologies 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 requirements, principles and standards in mind. Increasingly, digital inclusion – that is, the ability of all persons, including persons with disabilities, to access and use ICT – and ICT accessibility mainstreaming must be seen as critical elements for ensuring the inclusion of persons with disabilities and the achievement of SDG 9 as well as other SDGs for persons with disabilities.

The COVID-19 pandemic and resulting lockdowns significantly accelerated the demand for ICT-enabled services as many people, including persons with disabilities, turned to online options to continue their work and education, to access health services, and for shopping, networking and family connections. The pandemic thus raised the demand for ICT accessibility while also highlighting challenges in digital access and use for persons with disabilities.

This chapter offers an overview of the most recent information and statistics on global ICT access and usage among persons with disabilities. It highlights trends and progress in advancing the digital inclusion

of persons with disabilities since 2015. The chapter also highlights national initiatives and ends with recommendations to improve access to ICT among persons with disabilities.

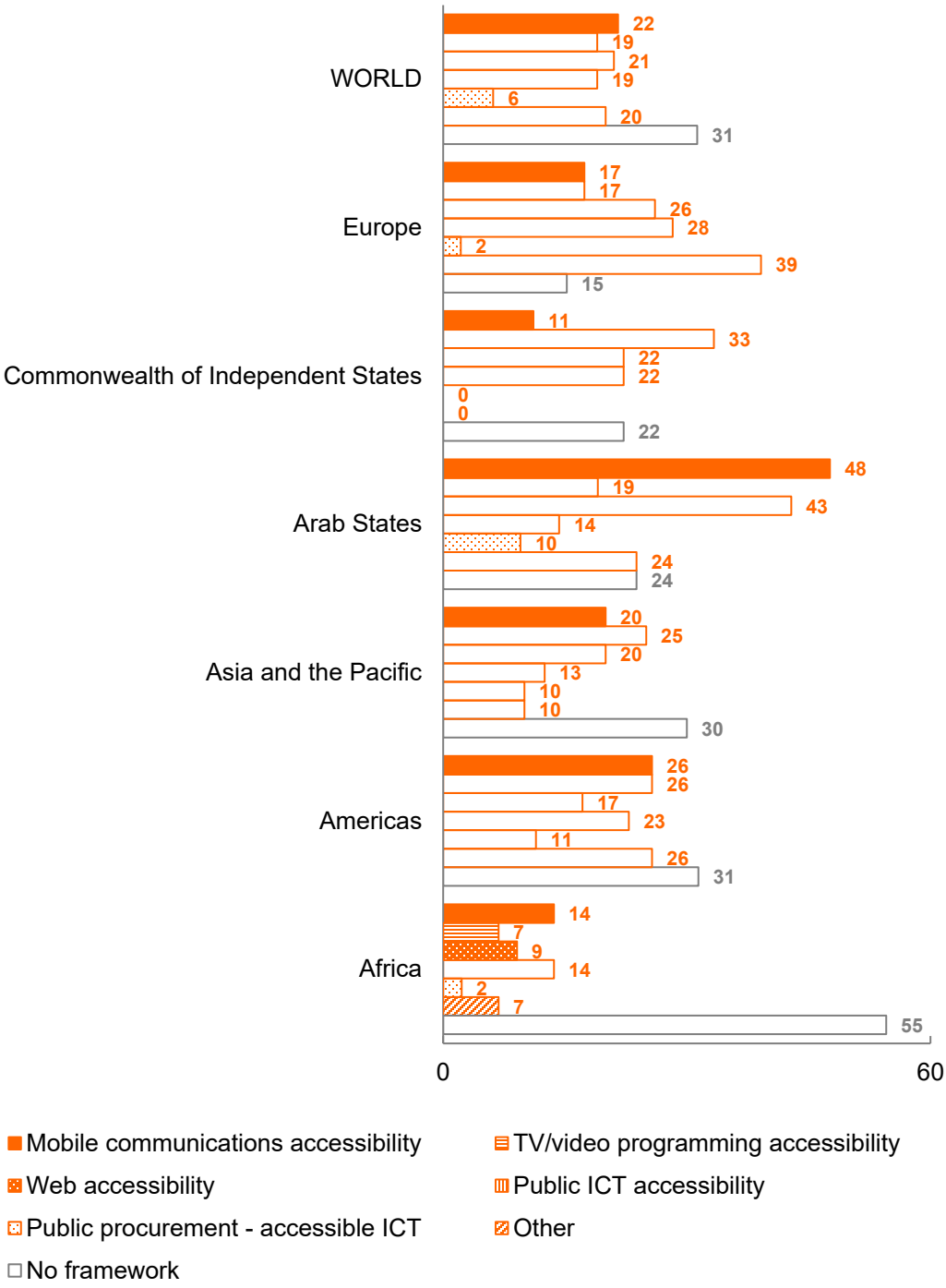
Current situation and progress so far

At the country level, laws, policies and programmes have been progressively introduced to enhance access to ICT for persons with disabilities. Most of these initiatives have focused on providing access on an equal basis with others and improving ICT accessibility. ICT accessibility refers to the design and development of digital technologies, applications and services that are accessible for persons with disabilities. Examples of ICT accessibility features include screen-readers, voice control, adjustable font sizes and gesture-based navigation.

Although many countries worldwide have regulations on the accessibility of ICT, 31 per cent of 195 countries or areas worldwide still do not have any regulatory frameworks on ICT accessibility (Figure 144). Accessibility requirements in public procurement influence accessibility in government services and promote overall ICT accessibility through ripple effects in the broader consumer market. However, this is the least common regulatory framework: only 6 per cent of countries have regulations on public procurement regarding accessible ICT. About 20 per cent of countries have regulations on the accessibility of mobile communications, TV/video programming, the Web and public ICT. Europe is the region where regulations are more common and Africa the least: only 15 per cent of countries in Europe have no regulations at all, while 55 per cent of countries in Africa have no regulations. Accessibility of mobile communications and the Web are more common in Arab States, as more than 40 per cent of these States have such regulations.

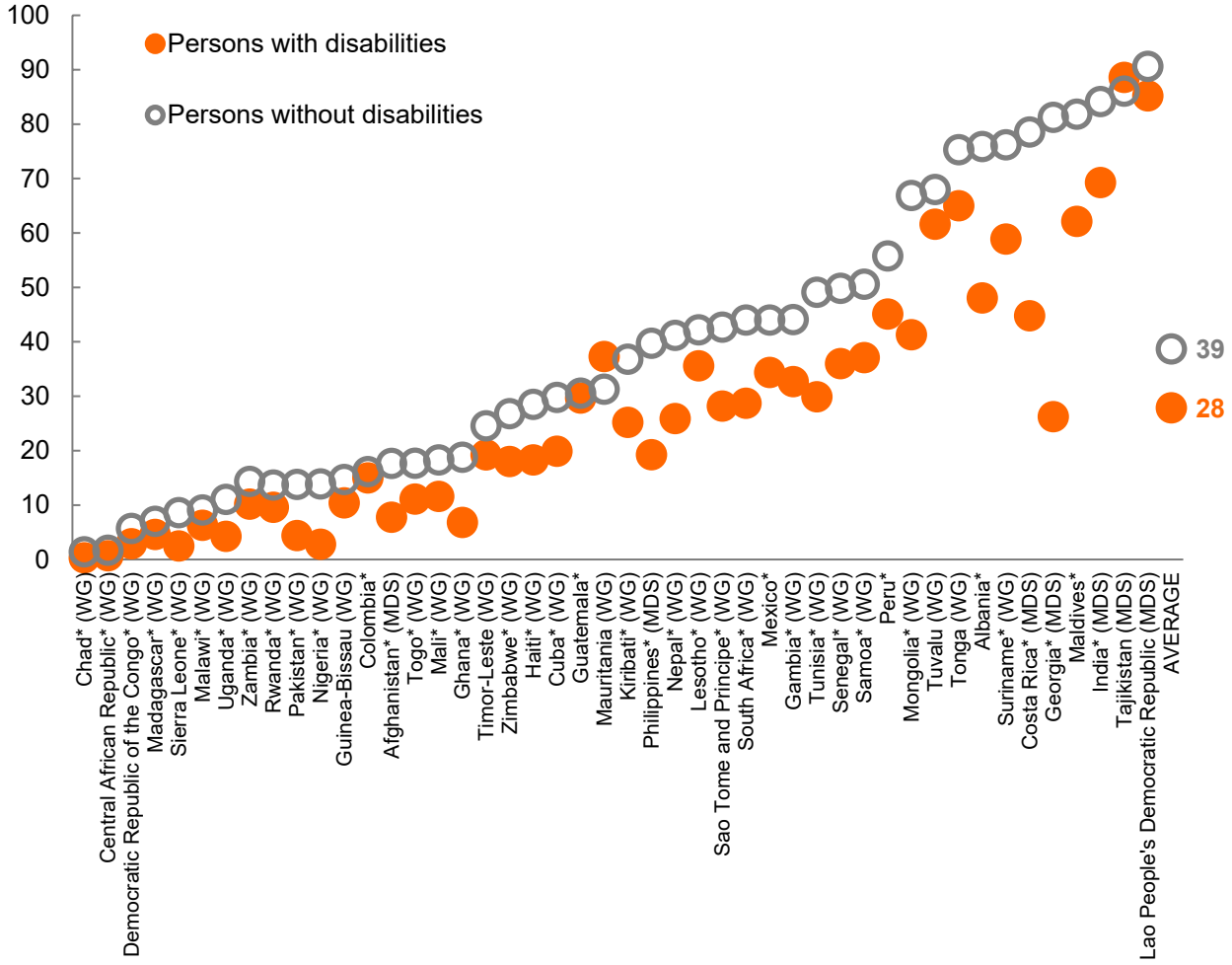
Internet websites have been ranked as one of the most important ICTs for persons with disabilities for healthcare, education, employment, access to government services and participation in political and public life.[400,401] However, significant gaps are observed between persons with and without disabilities in the use of the Internet, with persons with disabilities reporting lower usage. Among 46 countries or areas, the average gap is 11 percentage points, with 21 countries showing a gap above 10 percentage points (Figure 145). On average, in these 46 countries, 28 per cent of persons with disabilities use the Internet versus 39 per cent of persons without disabilities. In only two countries, Mauritania and Tajikistan, the percentage of persons using the Internet is higher for persons with disabilities than for persons without disabilities – in Mauritania, for instance, 37 per cent of persons with disabilities versus 31 per cent of persons without disabilities use the internet. A total of 24 out of these 46 countries are least developed countries, and these countries overall show lower Internet use among persons with disabilities, with an average of 20 per cent of persons with disabilities using the Internet, than among persons without disabilities (27 per cent) – a level of Internet penetration among persons with disabilities well below the universal access called for in target 9.c.

Figure 144. Percentage of countries with regulatory frameworks on ICT accessibility, by type of framework and by region, in 2020.



Note: Mobile communications accessibility refers to the accessibility of mobile devices, such as smartphones and tablets, and the applications running on them. Based on information from 195 countries or areas.
Source: ITU.

Figure 145. Percentage of persons who use the Internet, by disability status, in 46 countries or areas, in 2021 or latest year available.



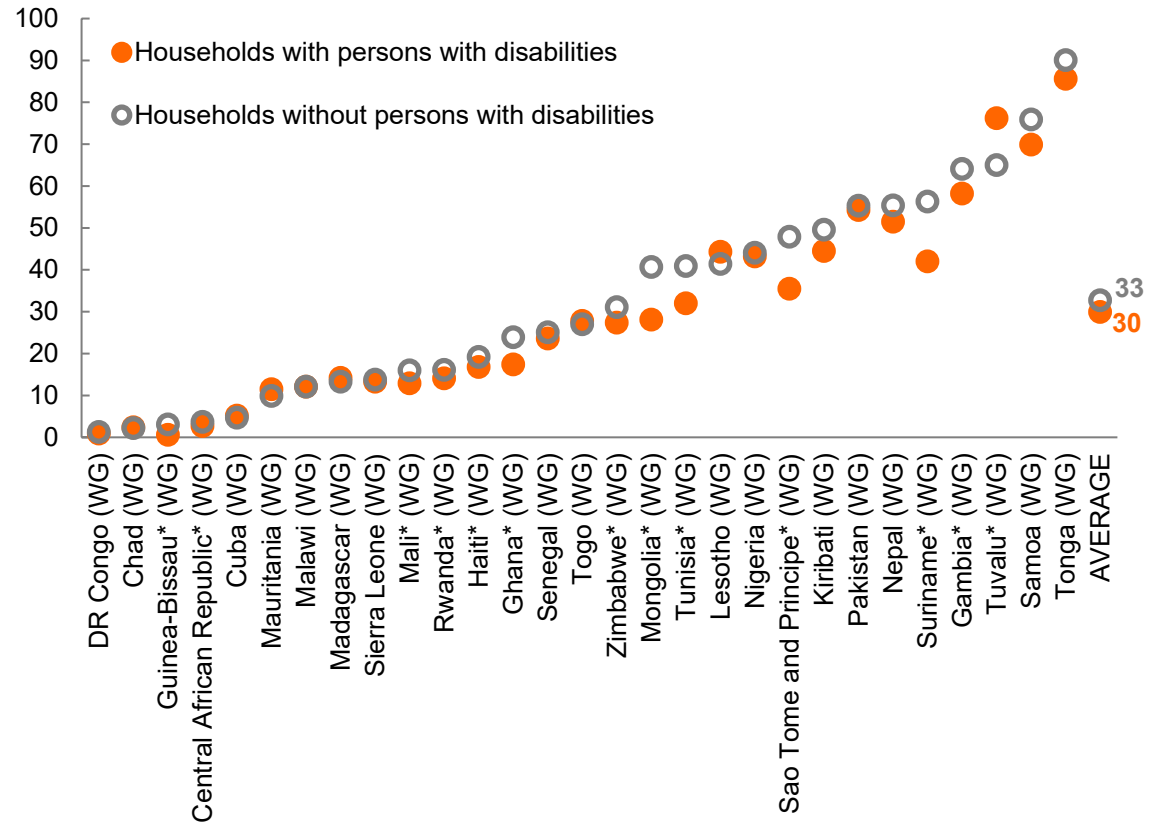
Note: (MDS) identifies data produced with the Model Disability Survey. (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: ECLAC,[13] UNDESA (on the basis of data from DHS[6] and SINTEF[9]), WHO and World Bank (on the basis of data from DHS[6] and MICS).

Across 29 countries, an average of 30 per cent of households with persons with disabilities versus 33 per cent of households without persons with disabilities have access to the Internet, with Mongolia, Nepal, Sao Tome and Principe, Tunisia and Tuvalu showing the largest gaps (Figure 146). The country with the highest percentage of households with persons with disabilities with access to the Internet is Tonga (86 per cent). Similar to Internet use, the 19 least developed countries in this set show slightly lower levels of access to the Internet in households compared to the other countries, with an average of 24 per cent of households with persons with disabilities having access to the Internet. In Lesotho and Rwanda, progress over time in Internet access in households has benefitted both households with persons with and without disabilities (Figure 147).

Household ownership of computers or tablets tends to be lower than Internet access and usage. Across 30 countries, on average, 16 per cent of households with persons with disabilities own a computer or tablet at home compared with 19 per cent of households without persons with disabilities (Figure 148). The largest gaps are observed in Mongolia, South Africa, Suriname and Tunisia. In Guinea-Bissau and Tuvalu, computer or tablet ownership is more common among households with persons with disabilities than among households without persons with disabilities.

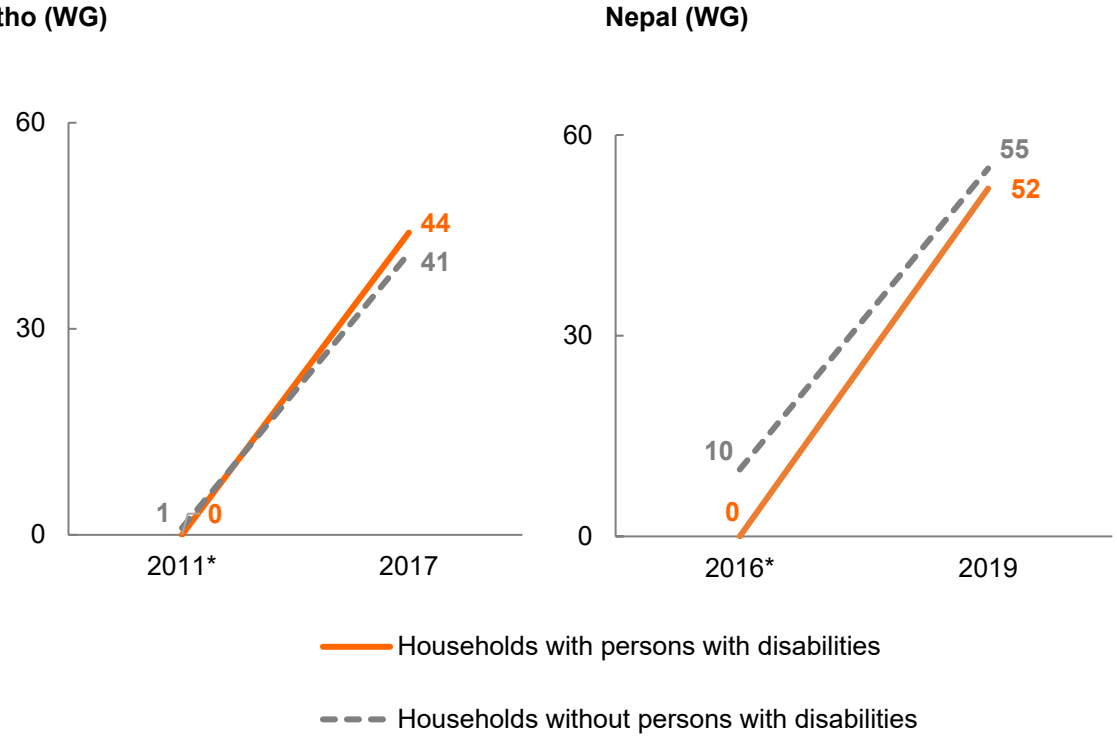
Households of persons with disabilities in urban areas have significantly higher access to Internet connectivity than those in rural areas (Figure 149). Among persons with disabilities, use of the Internet varies with age. Persons with disabilities between the ages of 18 and 35 have higher rates of Internet usage than persons between the ages of 36 and 49 (Figure 150). Women with disabilities on average have slightly lower rates of Internet use than men with disabilities (see the chapter on Goal 5).

Figure 146. Percentage of households, with and without persons with disabilities, that have Internet access, in 29 countries, in 2021 or latest year available.



Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent. DR Congo refers to the Democratic Republic of the Congo.
Source: World Bank (on the basis of data from DHS[6] and MICS).

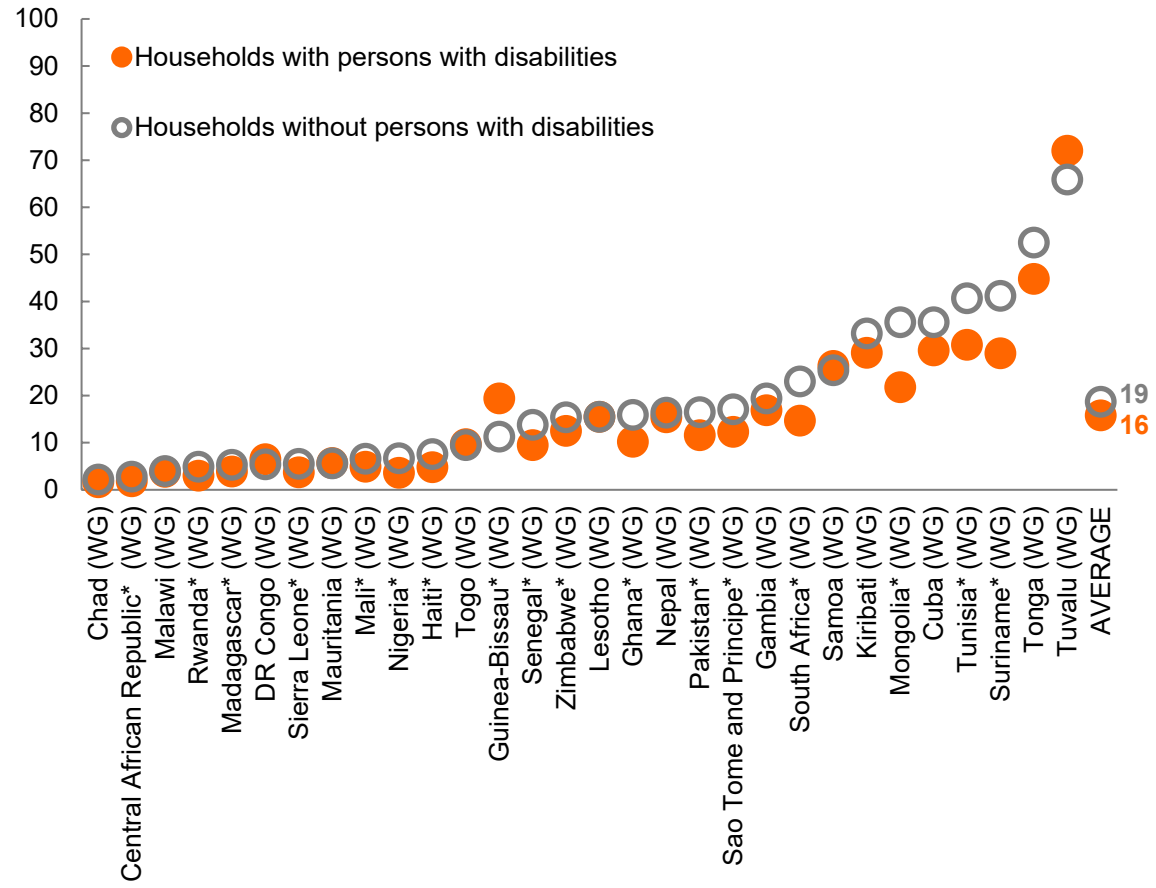
Figure 147. Trends over time in the percentage of households, with and without persons with disabilities, that have Internet access, in 2 countries.



Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: UNDESA and World Bank (on the basis of data from DHS,[6] MICS and SINTEF[9]).

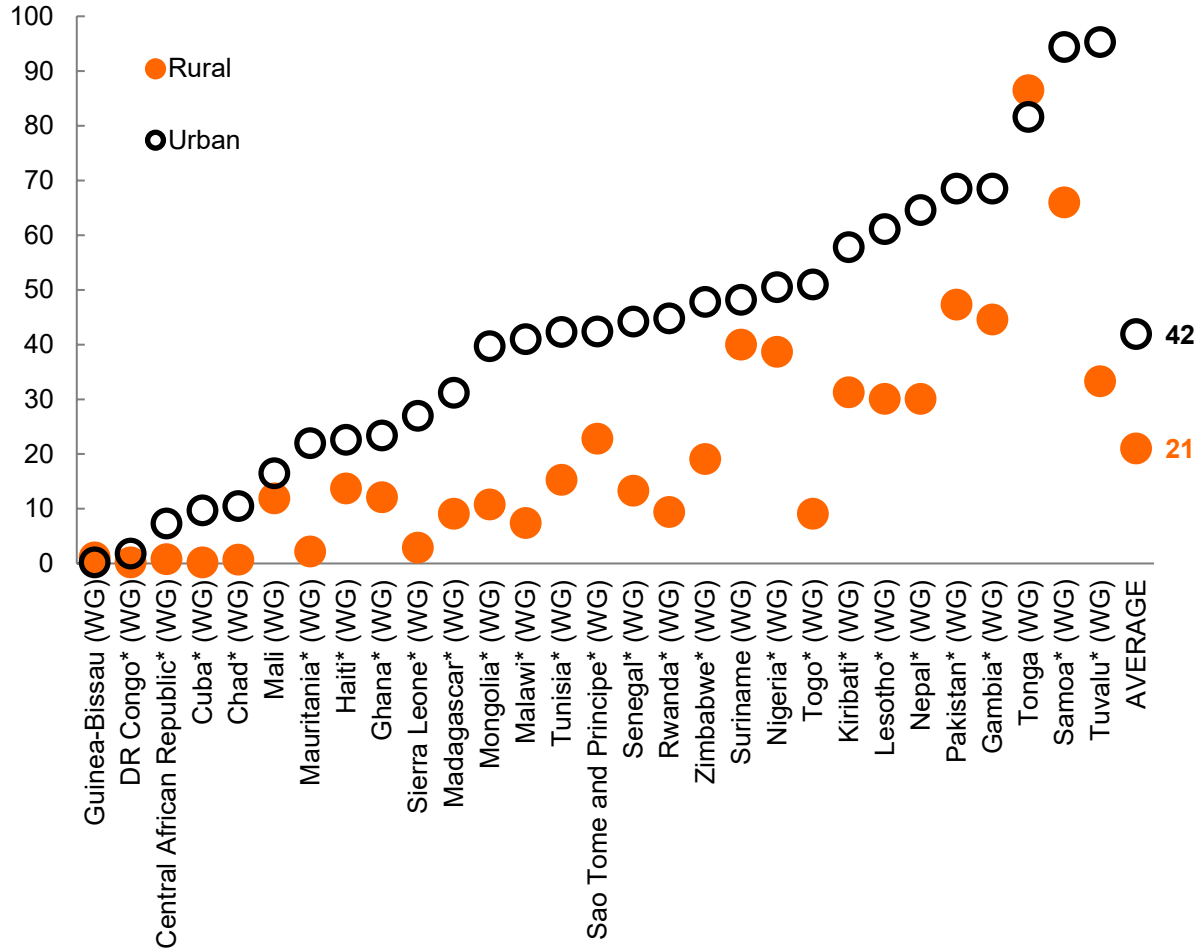
Barriers to Internet use exist in the household as well as outside the household. Public places for Internet access are still seldom designed considering accessibility for persons with disabilities. Worldwide, in 2022, 52 per cent of Internet cafes remained not accessible for wheelchair users, down from 59 per cent in 2019. In 2022, only 21 per cent of Internet cafes were partially accessible – the same percentage as in 2019 – and only 27 per cent were fully accessible – up from 20 per cent in 2019 (Figure 151).

Figure 148. Percentage of households, with and without persons with disabilities, that own a computer or tablet, in 30 countries, in 2021 or latest year available.



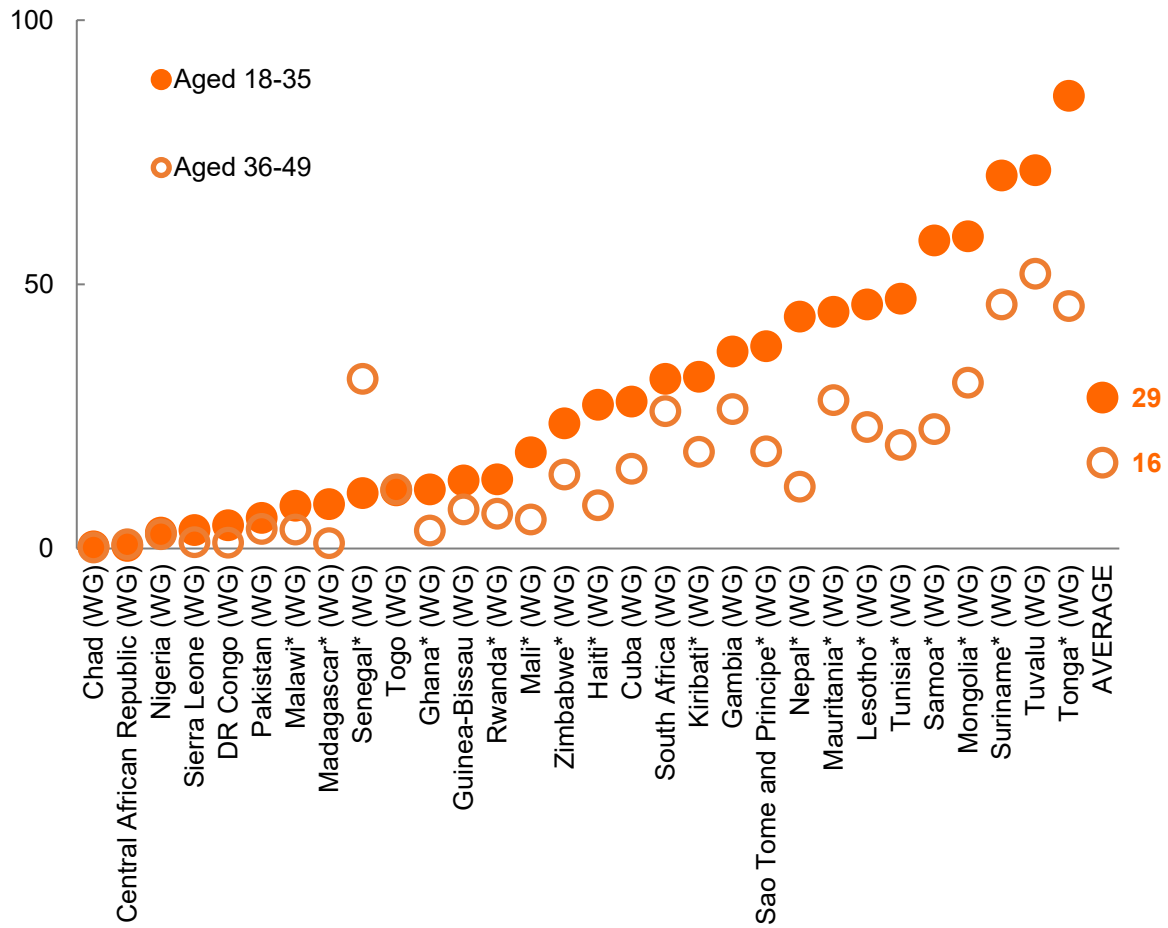
Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent. DR Congo refers to the Democratic Republic of the Congo.
Source: World Bank (on the basis of data from DHS[6] and MICS).

Figure 149. Percentage of households with persons with disabilities that have Internet access, by area of residence, in 29 countries, in 2021 or latest year available.



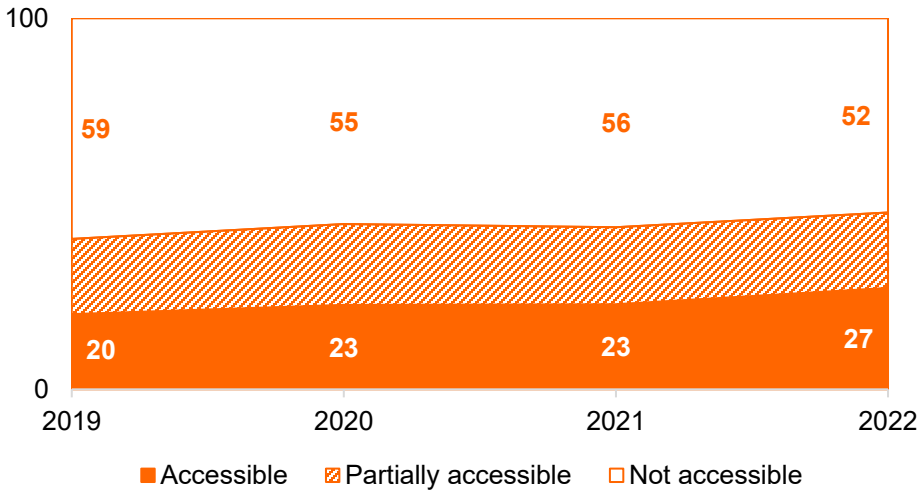
Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with disabilities in rural and urban areas is statistically significant at the level of 5 per cent. DR Congo refers to the Democratic Republic of the Congo.
Source: World Bank (on the basis of data from DHS[6] and MICS).

Figure 150. Percentage of persons with disabilities who use the Internet at least once a week, by age, in 30 countries, in 2021 or latest year available.



Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons aged 18-35 and persons aged 36-49 is statistically significant at the level of 5 per cent. DR Congo refers to the Democratic Republic of the Congo.
Source: World Bank (on the basis of data from DHS[6] and MICS).

Figure 151. Percentage of Internet cafes that are accessible for wheelchair users, worldwide, yearly from 2019 to 2022.



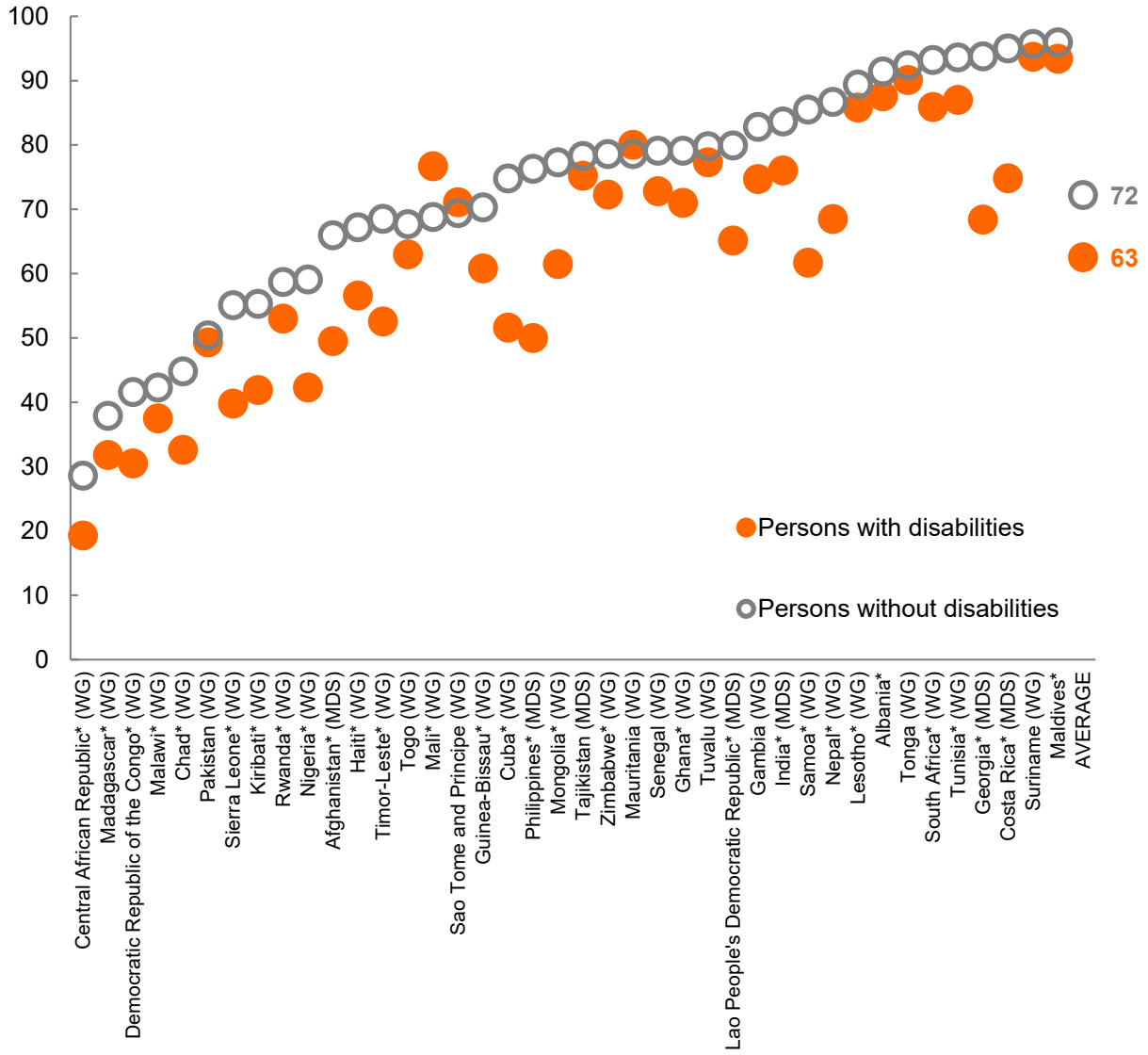
Source: UNDESA (on the basis of data from Sozialheden[10]).

Mobiles phones can have a strong impact on promoting the independent living of persons with disabilities.[400] Among 40 countries, 63 per cent of persons with disabilities own a mobile phone compared with 72 per cent of persons without disabilities (Figure 152). In 15 countries, the gap between persons with and without disabilities is 10 percentage points or higher. The percentage of persons with disabilities owning a mobile phone ranges from 19 per cent in the Central African Republic to 94 per cent in Suriname. Women with disabilities are the least likely to own a mobile phone lagging behind women and men without disabilities and men with disabilities (see the chapter on Goal 5).

Lack of comparable data over time is generally lacking. Among three countries, the percentage of households with persons with disabilities that own a mobile phone has been increasing and the gaps between households with and without persons with disabilities have narrowed or stagnated over time (Figure 153). For example, in Lesotho, while the gap between households with and without persons with disabilities was 14 percentage points in 2011, the gap closed to zero by 2017.

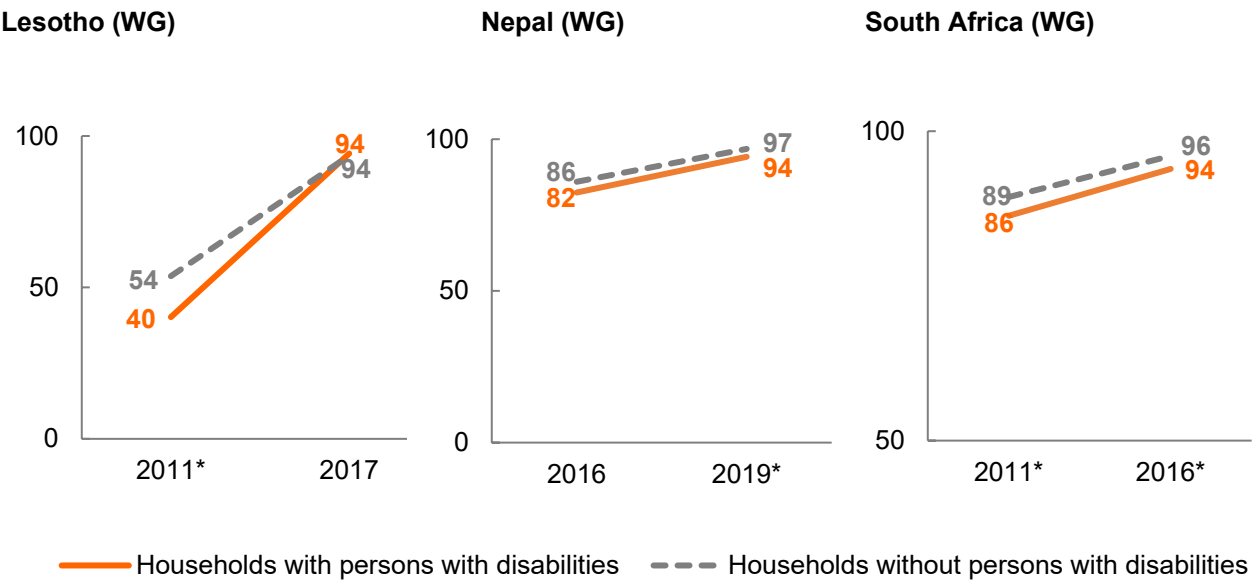
Persons with disabilities also face barriers to accessing and using digital banking services and are less likely to use mobile phones for financial transactions than persons without disabilities, with gaps of over 15 percentage points between persons with and without disabilities in some countries (see the chapter on Goal 1).

Figure 152. Percentage of persons who own a mobile phone, by disability status, in 40 countries, in 2021 or latest year available.



Note: (MDS) identifies data produced with the Model Disability Survey. (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: ESCWA (on the basis of data from DHS[6] and MICS), WHO and World Bank (on the basis of data from DHS[6] and MICS).

Figure 153. Trends over time in the percentage of households, with and without persons with disabilities, that own a mobile phone, in 3 countries.

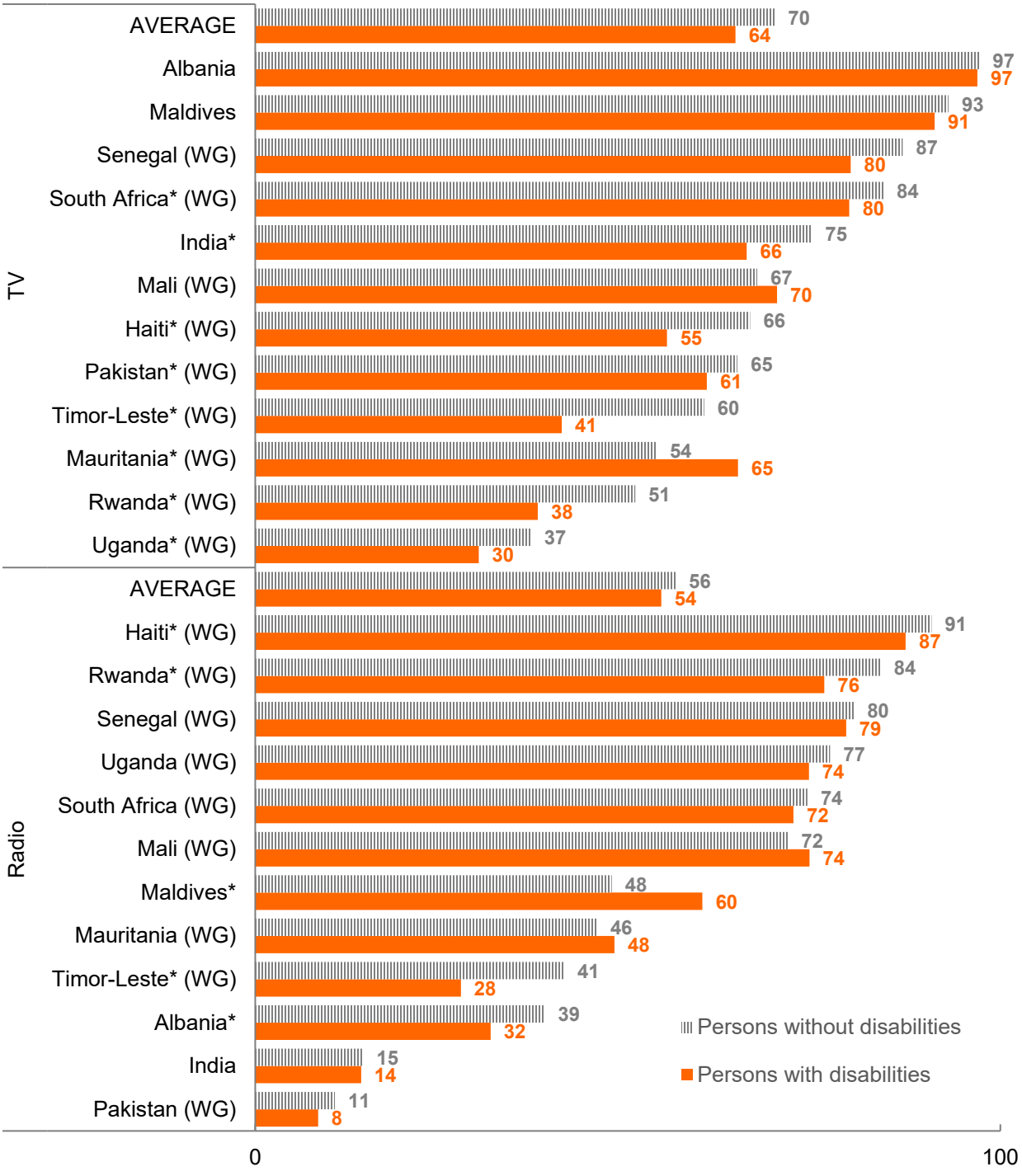


Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: UNDESA and World Bank (on the basis of data from DHS,[6] IPUMS,[8] MICS and SINTEF[9]).

In four developing countries, the use of radio and TV tends to be lower among persons with disabilities (Figure 154), but the gaps between persons with and without disabilities are narrower than those observed for the Internet. On average, 54 per cent of persons with disabilities and 56 per cent of persons without disabilities listened to the radio; 64 per cent of persons with disabilities and 70 per cent of persons without disabilities watched TV.

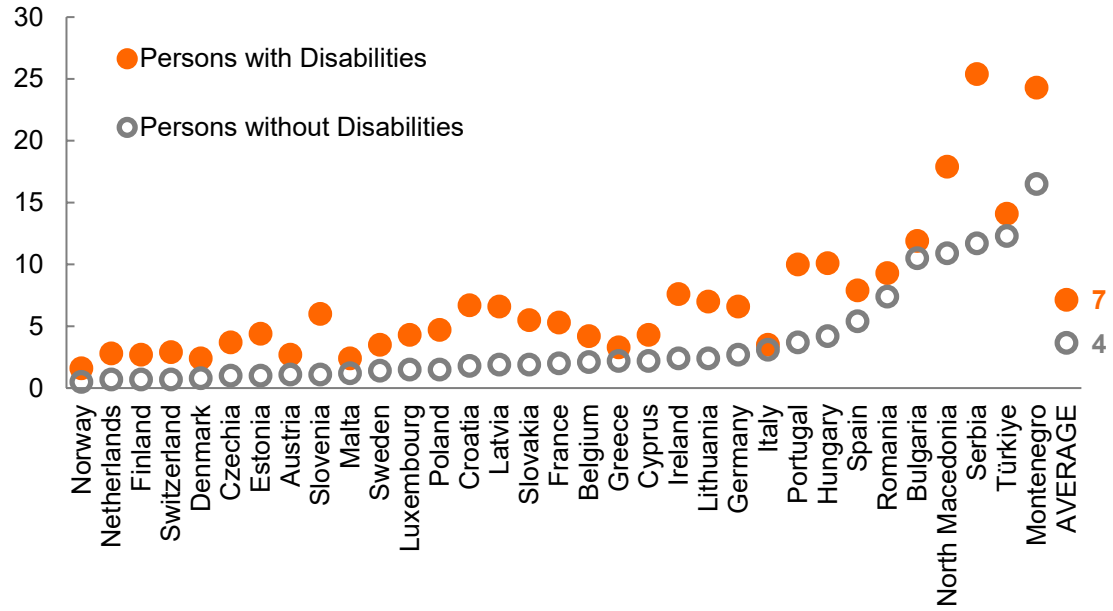
In Europe, persons with disabilities and their households face more barriers to affording ICT. Among 33 countries (Figure 155), the percentage of persons who cannot afford a computer is higher among persons with disabilities (7 per cent) than among persons without disabilities (4 per cent). In Hungary, North Macedonia, Montenegro, Portugal and Serbia, the gap is over 5 percentage points.

Figure 154. Percentage of persons who use radio and TV, by disability status, in 12 countries, in 2021 or latest year available.



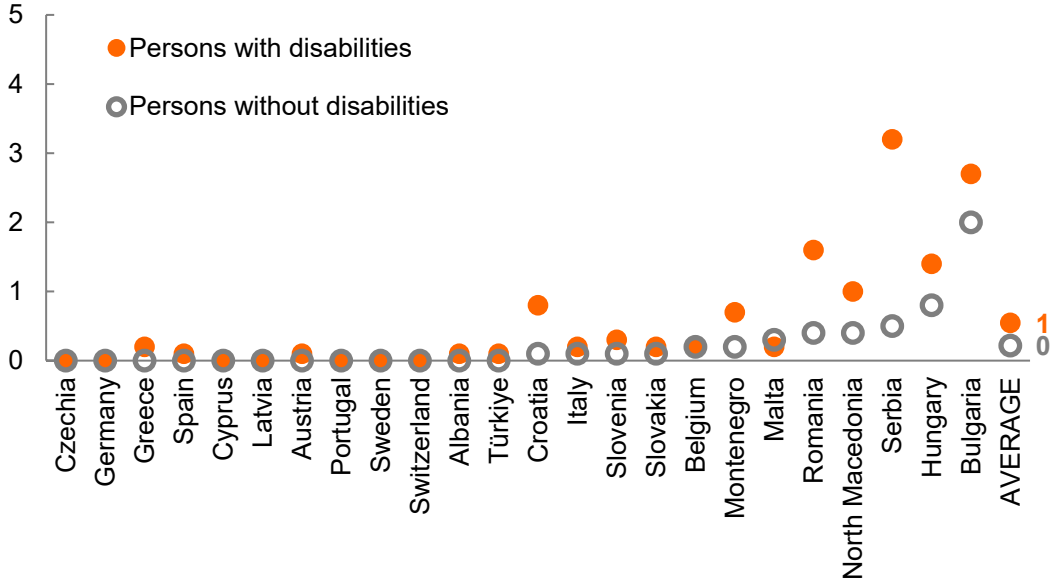
Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: UNDESA (on the basis of data from DHS[6]).

Figure 155. Percentage of persons aged 16 and over who cannot afford a computer, by disability status, in 33 countries, in 2021 or latest year available.



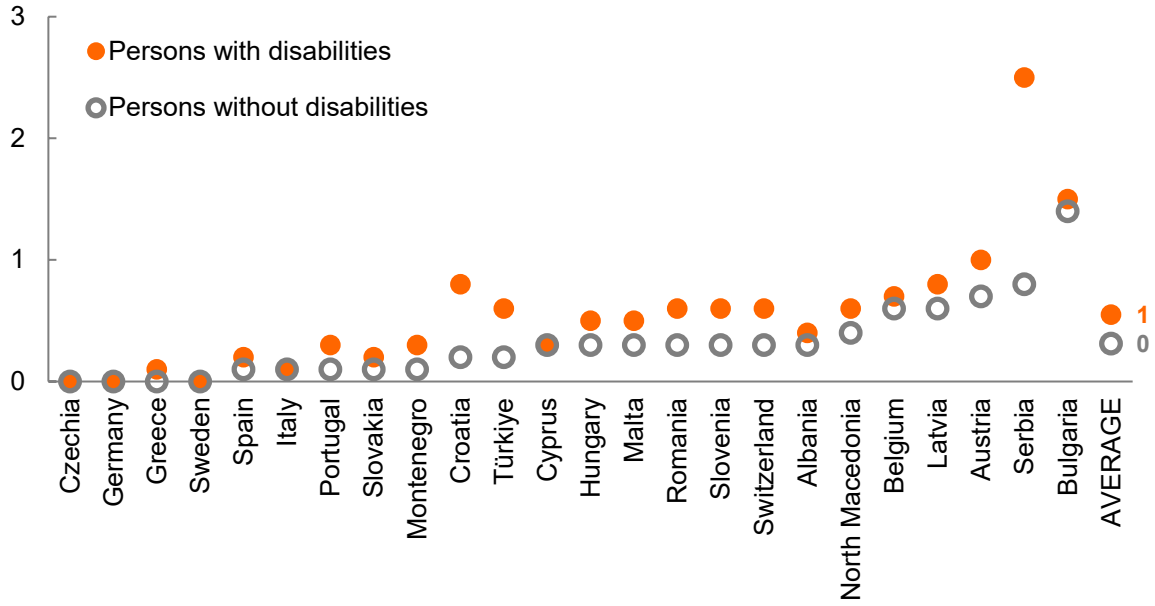
Note: Persons with disabilities include persons with some or severe limitations.
Source: Eurostat.[7]

Figure 156. Percentage of persons aged 16 and over who cannot afford a telephone, by disability status, in 24 countries, in 2020.



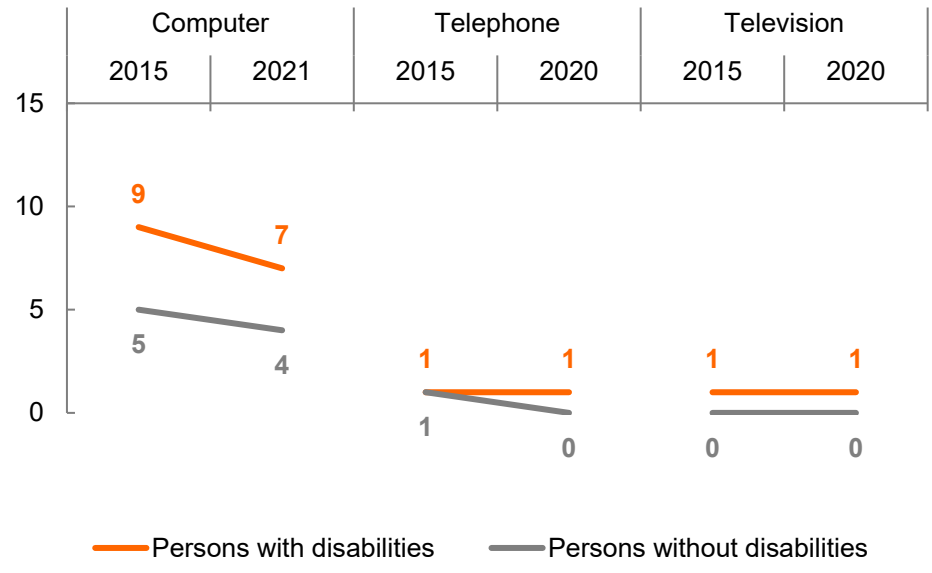
Note: Persons with disabilities include persons with some or severe limitations.
Source: Eurostat.[7]

Figure 157. Percentage of persons aged 16 and over who cannot afford a television, by disability status, in 24 countries, in 2020.



Note: Persons with disabilities include persons with some or severe limitations.
Source: Eurostat.[7]

Figure 158. Percentage of persons who cannot afford a computer, a telephone and a television, by disability status, in 24-33 countries in Europe, in 2015 and 2020-2021.



Note: Persons with disabilities include persons with some or severe limitations.
Source: Eurostat.[7]

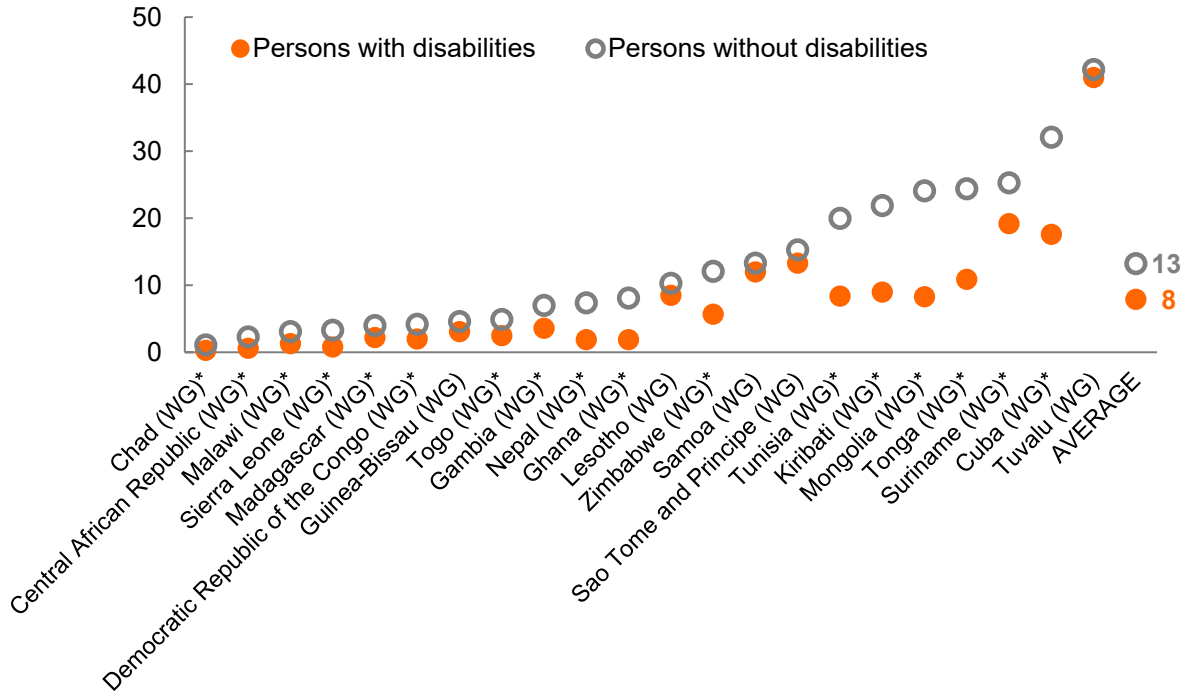
Fewer barriers exist to affording a telephone and a television (TV). Among 24 countries in Europe, 1 per cent of persons with disabilities cannot afford a telephone, compared to 0 per cent for persons without disabilities (Figure 156). In seven countries (Cyprus, Czechia, Germany, Latvia, Portugal, Sweden and Switzerland), all persons with disabilities can afford a telephone. In other countries, a small percentage of persons with disabilities still face barriers to affording a telephone – the widest gap between persons with and without disabilities is observed in Serbia where 3 per cent of persons with disabilities and 1 per cent of persons without disabilities cannot afford a telephone. Similar barriers are found to affording a TV: on average, 1 per cent of persons with disabilities versus 0 per cent of persons without disabilities cannot afford a TV – the widest gap is observed in Serbia, where 3 per cent of persons with disabilities but 1 per cent of persons without disabilities cannot afford a TV (Figure 157). Five countries show no gap between persons with and without disabilities: Cyprus, Czechia, Germany, Italy and Sweden, with all persons with and without disabilities being able to afford a TV in all of them except in Cyprus.

Across countries in Europe, progress has been made since 2015 in removing barriers for persons with disabilities to afford a computer, but no progress has been made in removing barriers to afford a telephone and a TV (Figure 158). Moreover, although there has been a faster decrease in the percentage of persons with disabilities who cannot afford a computer than in the percentage of persons without disabilities who cannot afford it, the decrease has not been enough to close the gap between persons with and without disabilities. For telephone affordability, progress since 2015 benefited persons without disabilities but not persons with disabilities. For TV affordability, there has been no improvement since 2015 and the gaps observed in 2015 remain in 2020.

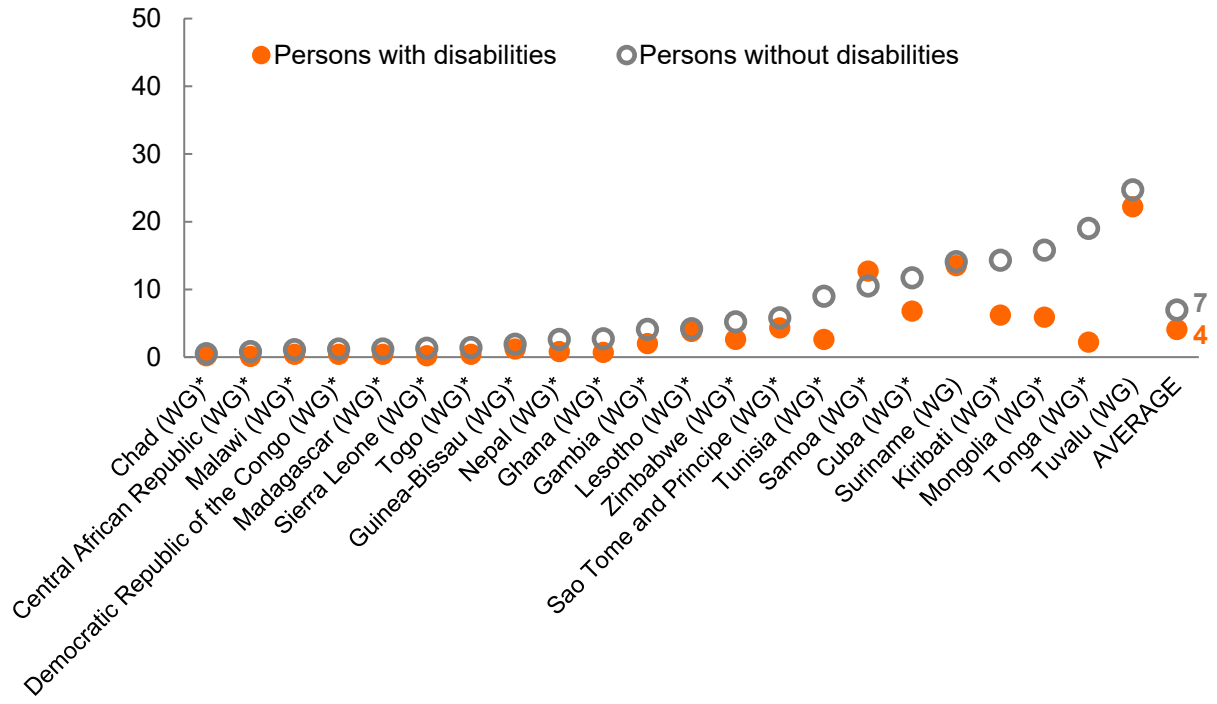
Meaningful access to ICT requires ICT skills. Some countries have focused on improving the ICT skills of persons with disabilities through training, especially of youth with disabilities.[402,403,404,405] But persons with disabilities are still often left behind in ICT skills training. Moreover, digital divides and barriers in accessing ICT limit opportunities for persons with disabilities to learn and enrich the types of digital skills required for the meaningful use of ICT and access to technology-enabled jobs and digital services (see the chapter on Goal 8). Among 22 countries, persons with disabilities were on average 3 percentage points behind persons without disabilities on the regular use of six digital skills: (a) copy or move a file or folder; (b) create an electronic presentation; (c) install and configure software; (d) connect and install a new device; (e) send e-mail with attached file; and (f) write a computer program (Figure 159). These gaps are above 10 percentage points in some countries.

Figure 159. Percentage of persons who used selected ICT skills on a weekly basis over the last 3 months, by disability status, in 22 countries, in 2020 or latest year available.

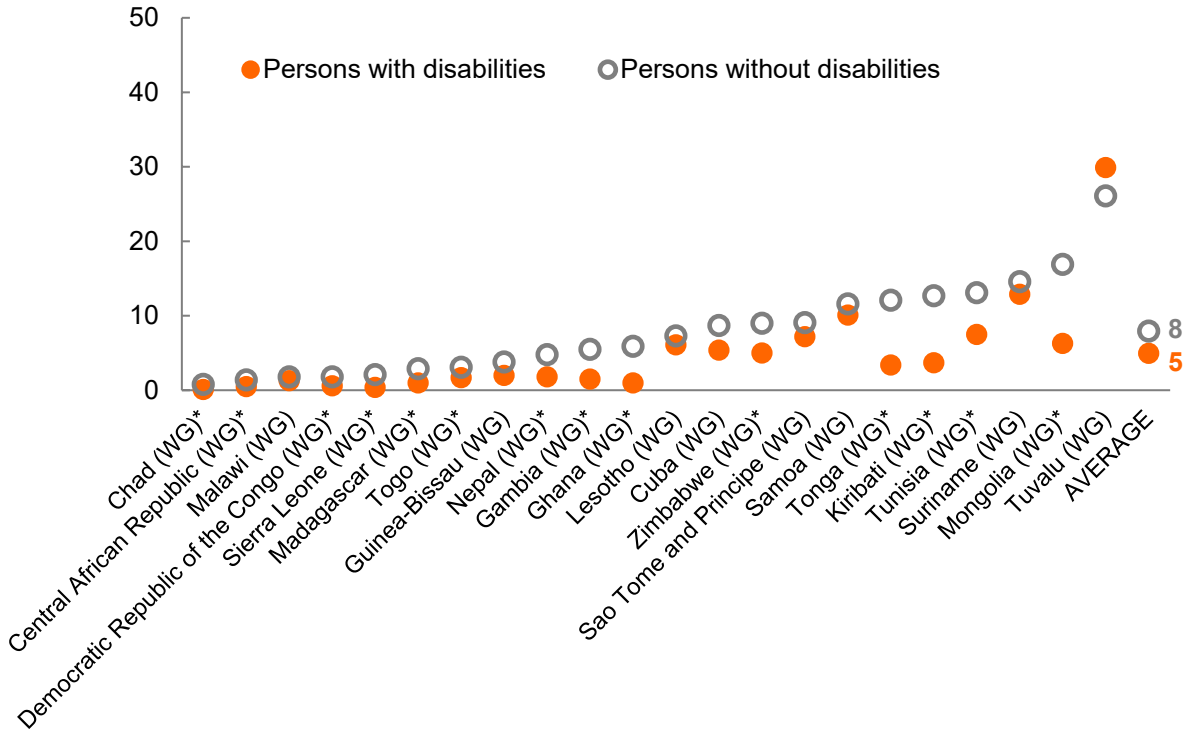
(a) Copy or move file/folder



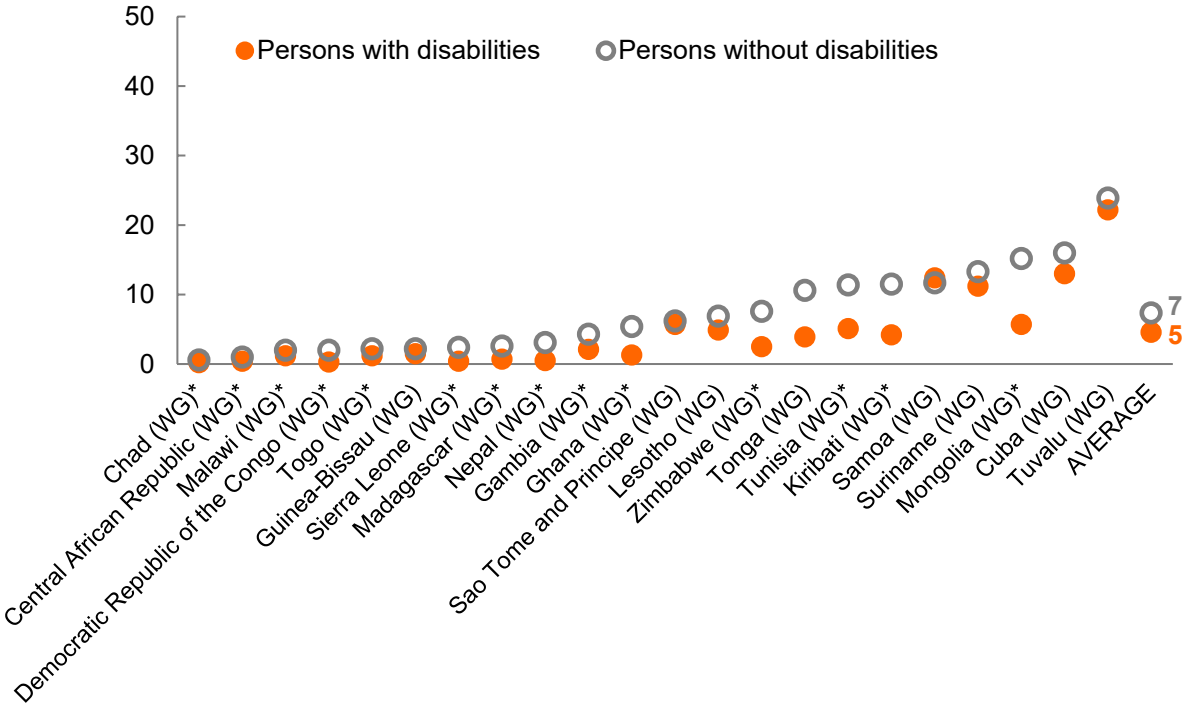
(b) Create an electronic presentation



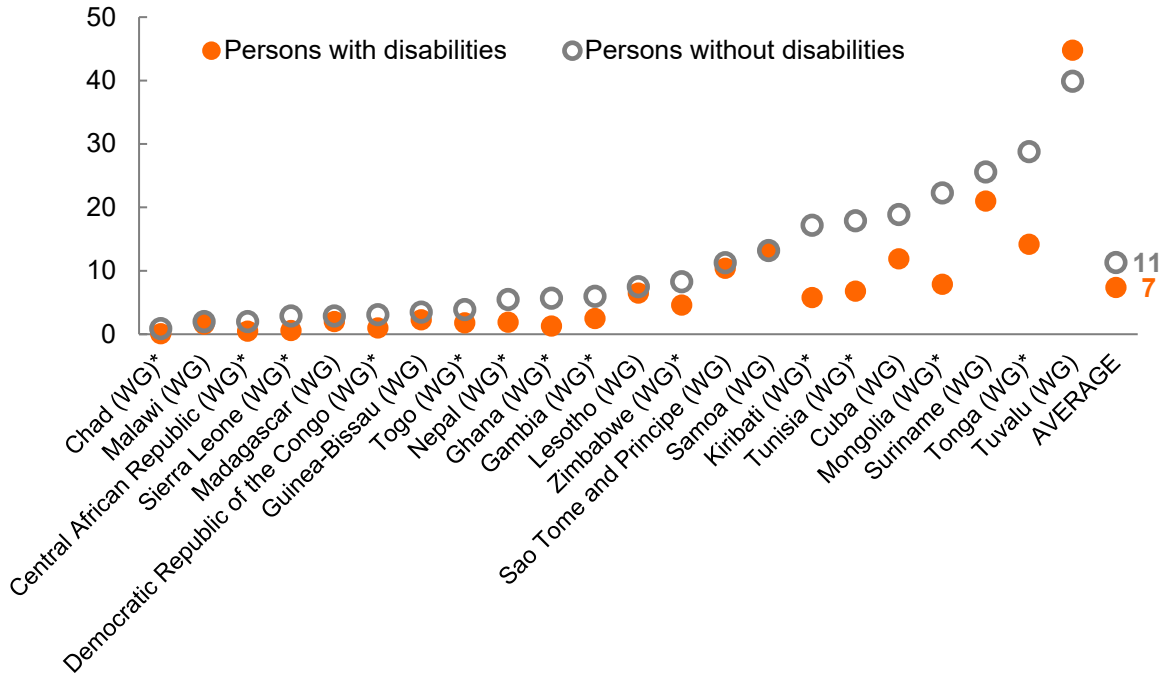
(c) Install and configure software



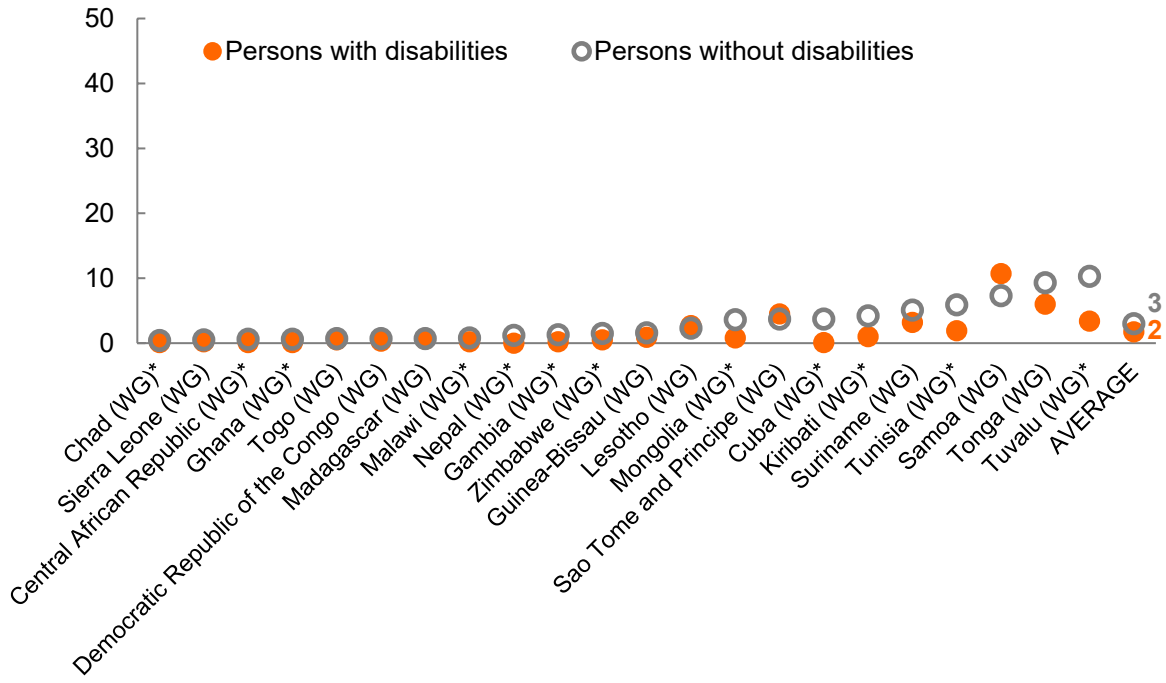
(d) Connect and install a new device



(e) Send an email with an attached file



(f) Write a computer program



Note: (WG) identifies data produced with the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: World Bank (on the basis of data from MICS).

A growing number of ICT, such as TV programmes and online websites, offer functionalities that facilitate communication and information access for persons with disabilities. Features such as sign language and captioning in TV programmes and alternative text or audio descriptions of images and videos in online sites are increasingly being used. These features break the barriers that persons with disabilities often find in these media. For example, persons with hearing impairments can access TV programmes that include sign language and persons with visual impairments can access images in online sites with screen-readers that read alternative text describing the image.

However, the use of these accessibility features is not yet universal. For example, in nine countries or areas in Asia and the Pacific, on average, only 17 per cent of news in national public TV channels include both captioning and sign language, 37 per cent include captioning only, 7 per cent include sign language only and 39 per cent do not include any of these accessibility features (see Figure 229. Percentage of duration of news programmes of national public TV channels that contain captioning and sign language, in 9 countries or areas in Asia and the Pacific, in 2022 or latest year available.Figure 229 in the chapter on target 16.10). The availability of these accessibility services in news programmes vary from country to country. In Bhutan, only 6 per cent of newscasts include accessibility features, and the only feature available is sign language. In Thailand 67 per cent of newscasts include both captioning and sign language. In China, Hong Kong (Special Administrative Region of China) and in the Republic of Korea, all news include captioning.

Lack of accessibility remains a barrier in other ICTs as well. While international standards for web accessibility have been adopted and updated since the late 1990s,[406] a 2019 study of the top one million websites found that 98 percent of website home pages had detectable failures to comply with the Web Content Accessibility Guidelines (W3C).[407] In 2020, 63 per cent of national governmental portals also failed to comply with W3C, with Africa having the largest percentage (87 percent) of countries with governmental websites that are not accessible for persons with disabilities, and Europe (30 per cent) having the lowest (see the chapter on Goal 16). Similar barriers are found in social media sites. Investigations into social media platforms in 2019 and 2022 concluded that they were generally not accessible for blind users and users with visual impairments.[408,409]

Impact of the COVID-19 pandemic

Since the declaration of COVID-19 as a pandemic in 2020, a majority of countries moved to curb the spread of the virus by instituting nationwide lockdowns and restrictions on mobility and gatherings in public spaces. This resulted in a massive need for digitally enabled solutions to offer continuity in schooling, jobs, healthcare, access to services and products, and information and communication. In the months after the declaration of the pandemic, mobile data usage in emerging markets surged by 23 per cent and international Internet bandwidth usage by 18 per cent.[410]

Despite this pressing need to access ICT, many persons with disabilities faced digital barriers with a

negative impact on their employment and education. During the school closures due to the pandemic, only 62 per cent of children with disabilities worldwide had access to a television in their household and only 47 per cent had access to the Internet (see the chapter on Goal 4). Among children with disabilities, only 7 per cent to 12 per cent had access and found ICT accessible, from 7 per cent for radio and tablets to 12 per cent for TV and the Internet. Many families with children with disabilities, 42 per cent, did not have access to financial support to cope with the cost of additional devices, Internet access and personal support that remote learning required (see the chapter on Goal 4). Educational and work online platforms were also not always accessible to persons with disabilities: 64 per cent of persons with disabilities in work or education indicated that at least one online platform was not accessible to them and 29 per cent indicated that all online platforms were not accessible to them.[411] Overall, 49 per cent of workers with disabilities faced barriers working online or by telephone.[411] In May 2022, two years after the start of the pandemic, many businesses continued to struggle to provide digital accessibility to persons with disabilities in the workplace: among 111 private sector companies committed to disability inclusion, 32 per cent reported a need for more capacity building in providing workplace adjustments for inclusive remote work (see the chapter on Goal 8).

The accessibility of online portals that served as gateways to COVID-19 testing, vaccination appointments and other crucial information was another critical necessity – yet many of these websites were not designed with accessibility features for persons with disabilities. In 2021, among 21 governmental COVID-19 vaccination information websites across Asia and Europe evaluated on their accessibility in relation to W3C Guidelines 2.0 and 2.1, all of the websites lacked essential features to make them accessible to persons with disabilities: 70 per cent were not accessible to blind persons, 71 per cent did not have accessible contrast between the text and background colours and none of the websites allowed for font size adjustment (crucial features for persons with visual impairments).[412] Similar accessibility barriers were found in COVID-19 vaccine registration and information websites in the United States, with the most common barriers including lack of accessible contrast between the text and background colours and lack of alternative text describing images.[413]

During the COVID-19 pandemic, the use of telehealth services increased substantially in many countries and telehealth became a basic need for the general population. But, again, many persons with disabilities experienced difficulties and challenges accessing and using telehealth services and were often forgotten in the design of these digital services. Especially in developing countries, persons with disabilities could not benefit from telehealth services due to highly inaccessible delivery formats. Very often telehealth platforms were not compatible with devices such as screen-readers used by persons with vision impairments or the lack of captioning or volume control in video conferencing impeded persons who are deaf or hard of hearing to interact with health professionals virtually.

To respond to these challenges, in 2020, the International Communication Union (ITU) released guidelines on how to ensure that digital information, services and products are accessible by all people,

including persons with disabilities, during COVID-19. The guidelines provided two key messages and actions: (i) to ensure that key digital information, services and requirements on reducing transmission of COVID-19 are provided in accessible formats to enable all people, including persons with disabilities, to have access to this vital information, and (ii) to consider public information, radio, television, text messages, WhatsApp, E-mail, social networks and websites when ensuring that all people, including persons with disabilities, can access, understand and use digital information and services.[414] Similarly, in 2021, the United Nations Educational, Scientific and Cultural Organization released guidelines on the inclusion of learners with disabilities in open and distance learning, with recommendations for key stakeholders to support opportunities for continued quality learning, including by harnessing open, free and publicly available solutions, such as open-sourced software and education materials released under an open license;[415] as well as guidelines for emergency movement to online and distance learning. The latter includes an emergency response actions checklist, for educators and ICT developers in situations that require the dissemination of Open and Distance Learning resources accessible to persons with disabilities.[416] ITU also adopted a new global standard on the accessibility of telehealth services, which defined accessibility requirements to be used and implemented by governments, healthcare providers and manufacturers of telehealth platforms to facilitate the access and use of telehealth services by persons with disabilities.[417]

Summary of findings and the way forward

ICT is crucial for the independent living and for the inclusion of persons with disabilities and is becoming imperative for achieving all SDGs. However, digital divides remain between persons with and without disabilities. In developing countries, Internet use is 11 percentage points lower for persons with disabilities than for persons without disabilities. In order to close the gap between persons with and without disabilities, Internet access among persons with disabilities will need to increase by 1.2 percentage points every year until 2030. In Europe, persons with disabilities are twice as likely to not be able to afford a computer than persons without disabilities. In least developed countries, an average of 20 per cent of persons with disabilities uses the Internet, a level that is too low compared to the universal access by 2020 called for in SDG target 9.c. This target was missed in 2020; in order to meet this target by 2030, Internet access among persons with disabilities in the least developed countries will need to speed up and increase by 9 percentage points every year until 2030.

ICT access among persons with disabilities is impacted by area of residence, gender and age, with persons with disabilities in urban areas, men with disabilities and younger persons with disabilities having higher access. In developing countries, households of persons with disabilities in urban areas are twice as likely to have access to Internet connectivity than those in rural areas. Younger persons with disabilities aged 18-35 are twice as likely to use the Internet regularly than persons with disabilities aged 36-49. In some countries, the gaps between women and men with disabilities exceed 20 percentage

points for Internet use and for ownership of a mobile phone.

Comparable data over time on access to ICT disaggregated by disability is generally lacking, especially in developing countries. In these countries, limited available data show increasing access to the Internet and increasing ownership of mobile phones among households with persons with disabilities. In Europe, more persons with disabilities can now afford a computer than in 2015 (91 per cent in 2015 versus 93 per cent in 2021), but 1 per cent of persons with disabilities cannot afford a telephone or a television – a percentage that has remained stagnant since 2015.

Lack of accessibility features in ICT continues to be a barrier for persons with disabilities. Despite the existence of international web content accessibility guidelines since the 1990s, most websites do not comply with these guidelines: 98 per cent of the top 1 million websites; 63 per cent of national governmental online portals worldwide; and 100 per cent of governmental COVID-19 vaccination information websites in Asia and Europe. Lack of accessibility features in governmental portals is particularly high among countries in Africa (87 per cent). Similarly, TV channels lack accessibility services in their programmes. For example, in Asia and the Pacific, 39 per cent of news programmes in national public TV channels do not include captioning or sign language.

Lack of accessibility of public places for Internet access also remains high, despite progress since 2019. For example, as of 2022, only 27 per cent of Internet cafes were fully accessible for wheelchair users compared to 20 per cent in 2019. At this rate of progress, only half of public Internet cafes are expected to be accessible to wheelchair users by 2030. The rate of progress needs to double in the remaining years until 2030 in order to make all Internet cafes fully accessible for wheelchair users.

In order to eliminate these barriers for persons with disabilities, countries have increasingly adopted regulatory frameworks on the accessibility of mobile communications, Web pages, public procurement for ICT, TV and video programming and public ICT. As of 2020, 69 per cent of countries had at least one of these regulatory frameworks. Europe is the region where these regulations are more common and Africa the least, as 55 per cent of countries in Africa have no regulations.

Due to its growing importance, it is critical that the digital economy becomes a source of inclusive income generation and access to products and services for persons with disabilities. This requires investments in the digital literacy and digital skills of persons with disabilities. Persons with disabilities are not far behind their peers without disabilities, although overall a lower percentage of persons with disabilities attest to a range of basic ICT skills like copying or moving a file or folder and sending an email with an attachment, with persons with disabilities being on average 3 percentage points behind. In various countries, the gaps between persons with and without disabilities in using ICT skills are above 10 percentage points, suggesting the need for more mainstream and targeted interventions to bring persons with disabilities to the same levels of ICT skills as persons without disabilities in these countries.

As digitalization of services and activities rose substantially during the COVID-19 pandemic, the digital

divide in ICT access and the lack of ICT accessibility for persons with disabilities impacted access to education and health services and created additional barriers to employment: in the middle of the pandemic, 88 per cent of children with disabilities either did not have access to the Internet for education or the Internet was not accessible and useful to them; and 49 per cent of workers with disabilities faced barriers to working online or by telephone. Gaps in digital access were also visible in remote telehealth services.

As a critical element to ensure that persons with disabilities have equitable opportunities and access to educational, economic, social and civic participation, policy and decision makers should build on the progress made so far and continue to invest in digital inclusion. Looking forward, the following recommendations offer guidance on how to strengthen the ICT ecosystem to ensure inclusion and accessibility for persons with disabilities:

1. Make disability inclusion a core feature of digital development investments and programmes. Planning and budgeting for disability inclusion in digital investments from the start will ensure comprehensive planning, targeting of beneficiaries with disabilities, cost efficiency and a lower need for expensive retrofitting.

2. Enhance knowledge and build human capacity on ICT accessibility. Digital inclusion requires investments in people. Improving 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 organizations of persons with disabilities, and ICT industries in the public and private sectors must be alerted to the vast potential and urgent need for accessible ICTs to improve the quality of life and inclusion of persons with disabilities. Methods to achieve this could include the development of academic programmes and training programmes highlighting ICT accessibility and Universal Design. Programmes are also needed to develop ICT accessible for persons with intellectual disabilities, including the use of easy-to-understand language in TV, radio, computers and smartphones, among others.

3. Promote digital skills training and digital literacy of persons with disabilities. Ensure that persons with disabilities have equitable opportunities to build digital literacy and digital skills to participate in and benefit from the digital economy. This can include twin track approaches by making sure that mainstream skills development programs are inclusive, while identifying and addressing unique challenges that persons with disabilities may face.

4. Involve persons with disabilities and their representative organizations. 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 and able to provide their input and insights at every stage of ICT development. One of the most effective ways to do this is to work together with organizations of persons with disabilities, particularly those which have expertise in the field of ICT

accessibility and connect them with ICT businesses.

5. Develop and strengthen the implementation of ICT accessibility policies and regulations. As countries continue to develop better policy, legislative and regulatory frameworks, it is also important to strengthen cross-ministerial collaboration, alignment of policies across sectors and monitoring and accountability mechanisms to ensure appropriate implementation of the policies.

6. Promote the principles of Universal Design in the ICT industry. Implementing Universal Design principles is more inclusive, affordable and often simpler than developing specialized software or hardware for persons with disabilities.

7. Provide affordable Internet access for persons with disabilities. Introduce programmes, 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 the 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.

8. Develop and publish comparable data on access to and use of ICTs disaggregated by disability as well as on accessibility of ICTs. Data on digital access, usage and growth should be disaggregated by disability to enable reliable and comparable analysis to monitor the progress towards meeting SDG target 9.c. 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.

Reducing inequalities and promoting inclusion (target 10.2)

Goal 10 aims at reducing inequalities and target 10.2 aims at empowering and promoting the social, economic and political inclusion of all, irrespective of disability status. Community support systems are central to the inclusion of persons with disabilities and thus for achieving target 10.2. These systems provide support to enable persons with disabilities to participate in school, the workplace and in communities on an equal basis with others. The community support needed varies from person to person and may include financial support, family support, personal assistance, community-based networks, provision of assistive technology, transport and housing programmes and supported decision-making.

The Convention on the Rights of Persons with Disabilities requires States to ensure that persons with disabilities have access to a range of support services to facilitate living and inclusion in the community. Community support and inclusion are cross-cutting obligations found in the purpose of the Convention (article 1), the general principles (article 3), the general obligations (article 4), as well as in the context of several substantive provisions, in particular the right to live independently and be included in the community (article 19) as well as the right to an adequate standard of living and social protection (article 28). Providing support to persons with disabilities to exercise their legal capacity is also required (article 12). Similarly, providing comprehensive services and support to children with disabilities and their families to prevent segregation of these children is required (article 23(3)).

The Human Rights Council has adopted a number of resolutions addressing community support and independent living, including in 2015 a resolution on the right of persons with disabilities to live independently and be included in the community on an equal basis with others,[418] which calls on States to provide persons with disabilities with access to a range of support services that are responsive to their individual choices, wishes and needs, including for their deinstitutionalization. The Council has also urged States to provide services and support systems across different issues, such as mental health[419] and violence against women and girls.[420]

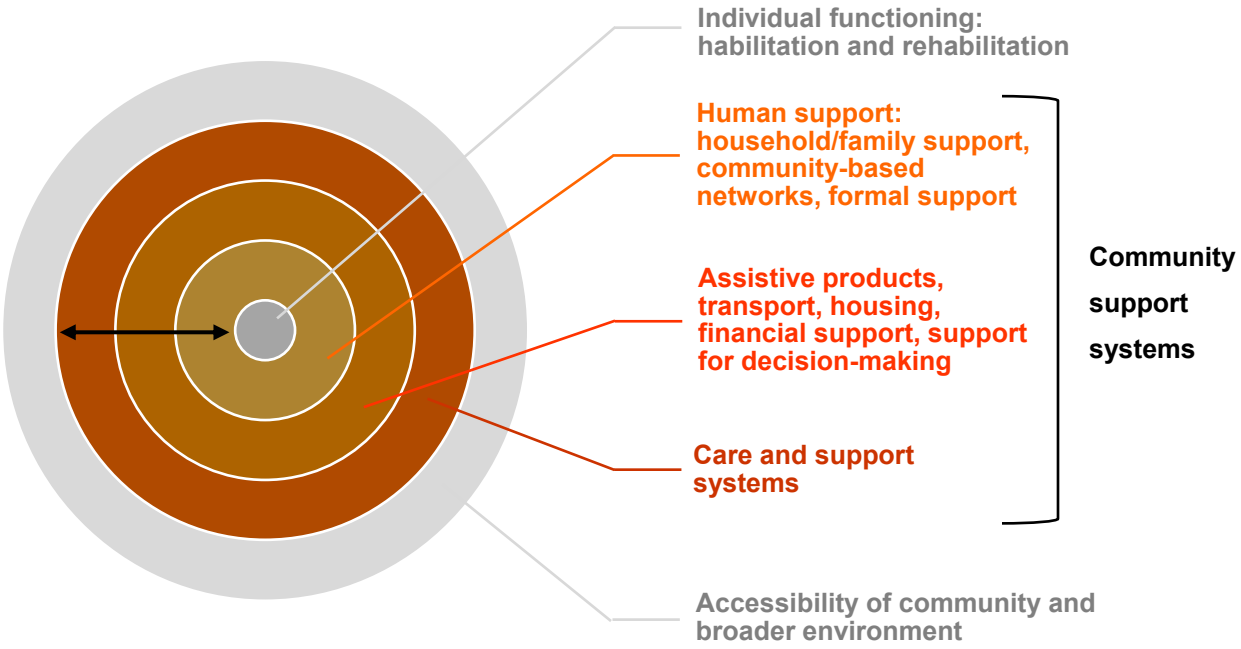
This chapter provides an overview of the availability and access to community support and care for persons with disabilities and their families, with an emphasis on developing countries. It finishes with recommendations on how to address unmet needs for community support for persons with disabilities.

Current situation and progress so far

Community support systems refer to the network of people, services and products that assist persons with disabilities to carry out daily life activities and participate in their communities, including: (i) human support, assistive technologies and inclusive transportation; (ii) financial support for covering extra costs related to the individualized support needed to prevent their exclusion from community life; (iii) housing assistance, both through cash transfers and social housing, that enable them to live in the community; (iv) support to exercise legal capacity, including through supported decision-making; (v) family support

programmes, including social protection schemes to reduce the impact on available household income where services are insufficient; and (vi) care and support systems, including other community-based services needed to prevent institutionalization.

Figure 160. Interdependence among community support systems, improvement of individual functioning and accessibility of the community and broader environment.



These community support systems are essential to overcome exclusion, prevent institutionalization, live independently in the community and support families of persons with disabilities. They enable inclusion by mobilizing communities and coordinating a diversity of schemes and services, connecting and leveraging inclusion efforts made by different sectors. Participation and inclusion are maximized where different types of support are available and operate in synergy to produce an enabling environment for all, including persons with disabilities.

There is an interdependence among (i) community support systems; (ii) improvement of individual functioning through habilitation and rehabilitation; and (iii) accessibility and inclusiveness of the community and broader environment (Figure 160). For example, improving individual functioning through habilitation and rehabilitation and increasing accessibility of the environment through universal design helps reduce the need for human support services. Having access to assistive technologies or human support helps navigate inaccessible environments and information, which are still the norm around the world.

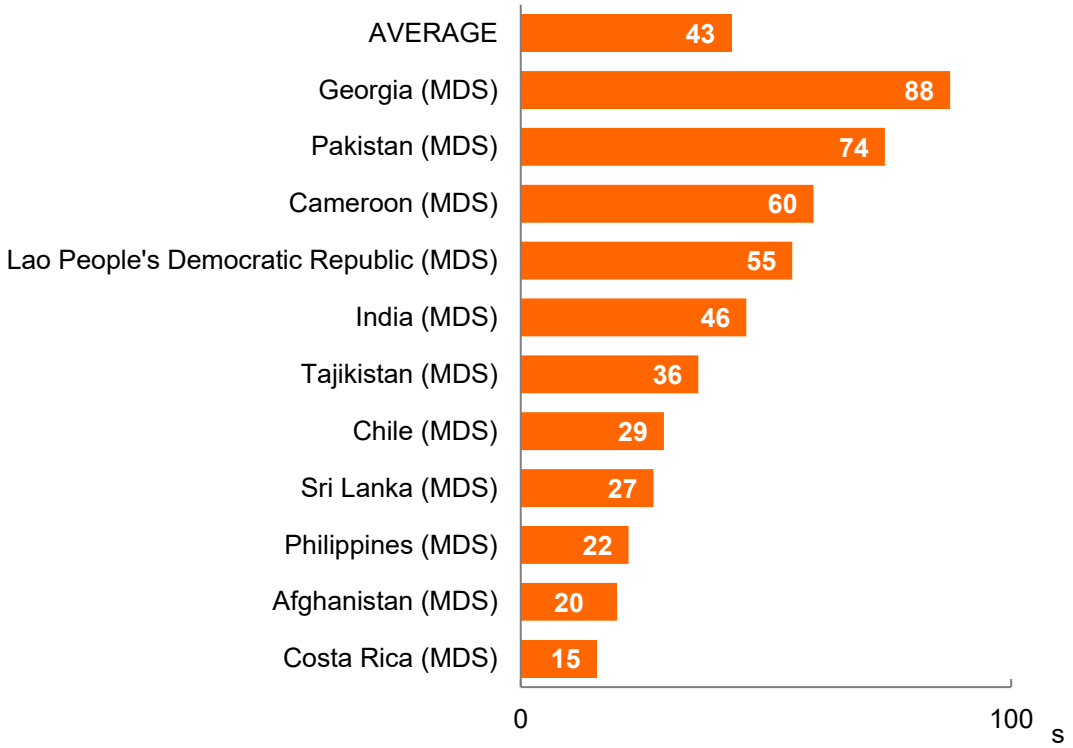
However, even where the environment is accessible, mainstream services are inclusive, and quality

habilitation and rehabilitation are available, individualized support may still be required to ensure the participation of persons with disabilities who face more severe functional limitations. The lack of community support services can negatively impact persons with disabilities and their families in various ways, including by inducing dependency, segregation and putting persons with disabilities at higher risk of violence and abuse.

Persons with disabilities have a range of unmet needs in relation to accessing services, financial and social support and other social resources, finding support for communication and socialization, getting information and, among parents of children with disabilities, receiving support for childcare.[421] While developed countries spend 1 per cent to 5 per cent of their gross domestic product (GDP) on disability benefits and support, developing countries spend only between 0.001 per cent and 1 per cent of their GDP (see the chapter on targets 16.5, 16.6 and 16.7).

In many communities, the support systems for persons with disabilities are insufficient, impeding persons with disabilities from participating on an equal basis with others. Among 11 developing countries, on average, 43 per cent of persons with disabilities indicate that joining community activities is problematic or very problematic, from 15 per cent in Costa Rica to 88 per cent in Georgia (Figure 161).

Figure 161. Percentage of persons with disabilities who indicate that joining community activities is problematic or very problematic, in 11 countries, in 2021 or latest year available.

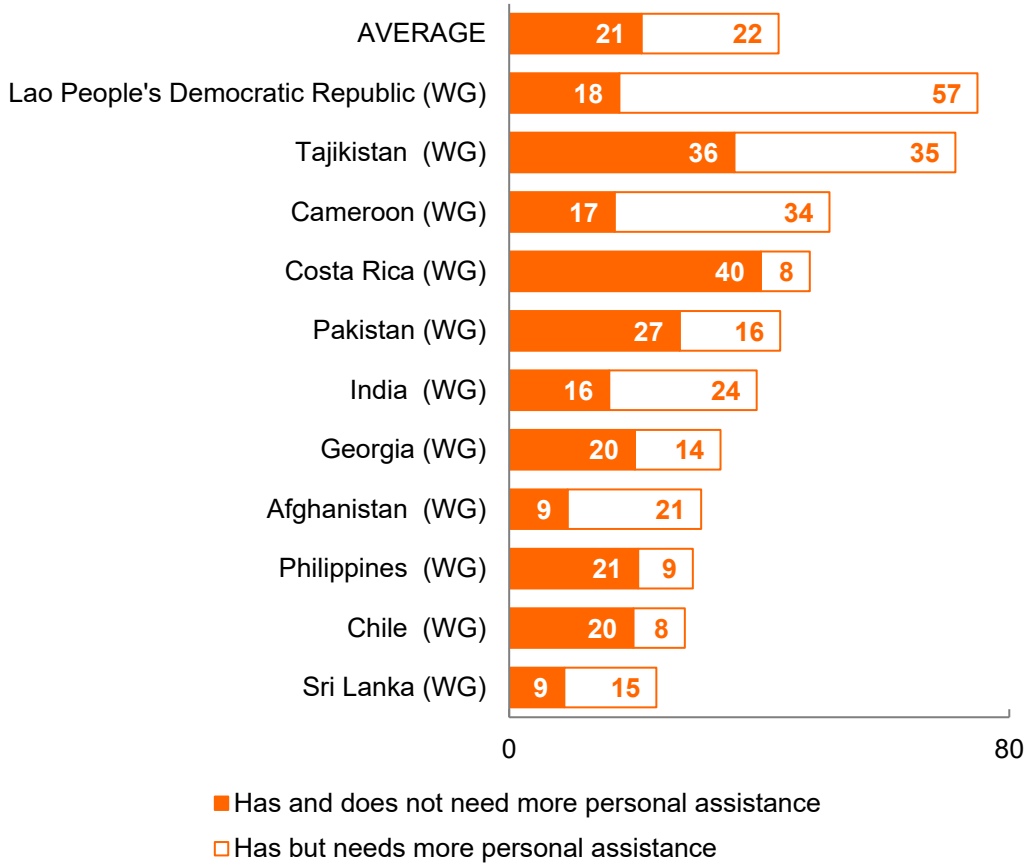


Note: (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from Model Disability Surveys).

Human support

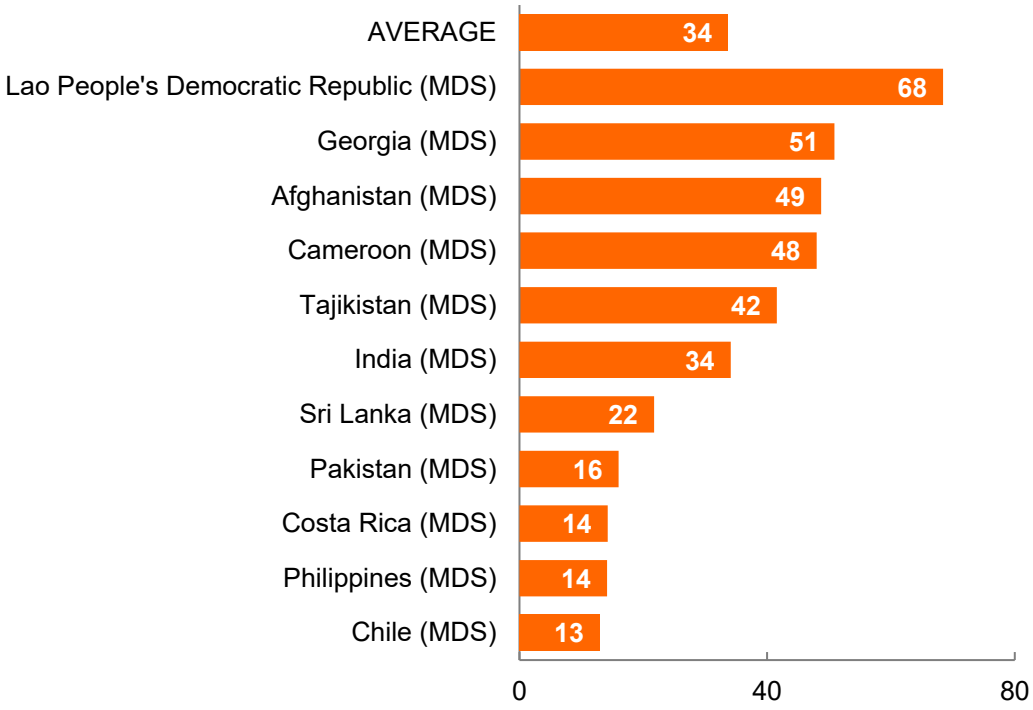
Many persons with disabilities, particularly those with long-term impairments, require human support throughout the life cycle to participate in the community equally and with dignity, autonomy and choice. Human support can involve formal or informal care, personal assistance services, sign language interpretation, guide-interpreters for deafblind people, peer support groups, circles of support, and other support networks and services. This support is required in various life domains, including communication, decision-making, personal mobility, self-care, daily living activities, as well as access to public services, education and work. The level of support required varies depending on the individual's level of functional limitation; the barriers in the home; community, transport, school or work environments; and the individual's desired level of participation.[422]

Figure 162. Percentage of persons with disabilities receiving sufficient and insufficient personal assistance for day-to-day activities at home or outside, in 11 countries, in 2021 or latest year available.



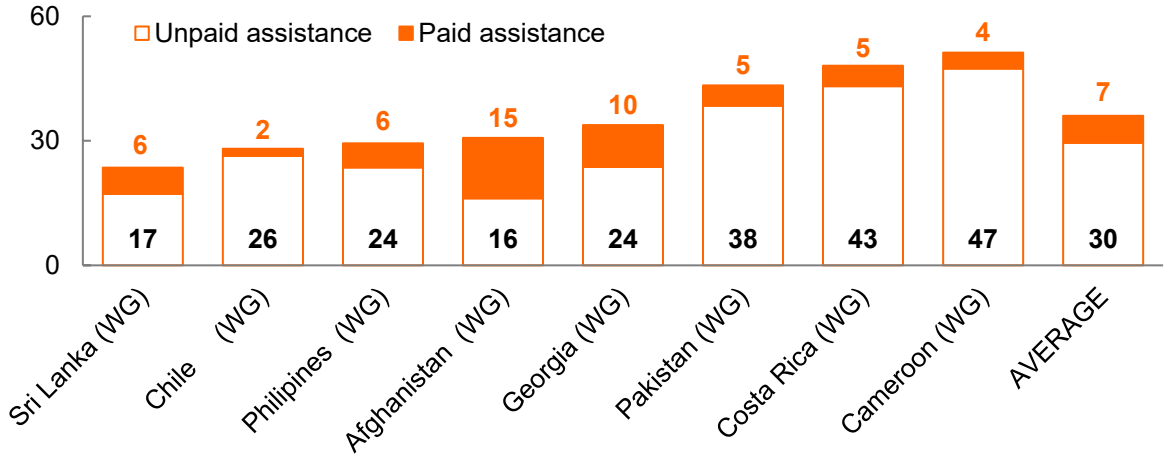
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: OHCHR (on the basis of data from MDS).

Figure 163. Percentage of persons with disabilities who need personal assistance for day-to-day activities at home or outside, among persons with disabilities who do not have any personal assistance, in 11 countries, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from the MDS).

Figure 164. Percentage of persons with disabilities receiving unpaid and paid personal assistance, in 8 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: OHCHR (on the basis of data from Model Disability Surveys).

Among 11 countries, on average, 43 per cent of persons with disabilities receive personal assistance for day-to-day activities (Figure 162). Despite this considerable level of support for day-to-day activities, unmet demand for human support remains substantial, with 22 per cent of persons with disabilities indicating that they need more support in addition to the support they are receiving. Moreover, among persons with disabilities who do not have personal assistance, 34 per cent would need this assistance, indicating an important gap that restricts their full participation and puts them at risk of exclusion (Figure 163).

Most of the personal support persons with disabilities receive is unpaid, mainly provided by family members (Figure 164). Paid personal assistance tends to be costly[423] and many persons with disabilities who need it cannot afford it, leading to their disempowerment and leaving them at risk of isolation, poverty, violence, abuse and institutionalization.

Historically, developed countries did not invest adequately in community support systems and relied heavily on segregated settings to provide human support, a practice that continues today. Recently, some countries have shifted towards personalized schemes for the provision of human support.[424] Developing countries tend to invest little to none in human support for persons with disabilities, as families are expected to provide such support without government assistance. Nevertheless, there are examples that show that investment in human support is also possible in resource-constrained settings when government initiatives are combined with community resources. For example, in Thailand, publicly funded personal assistance and sign language interpretation are provided to persons with disabilities through government disability centres and representative organizations of persons with disabilities.[425] Other developing countries that have developed personal assistance schemes include Argentina,[426] Bulgaria,[427] Costa Rica,[428] Iraq,[429] South Africa[430] and Tunisia,[431] albeit with various degrees of coverage, scope and success.

Family support programmes

Families are generally the main support network. In fact, in most countries, they are the main and often sole source of support for persons with disabilities of all ages. Support from family members has advantages: family members are often well-placed to understand the support needs and preferences of their relatives with disabilities and, because they have close ties with the community, their local knowledge and existing connections can benefit persons with disabilities. For children with disabilities, families play a critical role in child development and serve as role models for children to learn new skills and engage in the community.

While some persons with disabilities may prefer to receive support from family members, to complement or as an alternative to formal services, having families as the only source of support has limitations. The support that families can provide is often insufficient as it may be limited in terms of time, financial resources and knowledge. Furthermore, persons with disabilities may lack choice and control about the

support they receive. On the part of family caregivers, they may have to reduce or stop their own work or education to support their relatives with disabilities. Where they are the primary providers of care and support and do not receive appropriate support, they may risk burnout, and this could lead to neglect, abuse and institutionalization of persons with disabilities.

Several countries have invested in support programmes to assist families of persons with disabilities in their support role. Developing countries with disability-inclusive family support programmes include Brazil,[432] Colombia,[433] Ghana[434] and Rwanda.[435]

Assistive technology

Access to assistive technology is a pre-condition for inclusion and participation in all domains, including within education, political and civic life, employment and social and family life. Despite the great demand for assistive technology, a large number of persons with disabilities continue to face barriers to accessing such technology. Access to assistive technology varies from 11 per cent in countries with a low human development index to 88 per cent in countries with a very high human development index (see the chapter on target 17.8). The most commonly reported barrier is affordability, faced by 31 per cent of persons with disabilities (see the chapter on target 17.8). Social protection can thus assist with providing assistive technology, through health insurance, subsidies, cash transfers or direct provision.

Transport programmes

To access health, education and employment, persons with disabilities need accessible, affordable and reliable transportation systems. However, many public transport systems are either completely inaccessible or difficult to access. In developing countries, 43 per cent of persons with disabilities consider that transportation is not accessible to them (see the chapter on Goal 11). Barriers include poor vehicle design, bad platform accessibility of stations, lack of elevators and inaccessible signage and announcements. In rural communities, public transportation is generally in short supply due to a lack of funding and poor infrastructure.

Faced with this situation, various countries have adopted legal requirements on accessibility for persons with disabilities in public transportation and developed partnerships with representative organizations of persons with disabilities to implement accessibility features in various modes of transport (see the chapter on Goal 11). Some cities are also investing in paratransit solutions that provide individualized door-to-door transport. For example, in Cape Town, South Africa, a programme known as Dial-A-Ride provides accessible transportation to persons with physical disabilities who face barriers in accessing general public transport.[436] Although persons with disabilities have reported some problems with paratransit, such as the lack of training of bus drivers, restrictive eligibility criteria and slow service, these programmes remain necessary to ensure the full inclusion of persons with disabilities in their communities. In developing countries with underdeveloped public transportation, door-to-door transport may be the only

viable mobility option. In Phnom Penh, Cambodia, and in Karachi, Pakistan, low-cost wheelchair accessible *tuks* and *autorickshaws* have been developed to provide transport to persons with physical disabilities.[437]

To compensate for the extra cost of transportation that persons with disabilities may incur, either due to the lack of accessible transportation or the need to have a companion, several countries have also implemented transportation subsidies. For example, the city of Bogota, Colombia, provides transport subsidies to persons with disabilities through smartcards.[438]

Housing programmes

Housing programmes are essential for the inclusion of persons with disabilities in their communities. The lack of adequate housing aggravates the marginalization and dependency of persons with disabilities. The concept of housing involves more than physical shelter: it includes the notion of adequacy, which encompasses accessibility, affordability, independence, security, legal tenure, appropriate location, habitability, cultural adequacy and availability of services, materials, facilities and infrastructure.[439]

Persons with disabilities encounter numerous barriers to accessing adequate housing, including stigma and discrimination, low income, and laws and policies that legitimize institutionalization. As a result, they are disproportionately likely to experience homelessness or to be institutionalised.[440] Those with the opportunity to live in the community, experience barriers such as inappropriate and inaccessible housing design, lack of participation in housing programme design and inadequate housing support. In developing countries, 33 per cent of persons with disabilities consider their dwelling not accessible to them (see the chapter on Goal 11).

Some countries have programmes and services that help persons with disabilities to find and afford a place to live, or to modify an existing home to make it accessible, such as housing counselling, public housing programmes, rental assistance, vouchers programmes and supported housing.[441] At the same time, in response to the call for deinstitutionalization, there has been an increase in group homes in a number of countries,[442] including in developing countries,[443] which undermines community inclusion efforts. In such settings, large power imbalances between staff members and residents remain, choice and control are limited, and residents are more likely to be exposed to violence, abuse and neglect.[444]

Financial support

Persons with disabilities incur substantial extra costs associated with disability, such as costs related to healthcare, accessible transportation, personal assistance, modified residences and assistive technology, making inclusive social protection systems a prerequisite for community inclusion. These extra costs amount to about 43 per cent of household income in developed countries and 23 per cent of household income in developing countries (see the chapter on Goal 1). Financial support enables income security,

the ability to pay for support services, an increase in households' investment in children with disabilities, and an improvement in households' coping strategies. Many governments have started investing in social protection programmes for persons with disabilities, with 99 per cent of countries worldwide having some kind of disability benefits (see the chapter on Goal 1). Non-contributory cash transfers (such as disability benefits, social welfare pensions, conditional cash transfers) have been used to benefit both children, working-age adults and older persons with disabilities because they are not limited to only persons who have worked in the formal sector and contributed to social protection,[445] but these schemes are far from the norm with 48 per cent of countries not having any non-contributory scheme (see the chapter on Goal 1). Some countries have further utilized "cash-plus" programmes, providing cash transfers along with additional components such as information and additional benefits and support.[446] Despite these initiatives, the percentage of persons with disabilities who receive disability benefits remains low (these benefits only reach 34 per cent of persons with severe disabilities) and, in most cases, the amount allocated is insufficient to cover extra costs related to disabilities (see the chapter on Goal 1).

Support for decision-making

Some persons with disabilities may need assistance making decisions about living arrangements, healthcare, relationships and financial or other matters. Supported decision-making is an important example of such support. The term refers to the regimes or arrangements for assisting an individual to make, express and implement a decision. These vary in formality, intensity and scope, and may include support networks, support agreements, peer support, support for self-advocacy, independent ombudspersons and advance directives. The supporters are selected by the person with disabilities themselves and they can be inter-alia family members, co-workers, friends or past or present providers. Although supported decision-making tends to have a defined structure and process, it is also flexible and can be adapted to meet an individual's situation and needs. Instead of making a decision, the supporters respect the will and preferences of the individual and honour the choices and decisions the individual makes.

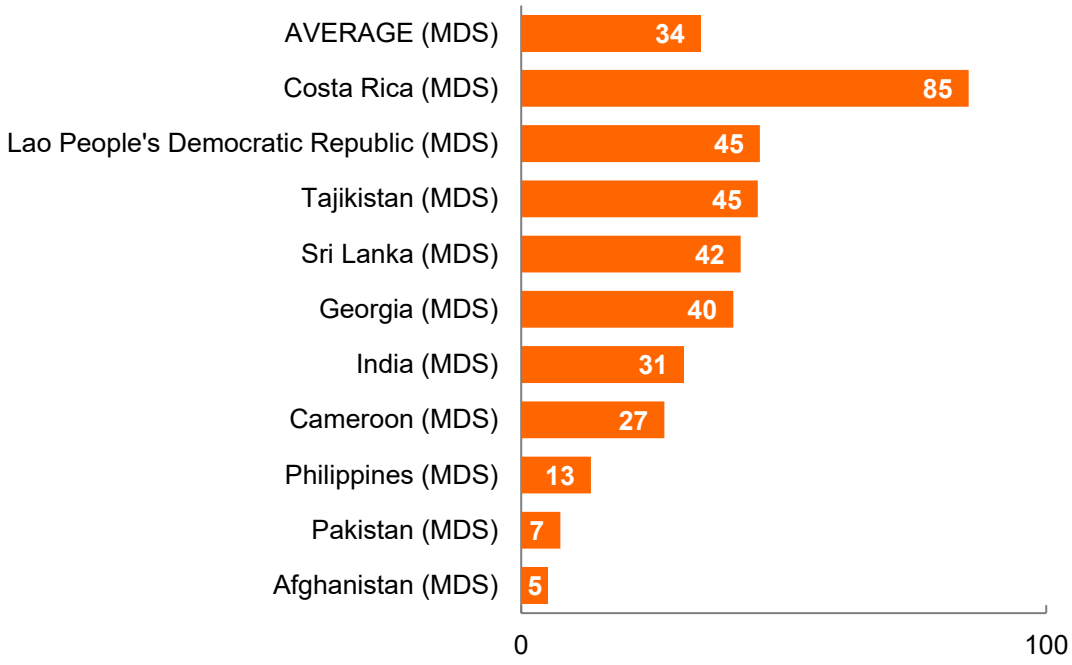
However, this type of support is still seldom available (see also the chapter on target 16.3). Instead, many persons with disabilities face barriers to making their own decisions and very often someone else is designated to make decisions for them. Among 10 countries, on average, only 34 per cent of persons with disabilities completely make decisions about day-to-day life and big decisions (such as where to live, who to live with and how to spend money), from 5 per cent in Afghanistan to 85 per cent in Costa Rica (Figure 165).

Since the adoption of the CRPD, several countries have taken measures towards supported decision-making, with varying levels of compliance with this arrangement (see the chapter on target 16.3). For instance, Austria, Colombia, Costa Rica, Peru and Spain have enacted legislation abolishing guardianships alongside the recognition of supported decision-making. Other countries, such as

Argentina, Australia, Brazil, Bulgaria, Canada, Czechia, Hungary, India, Ireland, Israel, Kenya, Latvia, Sweden, the United Kingdom, the United Republic of Tanzania and the United States of America, have introduced aspects of supported decision-making while retaining partial guardianship and other forms of substituted decision-making.

A concern that arises from these reforms is that the recognition of supported decision-making has not been accompanied by the development of services. Most experiences of provision of support for the exercise of legal capacity are on a small scale and come from representative organizations of persons with disabilities and non-governmental organizations; services developed or funded by the state are scarce.[447] One such example is the Supported Decision-Making New York programme,[448] recently expanded with public funding, which provides facilitation to ensure that people are assisted to implement supported decision-making agreements. In Catalonia, Spain, Support-Girona – an organization originally created to assume the traditional role of a guardian – provides support for decision-making to individuals dealing with complex situations and at risk of abandonment or institutionalization.[449] The government provides a personalized budget for each user.

Figure 165. Percentage of persons with disabilities who completely make decisions about day-to-day life and big decisions (e.g., where to live, who to live with and how to spend money), in 10 countries, in 2021 or latest year available.

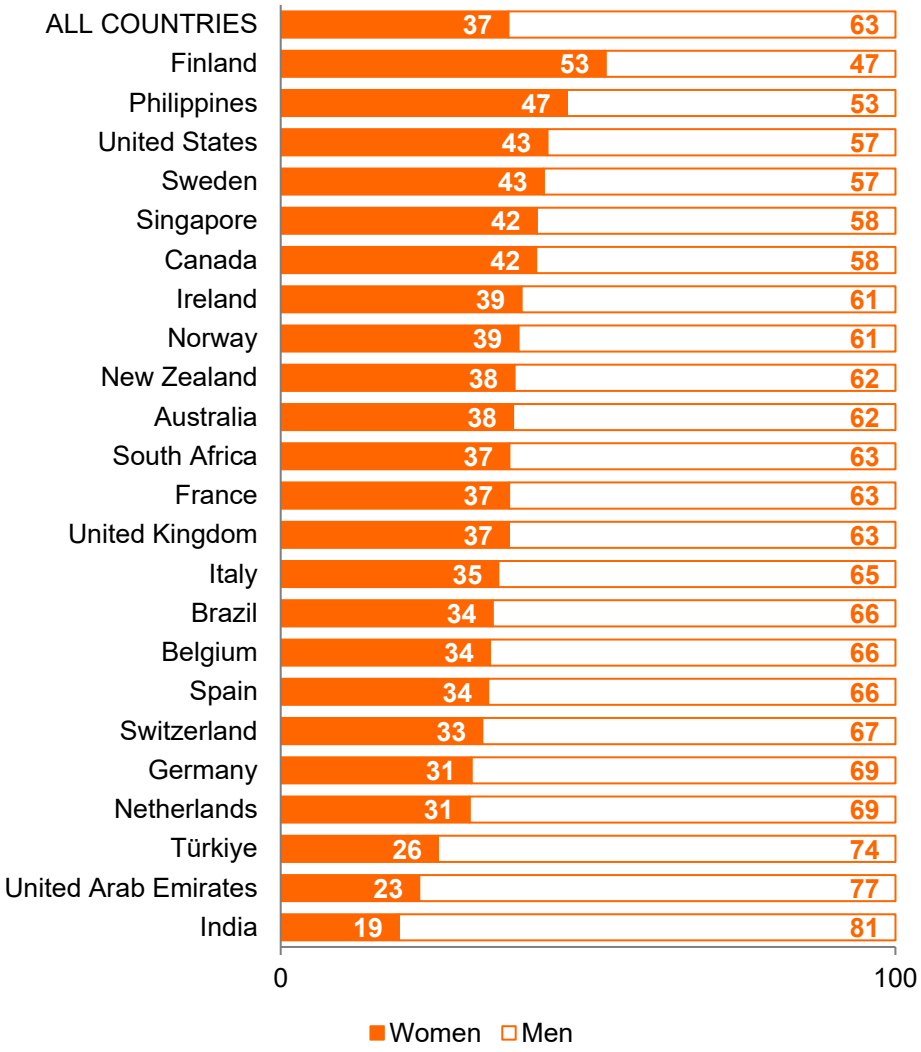


Note: (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from the MDS).

Care and support systems

The COVID-19 pandemic has increased the visibility of the care economy agenda resulting in the mobilization of unprecedented political support to develop and strengthen care and support systems, ensuring access to care and support for people who need it, and guaranteeing the rights of those who provide it. There is also greater awareness of the impact of demographic changes. Various factors, such as population ageing, shrinking families and women's increased participation in the labour force, have resulted in more people who need care and fewer people available to provide care.[450]

Figure 166. Percentage of directors and managers in services for persons with disabilities who are women, in 23 countries, in 2022.



Source: Country estimates calculated using data from LinkedIn.com.

Many persons with disabilities cannot afford formal care and support, that is, paid care provided by professional services. Moreover, the leadership of formal care and support systems tends to be occupied by men, which may pose barriers to integrate the perspectives of women in formal care and support systems for persons with disabilities. An analysis of social media data in 2022 indicated that the percentage of women directors or managers in services for persons with disabilities was 37 per cent compared to 63 per cent of directors or managers who are men (Figure 166). In some countries the percentage of women directors or managers in these services is as low as 19 per cent while in other countries similar percentages of women and men work as directors or managers of services for persons with disabilities.

For informal care and support (unpaid care and support provided by family or others such as neighbours or friends), the opposite tends to happen with more women than men assuming these roles. The care economy agenda has placed particular emphasis on this issue, focusing on enabling women's full participation in the economy and advancing gender equality, as the distribution of informal care and domestic work between men and women remains unequal. Girls and women are disproportionately tasked with informal care and support roles, putting them at higher risk of unpaid work.[451] Currently, the conversation on the care economy is focused on more time to care (such as work leave), compensation for care (such as cash-for-care), and respite from and replacement of care (such as respite services).

However, what is at stake for persons with disabilities remains relatively underexplored. Even though they are considered as one of the target populations, alongside children and older persons, they are not actively engaged in policy discussions and reform. Thus, their perspectives and lived experiences have yet to be reflected in the care agenda. Historically, representative organizations of persons with disabilities have been critical of the idea of "care" and "dependency" as persons with disabilities have been treated as "burdens" and "objects of care" rather than as rights holders bearing choice and control over support networks and services. In many countries, the negative legacy of care systems and services persists, impeding persons with disabilities from exercising their rights to live independently and be agents in society. This legacy also prevents the positive economic returns and social benefits for the wider community created by inclusive care and support systems. As such, representative organizations of persons with disabilities have been advocating for a move away from traditional "care" models and toward a support paradigm which recognizes support as an individual right with an obligation on countries to enable personal choice and control across all areas of life.

Deinstitutionalization

A large number of persons with disabilities across the world are institutionalized in mental health or social care facilities in contravention of the CRPD. In the European Union, it is estimated that there are still around 1.5 million persons living in institutions.[452] In the global South, official statistics are scarce, partly due to the proliferation of informal and private institutions.[453] Data from nine developing countries indicate

that, on average, 8 per cent of persons with disabilities have lived in an institution or special home for persons with disabilities at some point in their lives.[32]

Rates of institutionalization of children with disabilities remain high in many countries, including increasingly in many developing countries. In 2015, global estimates of children living in institutions were as high as 5 million,[454] but the true figure may be higher given the gaps in global statistics and indications that there are many unregistered children's homes.[455] Developed countries had the highest average prevalence of institutionalization, whereas developing countries had the lowest average prevalence. South Asia had the largest estimated number of children living in institutions (1.13 million), followed by Europe and Central Asia (1.01 million), East Asia and the Pacific (0.78 million), sub-Saharan Africa (0.65 million), Middle East and North Africa (0.30 million), Latin America and the Caribbean (0.23 million) and North America (0.09 million). While these numbers include children with and without disabilities, children without disabilities living in institutions are especially at risk of developing disabilities. Children in institutions tend to face neglect as well as chronic deficit of physical and emotional attention and affection, which are risk factors for developing disability. Data from Central Asia and Eastern Europe indicate that one third of children living in institutions are children with disabilities.[456]

Institutions keep persons with disabilities excluded from society and deprived of their liberty. Many institutions prevent persons with disabilities from accessing education and political participation and from making decisions about their own lives. Many institutions subject persons with disabilities to isolating, sub-standard and unhygienic living conditions and to torture and inhuman and degrading treatment, including forced sterilization and other coercive practices. Deinstitutionalization is not just crucial to ensure community inclusion, it is a human rights imperative.

Deinstitutionalization is more complex than simply shutting down institutions and changing place or type of residence. For deinstitutionalization to work, a range of community-based support networks and services must be in place to enable persons with disabilities to exercise choice and control over their lives. Moreover, additional financial resources are required to afford the double running costs of investing in community support networks and services while keeping some institutions operating during the transition period.

Several countries with a legacy of institutionalization are transitioning towards community-based care. For example, Croatia, Moldova and Romania have adopted policies and programmes to end institutionalization and expand community support systems.[457] However, a significant increase in financial resources is required to fully achieve this objective. To address this financial challenge, Italy adopted a law on support measures for persons with disabilities, which includes a dedicated annual fund to foster deinstitutionalization and the development of community-based services.[458] At the same time, some developing countries with historically low levels of investment in care systems, have begun to consider developing institutional care for working age adults with disabilities as well as older persons.[459] This trend shows the need to systematize past lessons from institutionalization and reinforce a robust economic and

human rights case against institutionalization.

Towards comprehensive community support systems

A number of countries have taken steps towards implementing comprehensive community support systems, which combine different types of interventions. For example, in Australia, the National Disability Insurance Scheme facilitates access to information, individualized support and services for persons with disabilities, their families and carers.[460] The types of supports that National Disability Insurance Scheme may fund include support for daily activities, consumables, transport, workplace help, therapeutic supports, lifelong learning, help with household tasks, assistive technologies and home or vehicle modifications. Individuals have the option to self-manage their funding, which gives them flexibility and choice.

An example of a comprehensive community-based programme for persons with psychosocial disabilities run by a non-governmental organization is the Seher Inclusion Programme in Pune, India.[461] This programme involves the provision of a range of services provided by informal supporters as well as formal services. With the full participation and involvement of the person, holistic assessments of the individual's psychosocial needs (including development needs, barriers to full participation and to the realization of human rights) and other needs (such as social, economic, familial, support and nutritional) are conducted to inform individualized intervention plans. The programme uses a variety of support interventions, including peer support, group support, family support, crisis support and circles of care in the community. Other countries, particularly in Latin America, have focused on the equally important goal of developing a comprehensive care agenda that is inclusive of persons with disabilities, paying particular attention to their right to live independently in the community.[462]

In situations of humanitarian crisis, substantial gaps in access to support networks and services, including cash transfers and human support, are usually exacerbated. In response, a number of support initiatives are being developed in developing countries. In Bangladesh, for example, non-governmental organizations have been working together to promote disability-inclusive disaster risk reduction in flood-prone areas.[463] The project entails interventions at the household and the community levels. It provides support to persons with disabilities to access livelihood opportunities, register for government social protection, access counselling for household preparedness, and establish self-help groups and community-run disaster management committees.

In the 2022 Global Disability Summit, a meeting convened by countries and civil society, a number of international organizations and governments made commitments to take action towards community inclusion. The commitments were aimed at the development, investment and research on assistive technology; and at providing community-based support services as well as social protection schemes to cover extra costs related to disabilities.[464]

Impact of the COVID-19 pandemic

The COVID-19 crisis has highlighted the need for robust support systems for community inclusion. Persons with disabilities, especially those living in institutions, were exposed to infection and death at a disproportionate rate. While persons with disabilities comprise 15 per cent of the world population, they constituted half of the COVID-19 deaths (see the chapter on Goal 3).[465] Moreover, abandonment, isolation and segregation, already present in institutions, worsened during the pandemic. Numerous challenges were documented, including understaffing, inadequately trained staff and staff transfer between institutions, resulting in a lack of day-to-day support that led to catastrophic results. Emergency measures implemented by governments to curb the spread of the pandemic, including confinement of residents and banning visitors, left persons with disabilities completely cut off from the rest of society thereby heightening their isolation and, in the absence of monitoring mechanisms, exacerbating human rights abuses and putting persons with disabilities at higher risk of violence.

The pandemic also took a heavy toll on persons with disabilities living in the community as many persons with disabilities and their families experienced a breakdown of community support networks and services.[466] Personal assistance, home support, informal care, respite services, assistive technologies and other necessary supports to live independently in the community were unavailable or under-resourced. In 2020, 32 per cent of persons with disabilities indicated that the pandemic had reduced their access to personal assistance, repair services for assistive technology or accessibility services like sign language interpretation (see the chapter on Goal 10). In 2021, only 37 per cent of persons with disabilities could use human support like personal assistance and family support compared to 92 per cent before the COVID-19 pandemic; only 49 per cent could use mobility assistive products compared to 86 per cent before the pandemic; and only 4 per cent could use hearing assistive technology compared to 19 per cent before the pandemic (see the chapter on Goal 10). These lack of community services impacted daily activities such as personal care and shopping. For example, in the United Kingdom, during the pandemic, 50 per cent of persons with disabilities stopped receiving health or personal care visits to their homes[467] and 41 per cent of persons with disabilities stopped receiving assistance with shopping (see the chapter on Goal 11). In addition, the closure of schools and workplaces overwhelmed family responsibilities related to informal care and support, particularly for women and girls, thereby deepening gender inequality.

Summary of findings and the way forward

Overall, 43 per cent of persons with disabilities indicate that joining community activities is problematic. A range of community networks and services are beginning to develop in various countries to support the inclusion of persons with disabilities in the community but gaps in these services remain: 22 per cent indicate that they need more personal assistance than they receive; 44 per cent of persons with disabilities who do not have any personal assistance need this assistance; and only 11 per cent of

persons with disabilities in countries with a low human development index have access to assistive technology. Persons with disabilities who need support to make their own decisions seldom receive this support and often someone else is designated to make decisions for them. Only 34 per cent of persons with disabilities indicate that they completely make decisions about day-to-day life, where and with whom to live and how to spend money.

This lack of community support systems sometimes pushes persons with disabilities to be placed in institutions, in contravention to the CRPD. Existing data point to 8 per cent of persons with disabilities having lived in an institution at some point in their lives and that a third of children in institutions are children with disabilities.

The COVID-19 pandemic caused a breakdown of community support networks and services. In 2020, early in the pandemic, 32 per cent of persons with disabilities indicated that the pandemic had reduced their access to personal assistance, repair services for assistive technology and accessibility service like sign language interpretation. This trend continued in 2021, as shown in the percentage of persons with disabilities with access to human support (92 per cent pre-pandemic, 37 per cent post-pandemic), with access to mobility assistive technology (86 per cent pre-pandemic, 49 per cent post-pandemic) and with access to hearing assistive technology (19 per cent pre-pandemic, 4 per cent post-pandemic).

To build back better after the COVID-19 pandemic and leave no one behind, governments need to invest in the development of comprehensive community support systems to enable community inclusion of persons with disabilities. This will require a focus on the provision of individualized support at the community level. There are several actions that countries, international organizations, civil society and other relevant stakeholders must begin to take to implement comprehensive care and support systems for persons with disabilities, including:

1. Adopt legislation and cross-sectoral policies to facilitate access to comprehensive care and support systems for persons with disabilities. National initiatives should be underpinned on gender equality and a rights-based approach to disability and be formulated with the active participation of representative organizations of persons with disabilities. Strengthen policies toward the recognition, reduction and redistribution of care and support work, and invest in accessible and inclusive care and support systems. Develop comprehensive policies that promote cross-sectoral coordination.

2. Invest in developing or scaling up community support and care systems, services and networks. Prioritize person-centred and gender-sensitive approaches that foster choice and autonomy for the diversity of persons with disabilities across the life cycle. Support the innovative and community-based strategies developed by representative organizations of persons with disabilities. Develop investment and financing mechanisms to make community support systems sustainable in the long term. Create and expand formal services and promote partnerships and community mobilization. Train and certify carers, supporters and service providers. Regulate services and working conditions for carers and other service providers. Identify good practices and replicate and scale them up.

3. Invest in support programmes to assist families of persons with disabilities. Governments must invest in this support to allow families to better fulfil their support role and mitigate some of the hardships they experience. This support can include information and counselling services, case management, peer support, respite services, mental health and psychosocial support, and financial support to compensate for the impact on household income.

4. Develop and invest in comprehensive disability-inclusive social protection systems. Adopt legislation, policies and programmes providing for comprehensive social protection tailored to meet the individual needs of persons with disabilities, reduce their vulnerability and to cover direct and indirect extra costs related to disabilities. Involve representative organizations of persons with disabilities in developing these systems.

5. Strengthen governance and build capacity to support community inclusion. Invest in rights-based, accessible and disability-inclusive needs assessment, information management systems, and outreach mechanisms to facilitate planning and service delivery. Prioritize investments in individualized housing support for persons with disabilities in all countries, including in developing countries.

6. Replace segregated institutions with community-based support. Invest in deinstitutionalization programmes that entail shutting down all forms of institutions and developing and strengthening community support services and networks.

7. Invest in accessible and inclusive infrastructure, transport and services. Adopt universal design principles and ensure that laws, policies and programmes providing for accessible infrastructure, transport and information are developed. Institute training and education of human resources of services providers in all sectors to raise their understanding of disability inclusion in service delivery.

8. Reshape the care agenda to be inclusive of persons with disabilities. Apply the human rights model of disability and abandon care proposals that reproduce negative paradigms, such as the creation of new institutions or the provision of financing support only to caregivers instead of directly to persons with disabilities. Clearly articulate the demands for independence and community inclusion of persons with disabilities in the care agenda. Invest in care and support systems that address the needs of persons with disabilities throughout their life cycle: childhood, adolescence, working age and old age. Remove barriers to accessing age-based benefits, while creating a smooth uninterrupted transition in receiving benefits from one age group to another. Actively engage persons with disabilities and their representative organizations in policy discussions and reform of the care agenda.

9. Improve research and data collection on community support. Invest in knowledge, research and innovation on providing community-based support in different contexts. Collect and disseminate data on unmet need for support services; support provision; and persons with disabilities still living in institutions.

Eliminating discriminatory laws, policies and practices (targets 10.3 and 16.b)

This section focuses on the status and progress made in eliminating discriminatory laws, policies and practices against persons with disabilities. This section relates to SDG targets 10.3 and 16.b: target 10.3 calls for ensuring equal opportunity and reducing inequality by, among others, eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard; and target 16.b calls for promoting and enforcing non-discriminatory laws and policies for sustainable development. The section concludes with recommendations to achieve these targets based on current evidence.

The Convention on the Rights of Persons with Disabilities (CRPD) recognizes that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person (preamble (h)). Discrimination on the basis of disability is defined in CRPD article 2 as any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

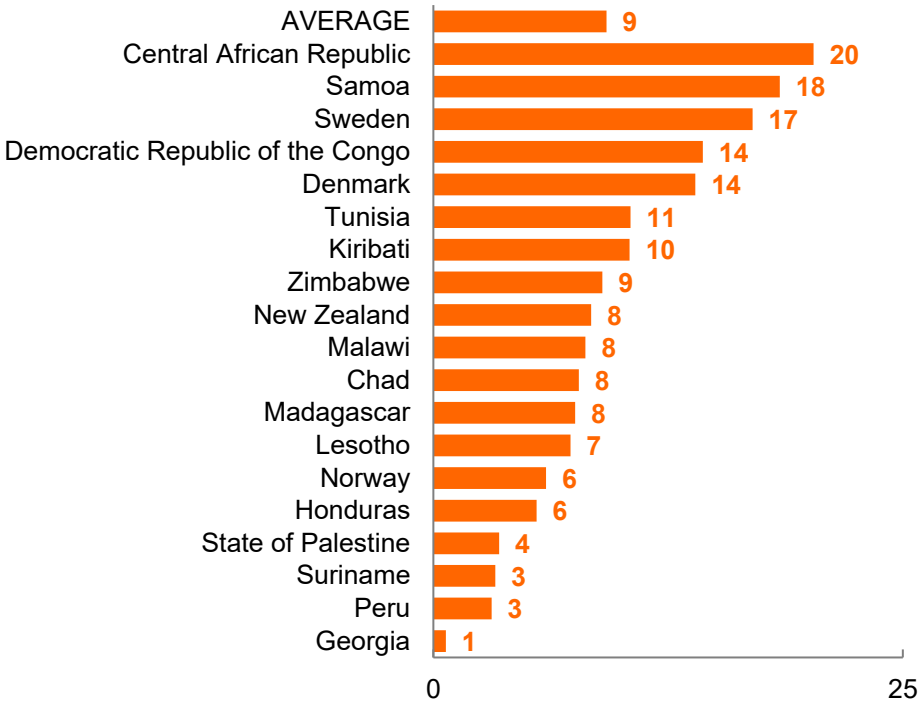
The CRPD stipulates that States Parties are to ensure the full realization of all human rights and fundamental freedoms for persons with disabilities without discrimination, including by modifying or abolishing existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities (article 4, paragraph1(b)), by prohibiting all discrimination on the basis of disability and by guaranteeing equal and effective legal protection against discrimination on all grounds (article 5, paragraph 2). In addition, the CRPD calls for the elimination of discrimination against persons with disabilities in the areas of family (article 23), education (article 24), health (article 25), work and employment (article 27), living standards (article 28) and political participation (article 29).

Discrimination 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 ultimately to the achievement of Goal 10 and of targets 10.3 and 16.b in particular.

Current situation and progress so far

Persons with disabilities face discrimination in many facets of life. Evidence from 19 countries or areas indicates that on average 9 per cent of persons with disabilities felt discriminated against on the basis of disability (Figure 167). This percentage varies from 1 per cent in Georgia to 20 per cent in the Central African Republic. Progress in eliminating discriminatory attitudes is limited. For example, in Peru, from 2015 to 2019, the percentage of persons with disabilities who felt discriminated against due to their disability decreased only slightly from 4 per cent to 3 per cent; in Sweden, from 2015 to 2018, this percentage increased slightly from 15 per cent to 17 per cent (Figure 168). Many persons with disabilities also face discrimination in public services (see the chapter on Goal 16).

Figure 167. Percentage of persons with disabilities who felt discriminated against on the basis of disability, in 19 countries or areas, in 2020 or latest year available.

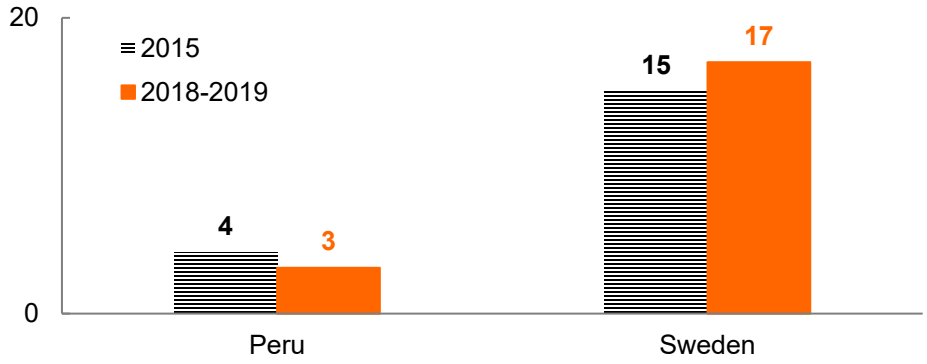


Source: UN SDG Indicators database.[285]

In legislation, progress has been made in recent years. In national constitutions, explicit guarantees of equality or non-discrimination for persons with disabilities existed for 53 countries in 2022 up from 52 countries in 2017.[468] In 2021, compared to 2016, more countries had included protections in their labour legislation that explicitly prohibit discrimination on the basis of disabilities: 79 per cent compared to 74 per cent in hiring, 78 per cent compared to 72 per cent in terminations, 76 per cent compared to 70 per cent in promotions or demotions and 76 per cent compared to 69 per cent in access to employer-provided

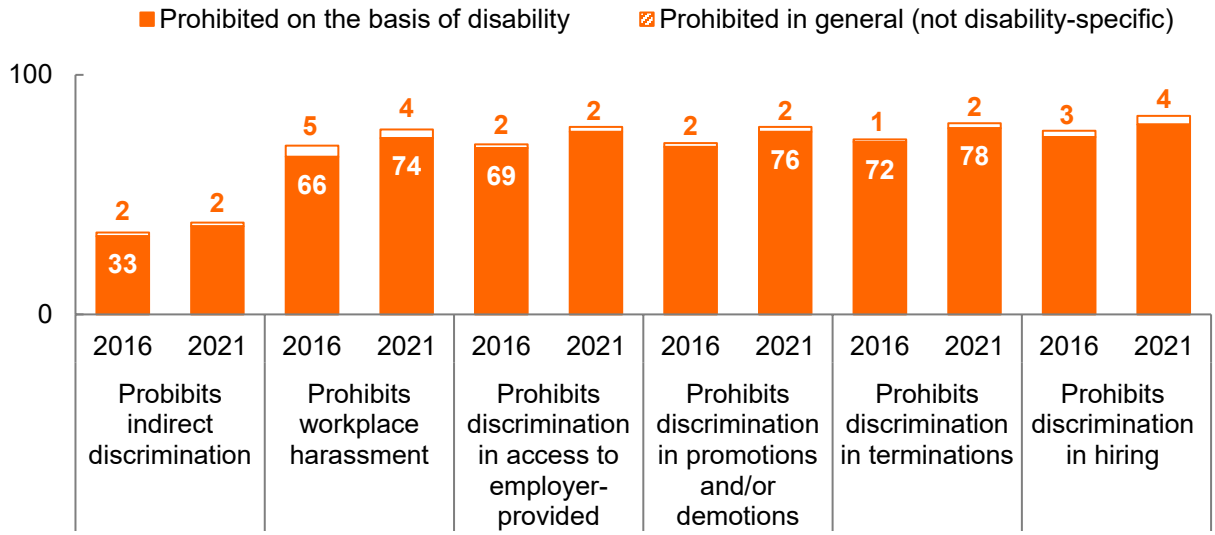
training (Figure 169). Furthermore, 74 per cent of countries in 2021 up from 66 per cent in 2016 prohibit discriminatory workplace harassment, and 37 per cent in 2021 up from 33 per cent in 2016 prohibit indirect discrimination on the basis of disability. Adoption of legal protections against indirect discrimination is particularly low compared to other protections.

Figure 168. Percentage of persons with disabilities who felt discriminated against due to their disability, in 2 countries, from 2015 to 2018-2019.



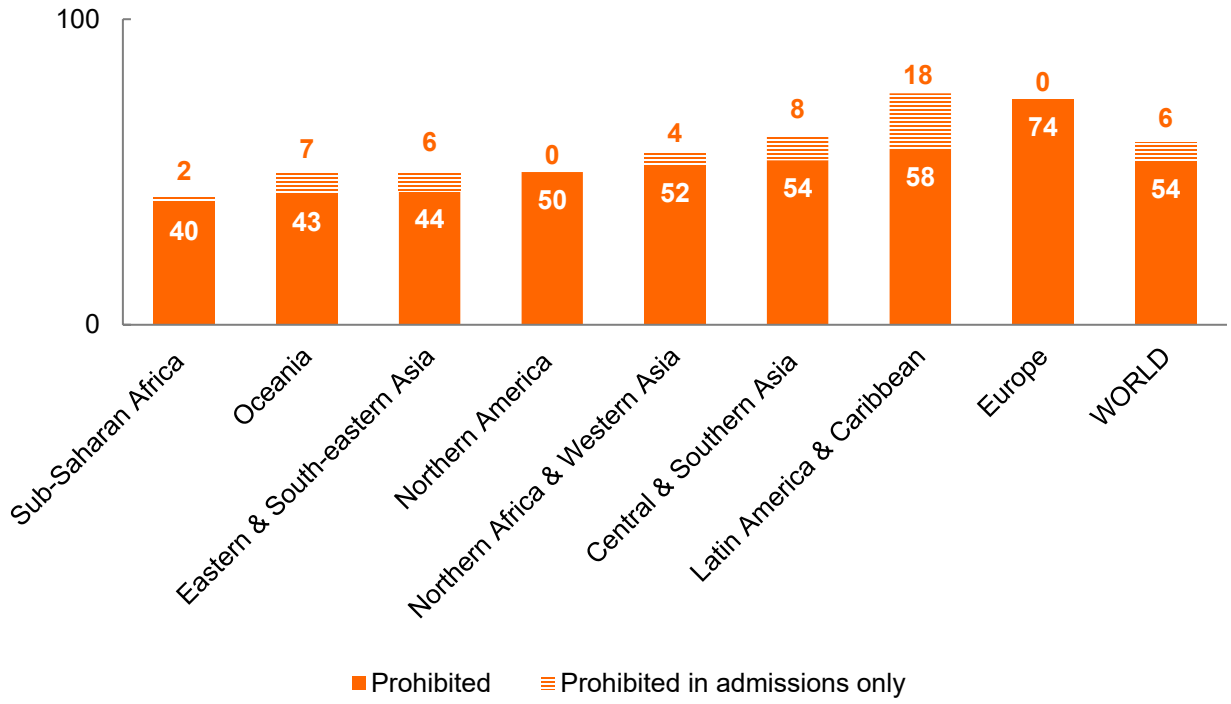
Note: Data from Peru refer to 2019; from Sweden to 2018.
Source: UN SDG Indicators database.[285]

Figure 169. Percentage of countries that prohibit discrimination against persons with disabilities in their laws regulating labour, among the 193 United Nations Member States, in 2016 and 2021.



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.[231]

Figure 170. Percentage of countries that prohibit discrimination against persons with disabilities in the laws regulating education, for the world and by region, in 2018.



Note: Based on data from 188 United Nations Member States.
Source: World Policy Analysis Center.[231]

In the laws regulating education, 54 per cent of countries prohibit discrimination on the basis of disability and another 6 per cent make this prohibition in school admissions only (Figure 170). In Eastern and South-eastern Asia, Oceania and sub-Saharan Africa, less than 50 per cent of countries prohibit discrimination on the basis of disability in their laws regulating education; in Europe, 74 per cent of countries have these protections.

Impact of the COVID-19 pandemic

Discriminatory practices continued throughout the pandemic, becoming in some countries a more acute and challenging concern experienced by more persons with disabilities. Persons with disabilities may have been more likely to develop severe symptoms or die from COVID-19 as a result of discriminatory triaging practices in some health facilities. For instance, in a review of triage policies for intensive-care units in 14 European countries in 2020, in more than half of the countries triage protocols recommended the consideration of functional status or frailty assessments,[128] terms which can be conflated with disability and may have led to many persons with disabilities receiving unequal and discriminatory medical treatment (see the chapter on Goal 3).

Persons with disabilities also faced discrimination in the pandemic response, which lacked reasonable accommodation measures in general. COVID-19 testing as well as many COVID-19 outpatient and inpatient services, including online health services, were not always accessible and did not always provide reasonable accommodations for persons with disabilities (see the chapter on Goal 3).[469]

Discriminatory practices during the pandemic may also have affected persons with disabilities in other ways. In some countries, persons with disabilities lost jobs at much higher rates than persons without disabilities (see the chapter on Goal 8).

Moreover, as courts and other public mechanisms to report and address discrimination closed due to the pandemic lockdowns in many countries, persons with disabilities found themselves without the resources to fight discrimination and realize their rights.

Summary of findings and the way forward

Discrimination is a major cause of exclusion of persons with disabilities and impedes persons with disabilities from realizing their rights and participating equality in society and development. One in ten persons with disabilities feels discriminated on the basis of disability. To combat this, a majority of countries has adopted laws prohibiting discrimination on the basis of disability: 79 per cent of countries prohibit discrimination on the basis of disability in job hiring and 54 per cent prohibit discrimination against persons with disabilities in education. Only 37 per cent of countries prohibit indirect discrimination in the workplace and in hiring.

These achievements reflect continued and sustained progress, including in recent years, in expanding the number of countries with laws prohibiting discrimination on the basis of disability. However, despite this positive trend, current rates of expansion are too slow to ensure that persons with disabilities in all countries will be legally protected against discrimination by 2030. For labour laws, to ensure protection in all countries by 2030, countries should adopt provisions prohibiting discrimination on the basis of disability in hiring, terminations, promotions and training at a rate twice as fast as current trends. For indirect discrimination in the workplace, legal provisions are particularly lacking. These provisions will need to be adopted at a rate that is eight times faster than current rates to guarantee that all persons with disabilities are legally protected against indirect discrimination in the workplace by 2030. Efforts to expand legal protections against the discrimination of persons with disabilities are particularly needed in Eastern and South-eastern Asia, Oceania and sub-Saharan Africa.

Discriminatory practices during the COVID-19 pandemic affected persons with disabilities, as they were affected by discriminatory healthcare due to triage rules at the height of the pandemic and dismissed from jobs at higher rates than others.

To eliminate discrimination against persons with disabilities, and achieve targets 10.3 and 16.b by, for and with persons with disabilities, it is recommended to:

1. Review national laws and policies, including laws and policies responding to crisis situations, to identify discriminatory provisions against persons with disabilities and modify or abolish these provisions. Include in the reviews policies made to respond to emergency and other crisis situations, like the COVID-19 pandemic, to ensure persons with disabilities are protected against discrimination in times of crisis. Guarantee the participation of persons with disabilities in the revision process to ensure that their needs and perspectives are considered. Laws and policies should also prohibit discrimination on the basis of disability by any person, organization, public authority or private enterprise.

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 such outreach activities. These campaigns should focus on raising awareness among the population on the needs and abilities of persons with disabilities.

3. Develop mechanisms for reporting and addressing discrimination, including during emergencies and other crises. Approaches to developing such mechanisms include the creation of a public service, where persons with disabilities can file or report incidences of discrimination, or the carrying out of periodic surveys and collection of feedback from persons with disabilities regarding how anti-discriminatory laws are being implemented in practical terms. These mechanisms would benefit from having contingency plans to operate during emergencies and other crises, such as the COVID-19 pandemic, to ensure the services to support persons with disabilities in reporting discrimination are not interrupted. Involve persons with disabilities and their organizations in developing these mechanisms to ensure that they are accessible to them and sensitive to their needs and perspectives. These mechanisms should address discrimination on the basis of disability by any person, organization, public authority or private enterprise.

Making cities and human settlements inclusive and sustainable (Goal 11)

Goal 11 is a call to make cities and human settlements inclusive, safe, resilient and sustainable. In the CRPD, Article 3 has accessibility as a general principle and Article 9 gives specific guidance outlining the responsibilities of States Parties to take appropriate measures to ensure access to persons with disabilities, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. General Comment number 2 of the Committee on the Rights of Persons with Disabilities provides additional guidance for implementation.

This chapter focuses in particular on four Goal 11 targets: (i) target 11.1, which calls for access for all to adequate, safe and affordable housing and basic services; (ii) 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; (iii) target 11.3 which calls for inclusive urbanization; and (iv) 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. Based on these analyses, the final section of this chapter identifies targeted actions to achieve Goal 11 by, for and with persons with disabilities.

Current situation and progress so far

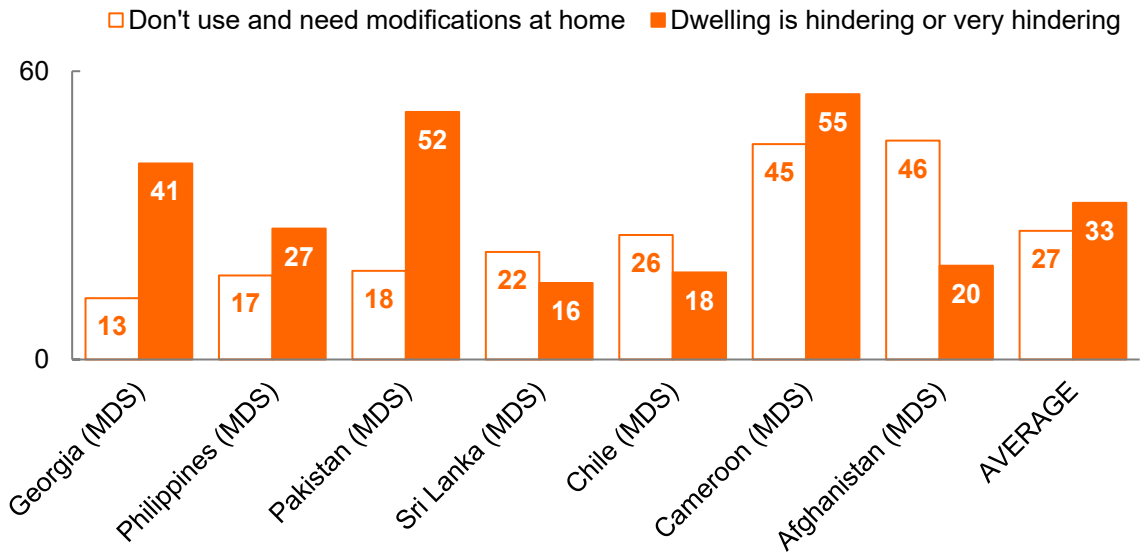
Adequate, safe and affordable housing (target 11.1)

Adequate housing includes the following elements: security of tenure; availability of services, materials, and infrastructure; affordability; accessibility; habitability; location and cultural adequacy.[470] Around the world, persons with disabilities are at a higher risk of living in inadequate housing than others. They are more likely to live in dwellings that lack access to an improved and safe water source and to improved sanitation facilities (see the chapter on Goal 6). They are more likely to live in poverty (see the chapter on Goal 1), less likely to have a job (see the chapter on Goal 8) and thus face more barriers to affording adequate housing. Many persons with disabilities end up in poorer housing and at higher risk of suffering the impact of weather-related disasters and hazards, such as floods (see the chapter on targets 1.5 and 11.5 and Goal 13).

Moreover, persons with disabilities often experience barriers to finding housing that is accessible and inclusive of persons with disabilities (Figure 171). In 7 countries, 33 per cent of persons with disabilities on average indicated that their dwelling is hindering, from 16 per cent in Sri Lanka to 55 per cent in Cameroon; and 27 per cent of persons with disabilities indicate that they do not have but need

modifications at home, from 13 per cent in Georgia to 46 per cent in Afghanistan. In the United States, in 2011, only 1 per cent of rented dwellings included five basic universal design features that make housing accessible to persons with mobility impairments (no-step entry; single-floor living with bedroom, bathroom, and kitchen on the same level; lever-style door handles; accessible electrical controls; and extra-wide doors and hallways),[471] and experts predicted a 24 percent chance that 10 per cent of rentals by 2030 would meet these universal design criteria.[472]

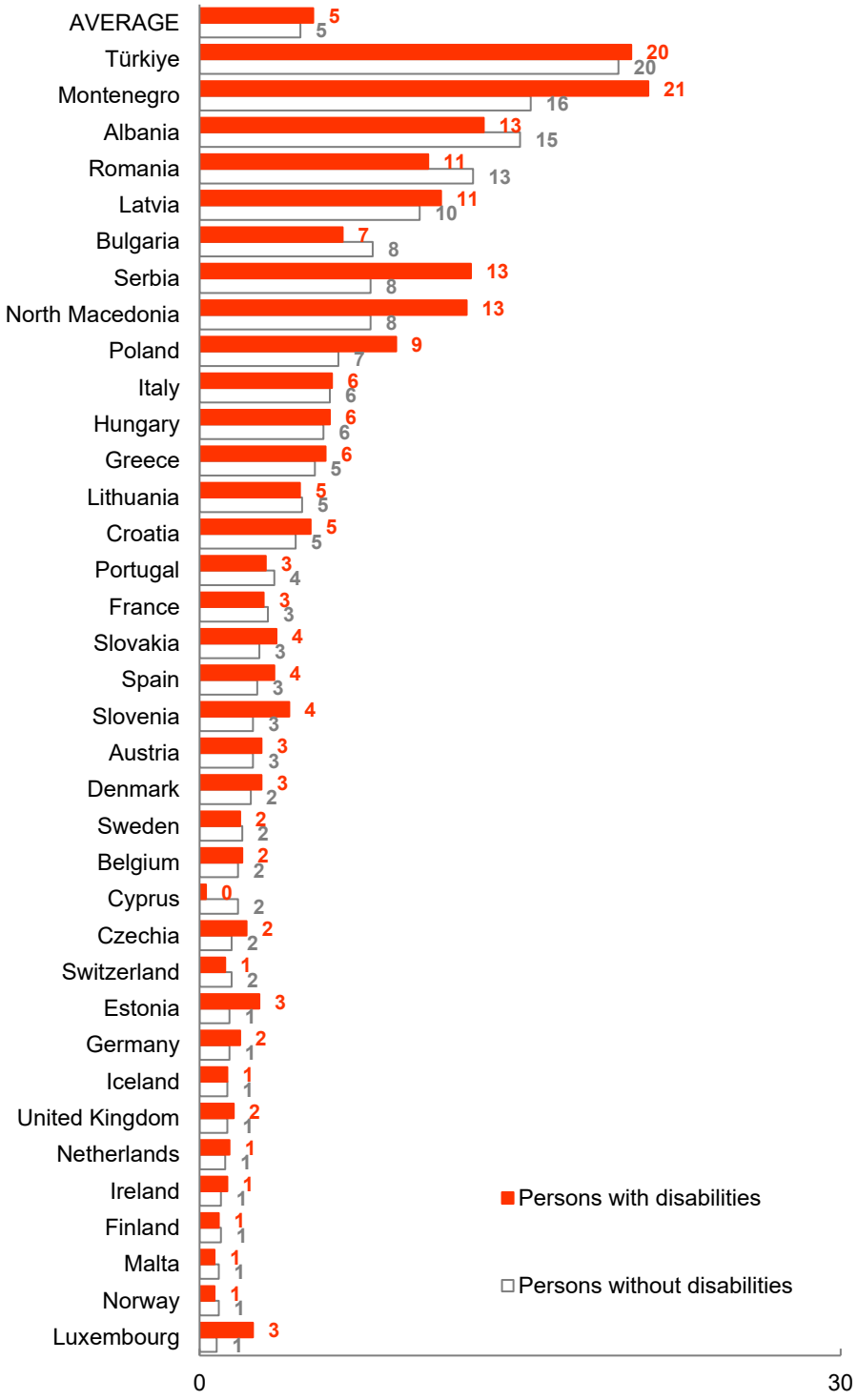
Figure 171. Percentage of persons with disabilities who (i) consider their dwelling hindering and (ii) do not have but need modifications at home, in 7 countries, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from the Model Disability Surveys).

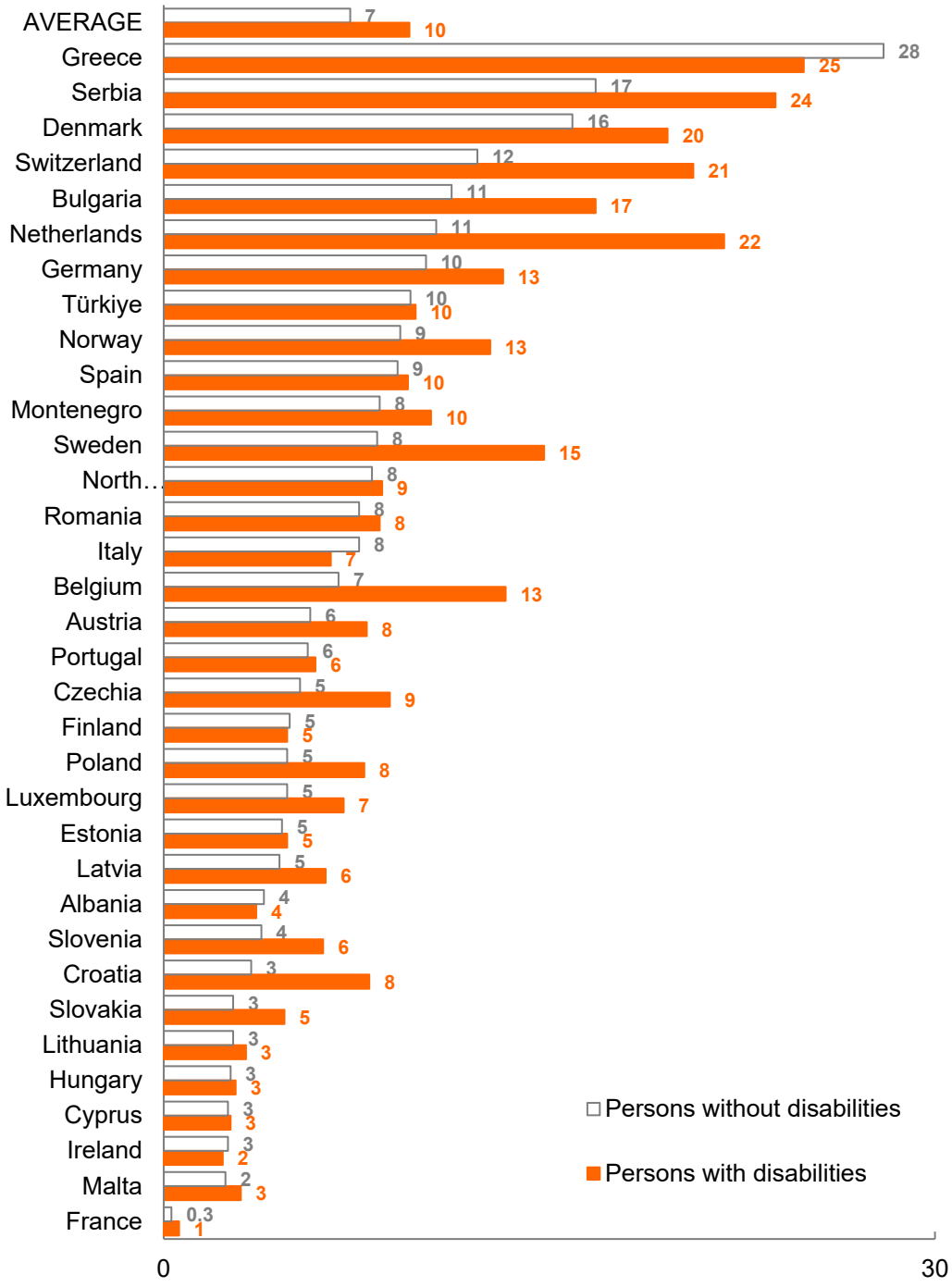
In Europe, severe housing deprivation has been defined as the simultaneous occurrence of overcrowding, together with at least one of the following housing deprivation measures: a leaking roof, no bath or shower and no flushing toilet, or a dwelling considered too dark. Among 36 countries, mainly in Europe, the average percentage of persons aged 16 and over living in severely deprived housing is similar, 5 per cent, for persons with disabilities and without disabilities (Figure 172). In Montenegro, North Macedonia and Serbia, the gap between persons with and without disabilities is 5 percentage points or more. In Montenegro and Türkiye, more than 20 per cent of persons with disabilities live in severely deprived housing, the largest percentages among these 36 countries.

Figure 172. Percentage of persons aged 16 and over living in severely deprived housing, by disability status, in 36 countries, in 2020.



Note: For Iceland and the United Kingdom, data are from 2018; for Poland, data are from 2019.
Source: Eurostat.[7]

Figure 173. Percentage of persons aged 16 and over living in households where the total housing costs represent more than 40 per cent of disposable income, by disability status, in 34 countries, in 2021.

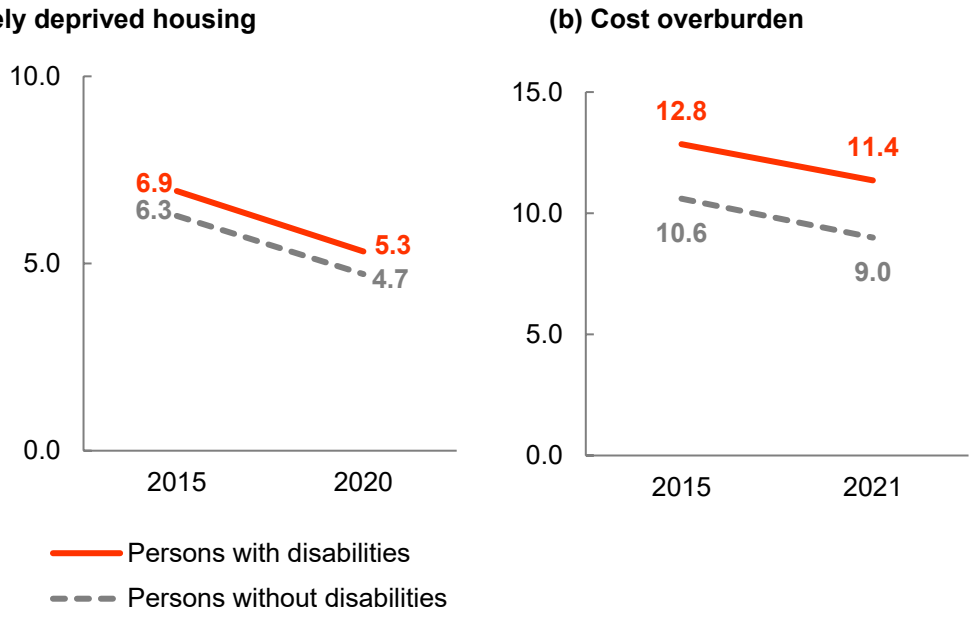


Note: Data for Albania, Montenegro, North Macedonia, Poland, Serbia, Slovakia, Switzerland and Türkiye are for 2020. Persons with disabilities include persons with some or severe limitations.
Source: Eurostat.[7]

In addition, for persons with disabilities, housing costs can place a heavy burden on their disposable income. In 2021, among the same 34 countries, 10 per cent of persons with disabilities lived in households where housing costs placed a heavy burden on disposable income, compared to 7 per cent of persons without disabilities (Figure 173). Greece (25 per cent), Serbia (24 per cent), Netherlands (22 per cent), Switzerland (21 per cent), Denmark (20 per cent) and Bulgaria (17 per cent) have the highest percentages of persons with disabilities experiencing housing cost overburden. On the other end of the scale, Malta and Cyprus (3 per cent), Ireland (2 per cent) and France (1 per cent) have the lowest percentages.

The average percentage of persons with disabilities living in severely deprived housing has decreased from 6.9 per cent to 5.3 per cent from 2015 to 2020; and those experiencing housing cost overburden decreased from 12.8 per cent to 11.4 per cent in the same period (**Error! Not a valid bookmark self-reference.**). For persons without disabilities, similar progress has been made and the gaps between persons with and without disabilities have stayed the same over time.

Figure 174. Percentage of persons aged 16 and over (a) living in severely deprived housing, by disability status and (b) living in households where the total housing costs represent more than 40 per cent of disposable income, average of more than 30 countries, in 2015 and 2020 or 2021.



Source: Eurostat.[7]

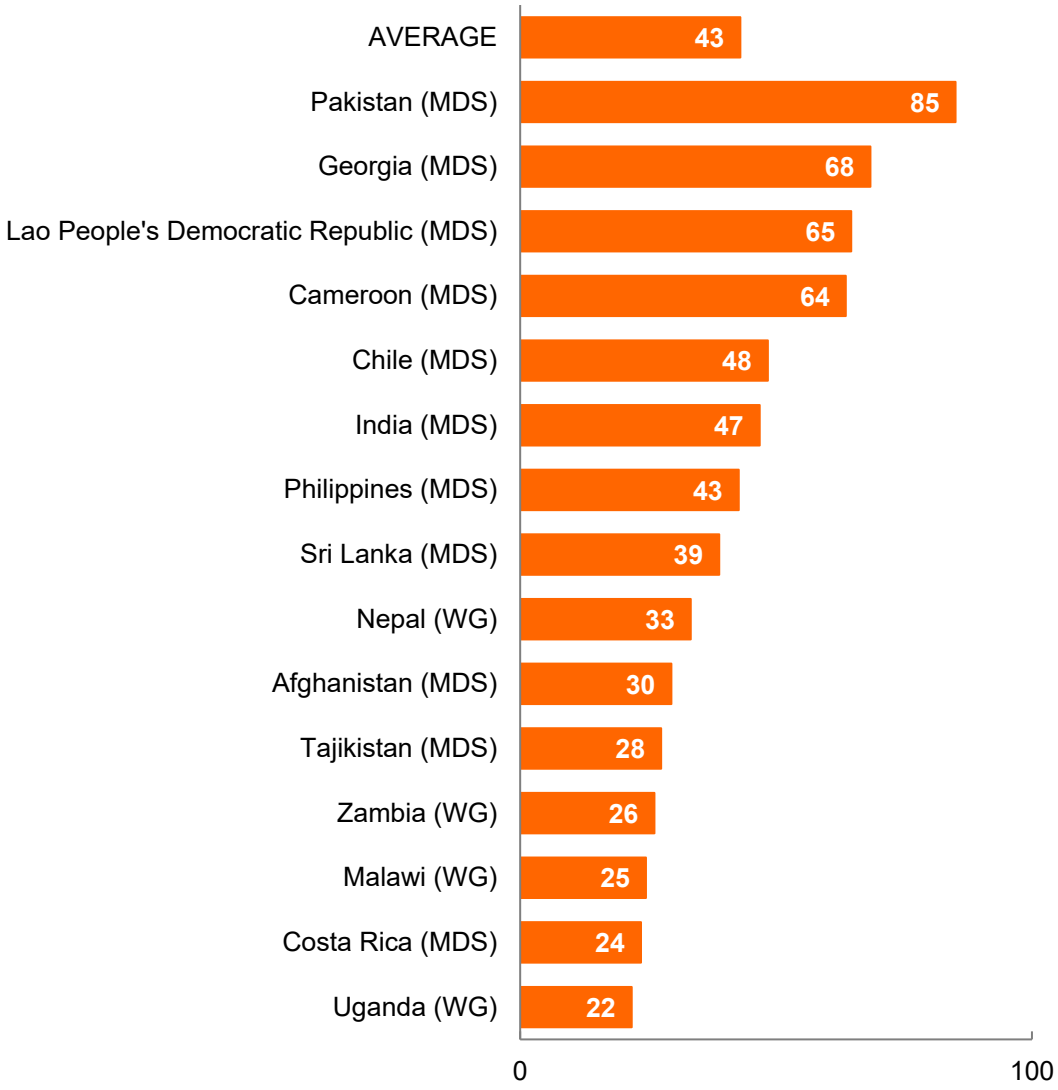
Persons with disabilities are more likely to experience problems associated with housing deprivation and worse housing conditions. In 2020, on average, 11 per cent of persons with disabilities experienced crime, violence or vandalism in the area where they live, compared to 8 per cent for persons without disabilities (see the chapter on targets 16.1 and 16.2); down from 14 per cent of persons with disabilities in 2015 (see the chapter on targets 16.1 and 16.2). Moreover, 11 per cent of persons with disabilities in European countries lack heating and cooling facilities at home compared with only 7 per cent for persons without disabilities (see the chapter on Goal 7). In addition, in 2020, 3 per cent of persons with disabilities had no indoor toilet in their dwelling, compared to 2 per cent of persons without disabilities and down from 5 per cent in 2015 (see the chapter on Goal 6) – similar percentages were found for persons having no baths or showers in their dwellings (see the chapter on Goal 6).

Various barriers persist for persons with disabilities in exercising their right to adequate housing. These barriers include discrimination in legislation and policies that have the effect of limiting the ability to exercise the right to adequate housing; the denial of the right to live independently and in community; the presence of environmental barriers; the lack of participation and access to resources and opportunities; and the lack of monitoring and complaint mechanisms.[473]

Accessible transport for persons with disabilities (target 11.2)

Inclusive and accessible transportation systems can increase access for persons with disabilities to employment, recreational and other essential opportunities that enable persons with disabilities to improve their living conditions and escape poverty. But, in many countries, transport is not always accessible to persons with disabilities. In 15 developing countries, on average, 43 per cent of persons with disabilities consider transportation hindering or nor accessible, ranging from 22 per cent in Uganda to 85 per cent in Pakistan (Figure 175).

Figure 175. Percentage of persons with disabilities who consider that transportation is hindering or not accessible, in 15 countries, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey; (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO (on the basis of data from the Model Disability Surveys).

Table 4. Percentage of countries or areas in Asia and the Pacific with legal requirements on the accessibility of international airports, by type of requirement, in 12 countries or areas, in 2022.

Legal requirement	Percentage of countries or areas
Stable, firm, wide and slip-resistant routes to the airports	83
Accessible parking spaces	83
Accessible common areas (ticketing, check-in, security clearance, boarding gates, baggage retrieval)	83
Ramps or elevators where changes in level are necessary	83
Accessible toilets at international airports	83
Lifts and ramps to support boarding and disembarkation	83
Signage, including emergency evacuation procedures and exits, available in easy-to-read formats	83
Vehicles with passengers with disabilities can drop off these passengers at the point closest to the airport entrance	82
Persons with disabilities travelling by themselves cannot be refused check-in due to their disabilities	82
Entrance doors with wide openings, without steps and equipped with automatic openers	75
Seating areas with spaces for users of assistive mobility devices	75
Signage (gate numbers, emergency evacuation procedures/exits) in tactile formats such as Braille	75
Personal assistance for persons with disabilities who need such services	75
Civil aviation authorities regularly conduct staff training on the provision of services for passengers with disabilities	75
Onsite/remote sign language interpretation services at check-in counters, boarding gates and information booths	73
Commonly used assistive products available if required	73
Grievance procedures for lack of accessibility	73
Organizations of persons with disabilities involved in accessibility audits	67
Accessible shuttle buses and trains	64
Accessibility features of airports available in accessible formats on the official airport websites	60
Selected check-in counters and ticketing offices with lower counter heights	58
Service animals allowed to enter the airports and relief areas available for these animals	55
Calming room and services for persons with hidden disabilities	50

Source: ESCAP.[14]

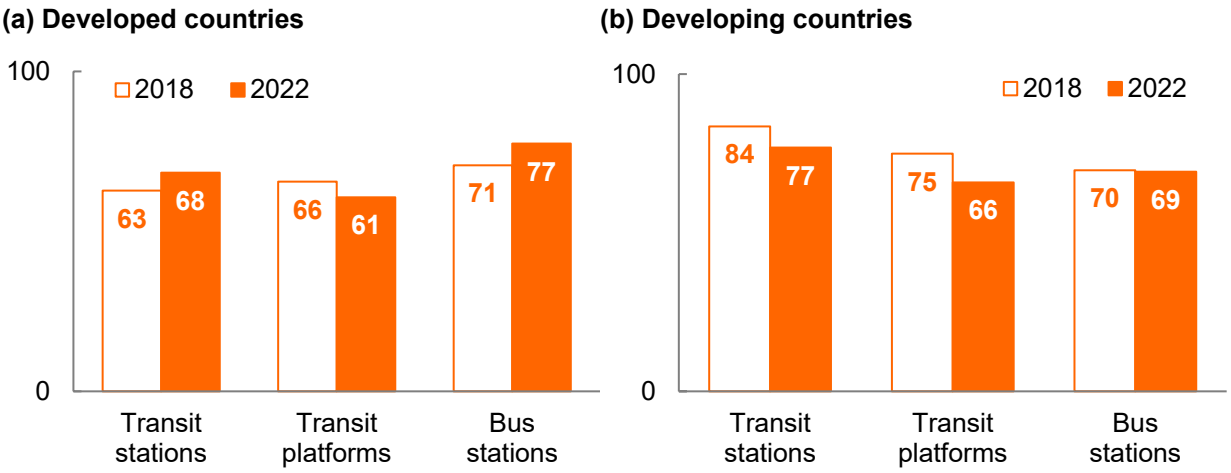
Table 5. Percentage of countries or areas in Asia and the Pacific with legal requirements on the accessibility of public transport, by type of requirement, in 11 countries or areas, in 2022.

Legal requirement	Bus system	Rapid transit system
Passenger doors sufficiently wide for users of assistive mobility devices to enter	89	56
Tactile paving or ground surface indicators to guide persons with visual impairments	88	67
Buses with level-changing mechanisms or boarding device (e.g., a ramp) for users of assistive mobility devices to board the vehicle	78	NA
Physically accessible and barrier-free bus stops/train stations	78	78
Information on public transport (schedules, routes, stations, platforms, exits, safety precautions) in accessible audio and easy-to-read formats	75	56
Carriages with priority seating for persons with disabilities	75	44
Wheelchair spaces in carriages	75	44
Interior of the carriage with sufficient turning and manoeuvring space for users of assistive mobility devices	75	33
Bus drivers allow adequate time for passengers with disabilities to board and alight and provide assistance throughout the ride	67	NA
Service animals are allowed to board	67	56
Regular staff training on the provision of services for the access and safety of passengers with disabilities	67	56
Organizations of persons with disabilities involved in conducting accessibility audits of bus/mass rapid transit systems	67	44
Accessibility features of stations and carriages explained in accessible formats on the official public transportation portal	63	56
Mechanism for customer feedback on accessibility services and grievance procedures for safety and accessibility issues	63	56
Online information on public transportation (routes, fares, etc.) in accessible formats (e.g., easy-to-read versions, subtitles and sign language)	63	44
Standard operating procedures for the safety and smooth use by passengers with disabilities of public transport systems	56	44
At least one barrier-free entrance and exit with wide fare gates in every station	NA	63
Accessible toilets in train stations	NA	63
Auditory and visual warning signs indicating closing of train doors	NA	56
Accessible elevator service to all levels in the stations, including Braille plates on lift buttons	NA	50
Minimal difference between the heights of train carriage and platform floor	NA	44

Source: ESCAP.[14]

Crowdsourced data from developed countries indicates that, in 2022, 68 per cent of transit stations, 61 per cent of transit platforms and 77 per cent of bus stations were accessible to wheelchair users, with some progress on the accessibility of transit and bus stations since 2018 but some deterioration in the accessibility of transit platforms for persons with disabilities (Figure 176). Similar percentages are found in developing countries, despite a deterioration in accessibility of transit stations and platforms since 2018.

Figure 176. Percentage of transit stations, transit platforms and bus stations that are accessible for wheelchair users, in developed and developing countries, in 2018 and 2022.



Source: UNDESA (on the basis of data from Sozialhelden[10]).

Several countries have introduced laws requiring airports to incorporate features, services and procedures to make the airports accessible for persons with disabilities. For example, in 12 countries or areas in Asia and the Pacific, the percentage of countries with such requirements varies from 50 per cent to 83 per cent depending on the type of requirement (Table 4): 83 per cent of countries or areas require international airports to have stable, firm, wide and slip-resistant routes to the airports (from parking, from transportation and from the street), accessible parking spaces, accessible common areas (in ticketing, check-in, security clearance, boarding gates and baggage retrieval), ramps or elevators where changes in level are necessary, accessible toilets at international airports, lifts and ramps to support boarding and disembarkation, signage available in easy-to-read formats (including emergency evacuation procedures and exits). Moreover, 67 per cent of countries or areas require organizations of persons with disabilities to be involved in accessibility audits of international airports; 75 per cent of countries or areas require civil aviation authorities to regularly conduct staff training on the provision of services for meeting the access and safety needs of passengers with disabilities; 73 per cent of countries or areas require that grievance procedures are available for persons with disabilities who have issues with the lack of accessibility of international airports in the country or area; and 50 per cent of countries or areas require international

airports to have calming rooms and services for persons with hidden disabilities.

Similarly, a number of countries in Asia and the Pacific have introduced laws requiring the public transportation system to incorporate features, services and procedures to make the system accessible for persons with disabilities (Table 5). In Europe and Africa, a number of initiatives have also made the transportation systems more accessible and inclusive to persons with disabilities (Box 6) and various countries have developed programmes to provide accessible, affordable and reliable transportation for persons with disabilities, such as paratransit transportation and transportation subsidies, as part of investments in community support systems (see the chapter on target 10.2).

Box 6. Making transportation more inclusive for persons with disabilities around the world

Accessible bus system in Dakar, Senegal

The Humanity & Inclusion programme in Dakar, Senegal, aims at increasing access to employment for persons with disabilities, including by improving safe and accessible urban mobility that allows a greater number of workers with disabilities to travel from home to work. Stronger political leadership and collaboration with local organizations of persons with disabilities has led to an improvement in national policy on accessible transport. The largest bus operator in Dakar agreed to increase the number of buses that have ramps and priority seats for persons with disabilities, and to train bus operator staff in the different needs of passengers with disabilities. Moreover, the bus company hired 25 persons with disabilities to sell tickets. Other noteworthy initiatives for safer and accessible transport in Dakar include the phasing out of old minibuses from the 1960s and 1970s and replacing them with a safer and more accessible fleet of buses.[474]

Accessible bus rapid transport in Johannesburg, South Africa

The city of Johannesburg launched a six-month pilot project to provide free travel for persons with disabilities on the Rea Vaya bus rapid transport system. Rea Vaya buses and stations have several features that allow access for persons using wheelchairs and commuters with visual or hearing impairments. The areas surrounding the bus stations are evenly paved and the stations are all fitted with access ramps of width and gradient that conform to universal design guidelines. Moreover, for persons with mobility impairments, the ramps have handrails on either side or a landing area halfway up for those who wish to rest. Rea Vaya buses have a double-section bus that runs on its trunk routes, each allowing for two wheelchairs. The standard length buses have at least one wheelchair position as well as grab rails and a curbside lift.[474]

Nationwide train station adaptations for persons with disabilities in the Netherlands

In a collaboration between the Dutch Member of the European Blind Union, the national rail operator and the respective infrastructure manager, all train stations in the Netherlands have been made accessible for persons with visual impairments. The same accessibility provisions have been coherently implemented in all stations of the national rail network, which means they are predictable for the passenger. These

features include route descriptions that can be downloaded in both print and audio versions in advance, tactile guidance and signage, adequate contrast values and harmonized location of ticketing machines. Once the accessibility provisions had been implemented, training was organized for both the passengers and staff to learn how to use the features in practice. Throughout the entire procedure, volunteers tested the proposed solutions, giving feedback on materials and measurements. Initial user evaluations show that passengers with visual impairments are independently mobile in all Dutch railway stations, even if they visit a station for the first time.[475]

Personal mobility service for persons with visual impairments in Iceland

The Personal Mobility Service in Iceland is a flexible taxi service for persons with visual impairments. In the absence of convenient public transport, this service is crucial to participate fully in society, go to school, work, or to shopping areas, among others. An agreement is set up between the local municipality, the Icelandic Member of the European Blind Union and a taxi company to establish the service. Only registered persons with a visual impairment are eligible for the service and can order a taxi for the price of a regular bus ticket at any time of the day. Taxi drivers are specifically trained on access needs. The service is cost-effective for all parties involved and thus is highly satisfactory. The difference in the actual taxi costs is covered by the municipality. The service is also cheaper than the other existing solution, a government-managed transport service for all persons with disabilities. Overall, 80 per cent of persons with visually impairments in Iceland evaluate this service positively, as it is easy to use, affordable and provides a high-quality service.[475]

Inclusive urbanization and safe and inclusive public spaces for persons with disabilities (targets 11.3 and 11.7)

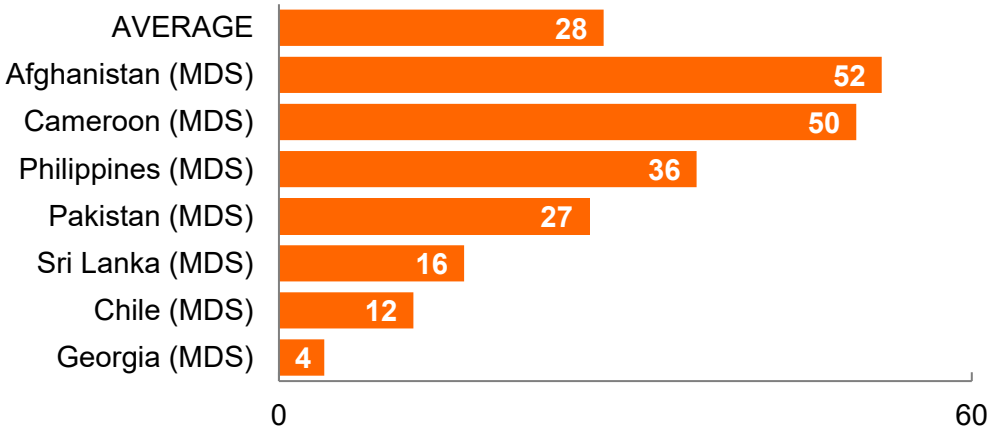
Target 11.3 calls for inclusive and sustainable urbanization and capacity for participatory, integrated and sustainable human settlement planning and management in all countries, with indicator 11.3.2 monitoring the proportion of cities with a direct participation structure of civil society in urban planning and management that operate regularly and democratically. However, many barriers persist for persons with disabilities in urban and public spaces due to the lack of consultation with persons with disabilities and their representative organizations. Persons with disabilities are often not involved in policy and decision-making regarding urbanization and urban mobility,[476] and their perspectives remain largely absent in research on urban planning.[477] For most cities, the design of buildings and roads is still made from the perspective of persons without disabilities. Lack of accessibility of recycling premises and stores for sustainable products can compromise the participation of persons with disabilities as agents of change to achieve Goal 12 (Box 8).

Figure 177. Percentage of persons with disabilities who report that recreational facilities (e.g., cinema, theatre, pubs) are generally not accessible to them, in 3 countries, in 2018 and latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]).

Figure 178. Percentage of persons with disabilities who need but do not encounter modifications to make it easier to participate in the community, in 7 countries, in 2021 or latest year available.



Note: Modifications in the community include barrier-free buildings open to the public such as shops, cinemas or places of worship; barrier-free public buildings, city hall or post office; barrier-free signage and way finding; barrier-free public toilets; barrier-free public transportation; and barrier-free roads, paths and trails. (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from Model Disability Surveys).

Target 11.7 calls for universal access to safe, inclusive and accessible, green and public spaces, in particular for inter alia persons with disabilities. Indicator 11.7.1 monitors the average share of the built-up area of cities that is open space for public use for inter alia persons with disabilities. But many public spaces continue to have barriers for persons with disabilities. Accessibility barriers that create obstacles for persons with disabilities in the public space include high curbs, uneven surfaces, lack of ramps, various footpath- and street crossing-related barriers, insufficient lighting and limited places to rest, limited reliability or availability of audible traffic lights, lack of visual aids, lack of curbs and controlled

crossings.[478] These barriers mean that persons with disabilities are often dependent on assistance from other pedestrians[478] and spend more time negotiating barriers and spaces.[479]

Box 7. Making public spaces accessible for persons with disabilities

New universally accessible playground opens in Surrey, British Columbia, Canada

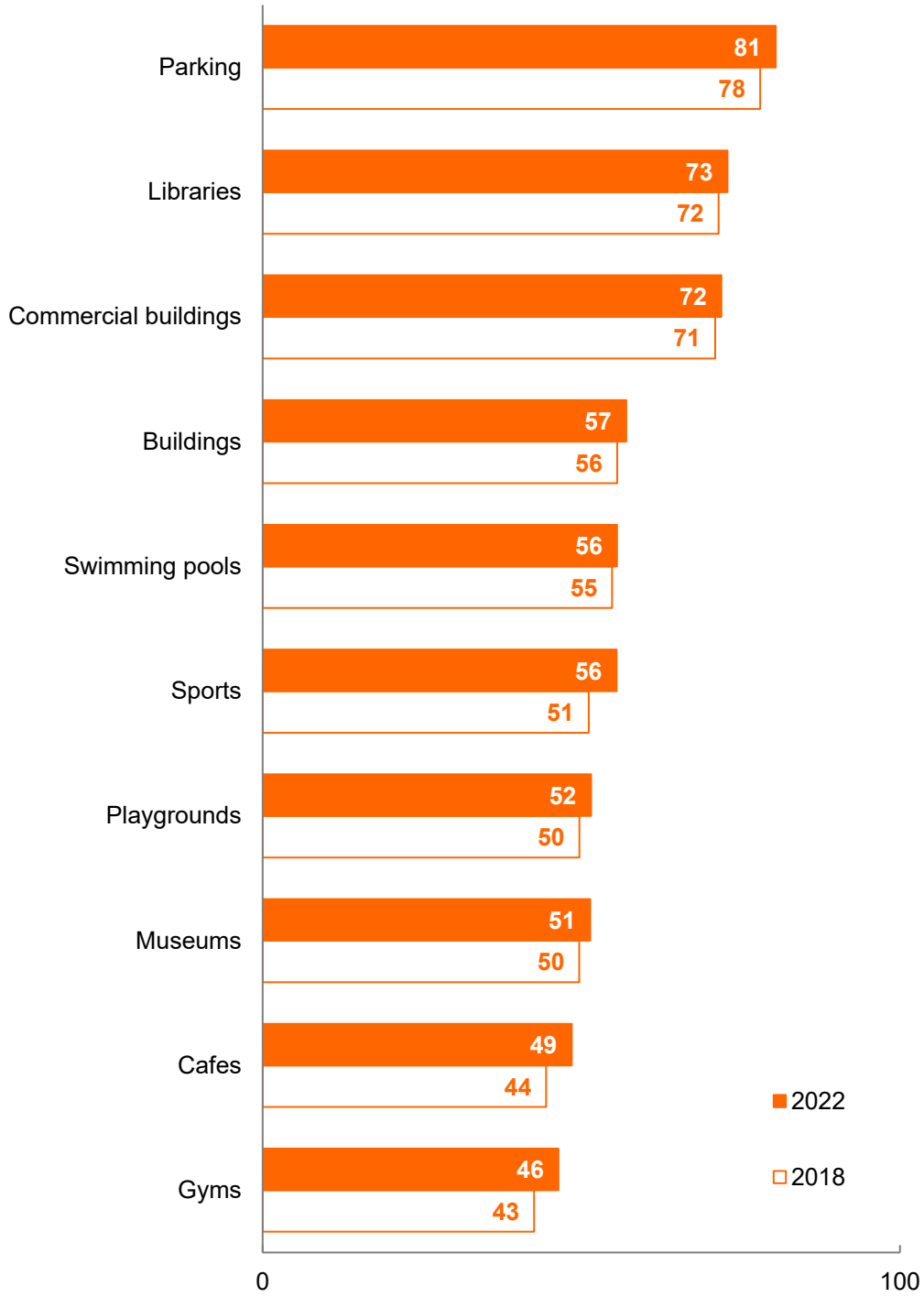
A new 12,000-square feet playground created to be inclusive of children with disabilities opened in Surrey, British Columbia, Canada. The space features adaptive equipment such as a wheelchair-accessible "we-go-round". The park has double-wide ramps, which allow children in wheelchairs to get into it.[480]

Creating inclusive and accessible public markets in Cairo, Egypt

The Zenin market is an example of an intersectional, participatory and inclusive design project. The location was identified by women in the community as a priority space for gender and disability-responsive planning interventions. The Zenin market is the country's first market to be redesigned using an approach that creates a safe space for women vendors and customers, including women with disabilities. The market design process included six months of consultations with market users and vendors and studies conducted by specialists, including architects as well as environmental, waste and gender consultants. Through this consultation process, women with disabilities explained their specific needs in accessing the market stalls and bathrooms and the additional barriers they may experience when using the market. Following recommendations made, the Zenin market has been made more accessible for persons with disabilities, including women, youth and children with disabilities. For instance, the accessibility of the market has been improved through wider paths and ramps to accommodate wheelchairs.[481] The program was implemented in partnership with the National Council for Women, the Ministry of Social Solidarity, the Giza Governorate, Care Egypt and three other local non-governmental organizations.

Data from three developing countries show that about 40 per cent of persons with disabilities indicate that recreational facilities are generally not accessible to them (Figure 177). And an average of 28 per cent of persons with disabilities in seven countries indicate that they need but do not encounter modifications to make it easier to participate in the community (Figure 178). According to crowdsourced accessibility data, in 2022, 81 per cent of parking lots, 73 per cent of libraries, 72 per cent of commercial buildings, 57 per cent of buildings, 56 per cent of swimming pools, 56 per cent of sports facilities, 52 per cent of playgrounds, 51 per cent of museums, 49 per cent of cafes and 46 per cent of gyms were accessible to users of wheelchairs (Figure 179). Although, for all these premises, accessibility has increased since 2018, the progress is small. Cafes and sports facilities show the largest increase, with a 5 percentage point increase since 2018. Countries worldwide have also been investing in making public places more accessible to persons with disabilities, such as playgrounds and markets (Box 7).

Figure 179. Percentage of various spaces in cities and human settlements that are accessible for wheelchair users, worldwide, in 2018 and 2022.



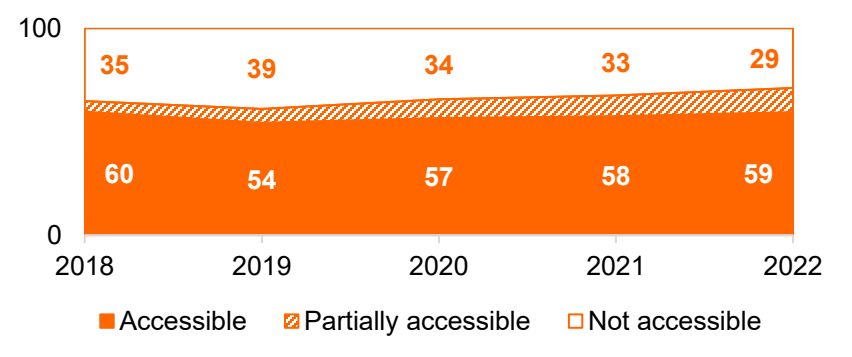
Source: UNDESA (on the basis of data from Sozialhelden[10]).

Box 8. Ensuring sustainable consumption and production patterns, conserving and sustainably using the oceans, seas and marine resources, protecting, restoring and promoting sustainable use of terrestrial ecosystems, sustainably managing forests, combating desertification, and halting and reversing land degradation and halting biodiversity loss (Goals 12, 14 and 15)

Achieving Goals 12, 14 and 15 will require the participation of all persons. Yet, persons with disabilities face barriers to acting as agents of change to achieve sustainable consumption and production patterns (Goal 12). Target 12.5 calls for substantially reducing waste generation through prevention, reduction, recycling and reuse. But persons with disabilities face barriers to accessing recycling premises: worldwide, only 59 per cent of recycling premises are accessible for wheelchair users, slightly down from 60 per cent in 2018 (Figure 180). With current trends, in 2030, only 60 per cent of these premises are expected to be accessible – the same level as in 2018. Progress needs to accelerate to 65 times past observed trends to make all these premises accessible to persons with disabilities by 2030.

Target 12.2 aims at achieving the sustainable management and efficient use of natural resources. However, persons with disabilities face barriers to accessing sustainable products: worldwide, only 67 per cent of shops selling organic and sustainable products are accessible for wheelchair users up from 60 per cent in 2018 (Figure 181). With the progress rates observed so far, 81 per cent of these shops are expected to be accessible for persons with disabilities by 2030: the rate of progress needs to accelerate to two times faster to ensure that all shops are accessible for wheelchair users by 2030.

Figure 180. Percentage of recycling premises that are accessible for wheelchair users, worldwide, yearly from 2018 to 2022.



Source: UNDESA (on the basis of data from Sozialhelden[10]).

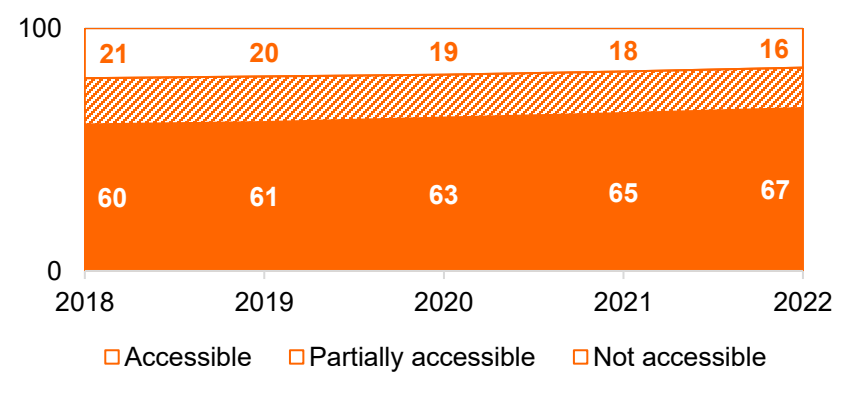
Persons with disabilities face barriers to participating in youth environmental activism and to promoting the realization of Goals 14 and 15. In 2021, no references to persons with disabilities were found in academic literature covering youth environmental activism and in social media from youth environmental activism groups.[482] When involved, persons with disabilities are often engaged only as environmental learners and given few opportunities to take roles such as environmental advocates or educators.[483]

Persons with disabilities are disproportionately impacted by environmental shocks, such as disasters caused by natural and climate-related hazards (see the chapters on Goals 1, 11 and 13), and addressing this impact will require engaging persons with disabilities in active roles in environmental issues. Furthermore, environmental discourses, policies, actions and activism can impact persons with disabilities in a negative way if the needs and perspectives of persons with disabilities are not considered. For example, various countries have introduced plastic straw bans to reduce plastic pollutants but some persons with disabilities need to use straws to assist with drinking. Single-use plastic straws are preferred as they are more flexible, more sanitary and safer for them than alternatives such as metal and plastic straws.[484,485]

As another example, protests to advocate against environmental degradation, such as roadblocks for cars, can create disproportionate barriers for persons with disabilities: users of wheelchairs often need to take a car or taxi to work and have no alternative transport because not all public transportation is yet accessible to them – unless all public transportation is made accessible, the traffic delays caused by protests will impact persons with disabilities more than others.[486] Climate mitigation and adaptation measures developed without consultation with persons with disabilities can also create additional barriers: bicycles lanes may cause bus stops to become wheelchair inaccessible; extra taxes on private transportation can disproportionally impact persons with disabilities if public transportation is not accessible. Despite the barriers, there are examples of persons with disabilities acting as environmental activists.[487]

Involving persons with disabilities in environmental discussion, action and decision-making and making recycling facilities and premises for sustainable products and services accessible to persons with disabilities will be positive steps contributing to the achievement of Goals 12, 14 and 15.

Figure 181. Percentage of shops of organic and sustainable products that are accessible for wheelchair users, worldwide, yearly from 2018 to 2022.



Source: UNDESA (on the basis of data from Sozialhelden[10]).

Indicator 11.7.2 monitors the proportion of persons that are victims of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months. Examples of harassment include offensive or derogatory jokes or remarks, racial or ethnic slurs, pressures for sexual favours and negative, offensive or unwelcome comments about a disability, unwanted or inappropriate touching, and hugging or other physical contact. The experience of physical and sexual harassment can have far-reaching negative impacts on the victims. Besides the emotional and psychological harm suffered, harassment can have negative consequences on the ability of its victims to fully participate in public life and to share in and contribute to the development of their communities.

In the European Union, persons with disabilities experience harassment at a higher rate than others: 50 per cent of persons with severe disabilities and 47 per cent of persons that do not have severe disabilities experienced harassment in 2019 or in the five preceding years, compared to 37 per cent of persons without disabilities.[488] Globally, persons with disabilities are two to six times more likely than others to experience violence, including harassment and other forms of violence, with women and girls with disabilities at higher risk than others (see the chapter on targets 16.1 and 16.2).

Impact of the COVID-19 pandemic

The COVID-19 pandemic brought challenges for persons with disabilities to affording housing, transport and basic services at home, such as water and other utilities. During the pandemic, a slightly higher proportion of households with persons with disabilities, compared to those without, reported difficulties paying for rent (28 per cent versus 24 per cent) and transport (16 per cent versus 15 per cent).[16] A higher proportion of parents and caregivers with disabilities, compared to those without, reported needing and not having access to water delivery during the pandemic (31 per cent versus 18 per cent).[16] A higher proportion of households with persons with disabilities, compared to those without, reported difficulties paying for utility bills (31 per cent versus 24 per cent).[16]

Due to financial difficulties, persons with disabilities, including children with disabilities, may have been at an increased risk of homelessness as a result of the pandemic. Surveys conducted in April 2020 among persons with disabilities, national human rights institutes and experts from governments aware of the situation of homeless persons with disabilities indicate that 51 per cent considered their government took no measures to protect the life, health and safety of persons with disabilities living on the streets or in homeless shelters during the pandemic; 41 per cent considered the government took some measures and 8 per cent considered the government took significant measures.[489]

Persons with disabilities in remote and rural areas may have faced additional barriers to accessing COVID-19 treatment and to accessing adequate information on COVID-19 prevention and vaccination, especially in areas without access to the Internet, phones and other information technologies. In the same surveys conducted in April 2020 among persons with disabilities and experts from governments and national human rights institutes, the majority of respondents (59 per cent) indicated that no measures

were taken by their government to protect persons with disabilities in remote and rural areas; 32 per cent considered the government took some measures and 9 per cent considered the government took significant measures.[489]

Lack of inclusive and accessible transportation during the pandemic, especially during lockdowns, may have caused negative impacts on persons with disabilities. For example, in South Africa, lack of transport and dependency on others for transportation led to persons with disabilities not being able to receive their COVID-19 vaccination in a timely manner.[490] In 2020, across 75 countries worldwide, 50 per cent of persons with visual impairments reported challenges in transportation.[491]

Another barrier to inclusive cities and human settlements during the pandemic was the adoption of face masks that were not inclusive of persons with disabilities, that is, face masks which are not transparent. Although transparent face masks exist, their adoption has not been promoted and research, pre- and during the pandemic, on the efficiency of these face masks in the protection against COVID-19 has been insufficient. Deaf persons and persons with hearing impairments, who rely on lip-reading and visual cues, were prevented from effective communication as they struggled to understand what was said to them: 85 per cent of deaf persons or persons with hearing impairments saw face coverings as an impediment for speechreading and 72 per cent thought that masks made it more difficult for them to use their residual hearing to aid speech comprehension.[492] The inability to communicate with fellow pedestrians and at services impeded the possibility for deaf persons and persons with hearing impairments to access important resources and services and confidently and safely use city and town streets.

Moreover, many persons with disabilities stopped receiving personal care and assistance with shopping during the pandemic lockdowns – another barrier for them to access resources and services in their communities. For instance, in the United Kingdom, 41 per cent of persons with disabilities were no longer receiving assistance with shopping. [493]

Evidence suggests increased harassment and violence against persons with disabilities during the pandemic (see the chapter on targets 16.1 and 16.2), including increased mocking, taunting and street harassment.[494]

Summary of findings and the way forward

Adequate, safe and affordable housing is a key component of inclusive development and an aim of target 11.1. Yet, persons with disabilities still face barriers to finding adequate and affordable housing. In developing countries, 33 per cent of persons with disabilities indicate their dwelling is hindering or not accessible to them; and 27 per cent report that they need but do not have modifications to make their home accessible to them. Barriers are also found in developed countries. In Europe, 5 per cent of persons with disabilities live in severely deprived housing, such as overcrowded housing with a leaking roof, no bath or shower, or too dark; and 10 per cent of persons with disabilities have heavy housing

costs, spending more than 40 per cent of their disposable income to pay these costs. Analysis in North America points to only 1 per cent of rented dwellings meeting the standards of universal design.

Safe, accessible and affordable transportation provides mobility for all, drives sustainable and inclusive growth and is a call of target 11.2. But 43 per cent of persons with disabilities in developing countries consider that transportation is hindering or not accessible to them. Persons with disabilities also encounter barriers in transit stations, transit platforms and bus stations: in 2022, only 68 per cent of transit stations, 61 per cent of transit platforms and 77 per cent of bus stations in developed countries were accessible to wheelchair users; and 77 per cent of transit stations, 66 per cent of transit platforms and 69 per cent of bus stations in developing countries.

Targets 11.3 and 11.7 call for inclusive urbanization and for safe, inclusive and accessible public and green spaces. However, about a third of persons with disabilities report that recreational facilities are not accessible to them; and 28 per cent report that they need but do not encounter modifications to make it easier to participate in the community. Globally, in 2022, only 57 per cent of buildings, only 52 per cent of playgrounds and only 51 per cent of museums were accessible to wheelchair users. Parking garages, libraries and commercial buildings tend to be more accessible (81 per cent of parking lots, 73 per cent of libraries and 72 per cent of commercial buildings).

The COVID-19 pandemic brought challenges to affording housing and basic services at home: 28 per cent of persons with disabilities reported difficulties paying rent (compared to 24 per cent of persons without disabilities) and 31 per cent paying utility bills (compared to 24 per cent of persons without disabilities); 31 per cent of persons with disabilities needed but did not have access to water delivery (compared to 18 per cent of persons with disabilities).

Progress since 2015 has been slow or stagnant. Trends in Europe show progress in reducing the percentage of persons with disabilities in severely deprived housing and facing housing cost overburdens. But, despite this progress, gaps between persons with disabilities remain. At the rates of progress observed so far, 2 per cent of persons with disabilities are expected to still live in severely deprived housing and 9 per cent to face housing cost overburdens by 2030. Progress needs to accelerate 1.1 times faster to eliminate the gap between persons with and without disabilities living in severely deprived housing and 1.4 times faster to eliminate severely deprived housing for persons with disabilities by 2030. Higher acceleration will be needed to address housing cost overburdens for persons with disabilities: two times faster to eliminate the gap between persons with and without disabilities and three times faster to eliminate housing cost overburdens by 2030.

The accessibility of transit stations, transit platforms and bus stations has been decreasing in developing countries. This trend needs to be reversed to achieve accessible transportation systems for all by 2030. In developed countries, the accessibility of transit platforms has also been deteriorating; accessibility of transit stations for wheelchair users has been increasing and is expected, if past observed trends continue, to reach 79 per cent by 2030. This trend would have to accelerate to twice as fast to achieve

100 per cent by 2030. Likewise, the accessibility of bus stations in developed countries for wheelchair users has been increasing and is expected, if past observed trends continue, to reach 91 per cent by 2030. This trend would have to accelerate 1.5 times to achieve 100 per cent by 2030.

The accessibility of spaces in cities and human settlements has been increasing but at a slow place. If past observed trends continue, by 2030, 85 per cent of car parking lots, 76 per cent of libraries, 75 per cent of commercial buildings, 60 per cent of buildings, 55 per cent of playgrounds and only 55 per cent of museums are expected to be accessible to wheelchair users. These trends need to accelerate at three times the current rates for car parking lots, seven times for libraries, seven times for commercial buildings, ten times for buildings, ten times for playgrounds and nine times for museums to achieve 100 per cent accessibility for wheelchair users by 2030.

To make cities and communities inclusive, accessible and sustainable for persons with disabilities, more efforts are needed to:

1. Raise awareness of disability among communities and create an enabling environment where persons with disabilities are included without discrimination and can participate equally in their communities. Involve representative organizations of persons with disabilities in awareness campaigns and share progress and best practices on disability-inclusion and accessibility.

2. Build capacity in accessibility and disability inclusion among decision makers and building professionals, such as architects, engineers, urban planners and managers. There is a lack of expertise and technical capacity to implement measures promoting accessibility and inclusion. Initiate, in collaboration with representative organizations of persons with disabilities, training programs for decision makers, ministerial and agency staff, and building professionals, such as architects, engineers, urban planners and managers on legal obligations, development frameworks and tools to support inclusive urban development strategies and practices. Enhance inter-ministerial coordination on inclusion, accessibility and human rights pertaining to urban development, avoiding duplication of and siloed efforts.

3. Adopt explicit commitments to inclusion, universal design and accessibility. Promote policies and practices to improve the accessibility of public spaces and disability-inclusive road and pedestrian environments. Develop policies, regulations and standards supporting accessible and universal design throughout the transport system. Include requirements for accessibility and universal design in standard procurement documents.

4. Regularly generate research, disaggregated data and city-wide assessments on accessibility and use this evidence to guide policymaking. Conduct surveys among persons with disabilities to assess the accessibility of public spaces and transportation systems and the barriers they face in these environments. Explore also crowdsourced data to monitor accessibility and disability inclusion in public spaces. Assess accessibility barriers in public spaces and transportation systems and conduct impact evaluations of policies and strategies implemented to promote accessibility. Involve persons with

disabilities and their representative organizations in data and research efforts. Use the evidence generated to produce roadmaps and action plans.

5. Establish clear participatory and accessible mechanisms for inclusive budgeting, planning, design, implementation, and monitoring of urban strategies, policies and practices. Engage persons with disabilities and their representative organizations in budgeting, planning, design, implementation, and monitoring of urban strategies, policies and practices. Make all consultations accessible to persons with disabilities.

Building resilience and reducing exposure and impact from climate-related hazards and other shocks and disasters (targets 1.5, 11.5 and 11.b and Goal 13)

Target 1.5 aims at building the resilience of the poor and those in vulnerable situations to climate-related extreme events and other economic, social and environmental shocks and disasters; target 11.5 aims at making human settlements sustainable and inclusive by ensuring the protection of people in vulnerable situations from disasters; target 11.b aims at inter alia substantially increasing the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change and resilience to disasters; and Goal 13 aims at taking urgent action to combat climate change and its impacts. Within Goal 13, target 13.1 aims at strengthening resilience and adaptive capacity to climate-related hazards and natural disasters in all countries; target 13.3 aims at improving education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning; and target 13.b aims at combating climate change by enhancing capacities for effective climate change-related planning and management, with a focus on marginalized communities.

This chapter assesses the current situation and trends of persons with disabilities vis-a-vis this Goal and these targets, which overall focus on climate change and disasters. Disasters caused by natural hazards, man-made disasters and climate hazards can cause harm to humans, property, livelihoods, resources and the environment. Disasters caused by natural hazards include agricultural diseases and pests, blizzards, cyclones, damaging winds, droughts, earthquakes, floods, heatwaves, hurricanes, infectious disease outbreaks, landslides, lightning and thunderstorms, pandemics, sinkholes, storms, tornadoes, tsunamis, typhoons, volcanic eruptions and wildfires. Man-made disasters and shocks include arson, biological and chemical attacks, chemical spills, cyber-attacks, economic and financial crises, groundwater poisoning, hazardous materials exposures and spills, nuclear explosions, pollution, terrorist attacks, transportation accidents and wars. Climatic hazards are weather-related events and include blizzards, cyclones, droughts, floods, heatwaves, hurricanes, storms and tornadoes.

The Convention on the Rights of Persons with Disabilities (CRPD) provides a framework to guide preparedness, response and recovery efforts in climate hazards and disasters. In particular, Article 11 of the Convention recognizes that situations of risk and humanitarian emergencies pose serious challenges to persons with disabilities and their rights and 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 disasters caused by natural hazards.

A number of other international agreements support the need to ensure the safety and protection of persons with disabilities in such emergency situations and to involve them in preparedness and response efforts. 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.[495] 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.[496] The SIDS Accelerated Modalities of Action (SAMOA) Pathway (2014) acknowledges the importance of engaging a broad range of stakeholders including persons with disabilities in the context of climate change and of strengthening the contingency planning and provisions for disaster preparedness and response, emergency relief and population evacuation for persons with disabilities.[497] The New York Declaration for Refugees and Migrants (2016) commits to address the special needs of people in vulnerable situations including refugees and migrants with disabilities and calls for the identification of specific assistance needs and protection arrangements for them.[498] The United Nations Security Council Resolution 2475 on the protection of persons with disabilities in conflict situations (2019) calls upon all parties to armed conflict to allow and facilitate safe, timely and unimpeded humanitarian access and prevent violence and abuses against civilians with disabilities in situations of armed conflict.

In addition, the Charter on Inclusion of Persons with Disabilities in Humanitarian Action, developed for the World Humanitarian Summit held in 2016 and endorsed by many states and stakeholders, commits to ensure that services and humanitarian assistance are equally available for and accessible to all persons with disabilities, and to guarantee the availability, affordability and access to specialized services, including assistive technology in the short, medium and long term.

This chapter focuses on the safety and protection of persons with disabilities during and after disasters caused by natural hazards, climate-related events and other disasters, provides an overview of the status of the inclusion of persons with disabilities in disaster risk reduction and humanitarian actions, and provides recommendations to address the needs of persons with disabilities in such shocks and crises.

Current situation and progress so far

Persons with disabilities are particularly vulnerable during man-made disasters and disasters caused by natural hazards, including extreme climate events. They tend to suffer higher mortality rates, have lower evacuation rates and are more likely to be negatively affected during and in the aftermath of disasters.[32] Disasters amplify the marginalization experienced by persons with disabilities, affecting their health, reducing access to healthcare and services, food, water and accessible infrastructure. During disasters and evacuations, transportation and shelters may not be accessible to persons with disabilities; persons with disabilities may lose essential medications and assistive devices; and mental, rehabilitation and other health and support services may become less available. This has led to persons with disabilities being hospitalized or institutionalized during disasters,[499] which goes against the provisions of the CRPD.

The COVID-19 pandemic again confirmed this disproportionate impact, with persons with disabilities

suffering much higher COVID-19 mortality rates than others. Available evidence points to half of COVID-19 deaths occurring among persons with disabilities and COVID-19 mortality rates among youth with intellectual disabilities 30 times higher than among other youth (see the chapter on Goal 3). Many households of persons with disabilities faced additional difficulties paying for food during the pandemic, especially in developing countries (see the chapter on Goal 2). Higher percentages of persons with disabilities than persons without disabilities did not have access to water delivery, sanitary products and were not able to pay water bills during the pandemic (see the chapter on Goal 6). A large majority of the COVID-19 response, especially in its early stages, was not accessible or inclusive for persons with disabilities, with tests, testing and vaccination sites not accessible (see the chapter on Goal 3) and COVID-19 information not released in accessible formats (see the chapter on target 16.10). The experience of persons with disabilities in countries suffering disasters caused by natural hazards or humanitarian emergencies during the pandemic was even more challenging: 64 per cent of persons with disabilities in these areas reported barriers to accessing healthcare and medicines.[500]

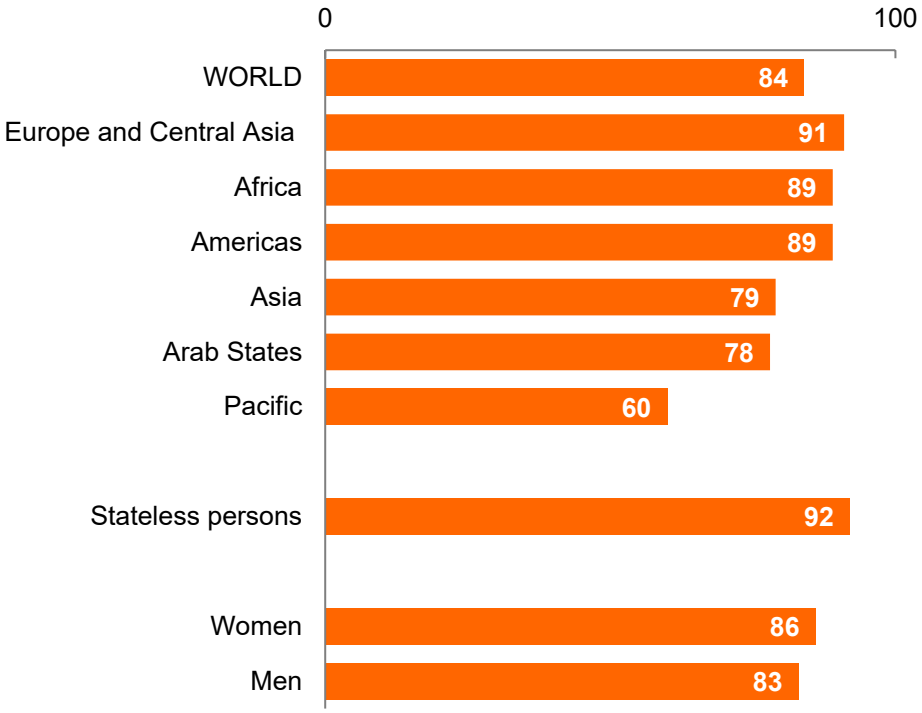
Recent data on the impact of climate-related extreme events on persons with disabilities is scarce. Estimates presented in the *Disability and Development Report* 2018 show that the mortality rates of persons with disabilities during such extreme events are twice as high as the mortality rates for persons without disabilities. The socio-economic vulnerabilities of persons with disabilities have remained since then and suggest that persons with disabilities will continue to suffer a disproportionate impact during climate-related extreme events: persons with disabilities are more likely to be poor than persons without disabilities (see the chapter on Goal 1), which means they often live in poorer housing (see the chapter on Goal 11) that is usually on less desirable flood- and heat-prone lands and that is less resistant to weather related events.

A key reason why a disproportionate number of persons with disabilities suffer and die in disasters is because their needs are ignored and neglected by the official planning process in the majority of situations. They are often totally reliant on the kindness of family, friends and neighbours for their survival and safety. A comparison between 2013 and 2023, indicates that many aspects of disaster risk preparedness and response for persons with disabilities have worsened in many regions in the world, particularly in Central Asia, Europe and the Americas. In Africa, Asia and the Pacific regions, despite some drawbacks, remarkable progress has been made in some aspects of disaster risk preparedness.

In 2023, worldwide, 84 per cent of persons with disabilities had no personal preparedness plan for disasters, a situation that has deteriorated since 2013 when fewer persons with disabilities, 72 per cent, lacked such a plan (Figure 182). In 2023, in all regions, the vast majority of persons with disabilities has no such plan. The highest percentage of persons with disabilities lacking a personal preparedness plan for disasters is found in Europe and Central Asia (91 per cent); and the lowest in the Pacific (60 per cent). The situation has worsened in all regions since 2013, as the percentages have increased in all regions since then, expect in the Pacific where there was a decrease from 71 per cent in 2013 to 60 per cent in

2023. But it is for stateless persons with disabilities that the lack of preparedness plans is more acute: 92 per cent of them lack these plans. A slightly higher percentage of women with disabilities (86 per cent) than men with disabilities (83 per cent) lack these plans.

Figure 182. Percentage of persons with disabilities who do not have a personal preparedness plan for disasters, in the world and by region, for stateless persons, and by sex, in 2023.

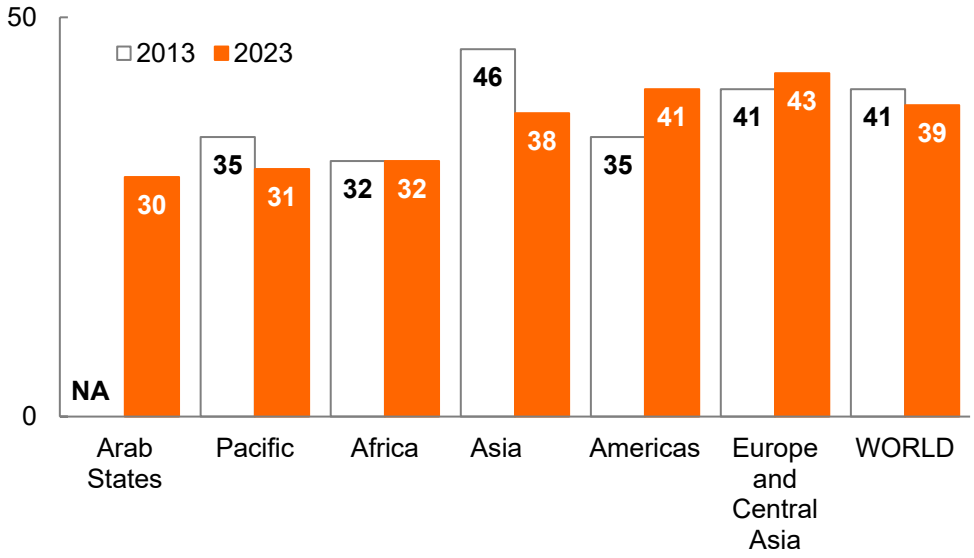


Source: UNDRR (2023).[501]

Worldwide, persons with disabilities face a lot of difficulties or are unable to evacuate without assistance in the event of a sudden disaster, a situation that has improved little since 2013: 39 per cent of persons with disabilities in 2023 down from 41 per cent in 2013 (Figure 183). While there has been progress in Asia, with an 8 percentage point decrease since 2013, and in the Pacific, with a 4 percentage point decrease since 2013, in other regions the situation has worsened, particularly in the Americas where 41 per cent of persons with disabilities would face difficulties or not be able to evacuate at all in 2023 up from 35 per cent in 2013. If given an early warning and sufficient time, the percentage of persons with disabilities worldwide who would face difficulties or not be able to evacuate decreases to 23 per cent.[501]

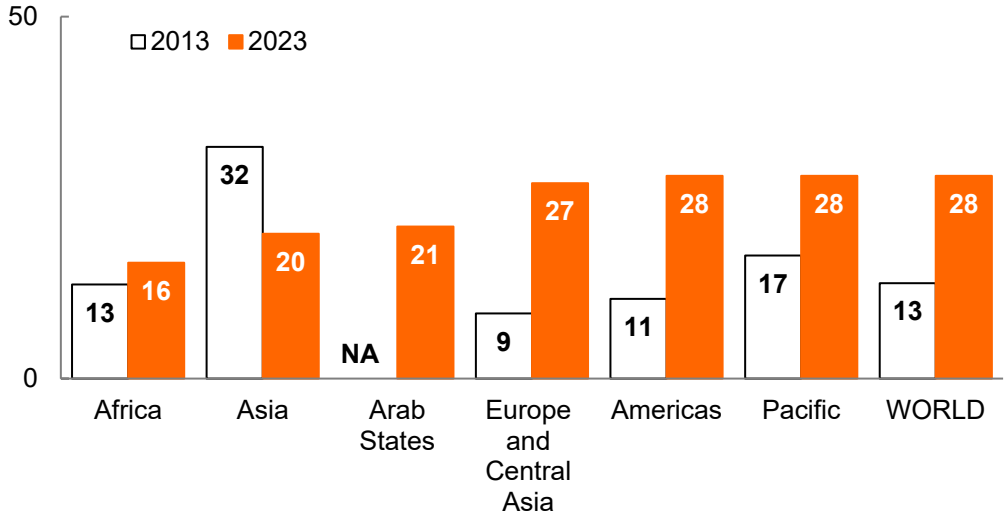
For persons with disabilities who require assistance to evacuate before a disaster, 28 per cent have no one to assist them, up from 13 per cent in 2013 (Figure 184). The situation has worsened in all regions since 2013, except for Asia, where 32 per cent of persons with disabilities in 2013 but only 20 per cent in 2023 had no one to assist them.

Figure 183. Percentage of persons with disabilities who, without assistance, would have a lot of difficulty evacuating or would not be able to evacuate at all in the event of a sudden disaster, in the world and by region, in 2013 and 2023.



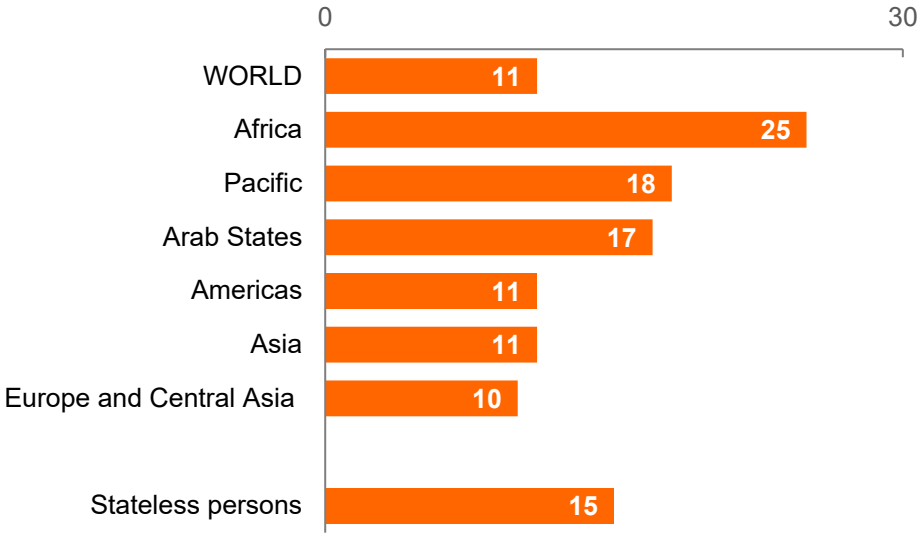
Source: UNISDR (2013)[502] and UNDRR (2023).[501]

Figure 184. Percentage of persons with disabilities who need but do not have someone to help them evacuate before a disaster, in the world and by region, in 2013 and 2023.



Source: UNISDR (2013)[502] and UNDRR (2023).[501]

Figure 185. Percentage of persons with disabilities who indicate that information on disaster management or risk reduction available in their community is disseminated in accessible formats (e.g., Braille, easy-to-read versions and sign language), in the world and by region, in 2023.



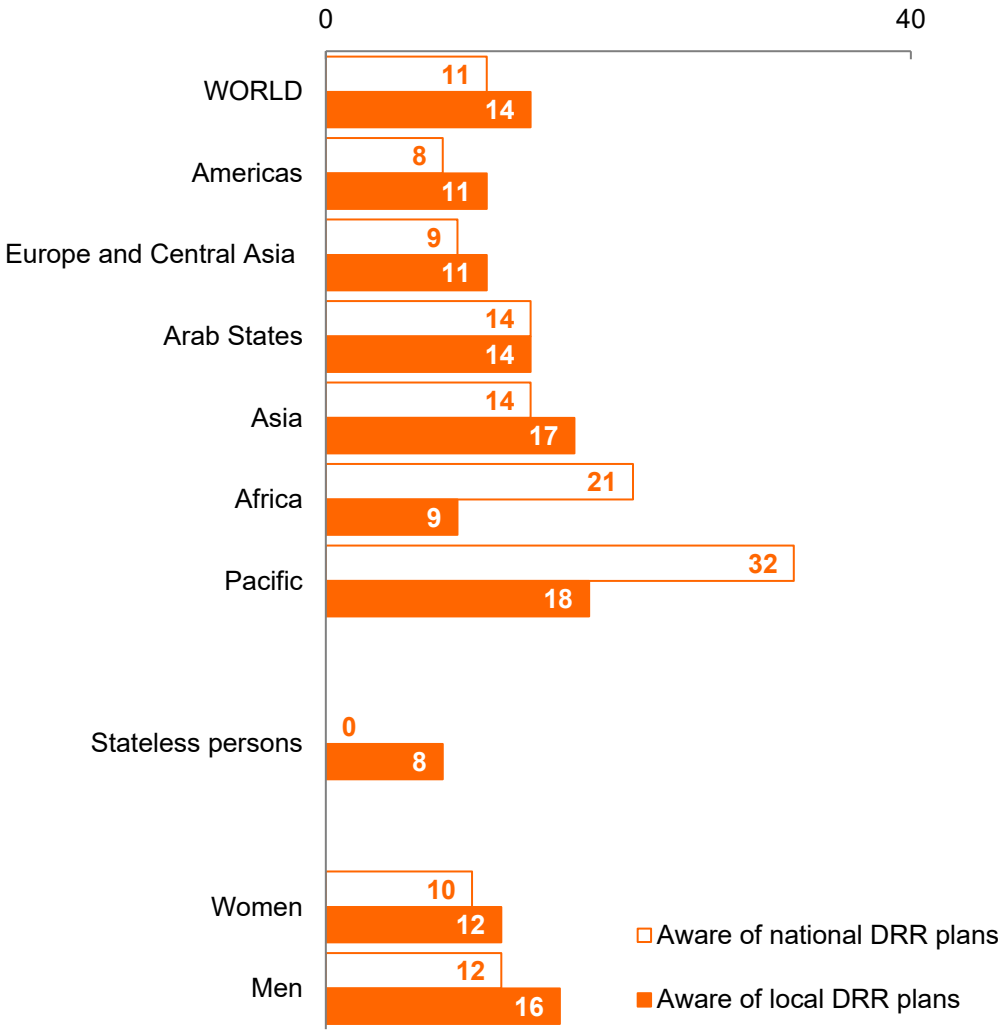
Source: UNDRR (2023).[501]

Persons with disabilities may experience more obstacles in evacuating and protecting themselves from disasters if they face barriers in accessing information on disaster management, risk reduction and early warnings because this information is not disseminated in formats accessible for them, such as Braille, easy-to-understand versions and sign language. Worldwide, only 11 per cent of persons with disabilities indicate that information on disaster management or risk reduction available in their community is disseminated in accessible formats, from 10 per cent in Europe and Central Asia to 25 per cent in Africa (Figure 185). Only 15 per cent of stateless persons with disabilities indicate that such information is disseminated in formats accessible to them.

Awareness of national and local-level disaster risk reduction plans is low among persons with disabilities. In 2023, only 11 per cent of persons with disabilities were aware of national disaster risk reduction plans and only 14 per cent were aware of local disaster risk reduction plans (Figure 186). This awareness has worsened since 2013: back then 14 per cent of persons with disabilities were aware of national disaster risk reduction plans and 17 per cent were aware of local disaster risk reduction plans. In 2023, awareness was highest in the Pacific region, where 32 per cent of persons with disabilities were aware of national disaster risk reduction plans and 18 per cent were aware of local disaster risk reduction plans. In all regions expect Africa and the Pacific, awareness of national plans was lower than awareness of local plans. A lower percentage of women with disabilities (10 per cent and 12 per cent) than men with disabilities (12 per cent and 16 per cent) was aware of national and local plans. Awareness among stateless persons with disabilities was particularly low, as none were aware of national plans and only 8

per cent were aware of local disaster risk reduction plans.

Figure 186. Percentage of persons with disabilities who are aware of national and local disaster risk reduction (DRR) plans, in the world and by region, for stateless persons and by sex, in 2023.

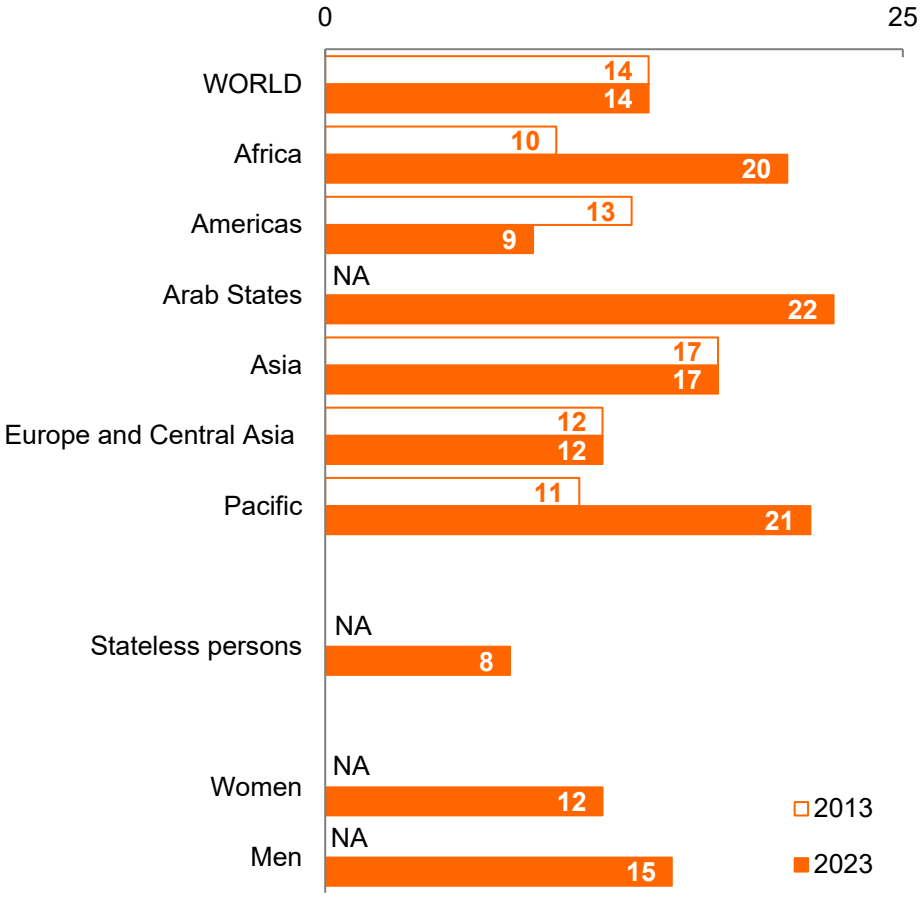


Source: UNDRR (2023).[501]

Persons with disabilities often remain alienated from emergency and disaster risk reduction and response planning. Worldwide, in 2023, as few as 14 per cent of persons with disabilities had participated in disaster risk reduction decision-making in their communities, the same percentage as in 2013, although more than half of persons with disabilities expressed a wish to participate in community disaster management in both 2013 and 2023 (Figure 187). Remarkable progress has been made in Africa and the Pacific, which doubled the percentage of persons with disabilities involved in decision-making processes on community disaster management and risk reduction from about 10 per cent in 2013 to about 20 per

cent in 2023. In all other regions, the situation either stagnated or became worse. Stateless persons with disabilities are much less involved in this type of decision-making than other persons with disabilities, with only 8 per cent of them reporting such participation. Women with disabilities (12 per cent) tend to be slightly less involved than men with disabilities (15 per cent).

Figure 187. Percentage of persons with disabilities who are involved in decision-making processes on community disaster management and risk reduction, in the world and by region, for stateless persons, and by sex, in 2013 and 2023.



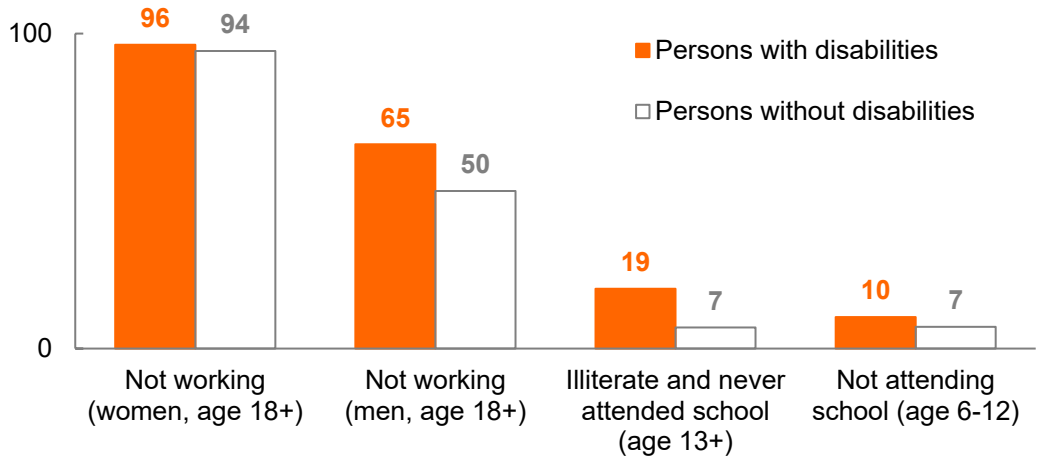
Source: UNISDR (2013)[502] and UNDRR (2023).[501]

Persons with disabilities are also seldom considered in decision-making regarding climate change. Only 35 of the 192 States Parties to the Paris Agreement refer to persons with disabilities in their Nationally Determined Contributions and Intended Nationally Determined Contributions; and only 45 States Parties to the Paris Agreement currently refer to persons with disabilities, people with health conditions or those with chronic illnesses in their climate adaptation policies.[503] Persons with disabilities are also often excluded from relief measures to address disasters and emergencies. For example, only 44 per cent of

countries that announced COVID-19 social protection relief measures included provisions for persons with disabilities (see the chapter on Goal 3).

Persons with disabilities fleeing disasters, armed conflict and humanitarian emergencies face barriers to accessing education, employment and services and face a higher risk of violence. For example, among Syrian refugees in Jordan, 19 per cent of persons with disabilities are illiterate compared to 7 per cent of persons without disabilities; 10 per cent of children with disabilities do not attend schools compared to 7 per cent of children without disabilities (Figure 188). Levels of unemployment are high among both women with and without disabilities, with about 95 per cent of them not working. Men with disabilities are less likely to be working: 65 per cent of men with disabilities do not work compared to 50 per cent of men without disabilities. In the Malakal protection of civilians site (South Sudan), 39 per cent of internally displaced persons with disabilities lack economic resources to access services, 38 per cent are too distant to the services, 34 per cent cannot physically access the services, 22 per cent lack information about the services, 5 per cent indicate the services do not respond to their needs, 4 per cent indicate communication barriers to access the services, 4 per cent do not feel safe accessing the services due to the risk of violence and 3 per cent fear discrimination or harassment when accessing the services (Figure 189). In this site, 10 per cent of persons with disabilities encounter verbal violence when accessing services and 7 per cent encounter physical violence (see Figure 207 in the chapter on targets 16.1 and 16.2). The episodes of physical and verbal violence include harassment from their neighbours as well as incidents of children pelting persons with disabilities with stones and insulting their disabilities.

Figure 188. Percentage of Syrian refugees in Jordan who do not work, are illiterate or do not attend school, in 2018.



Source: Humanity & Inclusion and iMMAP (2018).[504]

To remove the barriers that persons with disabilities face in disaster prevention, preparedness and response, countries have increasingly taken measures to include persons with disabilities in these efforts.

Many countries have used accessible formats for persons with disabilities in the dissemination of laws and policies related to climate change, disaster and evacuation measures. For example, among 27 countries, only 4 per cent of countries have no accessible formats for the laws and policies on disaster risk reduction (Figure 190). However, a higher percentage of countries, 22 per cent, have no accessible formats for the laws and policies on climate change adaptation. Only 14 per cent of countries have no accessible formats for the laws regulating evacuation measures from private premises, and only 254 per cent of countries for public buildings. Accessible doc/pdf are the most common accessible formats, followed by ePub, easy-to-understand versions and Braille. No countries disseminate the laws and policies on climate change adaptation in easy-to-understand and in Braille.

Figure 189. Percentage of internally displaced persons with disabilities facing barriers to accessing services, by type of barrier, in the Malakal protection of civilians site (South Sudan), in 2020.

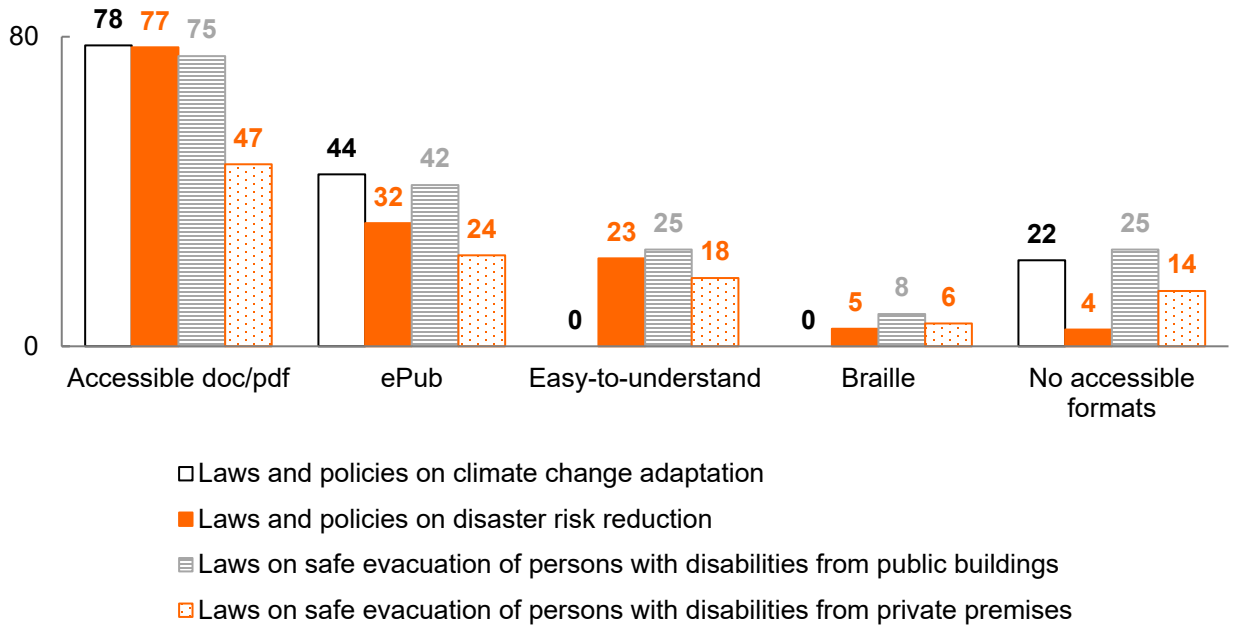


Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: International Organization for Migration's Displacement Tracking Matrix (2021).[505]

Countries have also been increasingly releasing early warnings and information about prevention, preparedness and response to disasters in accessible formats for persons with disabilities. All countries use at least one accessible format to release early warnings and only 4 per cent of countries use no accessible formats to release information on prevention, preparedness and recovery (Figure 191). Sign language, accessible doc/pdf and captioning are the most common features used by countries; ePub and Braille the least common. Easy-to-understand communication is more common than Braille or ePub, but its use remains low, with only 27 per cent of countries releasing early warnings in easy-to-understand communication and only 48 releasing information on prevention, preparedness and recovery from

disasters in this format.

Figure 190. Percentage of countries disseminating laws and policies related to climate change, disasters and evacuation in accessible formats for persons with disabilities, in 27 countries, in 2023.



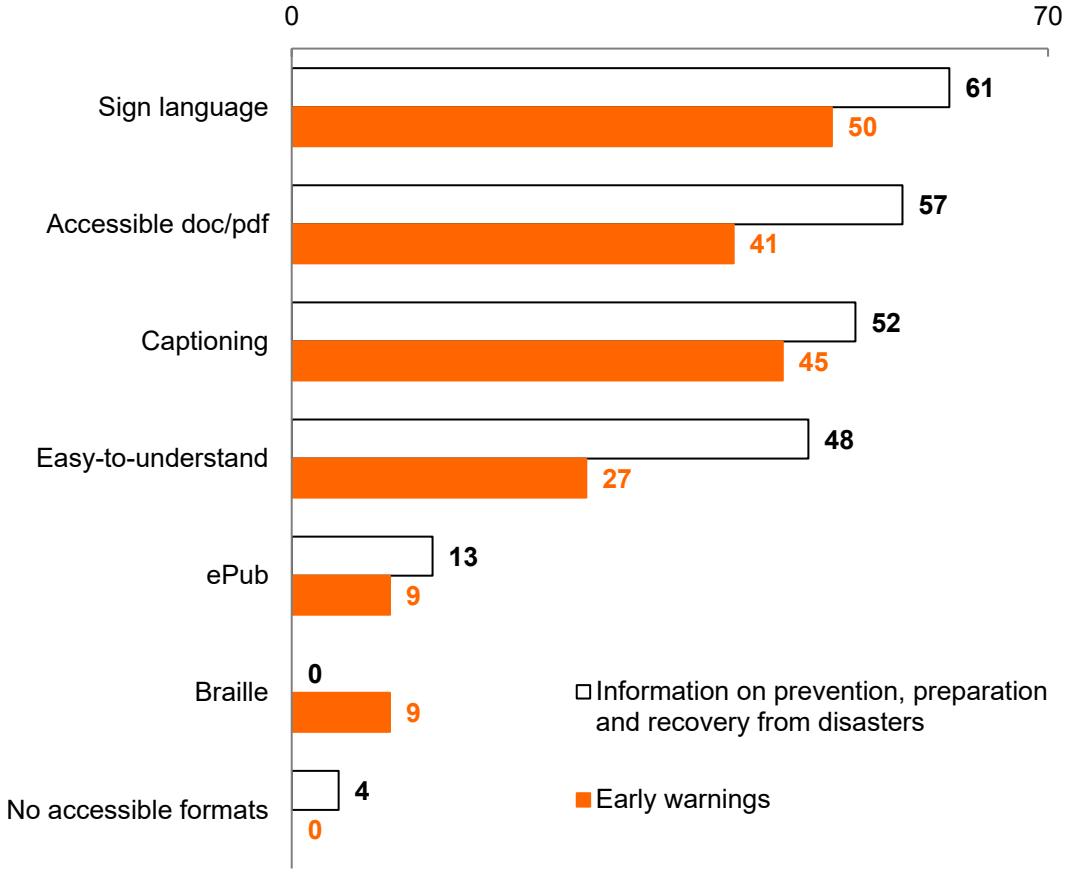
Source: UNDESA. [506]

Many countries have national emergency numbers and calls to these numbers are typically used to report a situation of risk, like a fire, and to request support, like an ambulance. Unless accessible features are embedded in these emergency numbers, like the possibility to text instead of calling, these numbers are not accessible to persons with hearing or speech impairments. Among countries that have a national emergency number, using the emergency number is accessible to persons with hearing or speech impairments in 58 per cent of countries.[506]

When escaping from a disaster, persons with disabilities may need to seek refuge in emergency shelters and disaster relief sites. However, these shelters are not always accessible for persons with disabilities. They may not be physically accessible to wheelchair users, may not have communication available in sign language, or have other barriers for persons with disabilities. Among 27 countries worldwide, 59 per cent have accessible shelters for persons with disabilities.[506]

The vast majorities of countries consult with persons with disabilities or their representative organizations when developing laws, policies and measures related to the prevention, preparedness and response to disasters and climate change (Figure 192).

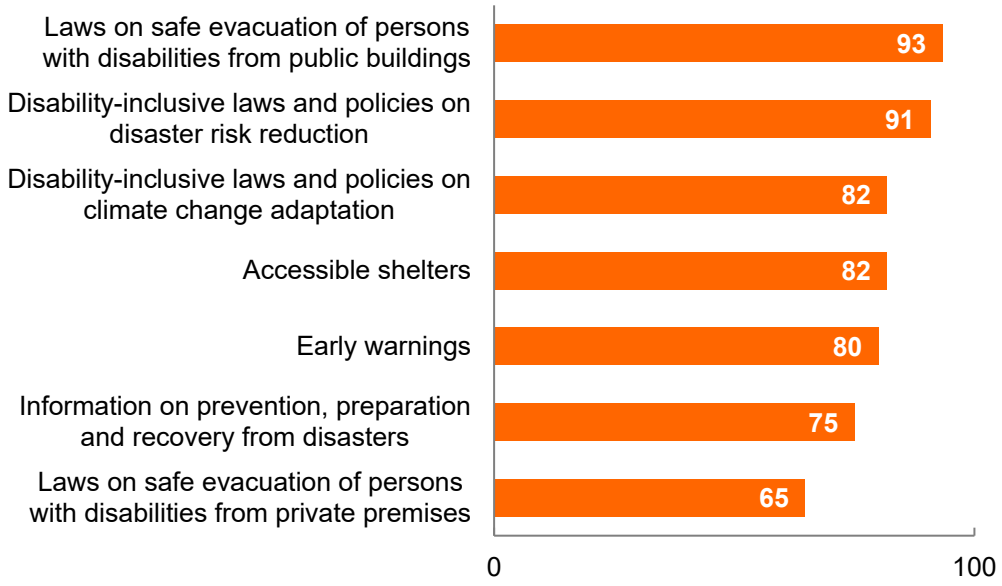
Figure 191. Percentage of countries disseminating early warnings and information on the prevention, preparation and recovery from disasters in accessible formats for persons with disabilities, in 27 countries, in 2023.



Source: UNDESA. [506]

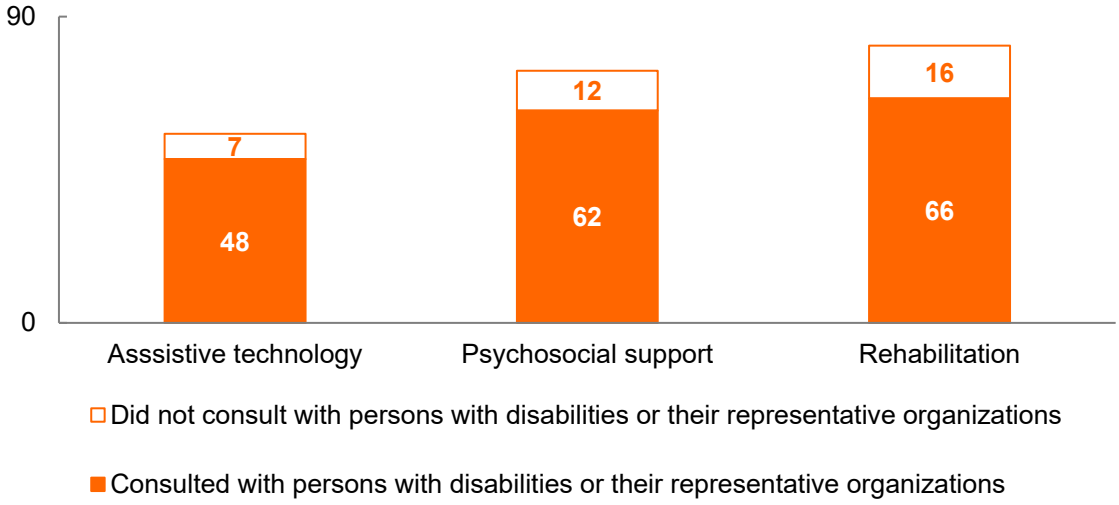
Countries have also been investing in putting in place mechanisms to ensure access by persons with disabilities to rehabilitation (82 per cent of countries), psychosocial support (74 per cent of countries) and assistive technology (55 per cent of countries) during and after a disaster or a humanitarian emergency (Figure 193). The vast majority of these countries consulted with persons with disabilities or their representative organizations in the development of these mechanisms. In the event of a power outage during or in the aftermath of a disaster or other shock, 39 per cent of countries have mechanisms to assist persons with disabilities using electricity-run assistive devices during these power disruptions; with two-thirds of these mechanisms designed in consultation with persons with disabilities (see Figure 120 of the chapter on Goal 7).

Figure 192. Percentage of countries that consulted with persons with disabilities and/or their representative organizations in developing laws, policies and measures related to climate change, disasters and evacuation, in 27 countries, in 2023.



Source: UNDESA.[506]

Figure 193. Percentage of countries that have mechanisms in place to ensure that persons with disabilities have access to rehabilitation, assistive technology and psychosocial support during and after a disaster or humanitarian emergency, by status of consultation with persons with disabilities or their representative organizations, in 27 countries, in 2023.



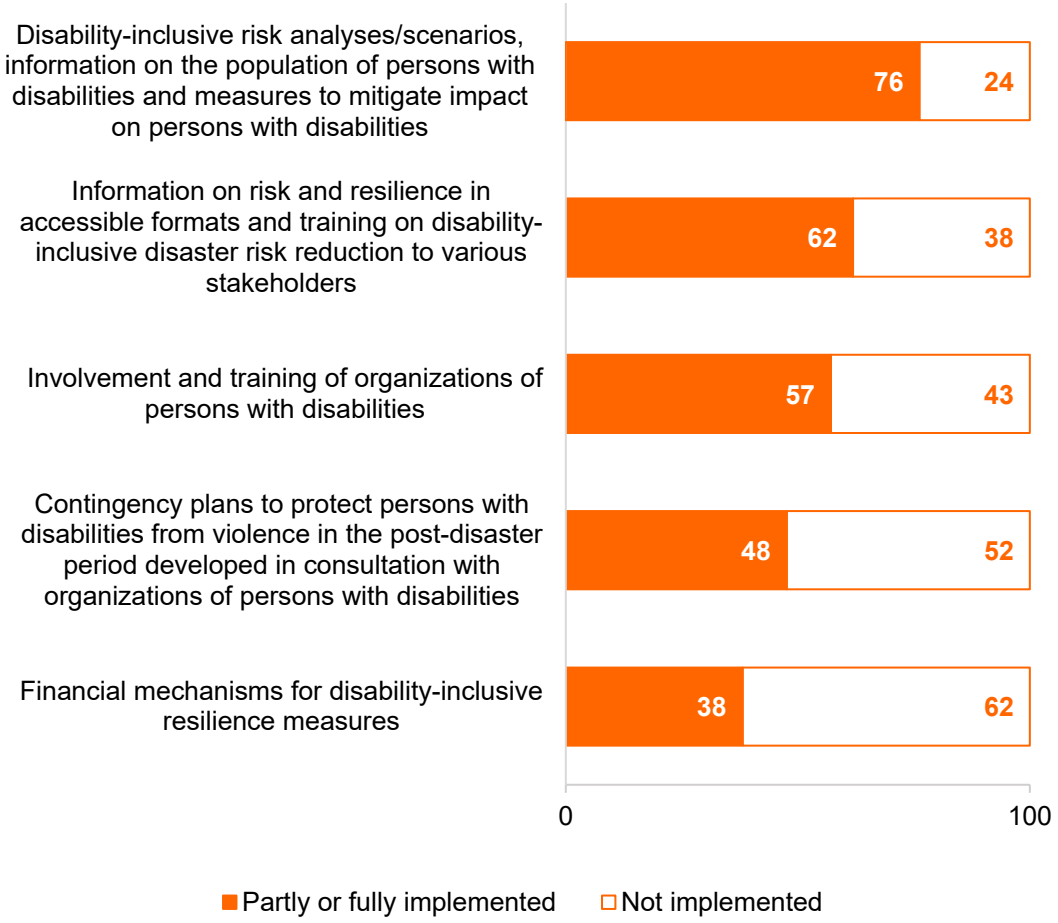
Source: UNDESA.[506]

Climate mitigation and adaptation approaches developed without consultation with persons with disabilities and their representative organizations create additional barriers. For example, added bicycles lanes without considering the needs of persons with disabilities may cause bus stops to become wheelchair inaccessible. Charging extra taxes on private transportation may cause additional barriers for persons with disabilities if public transportation is not accessible. Improvements in energy systems at home can lead to disruptions in the use of electricity, which can lead to disruptions in the use of life-saving assistive technology and in carefully planned layouts and routines that persons with disabilities may need; many persons with disabilities may not be able to go through such disruptions (see the chapter on Goal 7).

Local governments and urban communities play a major role in responding to shocks and climate-related events as well as in building resilience and preparing for crises, whether climate-related, conflict-driven or from other causes. It is therefore crucial that local governments and urban communities ensure that such plans are disability inclusive. Although an increasing number of cities has been taking this approach, not all municipalities and local governments have disability-inclusive plans and, when they have them, the extent of their development or implementation varies (Figure 194). Among 21 cities across 10 countries in Africa, Asia and Latin America, 24 per cent have not yet designed disability-inclusive multi-hazard risk scenarios and assessments nor developed measures to mitigate the impact of disasters on persons with disabilities; 38 per cent have no accessible formats for information on risk and resilience and have no training on disability-inclusive disaster risk reduction accessible to persons with disabilities and to all sectors of the city, such as local government, private businesses, non-governmental organizations and communities; 43 per cent do not actively involve representative organizations of persons with disabilities in planning for a potential disaster event in any area of the city and for responding to such events and have no disaster risk reduction training programmes designed by and for representative organizations of persons with disabilities; 52 per cent do not have or are not developing contingency plans in meaningful consultation with representative organizations of persons with disabilities to protect persons with disabilities from violent situations and for meeting their needs in post-disaster living and meeting spaces; and 62 per cent do not have financial mechanisms for disability-inclusive resilience measures.

The barriers that persons with disabilities face during and in the aftermath of disasters are also being addressed through international cooperation. Several donors made commitments to support the protection and safety of persons with disabilities in humanitarian contexts and emergencies: in 2021, 1.4 billion US dollars in bilateral aid was committed to provide assistance inclusive of persons with disabilities in humanitarian contexts and emergencies (about 9 per cent of all bilateral aid provided to disability-inclusive projects).[507] Nonetheless, improvements are needed to mainstream disability across the humanitarian response by coordinating the work in various sectors and among various stakeholders. Too often different stakeholders and sectors work in silos.

Figure 194. Percentage of cities that have implemented measures for advancing disability inclusion in local disaster risk reduction, in 21 cities across 10 countries, in 2023.



Source: UNDRR (2024).[508]

Summary of findings and the way forward

Similar to findings presented in the *Disability and Development Report* 2018, persons with disabilities continue to be disproportionally negatively impacted during and in the aftermath of man-made disasters and disasters caused by natural hazards, including extreme climate-related events. Available evidence indicates that persons with disabilities have suffered mortality rates twice as high as persons without disabilities during past disasters and constituted half of all COVID-19 deaths.

A key reason for this disproportionate impact is because the needs and perspectives of persons with disabilities are ignored or neglected by official planning processes: 84 per cent of persons with disabilities have no preparedness plan for disasters; 39 per cent would have a lot of difficulty or not be able to evacuate in the event of a sudden disaster; 28 per cent need but have no one to assist them to evacuate;

11 per cent indicate that information on disaster management or risk reduction is not accessible to them; more than 80 per cent are not aware of national and local disaster risk reduction plans; and 86 per cent are not involved in decision-making processes on community disaster management and risk reduction. Persons with disabilities are additionally vulnerable during extreme climate-related events because they face barriers to securing housing in lands and buildings that are resistant to floods, heatwaves and other extreme weather events.

When a disaster or humanitarian crisis occurs, persons with disabilities are often left behind during the evacuation, or are abandoned in institutions, which is not in line with the CRPD. Moreover, persons with disabilities in situations of conflict and forced displacement face barriers to accessing services, with more than 30 per cent lacking the economic resources to pay for essential services, lacking accessible transport to the services or lacking physical access to the services. Because their perspectives are not included in disaster planning, the disaster responses are typically not inclusive for persons with disabilities. For instance, the majority of the COVID-19 response was not inclusive, with COVID-19 tests, testing, vaccination sites and information not accessible to persons with disabilities.

Trends since 2013 indicate that many aspects of disaster preparedness deteriorated: compared to 2013, in 2023, the percentage of persons with disabilities with no preparedness plan for disasters increased 12 percentage points; the percentage of persons with disabilities who need but have no one to assist them to evacuate increased 15 percentage points; and the percentage of persons with disabilities who are not aware of national and local disaster risk reduction plans increased 3 percentage points. These trends need to be inverted in order to meet the disaster-related targets of Goals 1, 11 and 13.

Other aspects showed little progress or were stagnant: the percentage of persons with disabilities who are not involved in decision-making processes on community disaster management and risk reduction stayed the same in 2013 and 2023; and the percentage of persons with disabilities who would have a lot of difficulty or not be able to evacuate in the event of a sudden disaster only decreased by 2 percentage points. At this rate of progress, by 2030, 38 per cent of persons with disabilities are expected not to be able to evacuate. Progress will need to accelerate to a rate 12 times faster to ensure that all persons with disabilities can evacuate in the event of a sudden disaster by 2030.

Measures and actions have been taken in various countries to protect and include persons with disabilities in disaster preparedness, response and in humanitarian actions. In 2023, a majority of countries released key documents and information in at least one accessible format for persons with disabilities: 78 per cent of countries for laws or policies on climate change adaptation; 96 per cent of countries for laws or policies on disaster risk reduction; 75 per cent of countries for laws on safe evacuation from public buildings; 86 per cent of countries for laws on safe evacuation from private premises; 96 per cent of countries for information on prevention, preparation and recovery from disasters; and 100 per cent of countries for early warnings. Despite these efforts, the limited number of accessible formats available still leave many persons with disabilities behind. Most information is still only released in

accessible doc/pdf, with Braille, easy-to-understand and ePub less commonly used. More than 60 per cent of countries have been consulting with persons with disabilities and their representative organizations in developing disability-inclusive laws, policies and measures related to climate change, disasters and evacuation procedures.

New conflicts have been emerging and the frequency of climate-related disasters has been increasing. Persons with disabilities around the world bear more of the burdens of these shocks. War, permanent flooding and rising sea levels may force people to migrate, but persons with disabilities may face more barriers to such migration due to socio-economic reasons or lack of accessible transport.

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 with disabilities, fully and effectively 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 and their representative organizations in all planning and programming phases. When governments consider disaster or humanitarian policies or legislation, or when a community is developing an evacuation plan, an early warning system, or making decisions to combat climate change, it is crucial to include persons with disabilities.

2. Develop laws, policies, operational standards, checklists and indicators for the inclusion of persons with disabilities in emergency preparedness, planning and response and in climate change adaptation. Ensure that the standard operating procedures and operational manuals of agencies involved in humanitarian action and disaster response have clear guidance on the inclusion of persons with disabilities in emergency preparedness, planning and response. Prepare the standards, checklists and indicators before crises occur and involve persons with disabilities and their representative organizations in developing these instruments.

3. Ensure that emergency information, commodities, infrastructure and services are inclusive and accessible for all persons with disabilities. Apply the principles of Universal Design in all aspects of disaster risk reduction and humanitarian response. Make all emergency preparedness or disaster information available in accessible formats and languages for persons with disabilities. Ensure that shelters are safe and accessible spaces for persons with disabilities.

4. Mobilize adequate, timely and predictable resources to operationalize commitments for disability-inclusive emergency preparedness and response. Promote close cooperation of States with the private sector and civil society organizations. Ensure that refugees with disabilities and internally displaced persons with disabilities have access to crucial and essential services.

5. Raise awareness among persons with disabilities on disaster management plans at the local and national levels. Strengthen the 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 key contributors in 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 capacity-building for humanitarian actors in addressing the needs of persons with disabilities. 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 emergency planning often do not recognize the importance of inclusion and how persons with disabilities are at a disadvantage in accessing services if their needs are not considered. It is necessary to provide training on disability for all aid stakeholders at both policy and practice levels. Aid workers should understand the perspectives, needs and strengths of persons with disabilities, which will prove useful in working for and with persons with disabilities in crisis 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. Ensure that all post-crisis recovery efforts, including reconstruction and rebuilding, are inclusive of persons with disabilities. Disasters and conflicts devastate infrastructure and community systems. Apply the principles of Universal Design in all reconstruction and rebuilding programmes. Emphasis should be placed on accessibility features during the planning and reconstruction of infrastructure as well as public facilities as well as adopting accessible technologies and communication systems. Include persons with disabilities in peacebuilding and reconciliation processes. These measures will enable receiver plans to be inclusive and accessible to persons with disabilities, thus leaving no one behind.

8. 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, during and in the aftermath of disasters, conflicts and other emergencies. 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. Ensure accountability mechanisms at national levels for acts or omissions leading to discrimination or exclusion of persons with disabilities in the context of humanitarian actions and disaster response. Establish reporting and justice mechanisms to address discrimination and exclusion on the basis of disability. Ensure that these mechanisms are accessible to persons with disabilities,

including by incorporating accessible features and providing reasonable accommodation throughout these mechanisms. Ensure that these mechanisms continue to be operational during and in the aftermath of humanitarian emergencies and disasters.

10. Undertake evidence-based research and develop a data collection system on persons with disabilities relevant to conflicts and disasters. Use reliable data in all phases – before, during and after crises. 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 the different needs of persons with disabilities in certain communities when a disaster risk reduction plan is developed. Once an emergency situation develops, data that describe the situation of persons with disabilities in disasters and conflict situations are needed. Rapid assessments after crises should include a disability perspective and should develop a systematic way to evaluate magnitude and types of needs among persons with disabilities after conflicts or disasters – to assess just the number of injuries and deaths among persons with disabilities is not sufficient. Explore the use of new technologies, such as mobile phones and social media, to gather rapidly the data needed for an efficient response to persons with disabilities. Share the knowledge and experience of persons with disabilities during real disasters and conflicts.

11. Maintain a register that maps the needs of persons with disabilities during and in the aftermath of disasters. Some persons with disabilities might require support and specialized services in emergency and humanitarian situations. Persons with disabilities may not receive help promptly because the country's authorities did not adequately identify those with different needs before disaster struck. Maintain a register of persons with disabilities that maps the needs of specialized services and commodities and prepare this register together with persons with disabilities and their representative organizations before crises arise. This will help local authorities to immediately respond to persons with disabilities in need.

12. Invest in research and data to fully understand how persons with disabilities are impacted by climate change and the interventions which will be most effective in reducing this impact. Persons with disabilities are under-researched in the fields of science, medicine, law and policy. Disability-inclusive climate adaptation, disaster preparedness and response require data, research, innovation and collaboration across all these fields and in consultation with representative organizations of persons with disabilities.

Reducing all forms of violence and ending abuse, exploitation, trafficking and all forms of violence against children (targets 16.1 and 16.2)

This section will focus on the first two targets of Goal 16: target 16.1, which calls for reducing all forms of violence and related death rates everywhere, and target 16.2, which 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 article 16 of the Convention on the Rights of Persons with Disabilities (CRPD), 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. United Nations Security Council Resolution 2475 called upon Member States to protect persons with disabilities in situations of armed conflict, including to prevent violence and abuse.

Broad protections from violence against women and children, including against women and children with disabilities, have been established in various frameworks. The Convention on the Rights of the Child, adopted in 1989, has called for 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. The Beijing Declaration and Platform for Action (1995) has highlighted the importance of the elimination of all forms of violence against women and girls. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (the Trafficking in Persons Protocol), adopted in 2000, called for prevention and protection of women and children from trafficking. The Rome Statute of the International Criminal Court, adopted in 1998, in article 7, paragraph 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.

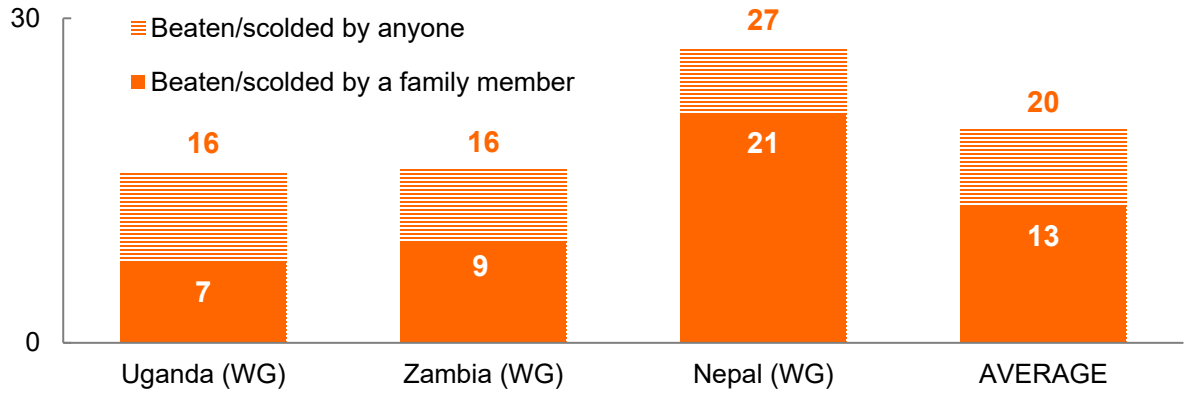
Persons with disabilities of all ages are at an increased risk of violence due to stigma and discrimination, exclusion from education and employment, communication barriers and a lack of social support. This section will present recent data and trends on the prevalence of violence among persons with disabilities and children with disabilities, as well initiatives and actions taken worldwide to prevent this violence. On the basis of this evidence, it will conclude with recommendations for action to end violence, abuse, exploitation and trafficking against persons with disabilities.

Current situation and progress so far

Persons with disabilities of all ages and genders suffer higher rates of abuse, exploitation, trafficking and

violence. Data from three developing countries (Figure 195) indicates that, on average, 20 per cent of persons with disabilities are beaten and scolded because of their disabilities, often by a family member (13 per cent), from 16 per cent of persons with disabilities in Uganda and Zambia to 27 per cent in Nepal suffering this type of violence. In Nepal, more than three quarters of persons with disabilities who have been beaten or scolded indicated that the perpetrator was a family member; in Uganda and Zambia, about half of them indicated this.

Figure 195. Percentage of persons with disabilities who have ever been beaten or scolded because of their disability, in 3 countries, in 2018 or latest year available.

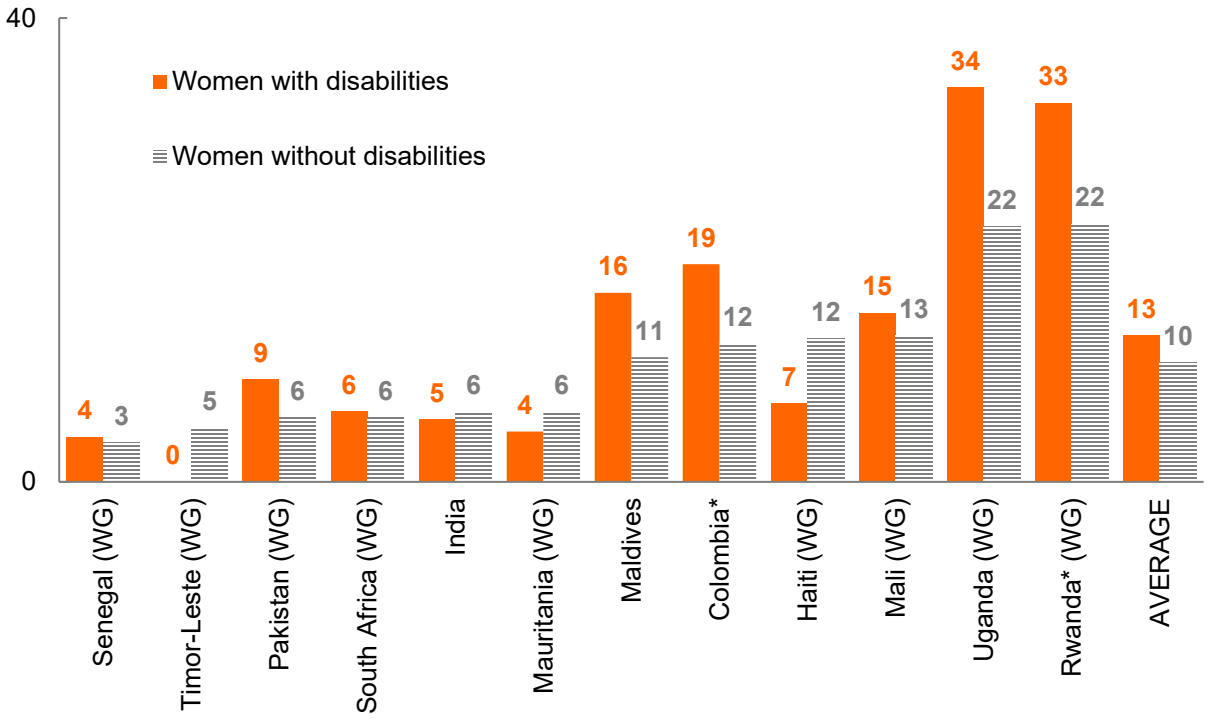


Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]).

Data from 12 developing countries (Figure 196) indicate that, on average, 13 per cent of women with disabilities compared to 10 per cent of women without disabilities have experienced sexual violence at least once in their lifetime. In Rwanda and Uganda, more than 30 per cent of women with disabilities have suffered sexual violence, and in Colombia and the Maldives more than 15 per cent.

In Uganda, men with disabilities were almost three times more likely to have ever been victims of sexual violence than men without disabilities: 21 per cent of men with disabilities versus 8 per cent of men without disabilities (Figure 197). In Rwanda, 8 per cent of adult men with disabilities suffered sexual violence compared to 5 per cent of men without disabilities. By contrast, the percentage of women with disabilities aged 15 to 49 who experienced sexual violence in these two countries is much higher, at 33-34 per cent, indicating that sexual violence is much more common against women with disabilities than against men with disabilities. Sexual violence can occur at home, in institutions, schools, health centres and other public and private facilities. Perpetrators are frequently relatives, caregivers and professionals on whom the girl or woman with disabilities may depend, such as medical staff (see the chapter on targets 3.1, 3.7 and 5.6).

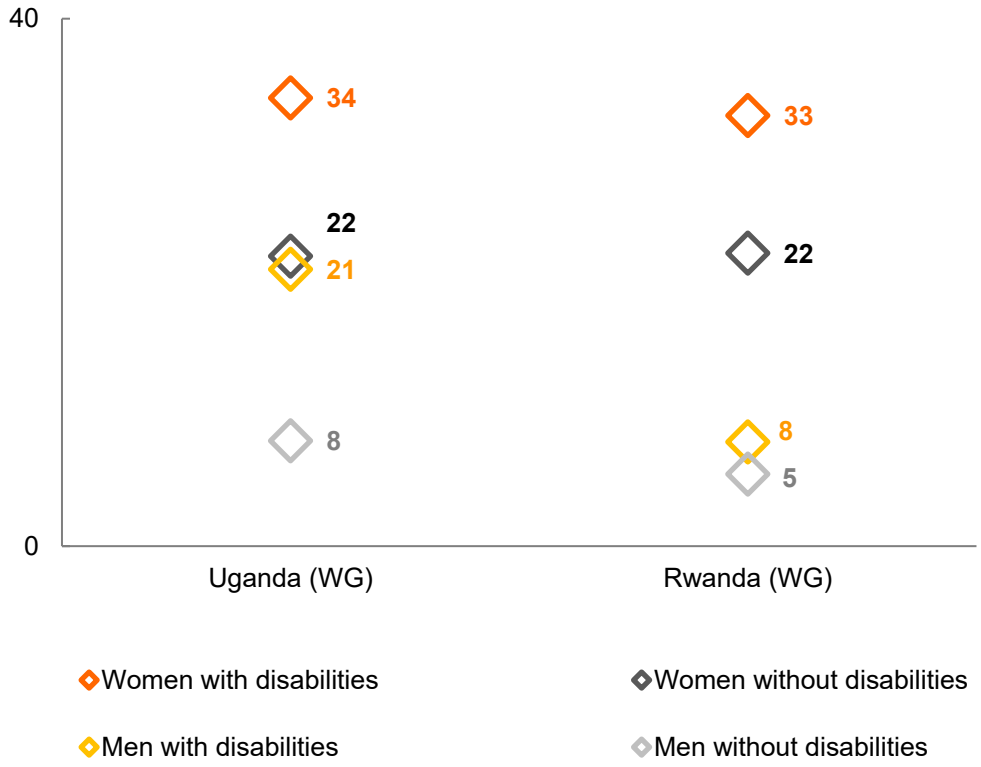
Figure 196. Percentage of women aged 15 to 49 who have suffered sexual violence, at least once in their lifetime, by disability status, in 12 countries, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the level of 5 per cent. Data for women with disabilities from Mali, Senegal and Timor-Leste are based on 25 to 49 observations and should be interpreted with caution.
Source: UNDESA (on the basis of data from DHS[6]).

Girls and women with disabilities are disproportionately affected by other forms of violence, including forced sterilizations and invasive and irreversible involuntary medical treatments, forced abortion, forced pregnancy, forced menstrual suppression, forced pregnancy prevention, criminalization of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, as well as female genital mutilation (see the chapter on targets 3.1, 3.7 and 5.6).

Figure 197. Percentage of persons aged 15 to 49 who have suffered sexual violence, at least once in their lifetime, by disability status and sex, in Rwanda and Uganda, in 2020 or latest year available.



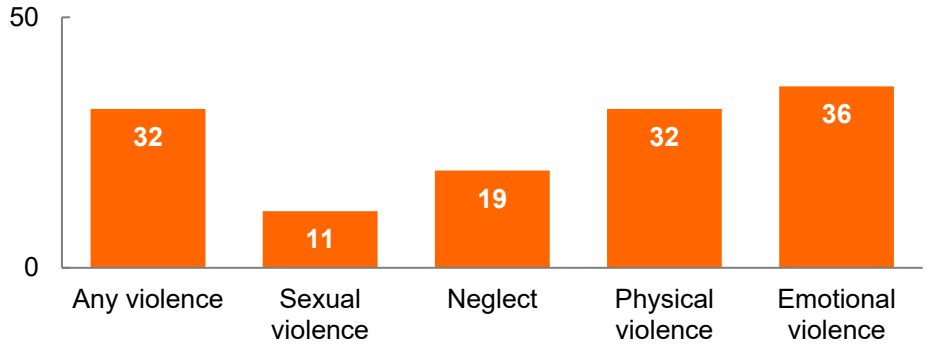
Note: (WG) identifies data collected using the Washington Group Short Set of Questions.
Source: UNDESA (on the basis of data from DHS[6]).

Violence against children with disabilities can take various forms, including physical, sexual and emotional violence and neglect. It can be perpetrated by caregivers, authority figures (for example, teachers or other service providers), other adults, other children or by intimate partners during adolescence. Among 26 countries or areas worldwide, 32 per cent of children with disabilities aged 0 to 18 experienced violence, and children with disabilities are more than twice as likely to experience violence than children without disabilities.[509] Emotional and physical violence are the most common forms of violence against children with disabilities, with 36 per cent of children with disabilities suffering emotional violence and 32 per cent of children with disabilities suffering physical violence (Figure 198). Moreover, 19 per cent of children with disabilities suffer neglect and 11 per cent of children with disabilities suffer sexual violence.

The most common perpetrator Is a peer through in-person bullying, with 37 per cent of children with disabilities experiencing this violence – children with disabilities are two times more likely to experience this type of violence than children without disabilities (Figure 199). Other perpetrators include adults

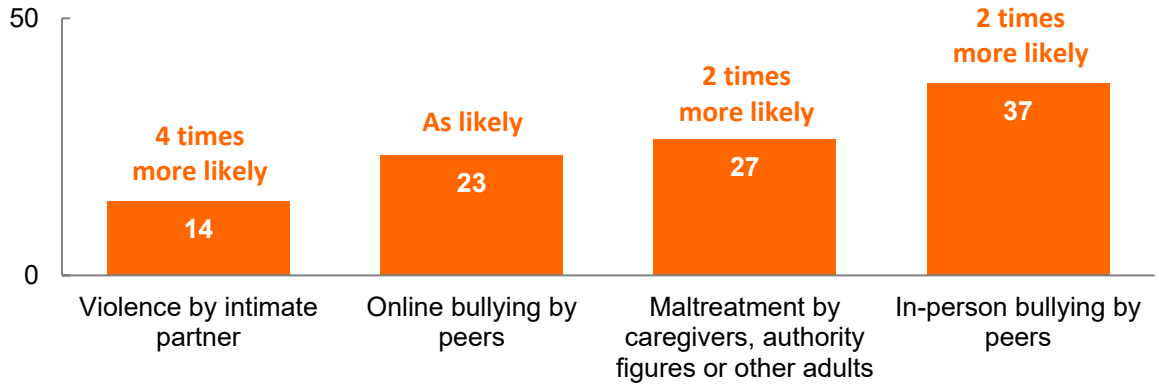
committing maltreatment, which affects 27 per cent of children with disabilities – children with disabilities are two times more likely to experience this type of violence than children without disabilities. Violence by their intimate partners during adolescence affects 14 per cent of children with disabilities and children with disabilities are four times more likely to experience this type of violence than children without disabilities. Online bullying by peers affects 23 per cent of children with disabilities and children with disabilities are as likely to experience this type of violence as children without disabilities.

Figure 198. Percentage of children with disabilities aged 0 to 18 who suffered violence, by type of violence, in 2020 or latest year available.



Source: Fang et al. (2022). [509]

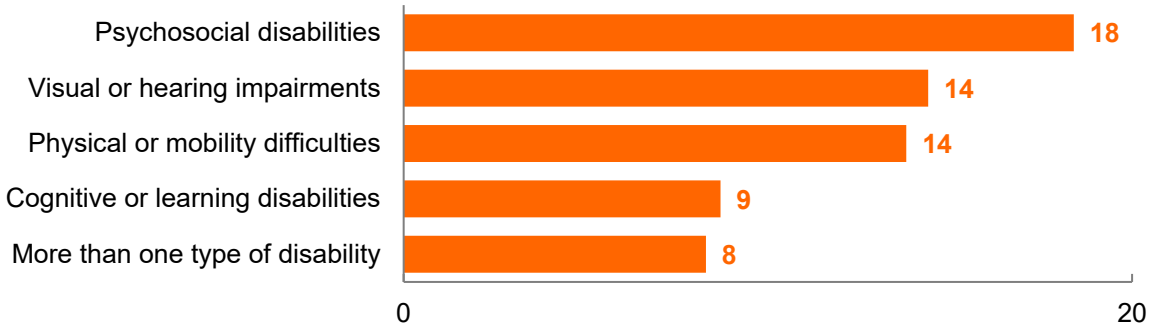
Figure 199. Percentage of children with disabilities aged 0 to 18 who suffered violence, by type of perpetrator, and comparison with children without disabilities, in 2020 or latest year available.



Source: Fang et al. (2022). [509]

Children with psychosocial disabilities (18 per cent) and children with visual, hearing, physical and mobility impairments (14 per cent) have a higher prevalence of sexual violence than children with cognitive or learning disabilities (9 per cent) or children with more than one type of disability (8 per cent) – see Figure 200.

Figure 200. Percentage of children with disabilities aged 0 to 18 who suffered sexual violence, by type of disability, in 2020 or latest year available.



Source: Fang et al. (2022). [509]

Figure 201. Percentage of children with disabilities aged 0 to 18 who suffered in-person or online peer bullying, by type of disability, in 2020 or latest year available.

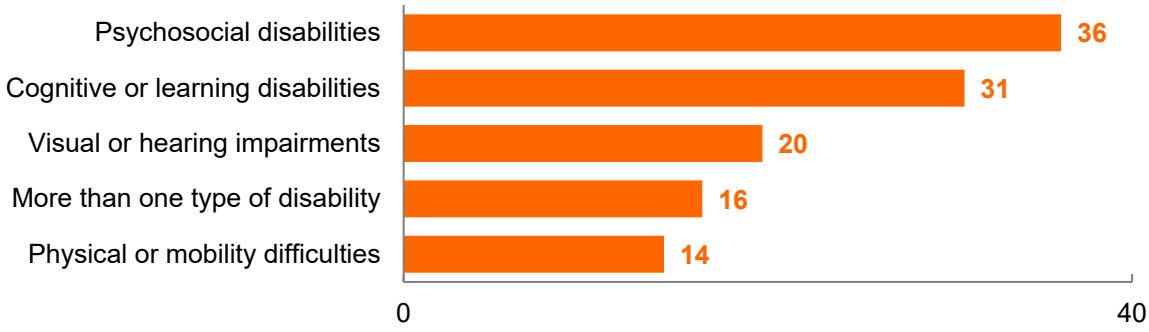


Source: Fang et al. (2022). [509]

Children with more than one type of disability (47 per cent) and children with visual or hearing impairments (43 per cent) have a higher prevalence of peer bullying than children with psychosocial, cognitive or learning disabilities (37 per cent) or children with physical or mobility difficulties (34 per cent) – see Figure 201.

Children with psychosocial disabilities (36 per cent) and children with cognitive or learning disabilities (31 per cent) have a higher prevalence of maltreatment by adults than children with visual or hearing impairments (20 per cent), children with multiple disabilities (16 per cent) or children with physical or mobility difficulties (14 per cent) – see Figure 202.

Figure 202. Percentage of children with disabilities aged 0 to 18 who suffered maltreatment by adults, by type of disability, in 2020 or latest year available.

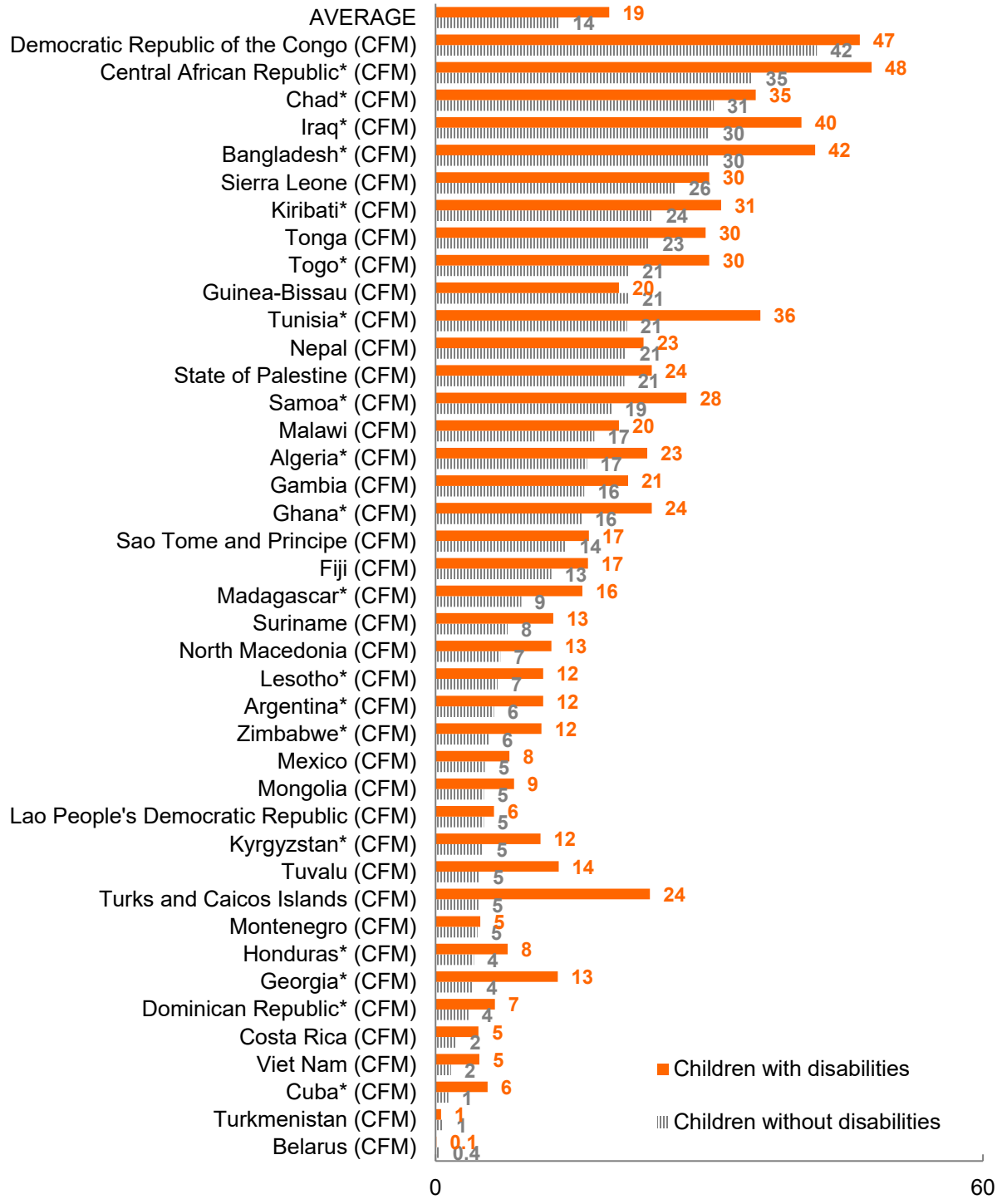


Source: Fang et al. (2022).[509]

Indicator 16.2.1 monitors the proportion of children who experience any physical punishment or psychological aggression by caregivers in the past month. Children with disabilities are more likely than children without disabilities to experience severe physical punishment by caregivers. Data from 41 countries or areas shows that severe physical punishment is more likely to be meted out by caregivers on children with disabilities in 38 of these countries (Figure 203). On average, 19 per cent of children with disabilities compared to 14 per cent of children without disabilities experience severe punishment by their caregivers. In some countries, the prevalence of severe punishment among children with disabilities is much higher and the disparities vis-à-vis children without disabilities are much wider. In Bangladesh, Central African Republic, Demographic Republic of the Congo and Iraq, more than 40 per cent of children with disabilities suffer severe punishment from their caregivers. In Cuba, Georgia and Turks and Caicos, children with disabilities are more than three times as likely to be victims of severe punishment by their caregivers than children without disabilities.

Persons with disabilities are particularly vulnerable to human trafficking. Perpetrators use force, fraud, abduction, deception, abuse of a position of vulnerability and coercion to hold victims with disabilities in exploitation. Perpetrators include family members, friends and strangers. Children and adults with disabilities are also at risk for human trafficking in residential institutions and orphanages that allow traffickers, which may include staff, to operate in or around the premises with impunity.

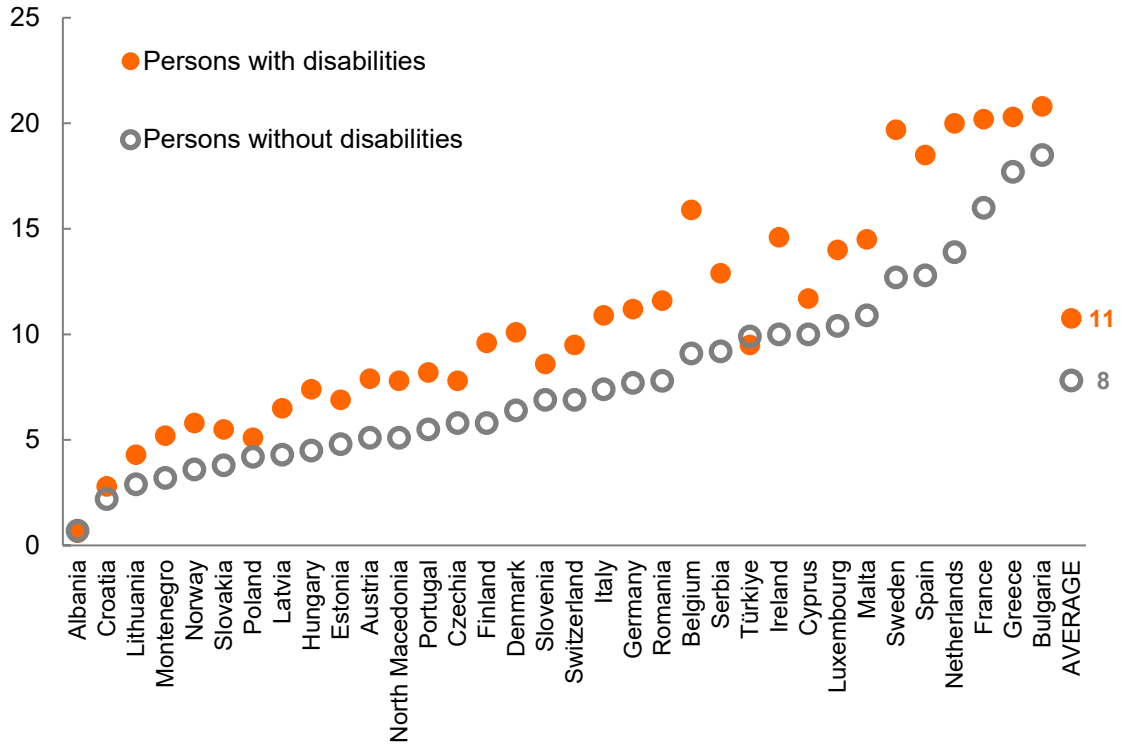
Figure 203. Percentage of children aged 2 to 14 years who experienced severe physical punishment by caregivers in the past month, by disability status, in 41 countries or areas, in 2021 or latest year available (indicator 16.2.1).



Note: An asterisk (*) indicates that the difference is statistically significant at the level of 5 per cent or less.
Source: UNICEF (on the basis of data from MICS[6]).

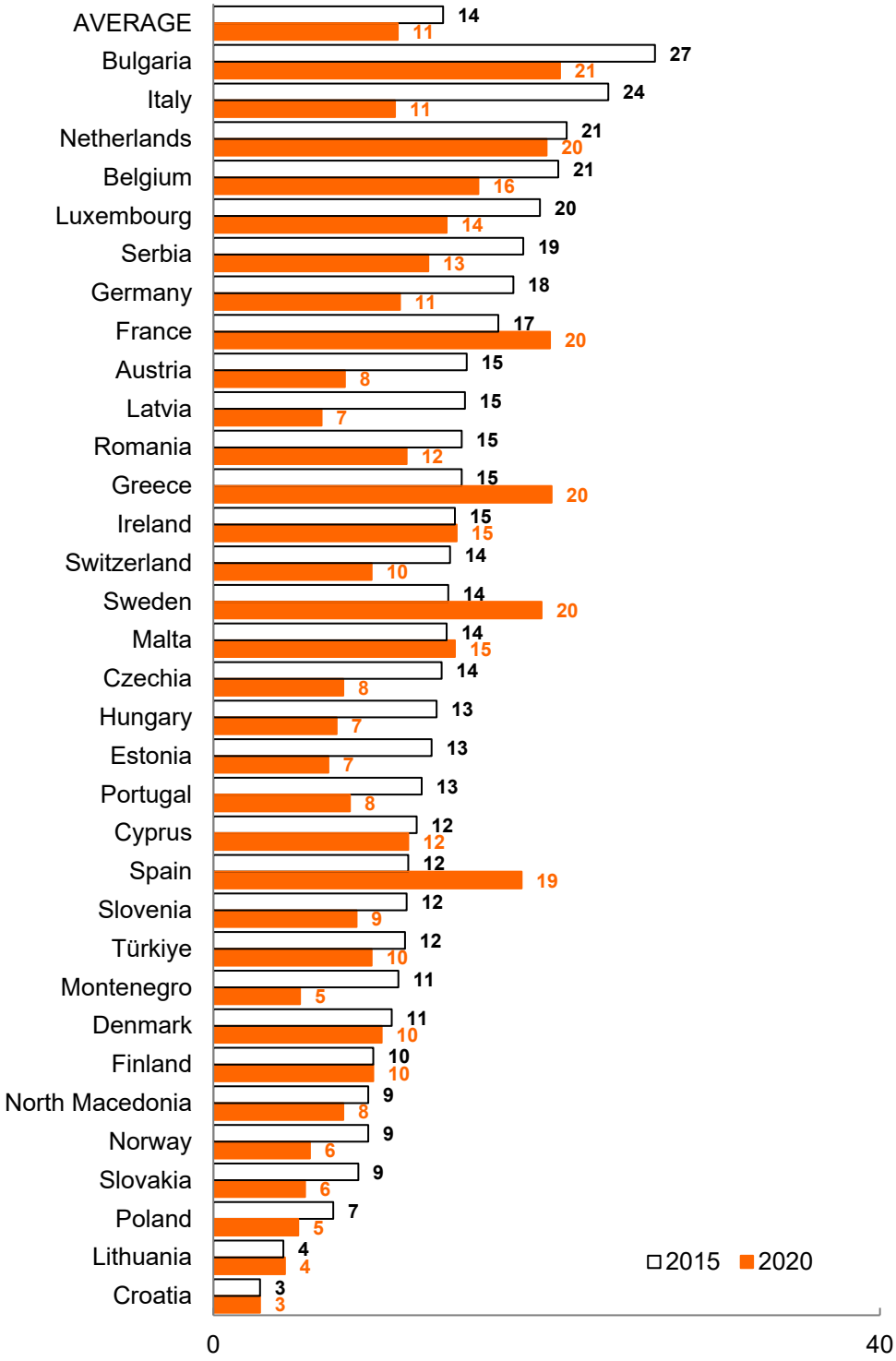
Victims with disabilities have been trafficked for sexual exploitation, forced labour, forced begging, forced participation in armed conflict, organ removal and the theft of their disability benefits.[510,511,512] Recent research points to the existence of intra-national and cross-national networks of trafficking for forced begging and sexual exploitation of deaf persons in western Africa, particularly of deaf women and girls.[513] Human trafficking of persons with disabilities has also been reported in Austria, Bulgaria, Burundi, China, Hungary, Iran, Iraq, Japan, Kenya, Madagascar, Mexico, Nicaragua, Pakistan, Republic of Korea, South Africa, United Republic of Tanzania and Viet Nam.[514] In the United States, 12 per cent of girls with severe physical disabilities and 10 per cent of girls with cognitive disabilities have experienced trafficking for sexual exploitation; girls with severe physical disabilities are six times more likely to experience this type of trafficking than girls without disabilities and girls with cognitive disabilities are five times more likely to experience this trafficking than girls without disabilities.[515]

Figure 204. Percentage of persons who report that crime, violence and vandalism are common in their accommodation or area of residence, by disability status, in 34 countries, in 2020.



Note: Data from Poland refer to 2019.
Source: Eurostat.[7]

Figure 205. Trend in the percentage of persons with disabilities who report that crime, violence and vandalism are common in their accommodation or area of residence, in 33 countries, from 2015 to 2020.

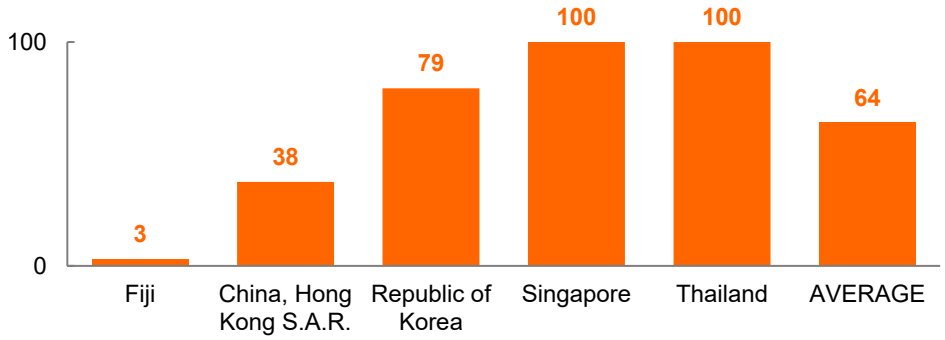


Note: Data from Poland refer to 2019.
Source: Eurostat.[7]

Indicator 16.1.4 monitors the proportion of the population that feel safe walking alone in the area where they live after dark. Persons with disabilities face barriers to securing housing (see the chapter on Goal 11) and may end up in less safe neighbourhoods as a result. In 34 countries, mostly in Europe, a higher percentage of persons with disabilities than persons without disabilities report that crime, violence and vandalism are common in their accommodation or area of residence (Figure 204). On average, 11 per cent of persons with disabilities versus 8 per cent of persons without disabilities report this. In two countries, Belgium and Sweden, the gap between the percentage of persons with and without disabilities experiencing this violent environment is 7 percentage points, the widest gap observed among these 34 countries. Since 2015, there has been progress: violence and vandalism in accommodation or area of residence has decreased from 14 per cent in 2015 to 11 per cent in 2021 (Figure 205). However, this progress was uneven across Europe, and in four countries – France, Greece, Spain and Sweden – the percentage of persons with disabilities experiencing living in such violent environments increased in 2020 to levels about 3 to 7 percentage points higher than in 2015.

Available evidence also suggests that persons with disabilities are at higher risk of suffering property crimes, such as burglaries, online banking frauds and payment card frauds. In the European Union, 15 per cent of persons with severe disabilities experienced burglary in 2019 or in the five preceding years, compared with 7 per cent of persons without severe disabilities; 14 per cent of persons with disabilities experienced online banking or payment card fraud, compared with 6 per cent of persons without disabilities.[516] Persons with disabilities also experienced consumer fraud[517] at a higher rate (36 per cent) than persons without disabilities (23 per cent).[516]

Figure 206. Percentage of emergency shelters that are accessible for persons with disabilities, in 5 countries or areas in Asia and the Pacific, in 2021 or latest year available.



Note: S.A.R. refers to Special Administrative Region.
Source: ESCAP.[14]

Countries have taken a number of initiatives to reduce abuse and violence against persons with disabilities and support victims with disabilities, such as enhancing access to justice by persons with

disabilities (see the section on SDG target 16.3) and putting in place mandatory mechanisms of reporting violence against persons with disabilities. For example, in Brazil, health services and authorities are obliged to report all cases of violence against persons with disabilities that reach them in the public health surveillance system.[518] Countries have also invested in services that can assist victims with disabilities, including the provision of accessible emergency numbers, accessible shelters and services to support victims with disabilities. In 2023, 58 per cent of countries had an emergency number accessible to persons with disabilities.[519] For example, Lithuania launched an emergency call mobile application enabling persons with hearing disabilities to connect with real-time video with on-call sign language interpreters and text communication. In 2023, 59 per cent of countries made shelters accessible and 82 per cent of these countries consulted with persons with disabilities in developing these accessible shelters.[519] However, the percentage of shelters that are accessible can vary widely from country to country. In five countries or areas in Asia and the Pacific, this percentage varies from 3 per cent to 100 per cent (Figure 206).

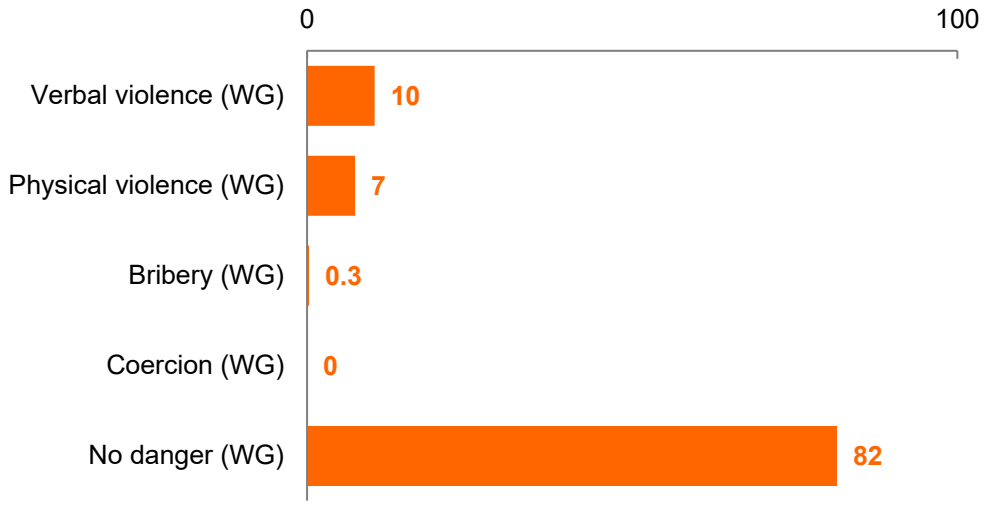
In 2023, among 27 countries, 74 per cent provided mental health and psychosocial support to persons with disabilities in situations of risk, including to victims of violence. Most of these countries (84 per cent) developed these services in consultation with persons with disabilities.[519] In Asia and the Pacific, at least 22 countries have programmes aimed at eliminating violence against women and girls with disabilities; 82 per cent of these countries also have programmes providing support for women and girls with disabilities who are survivors of violence and abuse.[14]

Persons with disabilities are still often left out of decision-making processes on measures to build and ensure sustainable peace, although very often they face the worst impact of armed conflict, including death. Although quantitative data on the number of conflict-related deaths of persons with disabilities (indicator 16.1.2) are not available, numerous reports exist of persons with disabilities being left behind during armed conflict, at times abandoned in institutions or facing death when barriers prevent them from evacuating. There are also reports of persons with disabilities being coerced by terrorist groups to participate in suicide attacks. Even when persons with disabilities manage to escape, they continue to be at a higher risk for violence. For example, in the protection of civilians site in Malakal (South Sudan), which harbours internally displaced persons, many persons with disabilities encounter violence and other dangers when accessing services: 10 per cent encounter verbal violence, 7 per cent encounter physical violence and 0.3 per cent encounter bribery (Figure 207). The episodes of physical and verbal violence include harassment from their neighbours as well as incidents of children pelting persons with disabilities with stones and insulting their disabilities.

Yet, despite the disproportionate negative impacts of armed conflict on persons with disabilities, the perspectives and needs of persons with disabilities are often disregarded during conflict and not adequately considered in military operations[520] nor in the post-conflict phase. For example, the rights of persons with disabilities were only mentioned in 118 out of 1,789 peace agreements from 1990 to 2019.[521]

During the past five years, there has been a substantial increase in the volume of available data on violence against persons with disabilities and children with disabilities, particularly through national surveys and dedicated research studies. Compared to the data available for the United Nations *Disability and Development Report* 2018, internationally comparable data are now available for a larger number of countries and for a wider range of forms of violence. Yet, for many forms of violence, data remain available only for a small number of countries and there are no data available to allow for the assessment of trends over time. Moreover, there is limited research and data available on the trafficking of adults and children with disabilities, including a lack of data on the role of organized crime in the trafficking of persons with disabilities, though existing research indicates this is an urgent concern and a widespread global issue.

Figure 207. Percentage of internally displaced persons with disabilities fleeing an armed conflict who encountered violence, bribery and coercion when accessing services, in the Malakal protection of civilians site (South Sudan), in 2020.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: International Organization for Migration's Displacement Tracking Matrix (2021).[522]

Existing data sources are likely to underestimate the prevalence of violence among persons with disabilities and among children with disabilities. First, many victims may be unwilling to report violence for fear of stigma or retaliation. Second, surveys and research studies tend to only include children and adults with disabilities who are alive, thus excluding counts of severe violence that may have led to death. Administrative sources such as public health surveillance systems and police and court records have been used to estimate the prevalence of violence among persons with disabilities (for example, in Brazil[523] and the United States[524]) – these approaches tend to produce lower estimates because they only capture instances of violence that reached health services, courts, the police or other national authorities,

but they may be able to capture cases of extreme violence not captured by official or academic surveys.

Impact of the COVID-19 pandemic

The COVID-19 pandemic exacerbated the already increased risk for violence and abuse against persons with disabilities. Persons with disabilities worldwide, including women and girls with disabilities, faced increased risk factors for violence and increased barriers to access help, support, police and justice. As persons with disabilities were confined at home and lost their usual systems of support, they were at higher risk of physical, sexual, emotional and psychological violence. Victims of violence may have been less likely to report the violence when they were locked down at home with their abusers. They may have relied on the perpetrator for care and assistance and feared retaliation and other negative consequences if the abuse was reported or if they sought help.

During the pandemic, police resources were often focused on enforcing COVID-19 restrictions and may have been re-allocated away from investigating violence, including gender-based violence. Justice mechanisms also moved more slowly in some contexts, leading to potential impunity for perpetrators. Many persons with disabilities lost financial resources and earnings during the pandemic, which made them more vulnerable and impacted their ability to fully exercise their right to be free from violence.

In the middle of the pandemic, violence in the home was reported at a higher rate in households with parents and caregivers or children with disabilities. Across the world, a higher proportion of parents and caregivers with disabilities (26 per cent) reported violence in the home than parents and caregivers without disabilities (19 per cent); female parents and caregivers with disabilities (31 per cent) were most likely to report violence in the home, compared to male parents and caregivers with disabilities (19 per cent); female parents and caregivers without disabilities (19 per cent) and male parents and caregivers without disabilities (17 per cent); and 43 per cent of children with disabilities reported violence at home, compared to 15 per cent of children without disabilities.[16]

When looking for relief from violence in their homes, persons with disabilities more frequently reported barriers to accessing domestic violence services as these services became harder to access due to lockdown measures. More than one in ten parents and caregivers with disabilities (12 per cent) reported needing, but not being able to access, domestic violence services, compared to 4 per cent of parents and caregivers without disabilities.[16] Female parents and caregivers with disabilities were more likely to report an unmet need to access domestic violence services (14 per cent), compared to male caregivers with disabilities (11 per cent).[16]

Moreover, during the pandemic, 40 per cent of persons with disabilities felt more vulnerable and more at risk of crime, compared to pre-pandemic times.[525] They perceived that higher unemployment had generated more crime in their areas of residence.

Summary of findings and the way forward

Persons with disabilities, particularly children, women and persons with psychosocial disabilities, are more likely than persons without disabilities to suffer violence, abuse, exploitation and human trafficking. Existing evidence indicates this is a severe global issue, affecting all regions in the world. Perpetrators of violence against persons with disabilities include family members, caregivers, guardians, friends, teachers, staff from health and other services as well as strangers.

In some countries, more than one in six persons with disabilities are beaten or scolded because of their disabilities; more than one in three women with disabilities suffer sexual violence; more than one in 12 men with disabilities suffer sexual violence; and more than one in two children suffer severe punishment from their caregivers. Global estimates point to one in every three children with disabilities suffering neglect, sexual, physical or emotional violence – they are twice as likely to encounter such violence than their peers without disabilities. The most common form of violence encountered by children with disabilities is in-person bullying by peers (37 per cent of children with disabilities are victims of this form of violence). Children with psychosocial disabilities suffer the highest prevalence of sexual violence (18 per cent of these children) and maltreatment by adults (36 per cent of these children). Children with multiple disabilities suffer the highest prevalence of in-person and online bullying (47 per cent of these children).

Barriers to the achievement of other Goals and targets – including in ending poverty and eliminating discrimination, and promoting education, employment and housing – cause barriers for persons with disabilities to exercise their right to be free from violence and to achieve targets 16.1 and 16.2. Barriers to housing, in particular, push persons with disabilities into unsafe accommodation and neighbourhoods where crime, violence and vandalism are common. In Europe, 11 per cent of persons with disabilities compared to 8 per cent of persons without disabilities live in such accommodation or neighbourhoods.

Limited data show the existence but impede an assessment of the extent of human trafficking of children and adults with disabilities. Recent reports and research indicate this is an urgent concern affecting countries in all regions of the world. The evidence points to existing intra-national and cross-national trafficking of children and adults with disabilities for forced begging, sexual exploitation, forced labour, organ removal, forced participation in armed conflict and theft of their disability benefits.

On all but one form of violence analysed in this chapter, persons with disabilities are more likely – for some forms of violence two to six times more likely – to suffer that violence than others: this includes emotional, physical and sexual violence, peer bullying, human trafficking, neglect and severe physical punishment by caregivers. The one exception is online bullying, for which children with disabilities are as likely to be targeted as children without disabilities.

Measures taken by countries to protect persons with disabilities from violence tend to focus on facilitating the reporting and legal prosecution of violence against persons with disabilities and on creating accessible services supporting victims of violence. In 2023, 58 per cent of countries had emergency

numbers accessible to persons with disabilities; 59 per cent had shelters accessible to persons with disabilities; and 74 per cent provided mental health and psychological support services to victims with disabilities.

The following recommendations offer guidance on how to end abuse, exploitation, trafficking and all forms of violence against persons with disabilities:

1. Raise awareness and provide training, on combating violence against persons with disabilities, among families and parent groups, the justice system, teachers and educational staff, service providers, policymakers and legislators. Public awareness and advocacy campaigns need to be targeted at changing mindsets and social norms directed at persons with disabilities, especially children with disabilities, and at promoting the elimination of discriminatory practices. Offer training to service providers so that they can identify cases of violence against persons with disabilities and provide adequate support to victims with disabilities. The capacity of service providers to support victims with disabilities should be strengthened to enhance the quality of services. Countries should provide training on disability and women's rights to all stakeholders involved in addressing violence, including those involved in early detection, protection and referral of victims of violence. This should include training of health officials, law enforcement, labour inspectors and judicial officials in the identification and respectful treatment of victims with disabilities. They should provide training for practitioners, including with the objective of combatting stereotypes and myths surrounding gender and disability that may affect access to justice, especially of women and girls with disabilities.

2. Offer trainings for persons with disabilities to enhance their knowledge of their rights and their skills to keep safe and to present themselves at police stations and in courts in the event of violence. All training and information should be provided in formats accessible to persons with disabilities. Persons with disabilities, including women with disabilities, and their representative organizations should be involved in the development and implementation of these trainings.

3. Establish mechanisms to report violence which are accessible for persons with disabilities and ensure that persons with disabilities have access to justice. Provide appropriate and sufficient support to report violence. Accessible formats, sign language interpreters, support services for victims with intellectual and psychosocial disabilities should be established. Make national emergency numbers accessible for all persons with disabilities. Ensure equal protection of the law and equality before the law for persons with disabilities, by ensuring non-discrimination on the basis of disability (see the chapter on target 16.3). Facilitate the participation of trafficked persons with disabilities in all legal proceedings through inclusive measures.

4. Make shelters and other services for victims of violence accessible to persons with disabilities. Shelters and victim support services should be fully accessible to persons with disabilities and provide appropriate attention and protection services, including supported decision-making when needed. Countries should also ensure full accessibility within the justice system. Countries should conduct an

evaluation of the accessibility for persons with disabilities of the current justice system, emergency numbers, shelters, other services and information aimed at victims of violence to ensure they fully meet the needs of victims with disabilities. Current barriers should be removed gradually in a systematic and continuously monitored manner, with the aim of achieving full accessibility. Persons with disabilities, including women with disabilities, and their representative organizations should be involved in the monitoring and implementation of accessibility features.

5. Address the conditions that make persons with disabilities more vulnerable to violence. Accelerate progress on ending poverty among persons with disabilities, increasing their education levels and employment, eliminating barriers to housing and to independent living and ending stigma and all discriminatory practices. Fully ensure the rights of persons with disabilities are realized, in particular their rights to equality and non-discrimination, education, work and employment, equal recognition before the law and legal capacity, liberty and security, living independently and being included in the community, and an adequate standard of living, to avoid placing them at higher risks of violence, abuse, exploitation and trafficking.

6. Design and implement targeted policies and programmes to address the high levels of violence against persons with disabilities, especially against women and girls with disabilities. The observed high prevalence of violence against persons with disabilities – much higher than among persons without disabilities – and the particular barriers that persons with disabilities face, including stigma and discrimination and their higher risk of poverty, require targeted actions specifically designed to eliminate violence against persons with disabilities. Broad general programmes directed at the overall population are unlikely to succeed in eliminating violence against persons with disabilities. Policies and programmes should take into account the specific needs of persons with disabilities and include a gender perspective. Targeted actions to eliminate violence against women and girls with disabilities may also be needed – they face higher levels of violence than men and boys with disabilities. Ending violence will also require adequate interventions to combat violence by any type of perpetrator, including family members, caregivers, relatives, friends, service providers and strangers. Persons with disabilities often depend on family members, caregivers and service providers and may not be able to report this type of violence. Actions should be developed to speedily identify such cases of violence and address them. Persons with disabilities, including women with disabilities, and their representative organizations should be involved in the development, implementation and monitoring of prevention and response measures, policies and programmes to combat violence against persons with disabilities.

7. Promote multi-country collaboration and partnerships with relevant stakeholders, including representative organizations of persons with disabilities, to end intra-national and cross-national human trafficking of children and adults with disabilities. Combat intra-national and cross-national networks of trafficking of children and adults with disabilities as well as isolated cases of trafficking. Address the conditions that make persons with disabilities vulnerable to trafficking, especially poverty,

which may lead families and caregivers to give or sell children and adults with disabilities to human traffickers. Provide support to documented and undocumented victims of trafficking who were moved away from their countries of citizenship or residency. Establish cross-border collaborations to avoid impunity of traffickers crossing borders.

8. Improve the availability and quality of data and research on violence against persons with disabilities, especially against children with disabilities as well as against women and girls with disabilities. Up-to-date evidence is essential to understand the extent of violence, its causes and to design effective policies to end violence. Violence against persons with disabilities and children with disabilities varies by type of disability and by gender: data should be disaggregated by these characteristics as well as by age. More data and research are needed to understand regional variations of violence against persons with disabilities (urban and rural as well as in different continents and sub-continents), violence by income level of the victim with disabilities, extent of human trafficking and trends of all forms of violence over time. A more comprehensive assessment of the prevalence of violence among persons with disabilities may be obtained by developing methods to combine data from various sources to obtain a more comprehensive picture of the incidence of violence among persons with disabilities; currently, there is a lack of methods to combine data produced by official or academic population surveys with data from administrative records such as public health surveillance systems and police and court records. There is also a need for research on the effectiveness of existing interventions to further inform policy and practice. All research and data should be made available in formats accessible to persons with disabilities, including in easy-to-understand formats. Persons with disabilities, including women with disabilities, and their representative organizations should be involved in the development of data and research.

Ensuring equal access to justice (target 16.3)

This section reflects on the achievement of target 16.3 by, for and with persons with disabilities, in line with the Convention on the Rights of Persons with Disabilities (CRPD). This target calls for ensuring equal access to justice for all. Article 13 of the CRPD 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 administration of justice. Article 12 of the CRPD 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. The principles enshrined in Articles 12 and 13 of the CRPD, as interpreted by the Committee of the CRPD in its concluding observations, have been developed into an international set of principles and standards by the Special Rapporteur on the rights of persons with disabilities in 2020.[526]

This section will address access to justice as it relates to persons with disabilities. It will give an overview of the current situation and progress thus far, highlight good practices and end with recommendations to ensure access to justice for all persons with disabilities.

Current situation and progress so far

Many barriers persist for persons with disabilities to access justice. One of these barriers is the persistence of guardianships and substituted decision-making in many countries, instead of supported decision-making (Box 9). With guardianships and substituted decision-making, the legal capacity of persons with disabilities is not recognized and another person is allowed to have the legal authority to make decisions on their behalf. Those most affected are persons with intellectual or psychosocial disabilities, persons who are deaf or blind, persons with hearing impairments, persons with autism, persons with dementia, women and girls with disabilities and older persons with disabilities.[527]

These practices are increasingly being abolished, with promising developments in recent years across a swathe of countries moving towards supported decision-making schemes and programmes (Table 6) – supported decision-making is an integral component of safeguarding the legal capacity of persons with disabilities. For instance, pioneering legislation in Austria, Colombia, Costa Rica, Peru and Spain, abolishes all forms of guardianship laws and substituted decision-making regimes. Parallel to this, a number of countries – for example, Argentina, Australia, Brazil, Bulgaria, Canada, Czechia, Hungary, India, Ireland, Israel, Kenya, Latvia, Sweden, United Kingdom, United Republic of Tanzania and the United States – have implemented pilot projects for instituting some form of supported decision-making or have introduced supported decision-making while retaining also substituted decision-making. These developments have also influenced mental health legislation, policy and practice to reflect the new

paradigm set by the standards of the CRPD.[528] In Peru for example, mental health legislation has been adopted to recognize and allow for some form of supported decision-making procedures in relation to mental health, a significant development given that mental health legislation and practice particularly affect persons with psychosocial or intellectual disabilities.[529]

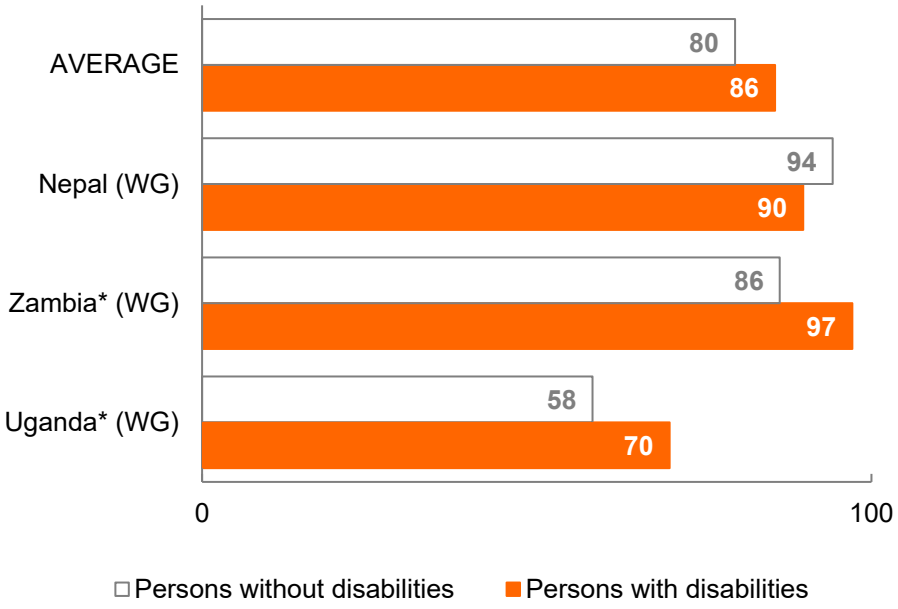
But even in countries in which supported decision-making is implemented, these regimes do not always adequately respond to the diversity, multiplicity and complexity of the needs of persons with disabilities in their access to justice.[530] Persons with disabilities may face barriers to access supported decision-making due to age and gender, particularly in the context of countries where supported decision-making schemes are largely implemented by informal family and community networks and where socio-cultural beliefs prescribe respect for elders and males. For instance, in supported decision-making schemes piloted in India, Kenya and Lebanon, it was found that young women in particular had limited access to such schemes and were more likely to have their legal capacity denied, particularly with respect to financial and property decisions.[531] Furthermore, restrictions to legal capacity may still persist under supported decision-making, especially if the same institutions of previous guardianship laws remain in place.[532]

For many persons with disabilities, access to legal services remains a challenge. In three countries, on average, among persons with disabilities who needed legal advice, 86 per cent were not able to receive it (Figure 208). This unmet need for legal advice among persons with disabilities is very high in all three countries, ranging from 70 per cent in Uganda to 97 per cent in Zambia. Many persons with disabilities lack access to education (see the chapter on Goal 4) and, without education, they may lack the skills to seek legal advice. Persons with disabilities also tend to have fewer financial resources (see the chapter on Goal 1) to meet the costs of legal services. Those who are able to overcome these obstacles and seek legal advice may face further barriers. Lack of disability awareness among legal officers, lack of accessibility features and lack of reasonable accommodation in legal services are ongoing obstacles for persons with disabilities to enjoy equal access to justice.

Box 9. Supported decision-making versus guardianships and substitute decision-making

Guardianships and substituted decision-making are used to allow another person to have the legal authority to make decisions on behalf of a person with disabilities. With *supported decision-making*, persons with disabilities enjoy full recognition and equality under the law, exercise their legal capacity to make decisions and receive support from a trusted individual, network of individuals or entity in making these decisions. According to General Comment No. 1 of the United Nations Committee on the Rights of Persons with Disabilities, governments are required to move away from *guardianships and substituted decision-making* in favour of *supported decision-making*.

Figure 208. Percentage of persons who needed but were not able to receive legal advice, by disability status, in 3 countries, in 2018 or latest year available.



Source: UNDESA (on the basis of data from SINTEF[9]).

Indicator 16.3.1 monitors the proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms. In the European Union, persons with disabilities report violence to the police more often than persons without disabilities: in 2019, 51 per cent of persons with severe disabilities reported the most recent incident of violence to the police, compared to 40 per cent of persons without severe disabilities and 29 per cent of persons without disabilities.[533]

Indicator 16.3.3 monitors the proportion of the population who have experienced a dispute in the past two years and who accessed a formal or informal dispute resolution mechanism. Persons with disabilities also face barriers to accessing formal and informal dispute resolution mechanisms. In Gambia, for example, 47 per cent of persons without disabilities but only 1 per cent of persons with disabilities experiencing a dispute have access to such mechanisms (Figure 209).

Accessibility for persons with disabilities is not in place throughout the justice system, including in police premises, courtrooms, legal documents and court decisions. In four developing countries, on average, 34 per cent of persons with disabilities indicate that the police stations are not accessible; and 36 per cent indicate that the courts are not accessible (Figure 210). About 25 per cent of persons with disabilities in Malawi and about 40 per cent of persons with disabilities in Nepal experience that lack of accessibility. Crowdsourced data on courts and police stations worldwide, mostly in developing countries, found that as of 2022, 59 per cent were accessible for wheelchair users, 19 per cent were partially accessible and 22

per cent were not accessible (Figure 211). There has been slight progress from 2018 to 2022 from 54 per cent to 59 per cent.

Figure 209. Percentage of persons who have experienced a dispute in the past two years who accessed a formal or informal dispute resolution mechanism, by disability status, in Gambia, in 2021 (indicator 16.3.3).



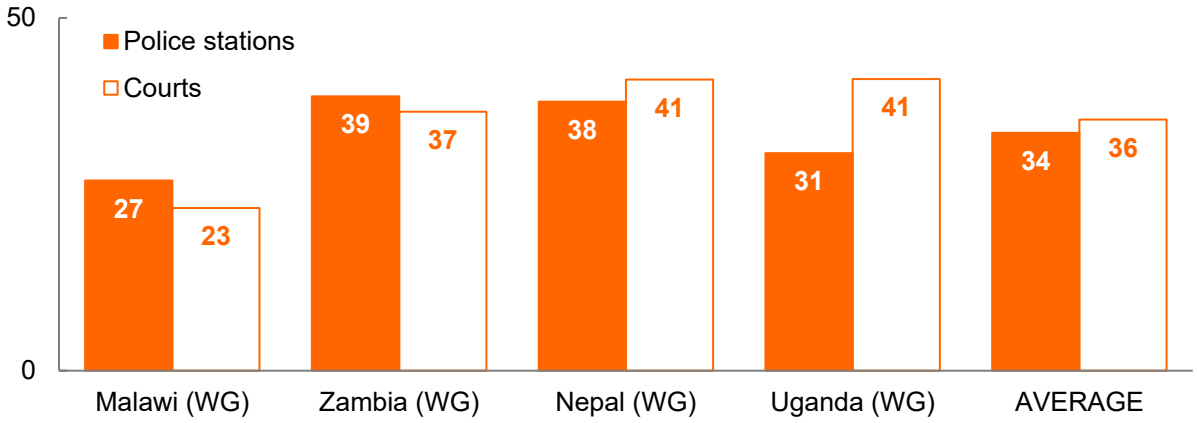
Source: United Nations SDG Indicators Database (2023).[285]

The lack of legal documents in formats that are accessible for persons with disabilities also remains a major barrier. For example, among 10-13 countries or areas in Asia and the Pacific, court judgements are typically not available in accessible formats: only 10 per cent of countries make all court judgements available in Braille and ePub, only 20 per cent in easy-to-read, only 30 per cent in accessible text in webpages and only 50 per cent in accessible doc/pdf (Figure 212). National laws tend to be more available in accessible formats but they are still largely not accessible, with only 20 per cent to 30 per cent of countries making all national laws available in easy-to-read, ePub and Braille. Accessible online text and accessible doc/pdf are more common, with 60 per cent of countries making all national laws available in these formats. Comparatively, constitutions are the legal documents most available in accessible formats, with about 80 per cent of these countries making their constitutions available in accessible text online and in accessible doc/pdf, but they are still seldom available in other accessible formats: less than 50 per cent of countries make these available in easy-to-read, ePub and Braille.

Reasonable accommodations for persons with disabilities are generally lacking throughout the justice system and vary by regions of the world.

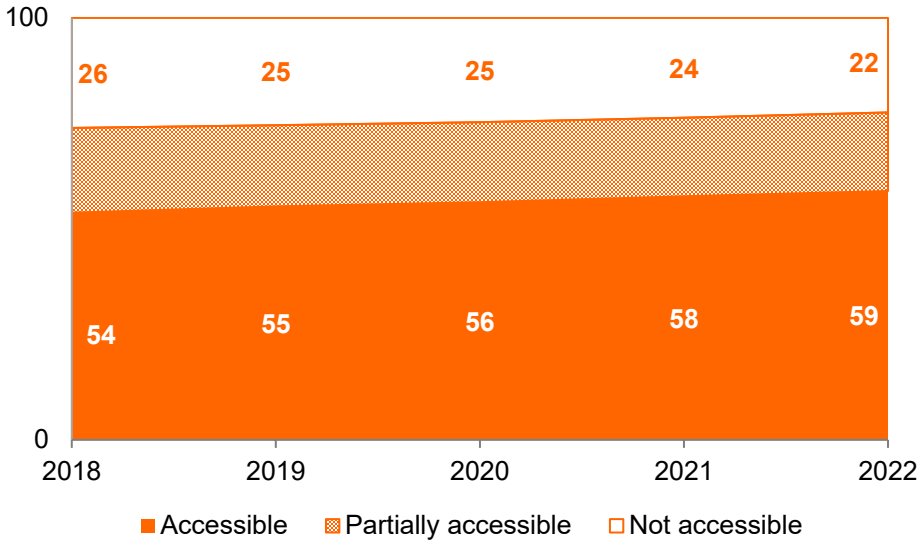
In the European Union, 89 per cent of countries provide procedural accommodations to persons with disabilities and 67 per cent provide adjusted alternative resolution procedures for persons with disabilities (Figure 213). In only 74 per cent of countries, persons with disabilities can be listened to in person and express their will. Accessible features vary: information in accessible formats in provided in 78 per cent of countries; Braille, sign language, easy-to-read and other accessible formats are available upon request in 59 per cent of countries; and accessible digital solutions at first instance courts are available in 56 per cent of countries. Only 9 countries in the European Union provide all these accommodations to make courts more accessible for persons with disabilities.

Figure 210. Percentage of persons with disabilities who reported that magistrate offices/traditional courts and police stations are not accessible, in 5 countries, in 2015-2018.



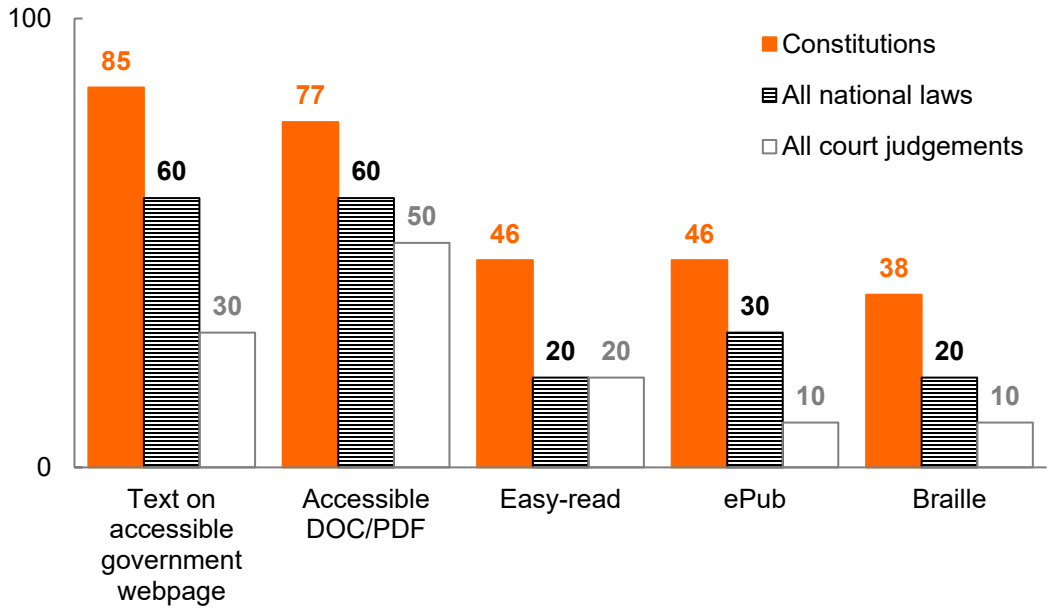
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]).

Figure 211. Percentage of courts and police stations that are accessible for wheelchair users, worldwide, from 2018-2022.



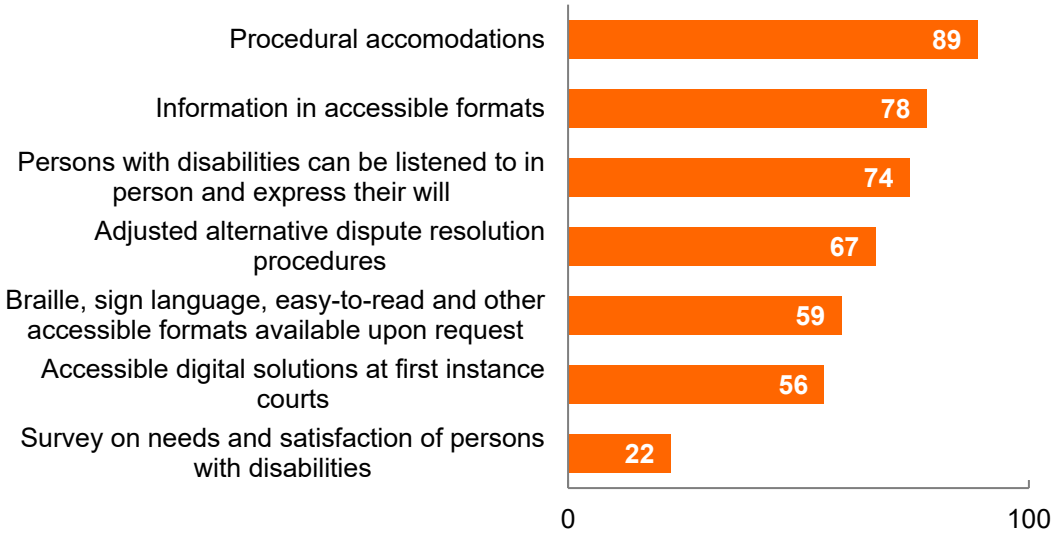
Source: UNDESA (on the basis of data from Sozialhelden[10]).

Figure 212. Percentage of countries or areas with constitutions, all national laws and all court judgements in accessible formats for persons with disabilities, in 10-13 countries or areas in Asia and the Pacific, in 2022 or latest year available.



Source: ESCAP.[14]

Figure 213. Percentage of countries with specific arrangements for access to justice for persons with disabilities, in 27 countries in the European Union, in 2021.



Source: European Commission (2022).[534]

In the United States, although court accommodations are provided under disability legislation and guidelines have been developed for the judiciary in this regard, access to court accommodations by persons with disabilities varies from state to state, particularly in criminal trials.[535] Some states charge defendants fees for accommodations such as Braille, large print documents and the use of a sign language interpreter, and half of states do not provide information on how to request accommodations during the trial.[535]

In African countries, the implementation of court accommodations varies from case to case and often depends on the individual discretion of the judge.[536] Moreover, the range of accommodations which are available cover only a fraction of the need, considering the diversity of persons with disabilities; court accommodations are broadly not suitable for persons with severe communication disabilities or those with multiple disabilities; persons with disabilities still encounter discriminatory practices or harmful attitudes, behaviours and stereotypes in the courtroom; and legislation, legal information and documents are still not always disseminated in an accessible manner.[537]

To overcome these challenges, an increasing number of countries has taken measures to provide accommodations in court (Table 6), including strategies, communication boards, intermediaries, court preparation officers and communication accommodations, as well as physical accommodations, such as wheelchair access and separate testifying rooms.[538]

Table 6. Examples of good practices to ensure access to justice for persons with disabilities.

Type of good practice	Examples of countries where this practice has been implemented
Abolishing guardianship and establishing supported decision-making (laws, partial implementation or pilot projects)	Argentina,[539] Australia,[539] Austria,[540] Brazil,[541] Bulgaria,[539] Canada,[539] Colombia,[539,542] Costa Rica,[543] Czechia,[539] Hungary,[539] India,[539,544] Ireland,[539] Israel,[539] Kenya,[539] Latvia,[539] Peru,[539,545,546] Spain,[547] Sweden,[539] United Kingdom,[539] Tanzania,[539] United States[539]
Providing reasonable accommodation in courts	Argentina,[548] Australia,[548] Azerbaijan,[548] Canada,[548] China,[548] Costa Rica,[548] Dominican Republic,[548] Ecuador,[548] European Union,[549] India,[548] Indonesia,[548] Israel,[548] Malawi,[548] Mexico,[548] New Zealand,[548] Peru,[548] South Africa,[548] Turkmenistan,[548] United States,[548] United Kingdom,[548] Zimbabwe[548]
Awareness-raising and training on disability inclusion for justice systems officials, including police, the judiciary, attorneys, representatives of the legal system and investigators	Argentina,[550] Costa Rica,[551] Israel,[552,553] Mexico,[554] United Kingdom[555]
Free legal assistance for persons with disabilities	Honduras[556]
Partnerships between persons with disabilities and the justice system	United States[557]

Over 180 countries have ratified the CRPD, which typically entails the adoption of laws at the national level to ensure access to justice for persons with disabilities. At the regional level, there have been notable developments in standards setting, such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, adopted in 2018, which expressly includes provisions on legal capacity and access to justice;[558] and the resolution by the Council of Europe on the treatment of detainees with disabilities, also adopted in 2018, which sets out the rights and standards for the treatment of persons with disabilities under detention.[559]

But many existing laws and policies on disability lack an intersectional lens and do not adequately account for the diversity of persons with disabilities and do not address barriers to access to justice. For example, Indigenous persons with disabilities require services which are culturally capable in order to ensure equal access to justice.[560] Women and girls with disabilities are at high risk of gender-based violence, particularly those with intellectual or psychosocial disabilities, yet many countries' criminal justice systems do not provide reporting mechanisms that are appropriate for women and girls with disabilities, nor specialized services that are sensitive to gender.[561]

A recent positive development is the implementation of surveys by the justice system to seek feedback from users with disabilities on their experience in the justice system, including the courts and legal aid programmes. For instance, in the European Union, 22 per cent of countries conduct these surveys (Figure 213). Awareness-raising, training and guidelines on disability inclusion for officials in the justice system have also been promoted in many countries, including national protocols addressed to the police and the judiciary on the treatment of persons with disabilities (Table 6).

Summary of findings and the way forward

Target 16.3 calls for equal access to justice for all. Achieving this target for persons with disabilities, in line with articles 12 and 13 of the CRPD, requires protecting their right to legal capacity and providing the support they may require in exercising this right. Although progress has been made in the realization of target 16.3 for persons with disabilities, obstacles to accessing justice remain. The persistence of these obstacles is especially concerning given that persons with disabilities – and especially children and women with disabilities and persons with psychosocial disabilities – are two to six times more likely than others to be victims of violence, abuse, exploitation and human trafficking (see the chapter on targets 16.1 and 16.2).

Guardianship laws are still in place in many countries, depriving persons with disabilities of their legal capacity – persons with intellectual or psychosocial disabilities, persons who are deaf or blind, persons with hearing impairments, persons with autism, persons with dementia, women and girls with disabilities and older persons with disabilities are particularly affected by these discriminatory laws. Moreover, the justice system overall lacks accessibility features and reasonable accommodations for persons with disabilities, including in court rooms, police stations and legal services. In developing countries, about a

third of persons with disabilities indicate that courts and police stations are not accessible to them. National laws and court documents, including court decisions, are also typically not available in formats that are accessible for persons with disabilities. In some developing countries, more than two thirds of persons with disabilities do not have access to legal services when they need them. Many officials throughout the justice system have no training on disability inclusion. Data remains scarce on the barriers persons with disabilities face in accessing justice and their experience in the justice system and research is lacking on the development and implementation of supported decision-making systems, especially in developing countries.

Progress has been made in the last five years, with more countries having moved away from guardianship laws to supported decision-making systems. There has been slow progress in improving the accessibility of courts and police stations to wheelchair users, from 54 per cent of courts and police stations accessible to them in 2018 to 59 per cent in 2022. At this rate of progress, by 2030, it is expected that one in every three courts and police stations will remain not accessible. To achieve universal accessibility for wheelchairs users by 2030, courts and police stations need to become accessible at a rate four times faster than current rates of progress.

To address the barriers that persons with disabilities face in accessing justice, the following measures are recommended:

1. Abolish laws and policies that impose substituted decision-making in legal proceedings, against the will of persons with disabilities. Ensure the meaningful and effective participation of representative organizations of persons with disabilities in all processes and stages of law reform and policy formulation. Promote supported decision-making.

2. Empower persons with disabilities to exercise their legal rights and access justice. Offer training 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. Provide free legal assistance to persons with disabilities who cannot afford legal services.

3. Make the justice system fully accessible and inclusive for persons with disabilities. Make the constitution, national laws, legal information and court decisions available in accessible formats, including in easy-to-understand communication. Make police stations, court rooms and premises providing legal services accessible to persons with disabilities. Provide reasonable accommodations upon request in courts and throughout the justice system. Mainstream an intersectional approach across the criminal and civil justice system to ensure that services reflect the diversity of persons with disabilities and are gender-sensitive, age appropriate and culturally capable for persons with disabilities. Involve persons with disabilities and their representative organizations in designing policies and practices to make the justice system fully accessible and inclusive.

4. Train judges and justice officials on disability inclusion and the rights of persons with disabilities. Focus training on eliminating harmful attitudes, behaviours and stereotypes and promoting practices inclusive of persons with disabilities of all genders, ages and ethnicities. Involve persons with disabilities and their representative organizations in designing and implementing these trainings. Ensure that all training is delivered in formats that are accessible for persons with disabilities.

5. Improve the availability of data and research on the experience of persons with disabilities in the justice system and the barriers they experience in accessing justice. Institute data collection systems in the police and in courts for the regular collection of administrative data disaggregated by disability, as well as sex and age, including on cases and outcomes of trials involving persons with disabilities (whether as victims of crime, defendants or claimants). Conduct regular satisfaction surveys among persons with disabilities using the police and the courts, including on the use and effectiveness of court accommodations. Conduct population surveys to collect data on the experience of persons with disabilities in accessing justice and the barriers they face; these surveys should be designed to allow disaggregation by sex, age, ethnicity and urban or rural location. Ensure monitoring and evaluation of supported decision-making systems for persons with disabilities. Involve persons with disabilities and their representative organizations in research as well as in data collection, dissemination and analysis.

Developing inclusive institutions, ensuring inclusive decision-making and reducing bribery and corruption (targets 16.5, 16.6 and 16.7)

Target 16.6 calls for effective, accountable and transparent institutions at all levels and target 16.7 aims to ensure responsive, inclusive, participatory and representative decision-making at all levels. Target 16.5 calls for substantially reducing corruption and bribery in all their forms.

Inclusive decision-making is one of the calls of the Convention on the Rights of Persons with Disabilities (CRPD), whose Preamble acknowledges that persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them. In addition, article 4 specifically requires 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 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, and should protect their right to vote, to stand for elections, to effectively hold office and perform all public functions at all levels of government.

In 2021, the United Nations General Assembly resolution 75/154 reiterated that persons with disabilities should be actively involved in all aspects of public and political life, including in decision-making processes about policies and programmes and in national and international development programmes. The resolution also called upon United Nations Member States and other stakeholders to include persons with disabilities in all stages of policymaking and decision-making related to COVID-19 response and recovery. In 2022, United Nations Economic and Social Council resolution 2022/9 encouraged Governments to address inequalities that exist within the public sector workforce and to take steps to address social inequities in the design and delivery of public services (paragraph 12).

This section discusses the implementation of targets 16.6 and 16.7 for persons with disabilities and the remaining barriers to disability-inclusive institutions and decision-making. It presents good practices and recommendations for realizing these two targets for persons with disabilities. The section also presents an illustrative analysis of the situation of persons with disabilities vis-à-vis target 16.5.

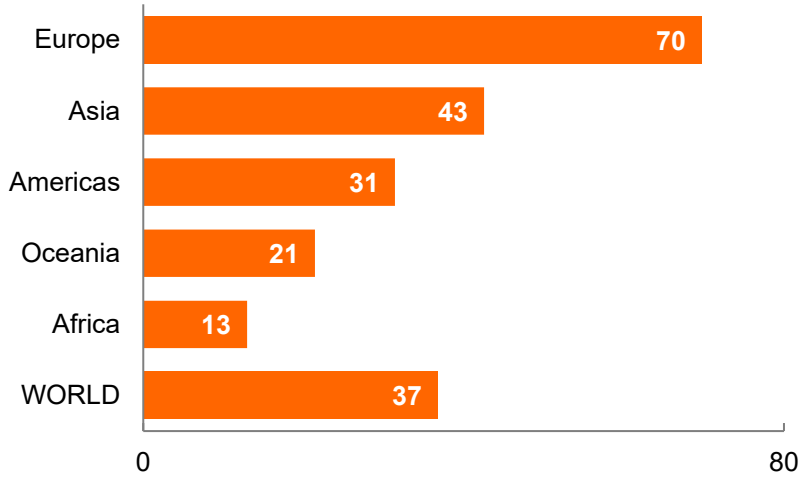
Current situation and progress so far

Inclusive institutions (target 16.6)

Target 16.6 calls for effective, accountable and transparent institutions at all levels. Barriers in access to public institutions and public services remain for persons with disabilities due to lack of accessibility, discrimination, stigma and negative attitudes, including barriers to accessing public buildings as well as

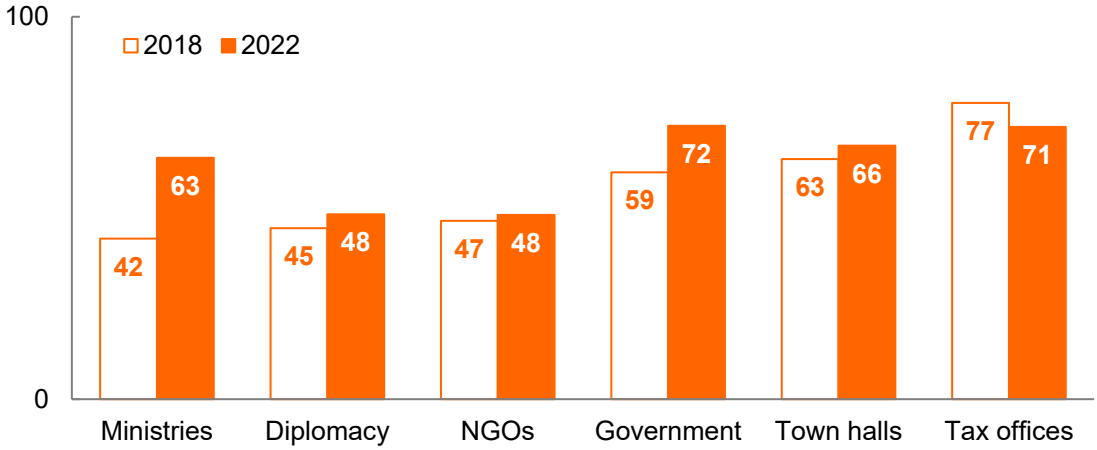
digital and in-person services.

Figure 214. Percentage of countries with a national portal that is accessible for persons with disabilities according to W3C guidelines, in the world and by region, among 193 countries, in 2020.



Source: 2020 United Nations E-Government Survey (UNDESA).

Figure 215. Percentage of ministries, diplomacy-related premises, non-governmental organizations (NGOs), government premises, town halls and tax offices that are accessible for wheelchair users, worldwide, in 2018 and 2022.

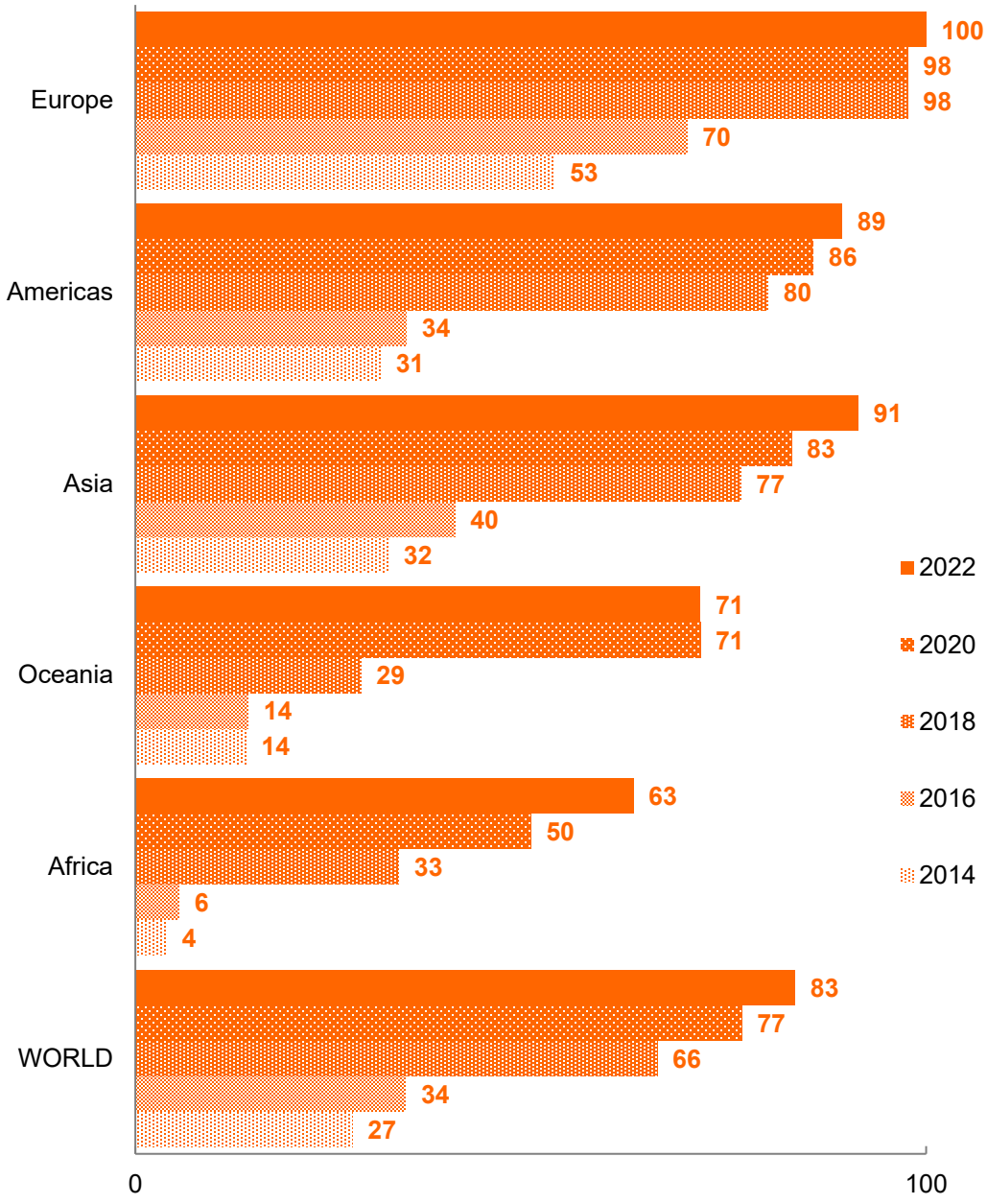


Source: UNDESA (on the basis of data from Sozialhelden[10]).

National online governmental portals are often not accessible to persons with disabilities (Figure 214). In 2020, only 37 per cent of countries offered a national website portal that was accessible for persons with

disabilities according to W3C guidelines, though the percentages vary according to region. Europe had the highest percentage of countries with accessible national portals (70 per cent), while Africa had the lowest (13 per cent). In between, 43 per cent of countries in Asia had accessible national portals, as did 31 per cent of countries in the Americas and 21 per cent of countries in Oceania.

Figure 216. Percentage of countries with online government services for persons with disabilities, in the world and by region, among 193 countries, in 2014, 2016, 2018, 2020 and 2022.



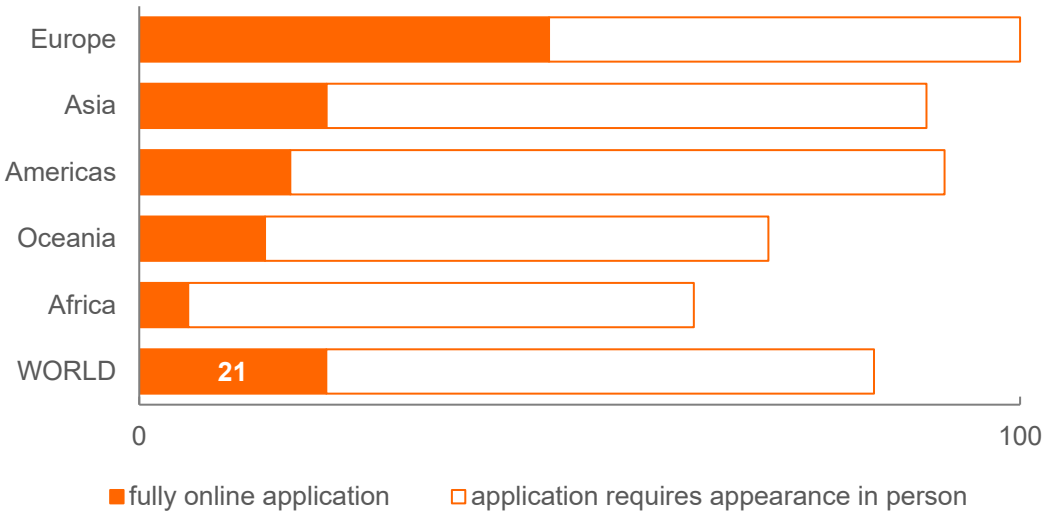
Source: 2014, 2016, 2018, 2020 and 2022 United Nations E-Government Surveys (UNDESA).

Apart from national portals, other public institutions and services lack inclusion and remain inaccessible for persons with disabilities. In 2022, among 43 countries, 56 per cent of libraries did not have an official policy on access for persons with disabilities. In addition, 22 per cent were not accessible for persons with physical disabilities; 51 per cent were not accessible for persons with sensory impairments; and 55 per cent were not accessible for persons with cognitive disabilities. Furthermore, 27 per cent of libraries indicated that their websites were not accessible for persons with disabilities. Human and financial resources to make libraries accessible and inclusive of persons with disabilities remained scarce. Only 29 per cent of libraries had a person responsible for accessibility in the library; only 11 per cent of libraries had all their staff trained in accessibility; and merely 16 per cent had a budget for accessibility.[562]

Crowdsourced data, mostly from developed countries, indicates that in 2022, 72 per cent of government premises, 71 per cent of tax offices, 66 per cent of town halls, 63 per cent of governmental ministries and 48 per cent of diplomacy-related premises and non-governmental organizations were accessible for wheelchair users, with little or no improvement in accessibility since 2018 for all these premises except for governmental ministries and government premises (Figure 215).

Countries have increasingly been investing in the provision of online governmental services for persons with disabilities (Figure 216). In 2022, 83 per cent of countries had these services, up from 27 per cent in 2014 – a threefold increase. In 2022, online services for persons with disabilities were highest in Europe (100 per cent) and lowest in Africa (63 per cent), though every region had made significant improvements since 2014.

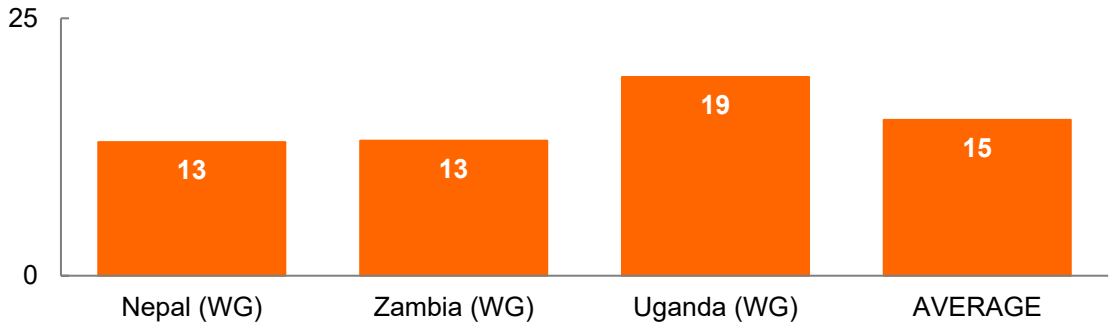
Figure 217. Percentage of countries in which persons with disabilities can apply fully online for services versus those which require appearance in person to benefit from the service, among 193 countries, in 2022.



Source: 2022 United Nations E-Government Survey (UNDESA).

A requirement to appear in person to access public services can be a barrier for persons with disabilities, particularly persons with mobility-related disabilities. Online access to public services therefore enhances much-needed access to persons with disabilities. However, 62 per cent of countries, despite offering information about the services online, still require that the individual with disabilities appear in person to benefit from the service (Figure 217). Only 21 per cent of countries in the world offer both online information about services for persons with disabilities and online access to these services without requiring an appearance in person – such as applying for a disability benefit. Europe has the highest percentage of countries that do so (47 per cent) and Africa has the lowest percentage (6 per cent).

Figure 218. Persons with disabilities who report being discriminated against in public services, in 3 countries, in 2018 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]).

Discriminatory attitudes within many public institutions remain a major barrier for persons with disabilities. In three developing countries, on average, 13 per cent to 19 per cent of persons with disabilities reported being discriminated against in public services (Figure 218).

The extent to which disability-inclusion projects and programs are prioritized in public budgeting and government expenditures is reflective of the commitment of governments and political leadership to promote an inclusive society and a governance system in which persons with disabilities can fully participate. These government expenditures may include spending to make public buildings and spaces accessible, education inclusive or to provide disability benefits.

Among 56 countries, public spending on social programmes for persons with disabilities corresponds on average to 1 per cent of their gross domestic product (GDP), with remarkable variations across countries (Figure 219). Denmark spends the most on disability benefits – about 5 per cent of its total GDP. India and Indonesia spend the least – about 0.001 per cent of their total GDP.

Among 37 countries, on average, public spending on social programmes for persons with disabilities as a percentage of GDP has slightly decreased since 2014 from 2.08 to 2.04 per cent of the GDP (Figure

220). This decrease was seen in 19 countries, though in 18 countries this percentage has increased. Germany, Israel, Latvia, Lithuania and Norway increased disability benefit spending (as a percentage of total GDP) anywhere from 0.22 percentage points to 0.56 percentage points.

The international development community has been funding projects to further the inclusion of persons with disabilities in government and civil society decision-making. In 2020, bilateral aid to support projects to further the inclusion of persons with disabilities in government and civil society totalled 993 million US dollars.[563] The largest commitments of bilateral aid went to countries in East Africa, including Ethiopia and Uganda, as well as in South Asia, such as Iraq and Pakistan.[563]

Box 10. Reducing the exposure of persons with disabilities to corruption and bribery in all their forms (target 16.5)

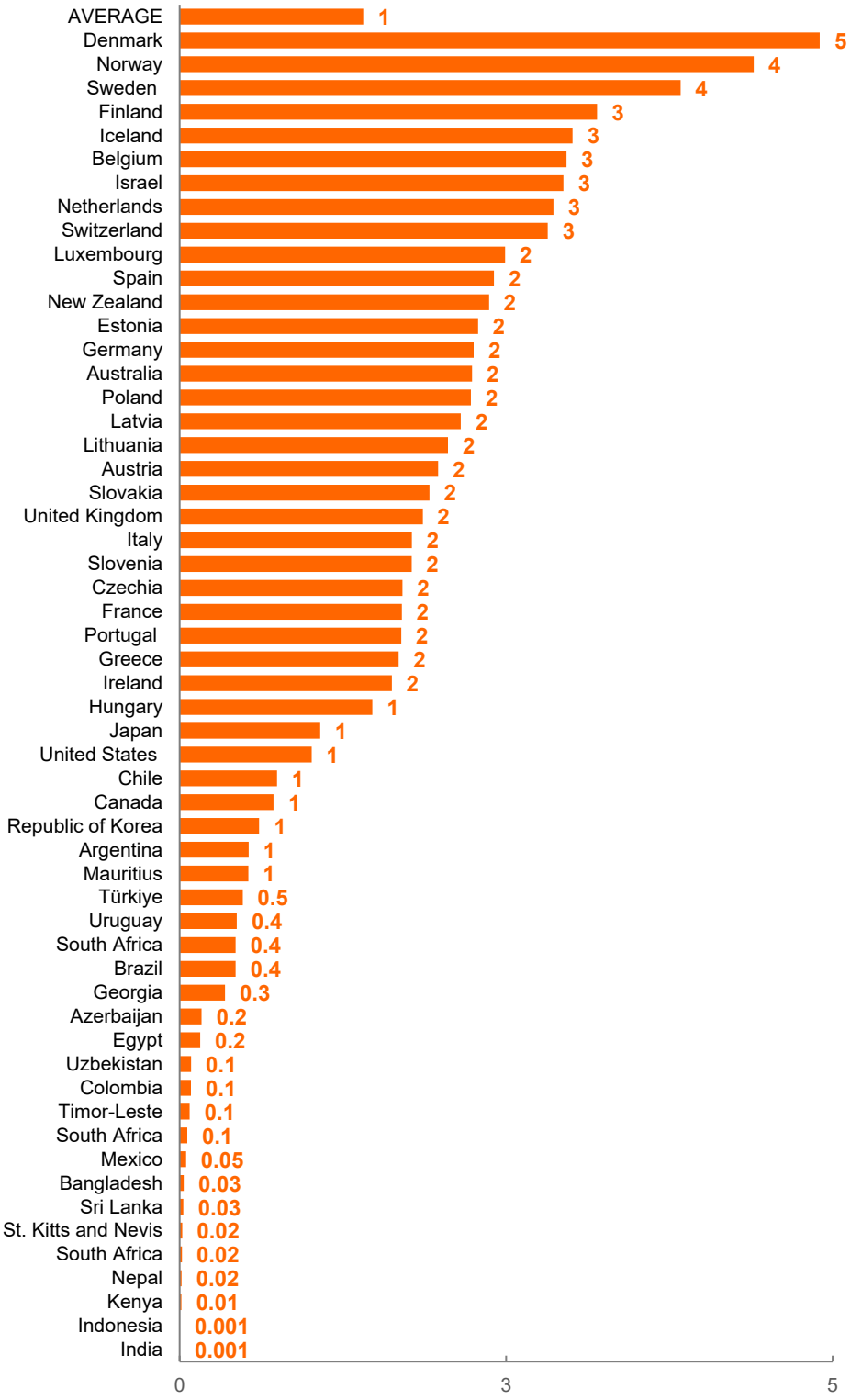
Target 16.5 calls for substantially reducing corruption and bribery in all their forms, and indicator 16.5.1 monitors the proportion of persons who had at least one contact with a public official and who paid a bribe to a public official or were asked for a bribe by public officials, during the previous 12 months.

Persons with disabilities may be exposed to corruption and bribery in a different way than the rest of the population. On one hand, because of the barriers persons with disabilities face, public officials may try to take advantage of them and request bribes from them more often than from persons without disabilities. On the other hand, public officials may target persons with disabilities less often than others because persons with disabilities often have less access to financial resources than others. A survey in Ghana in 2021 found that persons with disabilities (23 per cent) were slightly less likely than persons without disabilities (27 per cent) to pay or be asked to pay a bribe when interacting with public officials.[564]

During disasters, conflicts and other emergencies, persons with disabilities may also be at higher risk of being exposed to bribery. For example, in the protection of civilians site in Malakal (South Sudan), 0.3 per cent of internally displaced persons with disabilities encountered bribery when attempting to access services (Figure 207 of the chapter on targets 16.1 and 16.2).

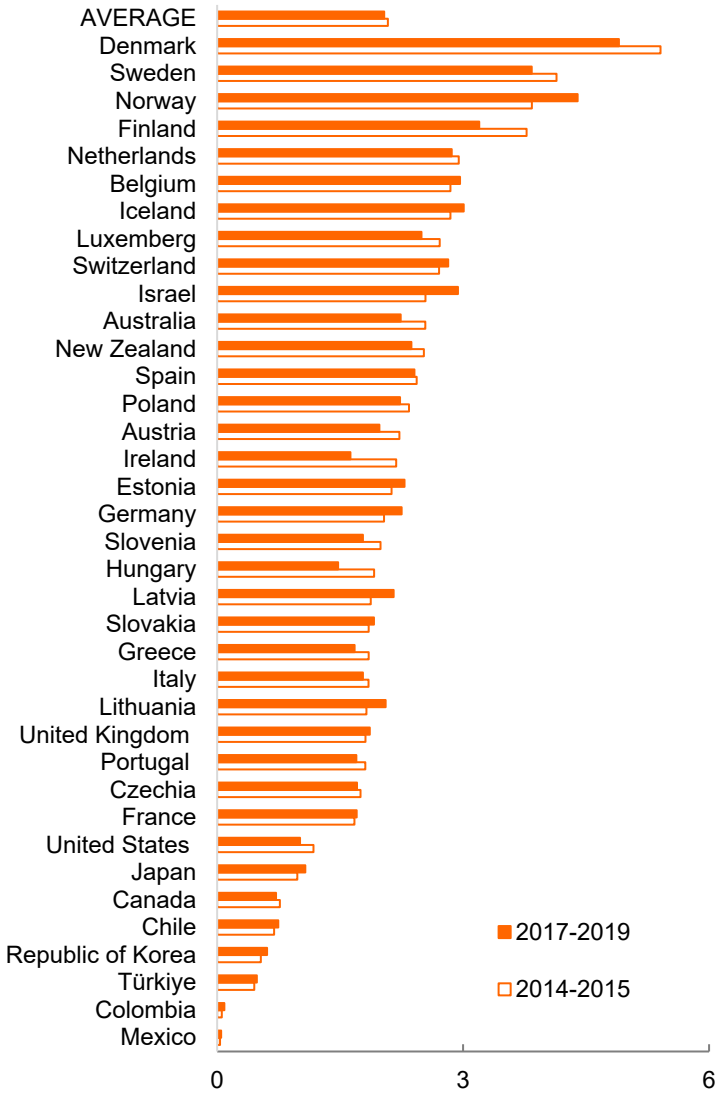
Note: All data collected with the Washington Group Short Set of Questions.

Figure 219. Public spending on social programmes for persons with disabilities as a percentage of gross domestic product (GDP), in 56 countries, in 2020 or latest year available.



Source: OECD[565] and Development Pathways.[566]

Figure 220. Trend in public spending on social programmes for persons with disabilities as a percentage of gross domestic product (GDP) over time, in 37 countries, from 2014-2015 to 2017-2019.



Source: OECD.[565]

Inclusive decision-making (target 16.7)

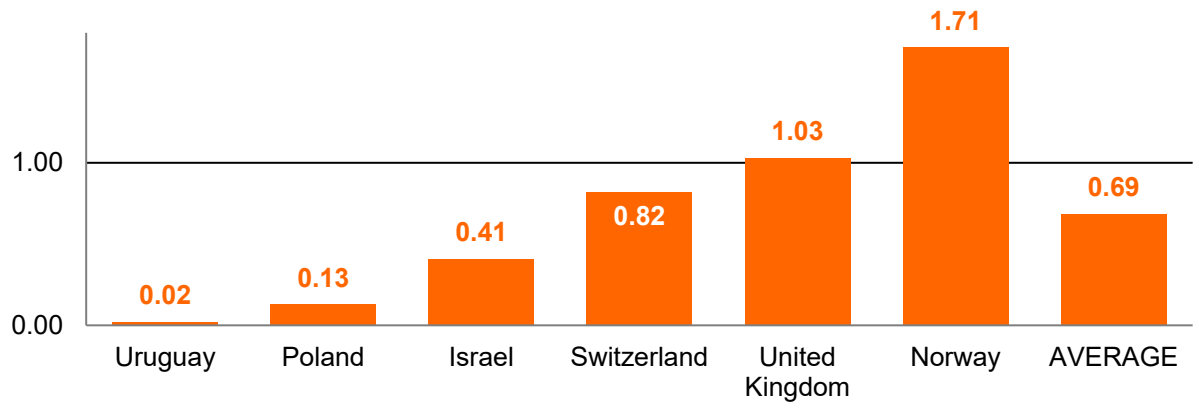
SDG target 16.7 calls for ensuring responsive, inclusive, participatory and representative decision-making at all levels and specifically includes two indicators to be disaggregated by disability.

Indicator 16.7.1 monitors the proportions of positions in national and local institutions, including (a) the legislatures; (b) the public service; and (c) the judiciary, compared to national distributions, for inter alia

persons with disabilities. Data on this indicator show that the percentage of persons with disabilities in the national-level public service personnel remains low in various countries (Figure 221). Persons with disabilities are significantly underrepresented, relative to their share of national populations, in Israel, Poland and Uruguay, and slightly underrepresented in Switzerland. In the United Kingdom, their representation is about the same as in the national population and in Norway, their representation is above their proportion in the national population.

Lack of data does not allow assessing the extent to which decision-making in governments and the political system are inclusive and responsive. Available data from Tunisia allow a glimpse into a potentially larger trend. In Tunisia, a lower percentage of persons with disabilities (29 per cent) than persons without disabilities (37 per cent) believe that decision-making is inclusive; but a higher percentage of persons with disabilities (11 per cent) than persons without disabilities (7 per cent) believe that decision-making is responsive.[285]

Figure 221. Ratio of the percentage of persons with disabilities in the national-level public service personnel (including police, education, health, front-desk administrative and all other public service personnel) to the percentage of persons with disabilities in the national population (indicator 16.7.1), in 6 countries, in 2020.



Source: UN SDG Indicators Database.[285]

Persons with disabilities tend to be underrepresented in decision-making bodies, such as national legislative bodies. For instance, in 2018-2022, four out of ten countries or areas in the Asia and Pacific region had no parliamentarians with disabilities in their national parliaments, and in the others, the percentage of parliamentarians with disabilities ranged between 0.4 per cent and 6 per cent of all parliamentarians.[14] Some countries, however, are showing some signs of progress towards the inclusion and representation of persons with disabilities in decision-making bodies. Uganda, for example, reported about 47,000 representatives with disabilities serving in elected bodies – a result which was facilitated by

the adoption and implementation of accessibility requirements in public sector buildings and federal and local disability inclusion quotas (including gender-balanced quotas).[567]

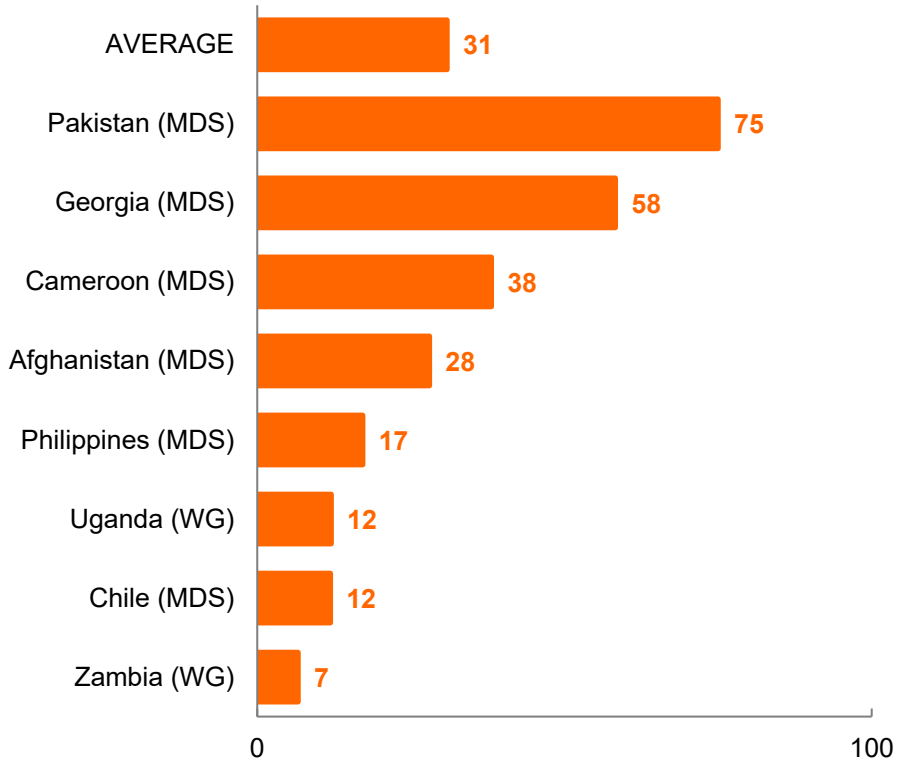
Box 11. Government engaging with persons with disabilities in Malta

The government of Malta has adopted a wide approach to engaging in consultations and dialogues with persons with disabilities and their representative organizations. In 2014, the first National Policy on the Rights of Persons with Disability was designed by the Committee for a Right Society. The committee is composed of persons with disabilities and their relatives, representatives of persons with disabilities and other experts. The government of Malta also promotes daily meetings with persons with disabilities, other civil society organizations and other stakeholders, and the Parliamentary Secretariat holds weekly meetings with the National Commission for the Rights of Persons with a Disability and other stakeholders, in which relevant governmental projects and policies are discussed. The Parliament of Malta passed the Sign Language Act (2015), which makes sign language an official language in Malta. Similarly, the Parliament of Malta has passed legislation that makes the inclusion of at least one person with disabilities within governmental boards mandatory.[568]

Persons with disabilities often remain alienated in decision-making on emergency and disaster risk reduction and response planning. Worldwide, in 2023, as few as 14 per cent of persons with disabilities had participated in disaster risk reduction decision-making in their communities, the same percentage as in 2013 (see the chapter on Goals 1, 11 and 13).

In addition to holding public office, voting is one of the most direct forms of political participation and a way for citizens to exercise their political rights. In many countries, persons with disabilities still face legal barriers to voting and to being elected for office: 67 per cent of countries have exceptions in their constitutions or laws that restrict the right to vote of persons with disabilities, of which 73 per cent have exclusions targeting persons with psychosocial or intellectual disabilities.[32] On the right of persons with disabilities to be elected for office, 91 per cent have exceptions, out of which 65 per cent include exclusions targeting persons with psychosocial or intellectual disabilities.[32] Electoral violence – including acts or threats to intimidate, physically harm, abuse or blackmail a political stakeholder to influence a political process – is another obstacle for persons with disabilities to exercise their political rights as many of them opt not to vote or stand for political office for fear of violence.[569] Recent research suggests that persons with disabilities are as likely as persons without disabilities to be targets of electoral violence, but experience more negative impacts in terms of mental health and social wellbeing.[570] There is a lack of research and data on electoral violence on women with disabilities and Indigenous persons with disabilities, but given the vulnerabilities of these groups and the higher levels of violence among women with disabilities than others (see the chapter on targets 16.1 and 16.2), it is likely that they are more impacted by electoral violence.

Figure 222. Percentage of persons with disabilities who found voting problematic or not accessible, the last election, in 8 countries, in 2021 or latest year available.

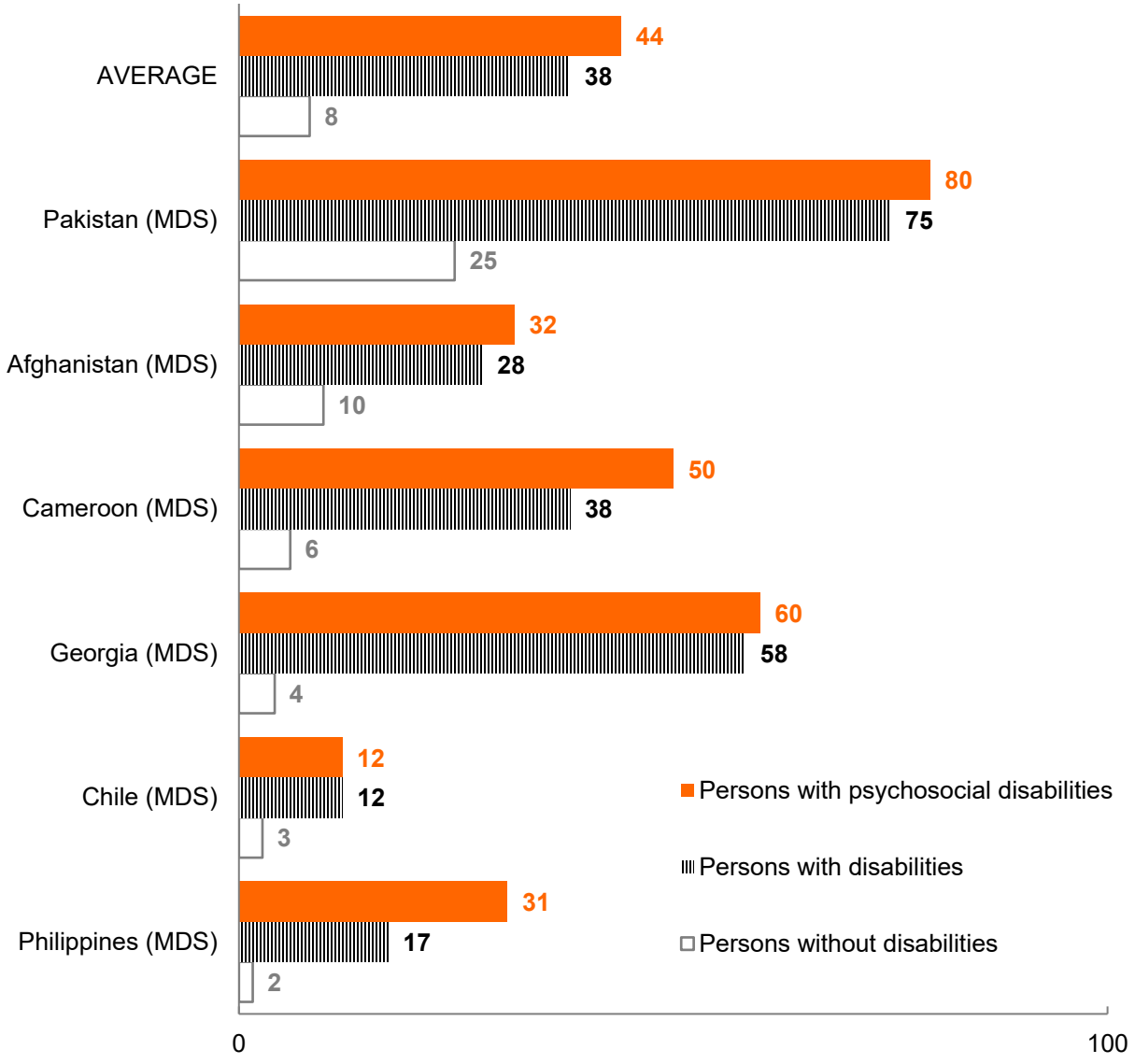


Note: (MDS) identifies data produced using the Model Disability Survey; (WG) identifies data produced using the Washington Group short set of questions on functioning.
Source: UNDESA (on the basis of data from SINTEF[9]) and WHO (on the basis of data from Model Disability Surveys).

Lack of accessibility of many voting sites is another barrier to persons with disabilities. Ballots are often not provided in accessible formats, entrances to polling premises are often not accessible to wheelchair users, voting often has long lines without priority access for persons with disabilities who have difficulties waiting in line, signs to the polling premises are often not provided in accessible formats, and there are often no election officials communicating in sign language. For example, among eight countries, on average, 31 per cent of persons with disabilities found voting problematic or not accessible (Figure 222). In six countries, persons with psychosocial disabilities were more likely to report that voting in the last election was problematic or very problematic compared to all persons with disabilities, and persons with disabilities found it very problematic to vote in the last election compared to persons without disabilities. On average, for instance, 8 per cent of the population of persons without disabilities reported it was problematic or very problematic to vote in the last election whereas 38 per cent of persons with disabilities found it was very problematic to vote. Further, 44 per cent of persons with psychosocial disabilities found it was problematic or very problematic to vote in the last election (Figure 223). In six out of nine capital

cities in Asia and the Pacific, more than 80 per cent of polling stations are accessible to persons with disabilities but in the remaining three capital cities, less than 10 per cent of polling stations are accessible.[14] Common voting obstacles reported by persons with disabilities include difficulties in reading the ballot, waiting in line, finding and entering the polling place, writing on the ballot and communicating with election officials.

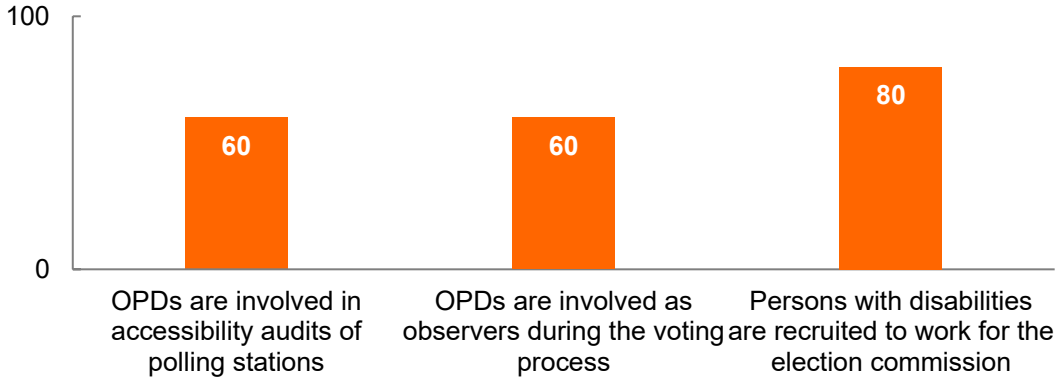
Figure 223. Percentage of persons who found voting problematic in the last election, by psychosocial disability and disability statuses, in 6 countries, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey.
Source: WHO (on the basis of data from Model Disability Surveys).

To better address the needs of persons with disabilities, countries have been increasing their involvement in national voting and election processes. For example, in 80 per cent of countries or areas in Asia and the Pacific, the law requires that persons with disabilities are recruited to work for the election commission; and, in 60 per cent, the law requires that representative organizations of persons with disabilities are involved in accessibility audits of polling stations and are observers during the voting process (Figure 224).

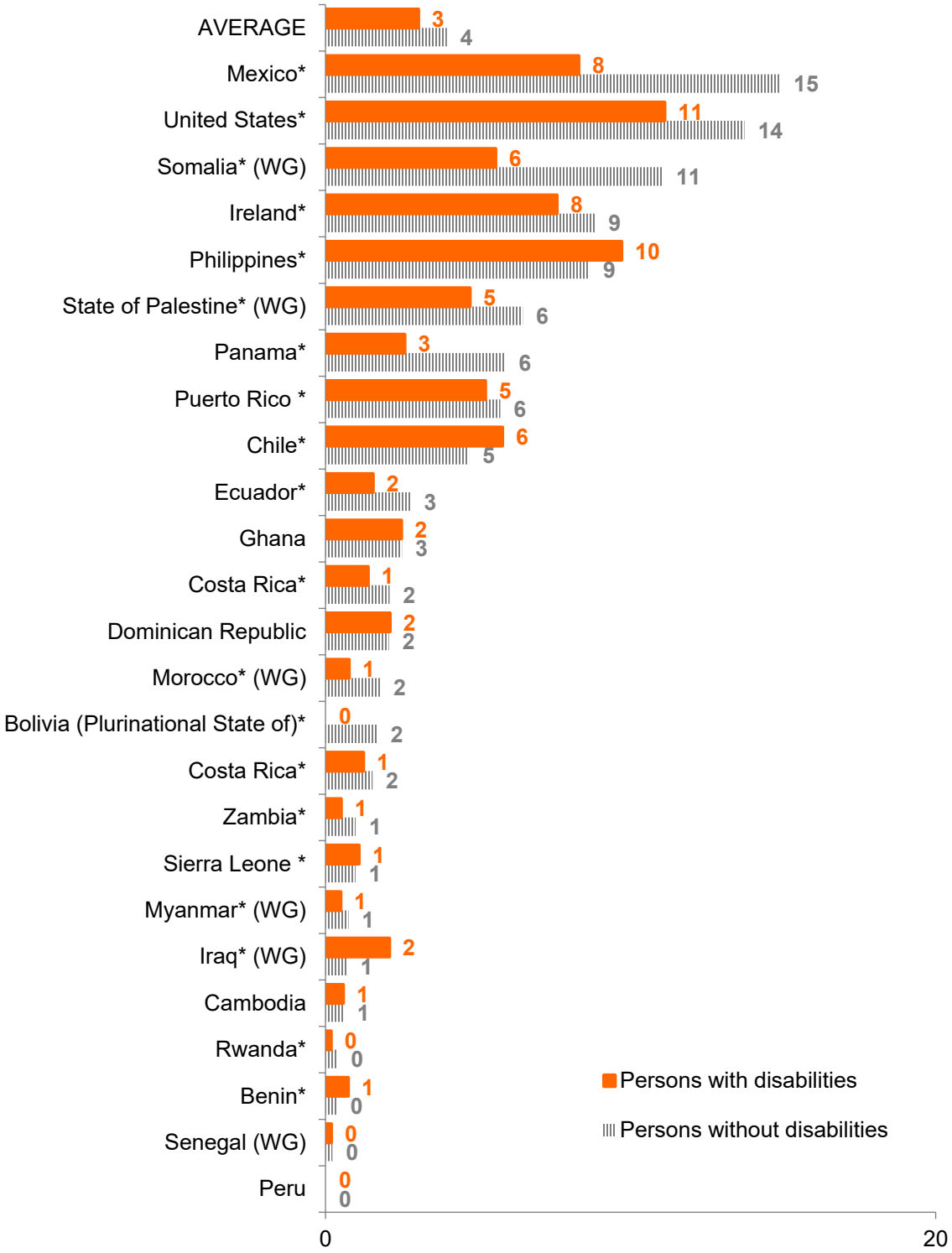
Figure 224. Percentage of countries with legal requirements for the involvement of persons with disabilities and their representative organizations (OPDs) in various processes relating to elections and voting, in 15 countries or areas in Asia and the Pacific, in 2022.



Source: ESCAP.[14]

Many persons with disabilities face numerous obstacles to obtaining high-level decision-making roles. Among 25 countries or areas, persons with disabilities are less likely than persons without disabilities to hold a position as a legislator, a senior official or a manager in 18 of these countries or areas (Figure 225). The gaps between persons with and without disabilities are widest in Mexico, Panama and Somalia, where employed persons without disabilities are twice as likely as persons with disabilities to work as legislators, senior officials or managers.

Figure 225. Percentage of employed persons aged 15 and over who work as legislators, senior officials or managers, by disability status, in 25 countries or areas, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference is statistically significant at the level of 5 per cent or less. Source: ECLAC,[13] ESCWA and UNDESA (on the basis of data from IPUMS[8]).

Summary of findings and the way forward

Public institutions and public services remain largely inaccessible to persons with disabilities, due to lack of accessibility and discrimination. A majority of countries, 83 per cent, offers online government services for persons with disabilities, but only 37 per cent of online governmental portals are accessible for persons with disabilities. Moreover, even when services are offered online, in-person appearance is often required to benefit from the public service, which poses a barrier to many persons with mobility-related disabilities: 62 per cent of countries require an in-person appearance. Data from a limited number of countries suggests that about 15 per cent of persons with disabilities experience discrimination in public services. Public spending on social programmes for persons with disabilities is on average 1 per cent of the gross domestic product (GDP).

Significant progress has been made since 2014 on the provision of online government services for persons with disabilities (from 27 per cent of countries in 2014 to 83 per cent of countries in 2022) and this trend is on track to reach all countries by 2030. Trends since 2014 in public spending on social programmes for persons with disabilities suggest that globally this spending is stagnant.

Barriers to inclusive decision-making for persons with disabilities persist. In various countries, persons with disabilities are significantly underrepresented in the national-level public service personnel, with levels of representation lower than half their share in the national population. About 30 per cent of persons with disabilities find voting problematic or not accessible for them. In various countries, employed persons without disabilities are twice as likely as persons with disabilities to work as legislators, senior officials or managers.

Inclusive institutions and inclusive decision-making require that persons with disabilities can access the premises of these institutions and the places where decisions at governmental and non-governmental levels are made. In 2022, 73 per cent of libraries, 71 per cent of tax offices, 66 per cent of town halls, 63 per cent of governmental ministries, 51 per cent of museums and 48 per cent of non-governmental organizations were accessible for wheelchair users. In the past five years, progress in increasing the accessibility of most of these premises has been slow or stagnant. Town halls would need to become accessible for persons using wheelchairs at a rate four times faster, libraries seven times faster, museums nine times faster and non-governmental organizations 19 times faster than current rates of progress to achieve full accessibility by 2030. The accessibility of tax offices has been deteriorating and this trend needs to be reversed. Significant progress has been made since 2018 in the accessibility of governmental ministries (from 42 per cent in 2018 to 63 per cent in 2022) and these premises are on track to achieve full accessibility for wheelchair users by 2030.

Data on the exposure of persons with disabilities to corruption and bribery are extremely scarce. The limited data available suggest that persons with disabilities are slightly less likely to pay or be asked to

pay a bribe when interacting with government officials. During disasters, conflicts and other emergencies, persons with disabilities encounter bribery when attempting to access services.

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. Eliminate discriminatory legislation that violates the right of persons with disabilities, including persons with intellectual and psychosocial disabilities, to vote and to participate in all aspects of political and public life. Adopt legislative measures to ensure that all persons with disabilities can exercise their right to vote and participate in public life, on an equal basis with others. Remove restrictions that impact the political participation of persons with intellectual and psychosocial disabilities. Engage persons with disabilities and their representative organizations in the process of adopting or revising these laws.

2. Increase the participation of persons with disabilities in national public service. Introduce and enforce quotas for persons with disabilities, and for women with disabilities. Improve recruitment and retention strategies, including the provision of mentorships and training. Remove discriminatory legislation and practices on eligibility for public service.

3. Support persons with disabilities who stand for political office. Mandate a certain number of representatives for persons with disabilities in legislatures and government organs. Ensure candidates with disabilities can campaign on an equal basis with others by providing additional support to overcome accessibility barriers or cover disability-related costs. Provide additional support and implement measures for the increased participation of women with disabilities as candidates.

4. Strengthen the skills of persons with disabilities to defend their political rights, including voting and running for public office. Offer civic education and training on legal rights and national constitutions – these trainings should be developed in consultation with representative organizations of persons with disabilities and be offered in accessible formats for persons with disabilities. Empower persons with psychosocial disabilities, who have been especially marginalized, to advocate for political rights.

5. Ensure that public institutions and public services are fully accessible to all persons with disabilities. Make ministries, town halls, other government offices and other public institutions accessible for persons with disabilities, including through the provision of reasonable accommodation upon request. Ensure that online governmental portals are accessible for persons with disabilities, by complying with the W3C guidelines. Make online application for public services possible. Ensure that the mechanisms for reporting discrimination in public institutions and public services are available and accessible to persons with disabilities.

6. Make the voting process fully accessible for all persons with disabilities. Make voting registration accessible. Make polling stations and public facilities physically accessible for persons with disabilities

and ensure that alternative methods of voting are available to accommodate the various needs of voters with disabilities. Make remote and virtual voting possible.

7. Promote an enabling environment for the political participation of persons with disabilities. Engage with media and other stakeholders to show persons with disabilities taking part in political life alongside their peers. Hire persons with disabilities, including women with disabilities, as poll workers and election observers. Make all information related to political participation available in accessible formats such as audio, braille, easy-to-understand, large print and sign language.

8. Prevent, identify and respond to instances of electoral violence against persons with disabilities. Electoral violence hinders persons with disabilities from participating in electoral processes. Involve persons with disabilities, including women with disabilities, and their representative organizations in the design and implementation of strategies to prevent electoral violence. Train election officials and law enforcement officers to identify and respond to electoral violence against persons with disabilities, particularly against Indigenous persons with disabilities and women with disabilities. Develop mechanisms to report and monitor electoral violence against persons with disabilities.

9. Ensure the participation of persons with disabilities and their representative organizations in the development and implementation of anti-corruption programmes. Develop complaint mechanisms to report corruption and bribery in consultation with representative organizations of persons with disabilities and make these mechanisms accessible to all persons with disabilities. In particular, information on these mechanisms should be made available in accessible formats, such as Braille and easy-to-understand.

10. Keep adequate levels of public spending and government expenditures for disability inclusion. Provide adequate funding to expand accessibility for persons with disabilities of public buildings, spaces and services, support the implementation of inclusive education for persons with disabilities (see the chapter on Goal 4) and cover disability benefits to support the independent living and inclusion of persons with disabilities (see the chapter on Goal 1).

Providing legal identity for all, including birth registration (target 16.9)

This section addresses the situation and progress for persons with disabilities vis-à-vis target 16.9, which aims at providing legal identity to all by 2030, including birth registration. Article 18 of the Convention on the Rights of Persons with Disabilities specifies children with disabilities shall be registered immediately after birth and have the right to a name and a nationality.

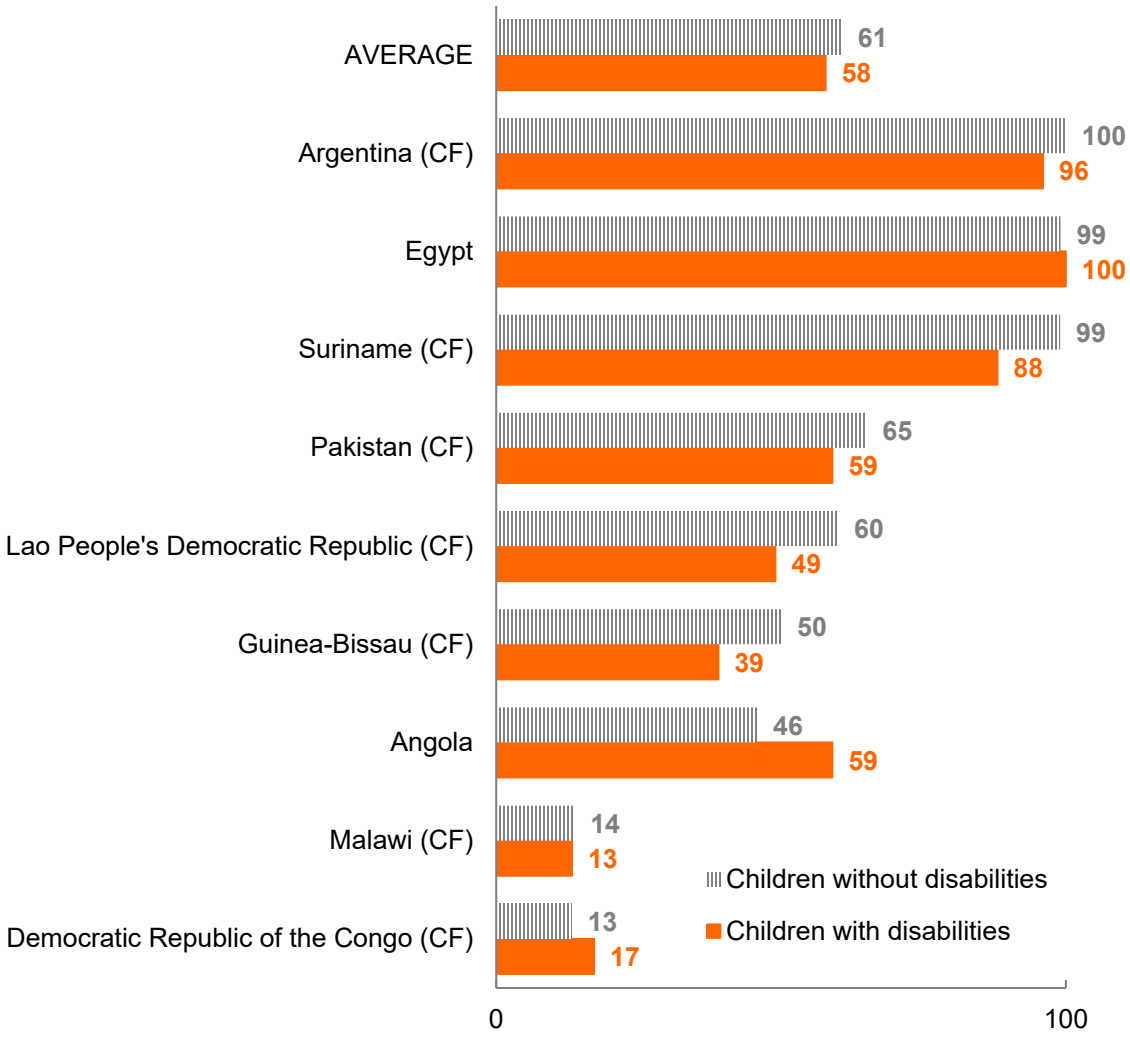
Birth registration, the official recording of a child's birth by the government, establishes the existence of the child under the law and provides the foundation for safeguarding many of the child's civil, political, economic, social and cultural rights. Due to stigma, families with children with disabilities sometimes fail to register them. This could have serious adverse implications for them in the realization of their rights and entitlements.

Current situation and progress so far

Birth registration for children with disabilities is typically ensured by general laws making birth registration compulsory for all. But due to stigma and negative stereotypes, families sometimes opt to hide family members with disabilities and do not register them at birth. Available data from nine countries shows that on average fewer children with disabilities, 58 per cent, were registered at birth than children without disabilities, 61 per cent (Figure 226). However, the gaps between children with and without disabilities vary across countries. Children with disabilities were less likely to be registered in six of these countries and more likely to be registered in three of these countries. Guinea-Bissau and Suriname showed the largest gaps between children with and without disabilities, 11 percentage points, with children with disabilities being less likely to be registered than others in both countries. Since hidden children with disabilities would not be counted in statistical surveys, it is possible that the gaps may be higher than shown in available data.

To address the lower birth registration among children with disabilities, some countries have enacted disability-specific laws to reaffirm the right of children with disabilities to be registered at birth;[571] others have conducted national surveys to understand the challenges that parents of infants with disabilities face in registering them at birth,[572] others have invested in online,[573] mobile registration programmes,[572] or registration by SMS.[574] Online, SMS and mobile registration can be particularly useful to increase the registration of children with disabilities in rural and remote areas, where parents may have challenges travelling to registration centres and may be more prone to register the birth of their infant within their communities or the comfort of their homes.

Figure 226. Percentage of children with disabilities who have been registered at birth, in 9 countries, in 2020 or latest year available.



Note: (CF) identifies data produced using the Child Functioning Module. Data from Angola cover children and youths under 18 years of age; data from Argentina, the Democratic Republic of the Congo, Guinea-Bissau, Lao People's Democratic Republic, Malawi, Pakistan and Suriname cover children aged 2 to 5 years; and data from Egypt cover children aged 0 to 4 years.
Source: UNDESA (on the basis of data from DHS[6]) and UNICEF (2021).[46]

More progress will be needed to achieve target 16.9 for persons with disabilities by 2030. For example, Angola, the Democratic Republic of the Congo, Guinea-Bissau, Lao People's Democratic Republic, Malawi and Pakistan will have to increase the birth registration rate for persons with disabilities by 3 to 6 percentage points every year until 2030 in order to ensure that all children with disabilities are registered by 2030. To eliminate the gap between children with and without disabilities in birth registration rates, Guinea-Bissau, Lao People's Democratic Republic, Pakistan and Suriname will have to decrease the gap by 1 percentage point every year until 2030.

Impact of the COVID-19 pandemic

The disruptions caused by lockdowns and social restrictions resulted in declines in birth registration during COVID-19. Only a minority of countries were able to maintain service continuity for birth registrations during the COVID-19 restrictions.[575] Many civil registration offices either closed or remained open with social distancing measures in place. Few countries established business continuity plans or developed strategies to deal with the backlog when restrictions were lifted.

As infants with disabilities have been at higher risk to die from COVID-19 (see the chapter on Goal 3), parents of infants with disabilities may have been particularly reticent to risk COVID-19 exposure when travelling to and attending civil registration offices to register their child. The pandemic is likely to have increased the gap in birth registration between children with and without disabilities.

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Summary of findings and the way forward

Birth registration makes children with disabilities visible and empowers them to access education, justice and health services. Birth certificates also protect children with disabilities against early marriage (see the chapter on Goal 5) and child labour (see the chapter on Goal 8). In some countries, a large percentage of children with disabilities remains unregistered and at higher rates than children without disabilities. Stigma is often the barrier.

Faster progress will be needed to achieve target 16.9 for persons with disabilities by 2030. Countries with birth registration for children with disabilities lower than 50 per cent as of 2023 will have to increase the birth registration rate for persons with disabilities by 7 or more percentage points every year until 2030 in order to ensure that all children with disabilities are registered by 2030. For some countries this means rates of progress will need to be at least twice the current rates of progress. Countries where children with disabilities are being left behind in registration may need targeted measures to address the gap.

The following targeted initiatives can promote the registration of children with disabilities:

1. Combat stigma and negative attitudes towards persons with disabilities. Use the media to portray positive images of persons with disabilities. Raise awareness among parents of infants with disabilities of the importance of registering their birth. Involve persons with disabilities in designing awareness campaigns.

2. Conduct studies to identify barriers to registering children with disabilities and target efforts to address those barriers.

3. Provide online, SMS and mobile birth registration. Remote and mobile birth registration will facilitate the process for all parents, and mobile registrations may especially help parents of children with disabilities in rural and remote areas.

4. Provide disability training for officers responsible for the birth registration process, both in civil registration offices and in health facilities, to combat negative attitudes towards disability.

5. Make contingency plans for maintaining birth registration in crisis situations and emergencies, like pandemics. To ensure the operational continuity of birth registrations of children with disabilities during crises and emergencies, make contingency plans to meet demand for registration during the crisis and to deal with possible backlogs after the crisis. Invest in online and SMS services for birth registration and have contingency plans to move fully remotely in case of emergency situations leading to lockdowns. Involve families of children with disabilities in designing these contingency plans.

Ensuring public access to information (target 16.10)

This section will focus on ensuring public access to information for persons with disabilities (target 16.10). Public access to information can be defined as seeking, receiving and imparting information held by public bodies. Information can be transmitted in various ways, in digital or hard formats.

The Universal Declaration of Human Rights establishes the right to seek and receive information. In line with this right, the Convention on the Rights of Persons with Disabilities requires States Parties to take appropriate measures to ensure that persons with disabilities: (i) have access to information (Article 9); and (ii) can exercise the right of freedom to seek and receive information on an equal basis with others and through all forms of communication of their choice (Article 21).

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 addresses the barriers that persons with visual impairments face in accessing published works by introducing limitations and exceptions to copyright rules in order to permit reproduction, distribution and the availability of published works in formats designed to be accessible to persons with visual impairments or print disabilities, and by permitting the exchange of these works across borders by organizations that serve these persons.

This section presents data and evidence depicting the current situation and trends in access to public information for persons with disabilities, discusses current practices and concludes with recommendations to achieve this target by 2030 for persons with disabilities.

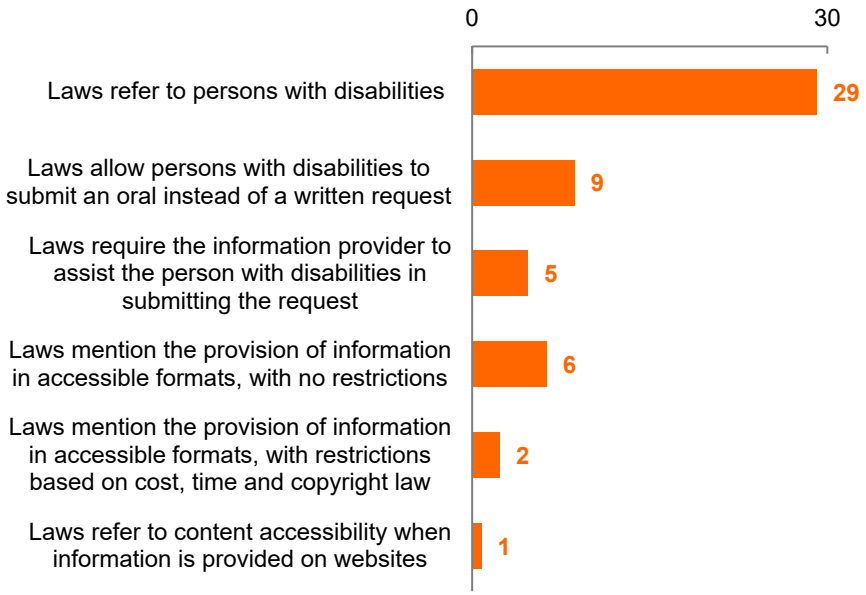
Current situation and progress so far

For many persons with disabilities, accessing public information is a path full of obstacles, with many countries lacking legal requirements for information to be shared in formats and languages that are accessible to persons with disabilities.

SDG indicator 16.10.2 monitors the number of countries that adopt and implement constitutional, statutory or policy guarantees for public access to information. These guarantees are often regulated by national laws on access to information, but the rights of persons with disabilities are absent in most of these laws and, when reference is made to persons with disabilities and accessibility, the scope is limited. Among 127 countries with laws on access to information, only 29 per cent of countries refer to persons with disabilities and their rights in these laws (Figure 227). With regard to making a request for access to information, only 9 per cent of countries allow applicants with disabilities to submit an oral request where a written request would normally be required. Additionally, only 5 per cent of countries require the information provider to assist the persons with disabilities in submitting the request when their disability prevents them from doing so in a manner prescribed by the law. In terms of the provision of information in accessible formats, only 6 per cent of countries mention the provision of information to persons with disabilities in an accessible format, and another 2 per cent of countries mention this provision but allow

for restrictions in the provision of accessible formats based on cost, time and copyright laws. Only 1 per cent of countries refers to content accessibility for persons with disabilities when information is provided on websites.

Figure 227. Percentage of countries that include provisions for persons with disabilities and for accessibility in their laws on access to information, in 127 countries, in 2020.



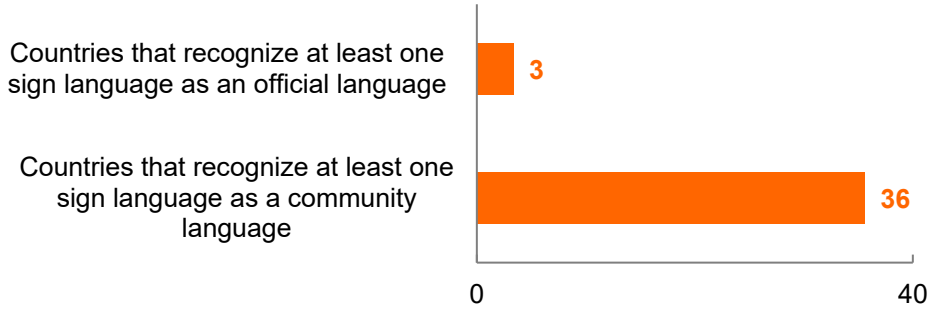
Source: UNESCO (2023).[576]

Public information presented in national government online portals is largely not accessible: 63 per cent of online national governmental portals worldwide do not comply with the Web Content Accessibility Guidelines (see the chapter on target 9.c and the chapter on targets 16.6 and 16.7). Africa has the largest percentage of countries with governmental websites that are not accessible for persons with disabilities (87 per cent) and Europe the lowest (30 per cent). Moreover, lack of access to ICT can also be a barrier to access public information for persons with disabilities, as public information is increasingly shared digitally. Many ICTs are not affordable and not accessible for persons with disabilities (see the chapter on target 9.c).

To ensure equal access to public information, information needs to be presented in languages used by persons with disabilities. Yet, in many countries, public information is typically not made available in sign languages. Among 90 countries, only 3 per cent recognize at least one sign language as an official language; and only 36 per cent recognize at least one sign language as a community language (Figure 228).

Barriers to persons with disabilities persist in public services that are often used to access public information. For example, a survey of 131 public libraries in 15 countries worldwide, indicated that only 49 per cent of libraries have a local policy on accessibility for persons with disabilities, only 15 per cent have a budget for accessibility, and only 10 per cent have all their staff trained on accessibility (with 37 per cent indicating that no staff has been trained on accessibility).[562] Accessible features are more prevalent, with 85 per cent of the libraries having features to make them accessible to persons with physical disabilities, but only 53 per cent for persons with sensory disabilities and 57 per cent for persons with cognitive disabilities. Overall, 59 per cent of these libraries cooperate with representative organizations of persons with disabilities, and many libraries provide dedicated services for persons with disabilities to access information, including for blind persons and persons with visual impairments (42 per cent of libraries), for persons with disabilities who are homebound (40 per cent of libraries), for persons with mobility impairments (37 per cent of libraries), for persons with print disabilities (34 per cent of libraries), for deaf persons and persons with hearing impairments (27 per cent of libraries), for persons with autism (25 per cent of libraries), for persons who have difficulty holding a book (15 per cent of libraries), for persons with mental or psychosocial disabilities (15 per cent of libraries) and for the deafblind (9 per cent of libraries).

Figure 228. Percentage of countries that recognize sign languages as community languages and as official languages, in 90 countries, in 2023.

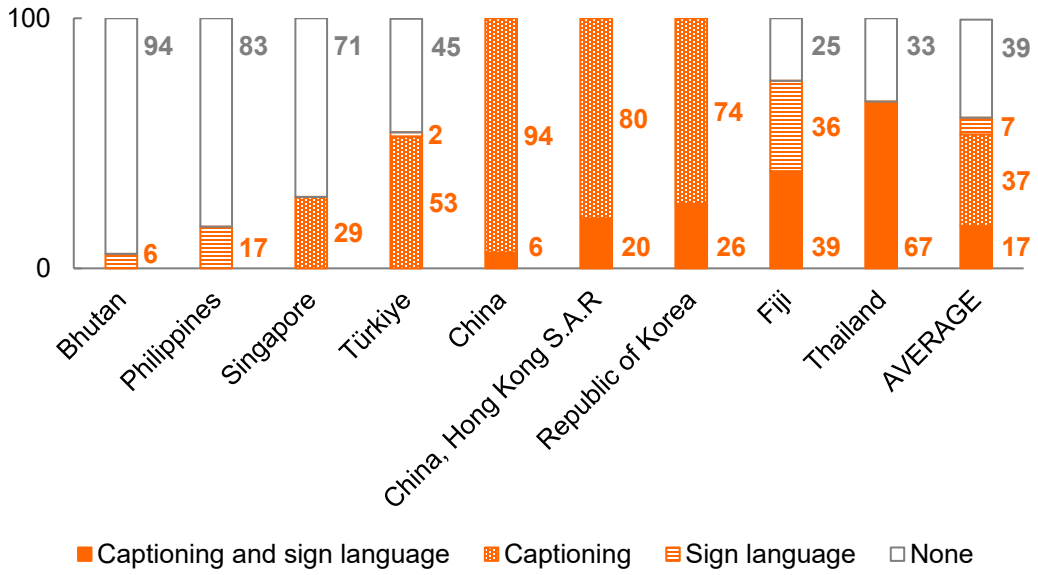


Source: UNESCO World Atlas of Languages.[577]

Many national public TV channels also lack features to make them accessible to persons with disabilities. In nine countries or areas in Asia and the Pacific, on average, only 17 per cent of newscasts on national public TV channels include both captioning and sign language, 37 per cent include captioning only, 7 per cent include sign language only and 39 per cent do not include any of these accessibility features (Figure 229). The availability of these accessibility services in news programmes on national public TV vary from country to country. In Bhutan, only 6 per cent of newscasts include accessibility features, and the only feature available is sign language. In Thailand 67 per cent of newscasts include both captioning and sign language. In China, Hong Kong (Special Administrative Region of China) and in the Republic of Korea, all newscasts include captioning.

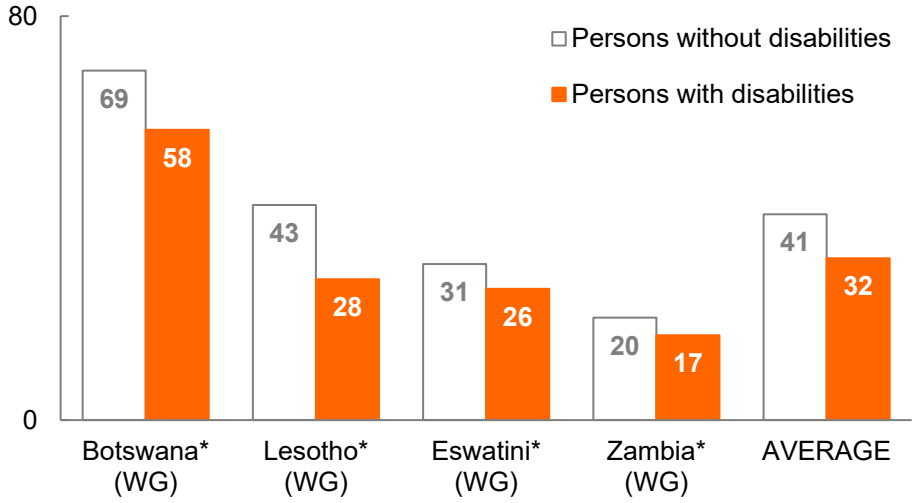
Moreover, persons with disabilities tend to have less access to sources of information that can act as alternatives or complements to public information. In particular, since persons with disabilities tend to have fewer financial resources and are less likely to be employed than others (see the chapters on Goal 1 and Goal 8), access to information may not be affordable to them, resulting in lower access. For instance, in four countries in Africa, on average, only 32 per cent of persons with disabilities can afford a newspaper compared to 41 per cent of persons without disabilities (Figure 230). In all four countries a lower percentage of persons with disabilities than persons without disabilities can afford a newspaper, with the widest gap observed in Lesotho (15 percentage points). Differences between men and women with disabilities in these countries are negligible (Figure 231), but marked differences exist between persons with disabilities living in rural versus urban areas, with a higher percentage of persons with disabilities in urban areas (50 per cent on average) than in rural areas (34 per cent on average) being able to afford a newspaper (Figure 232).

Figure 229. Percentage of duration of news programmes of national public TV channels that contain captioning and sign language, in 9 countries or areas in Asia and the Pacific, in 2022 or latest year available.



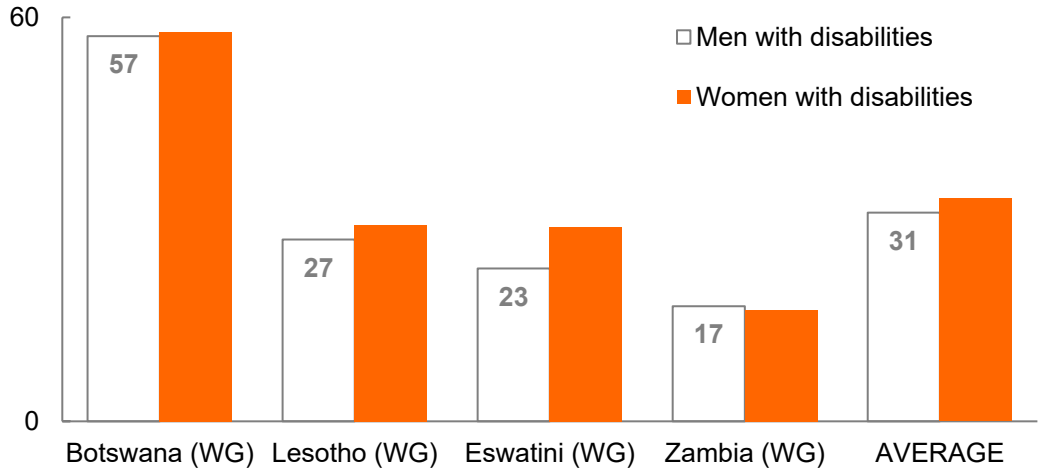
Note: S.A.R. refers to Special Administrative Region.
Source: ESCAP.[14]

Figure 230. Percentage of persons who can afford a newspaper, by disability status, in 4 countries, in 2015 or latest year available.



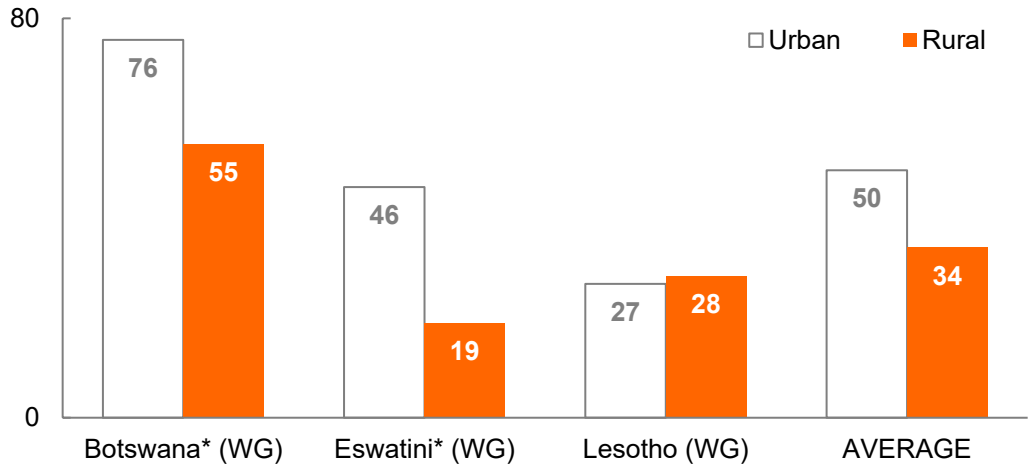
Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.
Source: UNDESA (on the basis of data from SINTEF[9]).

Figure 231. Percentage of persons with disabilities who can afford a newspaper, by sex, in 4 countries, in 2015 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between men and women with disabilities is statistically significant at the level of 5 per cent.
Source: UNDESA (on the basis of data from SINTEF[9]).

Figure 232. Percentage of persons with disabilities who can afford a newspaper, by area of residence, in 3 countries, in 2015 or latest year available.



Note: (WG) identifies data produced using the Washington Group short set of questions on functioning. An asterisk (*) indicates that the difference between persons with disabilities in rural and urban areas is statistically significant at the level of 5 per cent.
Source: UNDESA (on the basis of data from SINTEF[9]).

Summary of findings and the way forward

Persons with disabilities face a number of barriers to pursuing equal access to public information. National laws on access to public information do not always include the perspectives and needs of persons with disabilities and lack accessibility provisions: only 6 per of countries mention the provision of public information in accessible formats for persons with disabilities, with no restrictions; and only 1 per cent of countries refer to content accessibility for persons with disabilities when the information is provided online. Moreover, public information is not always available in accessible formats for persons with disabilities, such as easy-to-understand and sign language. One barrier to a wider use of sign language in the provision of public information is the lower number of countries that recognize sign languages as official languages: only 3 per cent of countries recognize at least one sign language as an official language.

Accessibility policies and features are also lacking in public bodies that typically provide public information. For instance, only 49 per cent of public libraries worldwide have a policy on accessibility for persons with disabilities and only 15 per cent have a budget for accessibility; in Asia and the Pacific, only 17 per cent of newscasts on national public TV channels include both captioning and sign language.

One barrier to persons with disabilities to access information in general is the lack of financial resources. For example, in some countries in Africa, less than 30 per cent of persons with disabilities can afford a newspaper, with persons with disabilities in rural areas being less likely to be able to afford a newspaper.

To enhance access to public information for persons with disabilities, these issues need to be addressed, namely by the following recommended actions:

1. Adopt or revise current laws on access to information to ensure equal access for persons with disabilities. Countries should take steps towards an inclusive and comprehensive legislative framework containing minimum mandatory accessibility standards that ensure access to public information for all persons with disabilities, without discrimination on any grounds including but not limited to type of disability, geographical location, financial means and language capabilities.

2. Raise awareness and conduct trainings on the rights of persons with disabilities among staff involved in access to public information. Train public employees on disability and accessibility to improve access and accessibility of information. Training modules should discuss accessibility standards and available tools and methods that could be utilized for enhancing the accessibility of the information. Involved persons with disabilities and their representative organizations in the design and implementation of awareness-raising campaigns and trainings.

3. Allocate adequate human and financial resources to ensure accessibility of public information. Develop an accessibility budget for public bodies involved in access to public information and hire the necessary human resources to make access to public information fully accessible to all persons with disabilities.

4. Monitor and evaluate access and accessibility of public information to persons with disabilities. Conduct periodic surveys and collect feedback from persons with disabilities to understand and overcome the obstacles they face in accessing public information.

Mobilizing official development assistance (target 17.2)

Target 17.2 calls on developed countries to implement fully their official development assistance commitments, with special targets set for least developing countries. This section will focus on the role of official development assistance in supporting the realization of the Convention on the Rights of Persons with Disabilities (CRPD) and of the Sustainable Development Goals (SDG) by, for and with persons with disabilities.

Official development assistance is one part of international cooperation, which the CRPD fully recognizes as important in supporting national efforts to pursue the objectives of the Convention (article 32). The CRPD also stresses the importance of making international cooperation inclusive and accessible to persons of disabilities and to promote economic assistance, including in facilitating access to assistive technologies.

The Addis Ababa Action Agenda committed to scale up international cooperation (i) to allow all children to complete free, equitable, inclusive and quality early childhood, primary and secondary education, (ii) to upgrade education facilities that are disability-sensitive and (iii) to increase the percentage of qualified teachers in developing countries, especially in least developed countries and small island developing States.

Although official development assistance for supporting disability inclusion and the realization of the rights of persons with disabilities has been in place for many years, its monitoring has remained elusive until recently due to the lack of monitoring mechanisms.

As monitoring mechanisms are now in place to provide insights into the role of one type of official development assistance – bilateral aid – on disability inclusion, this section will provide an overview of the current situation and of progress in bilateral aid for disability inclusion and the realization of the rights of persons with disabilities and provide recommendations on how to mobilize official development assistance for the realization of the CRPD and of the SDGs by, for and with persons with disabilities.

Current situation and progress so far

Since 2018, the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) started to collect data on development cooperation activities that support the inclusion and empowerment of persons with disabilities.[578] The data are collected yearly, and are part of the regular data collection on development cooperation activities from DAC members and other bilateral countries, multilateral institutions and philanthropic actors in the OECD-DAC Creditor Reporting System.

Disability-related data is collected through a voluntary policy marker. The marker tracks if, and to what extent, development cooperation activities support the inclusion and empowerment of persons with

disabilities. The marker distinguishes between activities that have disability inclusion as a principal objective (activities that have been specifically developed for this scope) and activities with disability inclusion as a significant objective (activities that have other prime objectives but have been formulated or adjusted to help meet the relevant disability concerns)[579] — see Box 12. The policy marker on disability can be applied to bilateral activities in any sector (excluding administrative costs).

Box 12. Aid for Disability inclusion – definitions

Bilateral aid is provided directly by a donor country to an aid recipient country.

Multilateral aid is channelled via an international organization that is active in development (for example, the World Bank or the United Nations Development Programme).

An activity can target disability inclusion as a "principal objective" or a "significant objective".

Principal objective means disability was an explicit objective of the activity and fundamental in its design.

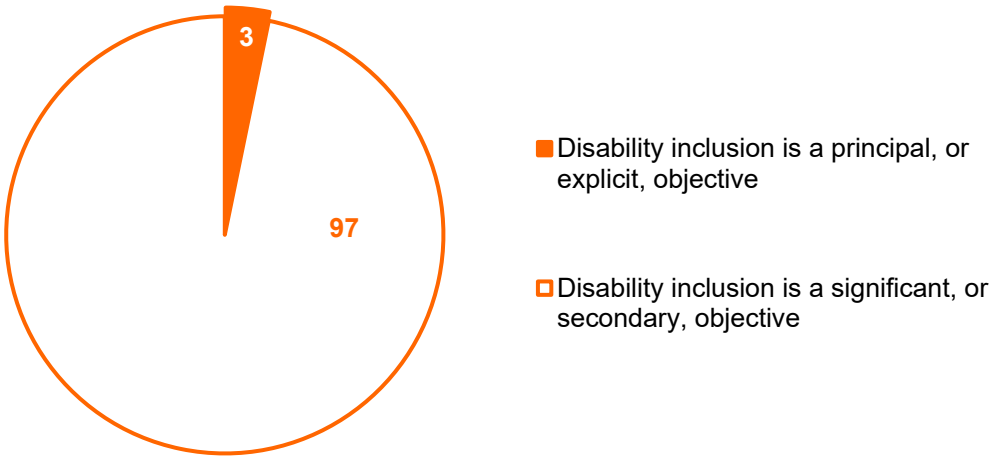
Significant objective means disability was an important, but secondary, objective of the activity.

Several countries implemented the policy marker: 24 countries reported disability-related development commitments in 2021. These countries reported 15.6 billion US dollars of bilateral ODA with disability inclusion objectives. In most cases (15.1 billion US dollars, corresponding to 97 per cent of the disability-inclusive ODA), the disability objectives are recorded as *significant* or secondary objectives, while activities with disability as *principal* objectives amounted to 504 million US dollars, corresponding to 3 per cent of the disability-inclusive ODA (Figure 233). This indicates that support to disability inclusion largely consists in mainstreaming disability-inclusion in activities that have other main objectives. These figures are similar to the ones observed for other policy areas of development cooperation. In particular, ODA that supports gender equality, which is also tracked by a policy marker, is also mainly composed (95 per cent) of activities with gender equality as a significant objective.[580]

For several donors, disability objectives are included in a relatively large part of their bilateral aid (Figure 234), the largest being Iceland (44 per cent), the European Union (29 per cent), Japan (29 per cent), Ireland (24 per cent) and the United Kingdom (24 per cent). In total, 17 per cent of bilateral ODA was reported as disability-related in 2021.

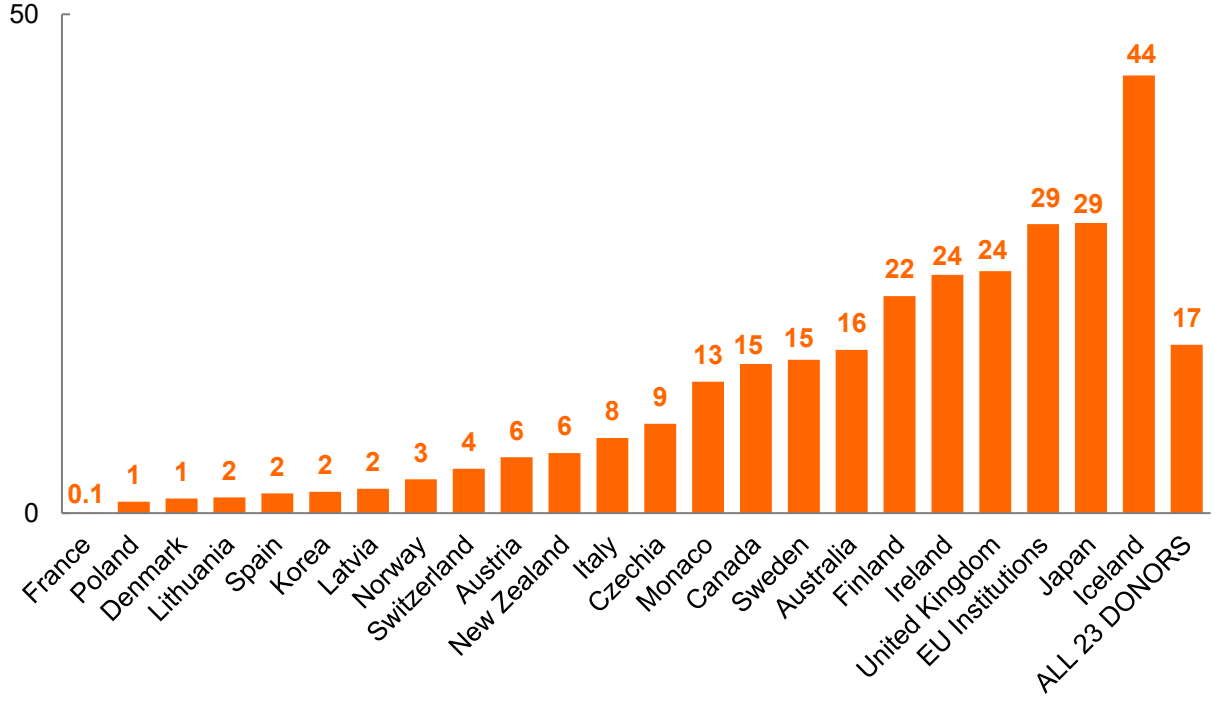
Support for disability inclusion is embedded in aid activities in many sectors (Figure 235). The sector with the most disability-related commitments in 2021 was Transport and storage (3.4 billion US dollars), mostly for activities in support of rail transport, followed by Health (2.8 billion US dollars).

Figure 233. Percentage of disability-inclusive bilateral aid, for which disability is a main or secondary objective, in 2021.



Note: Bilateral aid refers to bilateral official development assistance.
Source: OECD Creditor Reporting System.

Figure 234. Percentage of bilateral aid that is disability inclusive, for 23 country donors, in 2021.

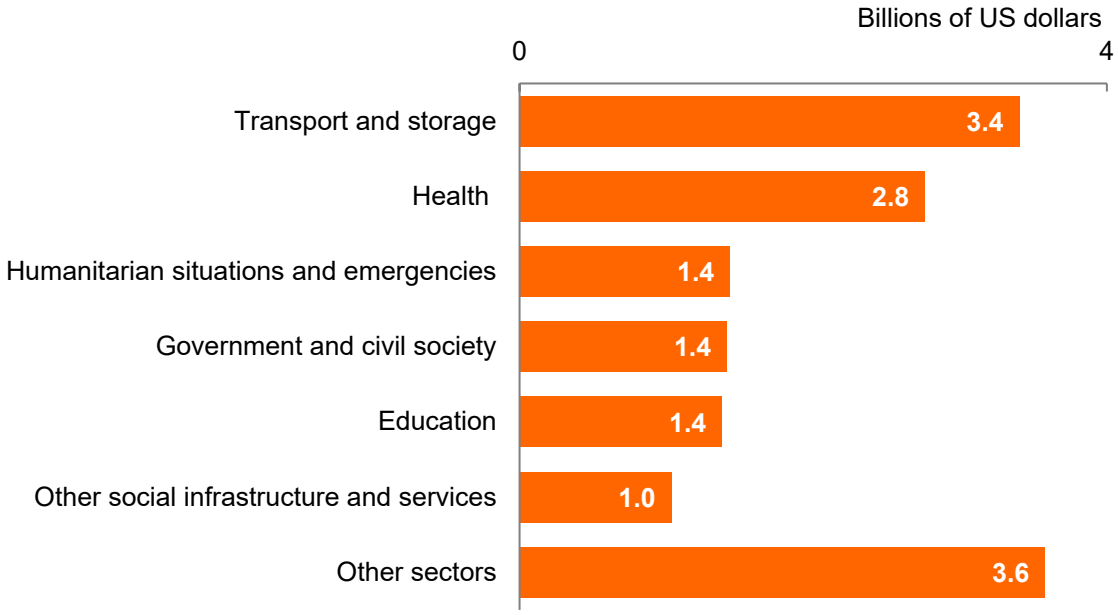


Note: Bilateral aid refers to bilateral official development assistance.
Source: OECD Creditor Reporting System.

Humanitarian aid (which includes emergency response, reconstruction relief and rehabilitation and disaster prevention and preparedness) is also a focus of disability-related activities (1.5 billion US dollars) as well as government and civil society (1.5 billion US dollars) and education (1.4 billion US dollars).

Looking exclusively at the activities that have disability inclusion as the main objective of the activity, the largest sectors are health (145 million US dollars as of 2021), followed by government and civil society (74 million US dollars) and education (54 million US dollars).

Figure 235. Disability-inclusive aid, by sector, in 2021.



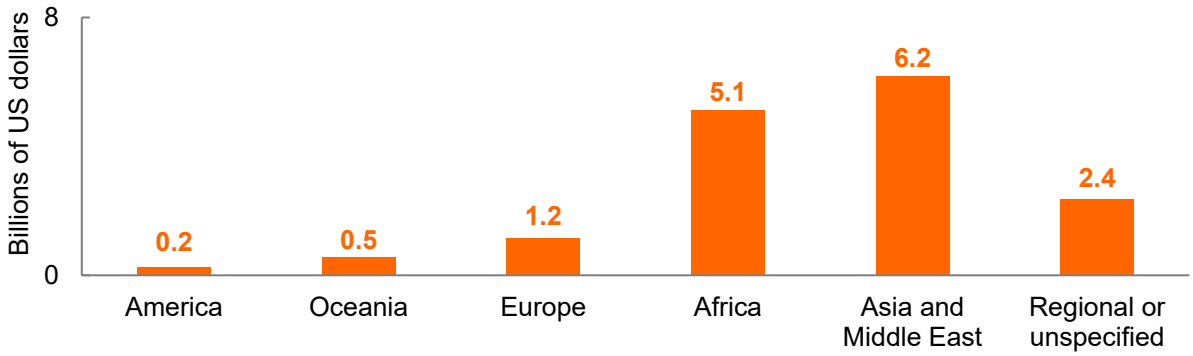
Note: Aid refers to official development assistance. Amounts shown in current 2021 US dollars.
Source: OECD Creditor Reporting System.

Disability inclusive aid focuses mainly on Asia and the Middle East (6.2 billion US dollars in 2021) followed by Africa (5.1 billion US dollars) – Figure 236. The major recipient of disability-inclusive ODA is India (2.3 billion US dollars in 2021), followed by Bangladesh (1.7 billion US dollars), Türkiye (756 million US dollars) and Indonesia (506 million US dollars). The majority of disability-inclusive ODA is focused on few recipients, in fact the commitments to the top 10 recipient countries amount to 67 per cent of the total disability-related ODA committed to individual countries (that is, excluding regional and global programmes).

Data show strong linkages between the activities that support disability inclusion and the activities that support gender equality. In fact, in 2021, over 90 per cent of the disability-related activities are also reported as contributing to gender equality. In particular, 87 per cent of the activities marked significant for disability are also marked significant for gender equality. This shows that development cooperation

activities aim to support the equality, inclusion and empowerment of persons with disabilities and of women with cross-cutting approaches that include different groups of beneficiaries and their intersectionality.

Figure 236. Disability inclusive aid, by recipient region, in 2021.

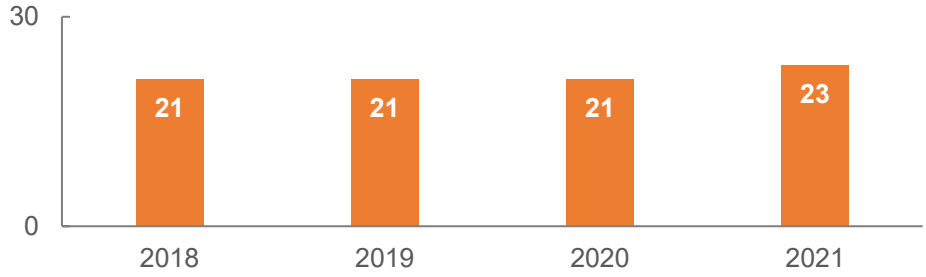


Note: Aid refers to official development assistance. Amounts shown in current 2021 US dollars.
Source: OECD Creditor Reporting System.

Countries have increasingly reported on the disability marker in their bilateral aid (Figure 237). In 2018, the first year of adoption of the disability marker, 21 country donors reported on this marker in their bilateral aid. In 2021, 23 reported.

The disability marker was already picked up by donors other than countries. In 2018-2021, 18 philanthropic foundations reported on the disability marker for their aid, totalling 452 million US dollars[581] to activities with disability inclusion objectives over this four-year period.

Figure 237. Number of country donors reporting on the disability marker in their bilateral aid, by year, in 2018-2021.



Note: Aid refers to official development assistance. The data refer to individual countries and the European Union.
Source: OECD Creditor Reporting System.

Apart from monitoring aid for disability inclusion, there have been efforts in recent years to coordinate this aid through the creation in 2015 of the Global Action on Disability (GLAD) Network, a coordination body of bilateral and multilateral donors and agencies, public and private foundations as well as representative organizations of persons with disabilities.

Summary of findings and the way forward

The OECD DAC introduced in 2018 a policy marker to track bilateral aid in support of the inclusion and empowerment of persons with disabilities. As of 2021, 23 country donors reported commitments on disability-inclusive bilateral aid. Bilateral aid in support of disability inclusion surpassed 15 billion US dollars in 2021, with 17 per cent of total bilateral aid reported in 2021 including disability inclusion objectives.

In most cases, disability inclusion objectives are being incorporated as the secondary (significant) objectives of activities that have other focus areas, showing that disability inclusion is being mainstreamed in broader bilateral aid activities. Only a small portion of disability-inclusion aid, 3 per cent, includes disability inclusion as the main (principal) objective of the activity.

As disability markers for multilateral aid are largely missing, it is not possible at this point to assess the role of international organizations in providing this assistance. Several philanthropic foundations are already reporting on the disability marker, but there is scope for increasing the reporting from public and private foundations.

The following steps can contribute to ensuring that aid is increasingly disability-inclusive:

1. Improve data and research on multilateral aid for disability inclusion. Encourage multilateral organizations to report on a disability marker for their multilateral aid and encourage all donors to report the disability marker in their bilateral aid. Encourage research tracking aid from private entities to create a global mapping of aid for disability inclusion. Undertake evidence-based research on the application of aid versus country needs to identify and address gaps.

2. Encourage bilateral and multilateral donors to include disability-inclusion objectives across all relevant aid, avoid duplication of aid activities and cover areas where aid activities are lacking, such as disability-inclusive climate action and combating multiple intersecting forms of discrimination. Encourage donors to invest in areas that need more attention, such as access to basic services for persons with disabilities, like access to water, sanitation and energy. Encourage donors to also invest in areas that can create synergies and be impactful for all, if not most SDGs, like access to assistive technology, including transfer of technology from developed countries to other countries. Some countries tend to receive the bulk of aid, while others urgently needing assistance to implement disability-inclusion activities are struggling to receive assistance. Conducting a comprehensive study on needs versus assistance can identify gaps and duplication.

3. Encourage focal points from sectors other than disability inclusion to participate in mechanisms of coordination of bilateral and multilateral aid. These mechanisms have mostly focal points on disability and would benefit from wider cross-sectoral expertise to ensure that aid is effectively allocated, coordinated and used with successful outcomes.

4. Raise awareness of CRPD among the private sector involved in aid activities and encourage them to build partnerships with implementing partners that follow the CRPD. Many private sector donors work with organizations that follow a traditional model of disability not in line with the CRPD.

5. Involve representative organizations of persons with disabilities in the implementation of international cooperation activities. To ensure an effective implementation of international cooperation activities regarding disability inclusion, donors should ensure that representative organizations of persons with disabilities are consulted and meaningfully engaged from the beginning of these activities and in all stages of implementation.

Enhancing the use of enabling technology (target 17.8)

Target 17.8 calls for enhancing the use of enabling technology. This section focuses on enhancing the use by persons with disabilities of assistive technology, an enabling technology that can drive remarkable change in promoting the inclusion, participation and engagement of persons with disabilities, in reducing inequalities between persons with and without disabilities and therefore in achieving all Sustainable Development Goals and leaving no one behind.

Assistive technology is an umbrella term for assistive products and related systems and services. Assistive products include items such as wheelchairs, spectacles, hearing aids, prostheses, continence pads, communication boards and reminders. A key target to providing access to this technology is target 3.8, which focuses on achieving universal health coverage as the delivery of assistive technology is often carried out through health systems.

The Convention on the Rights of Persons with Disabilities requires States to provide assistive technology to enable people with disabilities to exercise their rights (articles 4, 20, 26, 29 and 32). States should undertake or promote research and development of, and promote the availability and use of, assistive technology at an affordable cost (article 4). They should also provide accessible information about assistive technology (article 4). In international cooperation, States should provide, as appropriate, technical and economic assistance, including by facilitating access to and sharing of accessible and assistive technologies, and through the transfer of technologies (article 32).

The World Health Assembly Resolution 71.8 on improving access to assistive technology, adopted in 2018, urges States (i) to develop, implement and strengthen policies and programmes to improve access to assistive technology; (ii) to ensure that adequate and trained human resources for the provision and maintenance of assistive products are available; and (iii) to ensure that users and their carers have access to the most appropriate assistive products, and use them safely and effectively. Other areas covered by the Resolution include the development of a national list of priority assistive products; conducting research, development, innovation and design; engaging in international and regional collaboration; producing relevant population-based data; investing in barrier-free environments; and investing in access to assistive technology in the context of emergency preparedness and response programmes.

Current situation and progress so far

In 2021, one in three persons needed one or more assistive products and more than 2.5 billion people around the world would have benefited from using one or more assistive products.[301] This number is expected to rise above 3.5 billion by 2050.[301] There is considerable global inequity among countries in terms of access to assistive technology. Among 29 countries, the percentage of persons with their needs for assistive technology met among those with needs varied from 3 per cent to 89 per cent (Table 7). Both

overall need and met need for assistive products increase with the human development index, a composite index of life expectancy, education and per capita income indicators.[301] In countries with a low human development index, only 11 per cent of persons who need assistive technology have these needs met, whereas this percentage is 88 per cent in countries with a very high human development index. Worldwide, this corresponds to more than 800 million persons who needed assistive technology in 2021 and did not have access to it. By 2030, this is expected to increase to at least 1.2 billion unless action is taken to reduce this unmet need.

Table 7. Percentage of persons with need for assistive products and those with their needs met, by human development index category, in 2021.

Human development index (Number of countries)	**Percentage of persons with need for assistive products** (Median and range)	**Percentage of persons with their needs for assistive technology met among those with needs** (Median and range)
Low (7)	15 (10 – 27)	11 (3 – 17)
Medium (9)	21 (13 – 31)	33 (16 – 65)
High (9)	26 (15 – 40)	65 (35 – 80)
Very high (4)	56 (35 – 69)	88 (55 – 89)

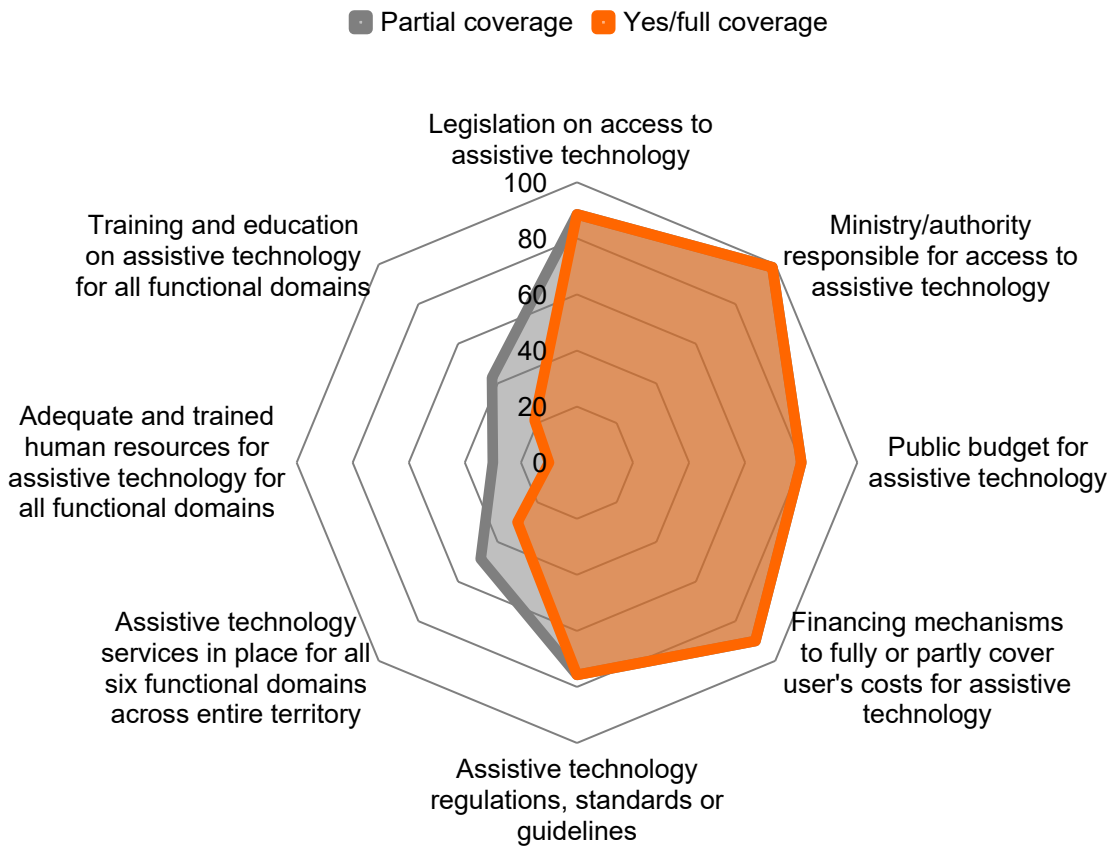
Source: WHO and UNICEF (2022).[301]

The most frequently reported barrier to accessing assistive products across the surveyed countries was affordability (31 per cent) followed by lack of support to get them. Regarding funding for assistive products, out-of-pocket payments for assistive products were reported by a majority of users (66 per cent). Funding from family and friends was the second most common funding source. Users mainly got their assistive products from private shops, clinics or pharmacies (67 per cent) while self-made products and products from public services were other important sources. Most users (68 per cent) travelled less than 25 kilometres to obtain their assistive products, but some had travelled more than 100 kilometres.[301]

Various countries have taken measures to promote access to assistive technology (Figure 238). In 2021, among 70 countries, 89 per cent had at least one piece of legislation on access to assistive technology, and 99 per cent had at least one ministry or other authority responsible for access to assistive technology. Eighty per cent had a public budget allocated for assistive technology and 90 per cent had financing mechanisms in place to cover users' costs for assistive technology fully or partly. Seventy-six per cent of countries had assistive technology regulations, standards or guidelines in place. Thirty per cent had services in place for all six functional domains (cognition, communication, hearing, mobility, self-care and vision) across their entire territory, while the services in 49 per cent of countries did not cover all

functional domains or the entire territory. Only 10 per cent of countries reported adequate and trained human resources at all levels for all functional domains. An additional 30 per cent of countries had human resources only for some functional domains (mainly mobility, vision and hearing). In relation to training, 21 per cent of countries had training and education on assistive technology for all functional domains, while 43 per cent of countries had training and education for some functional domains (mainly mobility, vision and hearing).[301]

Figure 238. Percentage of countries with measures to promote access to assistive technology, by type of measure, in 70 countries, in 2021.



Note: The six functional domains are cognition, communication, hearing, mobility, self-care and vision. Full coverage refers to all six functional domains being covered or covers entire territory. Partial coverage refers to one to five functional domains covered or only part of territory covered.
Source: WHO and UNICEF (2022).[301]

For many persons with disabilities, social protection systems are critical to financing the costs of assistive technology through different mechanisms such as health insurance, subsidies and direct provision.[582]

Among the 63 countries that reported at least one financing mechanism to cover users' costs, 45 had a combination of measures.[301] However, in most developing countries, the costs of assistive technology are covered out-of-pocket or from families and friends, with government support being less frequent. This is explained by two main elements: the limited scope of assistive technology covered by existing social protection or universal health coverage schemes combined with the limited coverage of those schemes due to issues related to disability certification, access to information and indirect costs of accessing assistive technology, such as transport, which are rarely covered by those schemes.[583,584]

Having laws and responsible government bodies in place does not necessarily guarantee that assistive technology is available to those in need. Similarly, public budgets and multiple financing mechanisms do not necessarily cover costs sufficiently to obtain assistive technology. Moreover, shortfalls in well-trained workforces and service provision likely exacerbate the lack of necessary support for people to access assistive products and to use them safely and effectively.[301]

To support countries in their efforts to improve access to assistive technology, WHO published a global priority assistive products list in 2016. It is not a restrictive list but aims to provide States with a model from which to develop national lists of priority assistive products. Since then, at least seven countries have adopted national lists of priority assistive products (for an example, see Box 13).[585]

Box 13. Improving access to good quality and affordable assistive products in Nepal

In 2018, the Ministry of Health and Population of the Government of Nepal published a national priority assistive products list. The list contains 45 assistive products and recommends 13 assistive products for emergencies. Guiding principles for budgeting, supply and provision were published and actions were set for improving access to the priority assistive products. In May 2022, standards for assistive technology were approved by the Ministry of Health and Population, which include measures on the responsibility of institutions and personnel in the provision of assistive products, the quality requirements and regulations on prices for the 45 priority assistive products.

Source: Government of Nepal (2018)[586] and Gurung (2022).[587]

A number of factors can affect the availability of assistive technology at the national level, including intellectual property rights, international trade and international cooperation. These factors can particularly impact countries with low resources that cannot produce or finance the assistive technology they need.

Access to innovative assistive technology needs to become widespread to ensure that no one is left behind. Inventions related to innovative assistive technologies are often disclosed through patents. Patents offer their owners an exclusive right to prevent others from commercially exploiting a patented invention for a limited period of time in the countries or regions in which the patent has been granted. At the same time, patents are a source of technical information and help stimulate follow-on innovations

because detailed information about an invention must be disclosed to the public by a patent applicant seeking to obtain an exclusive right over their invention. More than 132,000 inventions related to assistive technology have been patented worldwide from 1998 to 2019, with 88 per cent of these patents corresponding to conventional assistive technology (that is, innovations on well-established technology, such as hearing aids) and 12 per cent to emerging assistive technology (that is, innovations that improve conventional technology or introduce novel solutions, such as brain-computer interfaces). Some of these inventions have been filed as patents in more than one country. Patent protection for conventional assistive technology is sought primarily in China (41 per cent), the United States (27 per cent) and Japan (21 per cent) – and 16 per cent in other countries.[588] Patent protection for emerging assistive technology is sought primarily in China (44 per cent of patent families from 1998 to 2019) and the United States (38 per cent) – and 18 per cent in other countries.[588]

International trade of assistive products is concentrated in developed countries: they account for 74 per cent of the value of exports of assistive products in the world and 82 per cent of the value of imported assistive products (see the chapter on targets 17.10-17.12). The per capita value of imports of assistive products is five times higher in Europe, Northern America and Oceania than in Asia, Latin America and the Caribbean, and sub-Saharan Africa. Barriers to trade persist in assistive products. Many assistive products have taxes imposed at the border in the form of tariffs. Tariffs on some assistive products remain high. Depending on the type of assistive product, 29 to 97 per cent of least developed countries apply non-zero tariffs; and 21 per cent to 80 per cent of other countries apply non-zero tariffs. The average applied tariff is 5 per cent for wheelchairs, orthotics and prosthetics and hearing aids; and 5 per cent to 10 per cent for spectacles and lenses. Behind these average values lies a wide range of applied tariffs, sometimes as high as 35 per cent (see the chapter on targets 17.10-17.12).

International cooperation can play a major role in facilitating access to and sharing of assistive technology, including through technical and economic assistance as well as transfer of technologies. From 2018 to 2021, only a small percentage of disability-related bilateral aid focused on widening access and providing training on assistive technology (0.1 per cent, corresponding to 19 million US dollars).[589] This aid came from various donors, with the United Kingdom providing most of this aid (61 per cent), followed by Norway (23 per cent), Canada and Italy (4 per cent each), Finland (3 per cent), Czechia and Japan (2 per cent each), Austria (0.4 per cent) and Poland (0.1 per cent). Philanthropic foundations contributed 2 per cent of this aid. Among the bilateral aid directed to assistive technology, 64 per cent was directed at multiple countries worldwide, 25 per cent at countries in Asia and the Pacific, 7 per cent at countries in Africa, 3 per cent at countries in the Americas and 0.2 per cent at countries in Europe.[589] Eight per cent of the bilateral aid focusing on assistive technology was directed at least developed countries.[589]

In an international effort to accelerate the availability of assistive technology for those who need it, ATscale, a global partnership for assistive technology, was launched in 2018 with the goal of catalysing

action to reach 500 million more people with assistive technology by 2030.[590]

Impact of the COVID-19 pandemic

During the COVID-19 pandemic, from 2020 to 2022, the cost and availability of assistive products and services were affected, leading to increasing unmet needs.[591] Access barriers to assistive products and services, such as training and repair, were exacerbated worldwide due to disruptions in supply chains, social distancing requirements, and strains placed on healthcare, education, and other economic and social systems.[592,591,593] In some countries, persons with disabilities suffered a greater socioeconomic impact of the pandemic, such as job losses and reduced income (see the chapters on Goals 1 and 8), leading to additional barriers to afford the assistive technology they needed. Moreover, rising inflation since the start of the COVID-19 pandemic has impacted the cost of assistive technology. For example, in the Maldives, inflation was 8 per cent for assistive products in the first quarter of 2022, compared to a national inflation rate of 0.6 per cent.[594]

Box 14. The impact of the COVID-19 pandemic on the use of and access to assistive technology in Sweden

In Sweden, a majority of persons (86 per cent) used their assistive products as much during the COVID-19 pandemic as before the pandemic. Among those that used their assistive products less (5 per cent) or more (8 per cent) during the pandemic, the major reasons for changes in use were the same, namely: choosing to stay at home (25 per cent and 11 per cent), studying or working from home (18 per cent and 24 per cent) and doing different activities than before the pandemic (12 per cent for both groups). Less frequent reasons for changes in the use of assistive products were deteriorating health, keeping distance and others.

During the pandemic, 13 per cent of these users needed to acquire at least one assistive product and 9 per cent needed to get their assistive product serviced or repaired. Among those that needed to acquire an assistive product, 10 per cent reported that the delivery of the assistive product was delayed because of the pandemic. Similarly, among those that needed their assistive product serviced or repaired, 16 per cent reported delays in the service or repair because of the pandemic.

Source: Borg and Zhang (2022).[595]

A 2020-2021 study conducted among persons with disabilities in 24 countries around the world, found a decrease in access to needed assistive technology when comparing pre- and post-COVID-19 access: only 37 per cent of persons with disabilities could use human support like personal assistance post-COVID-19 compared to 92 per cent before COVID-19; only 49 per cent of persons with disabilities could use mobility products like wheelchairs post-COVID-19 compared to 86 per cent before COVID-19; only 4

per cent of persons with disabilities could use hearing products like hearing aids post-COVID-19 compared to 19 per cent before COVID-19.[596] The negative impact on access to assistive technology was already felt early in the pandemic. In a study in March and April 2020, 32 per cent of persons with disabilities indicated that the COVID-19 crisis had decreased their access to personal assistance, wheelchair replacement and repair, or accessibility services such as sign language interpretation.[597] However, the situation was not heavily disrupted in all countries (see Box 14).

Summary of findings and the way forward

Target 17.8 calls for enhancing the use of enabling technology and universal access to assistive technology, which is essential to ensuring the equal social, economic and political participation of persons with disabilities, and which in turn is integral to the implementation of all Goals of the 2030 Agenda for Sustainable Development. However, much work remains to be done until everyone, everywhere, uses the assistive technology they need without delay or financial or other hardships.

In countries with low levels of the human development index, only 11 per cent of the persons who need assistive products can get them; in countries with medium levels of the human development index, only 33 per cent. The most frequent barrier to accessing assistive products is cost, with this barrier being experienced by 31 per cent of those who cannot access the assistive products they need. Although 90 per cent of countries have a financing mechanism in place to fully or partially cover the users' costs for assistive technology, in practice, in most developing countries, the cost of assistive technology is covered out-of-pocket or by families or friends.

During the COVID-19 pandemic, rising inflation, especially on assistive technology, reduced incomes and financial means to afford the technology, disruptions in supply chains, access barriers created by lockdowns and other strains placed on supplying systems, led to higher unmet needs for assistive technology in many countries. For personal assistance and hearing aids, fewer than half the number of persons used them during the pandemic compared to before the pandemic.

Over the past few years, several promising steps have been taken by individual countries, regions and the international community to improve access to assistive technology. More than 80 per cent of countries have laws, regulations and financing mechanisms to support access to assistive technology. Adequate services, human resources and education on assistive technology have progressed more slowly, with less than 50 per cent of countries providing these. At least seven countries have developed national lists of priority assistive products to facilitate acquisition and prioritization of essential assistive technology.

The transfer of assistive technology from developed to developing countries can boost access to this technology worldwide. But overall, many developing countries receive insufficient aid for assistive technology, cannot import the technology they need and do not have the resources to produce or finance their own research and innovations on assistive technology. Innovations are concentrated on a few

countries, with more than 80 per cent of patents of assistive technology filed in China, Japan and the United States. Bilateral aid dedicated to providing access to assistive technology is small, corresponding to only 0.1 per cent of all bilateral aid dedicated to disability-inclusion. International trade of assistive technology happens mostly from and to developed countries, leaving developing countries mostly outside this trade. In particular, the per capita value of imports of assistive products is five times higher in Europe, Northern America and Oceania than in Asia, Latin America and the Caribbean, and sub-Saharan Africa. Trade barriers persist, with trade tariffs for some assistive products as high as 35 per cent.

The ATscale partnership launched in 2018 aims to meet the assistive technology needs of 500 million persons by 2030. This will cover a substantial part of the numbers of persons with unmet needs for assistive technology, which is expected to be over 1.2 billion by 2030. For the remaining 700 million, current bilateral aid to assistive technology, if kept at the same level as in the past years, will provide 4 cents of a US dollar for each remaining person with an unmet need for assistive technology, a level too low to cover the costs of assistive technology, which can range from a few US dollars to several thousand US dollars depending on the assistive product or service.

To address the remaining unmet needs of assistive technology by 2030, existing national, regional and international initiatives need to be expanded or complemented by other initiatives. In particular, to accelerate and better coordinate efforts to progressively improve access to assistive technology, the following recommendations should be considered:

1. Improve awareness and access to safe, effective and affordable assistive technology. Introduce, expand or advance systems and programmes for the provision of assistive technology. Strengthen regulatory systems, standards and procurement processes to ensure that assistive products are safe, effective and affordable. Enlarge, diversify and improve workforce capacity at all levels for the provision of assistive products, and increase the capacity of government officials to administer, manage and supervise assistive technology programmes. Develop and invest in enabling environments to ensure barrier-free access and use for all, including users of assistive products. Increase awareness about the benefits and availability of assistive technology among policymakers, duty bearers, media and the public at large.

2. Involve users of assistive products and their families as well as representative organizations of persons with disabilities in policy development and programme planning. Ensure that they have access to necessary information and knowledge about assistive products and related services and schemes, in accessible formats.

3. Invest in data and research on unmet needs for assistive technology to guide policymaking. Invest in data by monitoring needs for and access to assistive technology and the capacity of countries to meet those needs. Invest in research on innovation in and an enabling ecosystem for assistive technology to ensure that assistive products and related services meet identified needs. Formulate and

implement evidence-based policies and laws to support the provision of assistive technology on the basis of evidence.

4. Include assistive technology in emergency and humanitarian responses. Train all stakeholders involved in humanitarian assistance on assistive technology and make assistive technology accessible to frontline staff. Ensure that the production, distribution, delivery and provision of assistive products are resilient to disruptions in supply and service chains during pandemics and other crises.

5. Provide technical and financial assistance through international cooperation. Support national efforts, especially in least developed countries, in areas such as research, policies, regulations, fair pricing, market shaping, product development, technology transfer, manufacturing, procurement, supply, service provision and human resources.

6. Encourage local and regional production of assistive products. Support technology transfer and waivers of intellectual property rights, while creating incentives for innovation, research and development in the assistive technology sector.

7. Reduce barriers to international trade of assistive technology to help make this technology available for all persons with disabilities who need it. Promote trade of assistive technology among developing countries. Keep commitments on imports and exports of assistive technology during global health emergencies and other crises.

International trade (targets 17.10 to 17.12)

This section will focus on the role of international trade as a means of improving access to assistive technology and empowering persons with disabilities, thus supporting the implementation of the SDGs by, for and with persons with disabilities. International trade can promote inclusive practices, including inclusive labour, through trade agreements incorporating clauses promoting the rights and inclusion of persons with disabilities.

Assistive technology is crucial to ensure the inclusion and participation of persons with disabilities, their independent living, the realization of their rights and, for some persons with disabilities, assistive technology is essential for their survival. International trade of assistive technology can affect the supply, availability and affordability of this technology in countries and is therefore an important means of implementation of the SDGs for persons with disabilities at the global level. Restrictions on exports, high tariffs and other trade barriers can be an obstacle for countries to export and import assistive technology. The application of custom duties or tariffs on assistive technology can render this technology unaffordable for many persons with disabilities. It is important to establish effective supply and delivery chains to improve the provision of assistive technology around the world and create a favourable market environment that can eliminate unmet needs for assistive technology (for more information on unmet needs for assistive technology, see the chapter on Goal 10).

In the 2030 Agenda, targets 17.10, 17.11 and 17.12 call for the promotion of a universal, rules-based, open, non-discriminatory and equitable multilateral trading system, for a significant increase in the exports of developing countries, in particular with a view to doubling the least developed countries' share of global exports by 2020 and for the realization of a timely implementation of duty-free and quota-free market access on a lasting basis for all least developed countries.

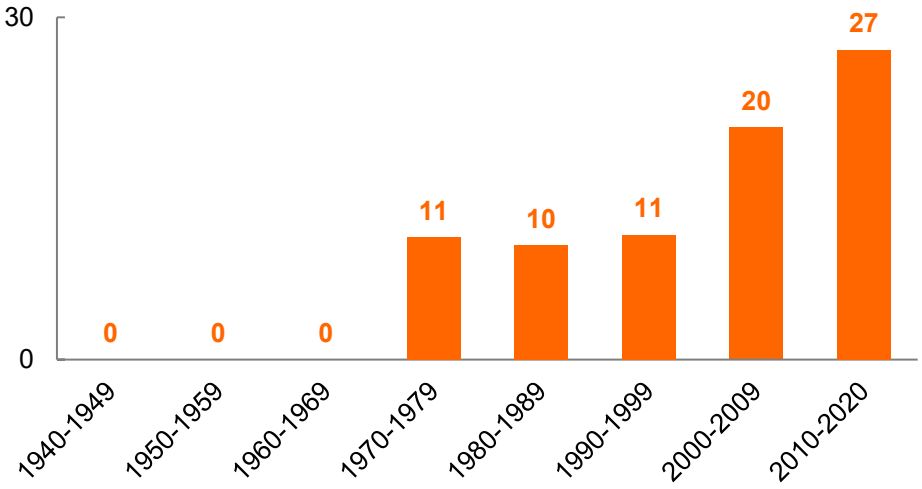
This section will provide an overview of the inclusion of disability provisions in trade agreements. This section will also analyse trends in exports and imports of assistive technology from and to developed countries and developing countries, as well as trends in imposed custom duties and tariffs on such products, with a focus on the case of least developed countries. Based on this evidence, the section will put forward recommendations for ensuring that international trade acts as an effective means of empowering persons with disabilities and improving access to assistive technology, thus supporting the implementation of the SDGs by, for and with persons with disabilities.

Current situation and progress so far

Better economic opportunities for persons with disabilities can be promoted through their integration in international trade. In particular, free trade agreements are a useful tool that can help integrate persons with disabilities into the economy, by removing barriers to their participation in economic life and by creating business and employment opportunities. The agreements can be used to incentivize negotiating

partners to implement changes at the domestic level in exchange for market access.

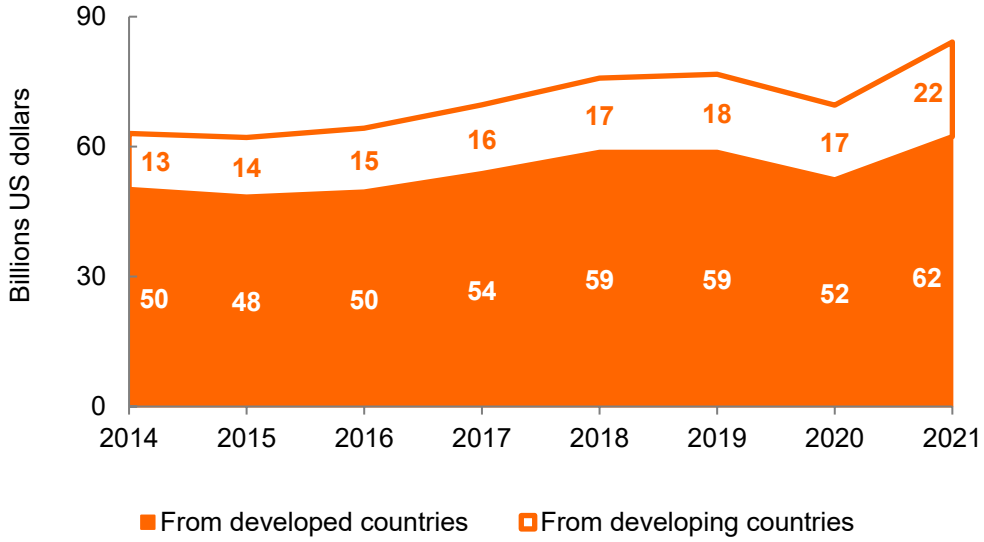
Figure 239. Percentage of preferential trade agreements that include clauses related to persons with disabilities, by decade, from 1940 to 2020.



Source: Jaramillo (2022).[598]

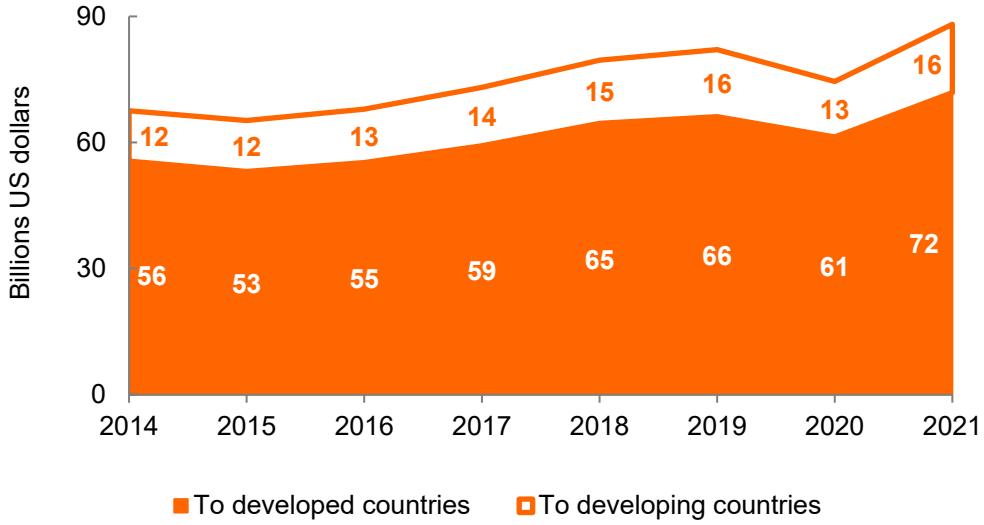
An increasing number of preferential trade agreements has included clauses relating to persons with disabilities (Figure 239). Before 1970, no preferential trade agreements included such clauses. These clauses started to be included in the 1970s, with 11 per cent of preferential trade agreements including them, a percentage that increased sharply from 2000 onward leading to 27 per cent of preferential trade agreements negotiated in 2010-2020 including clauses related to persons with disabilities. The impact of these provisions can be significant as more than a third of international trade is estimated to be carried out under preferential trade agreements.[598] The clauses introduced in agreements since the 1970s provide for non-discrimination (2 per cent of preferential trade agreements), allowing movement of workers across states while maintaining disability pensions (22 per cent of preferential trade agreements), inclusion of persons with disabilities through inter alia professional skills development for persons with disabilities (3 per cent of preferential trade agreements), cooperation among parties on policymaking related to the rights and inclusion of persons with disabilities (6 per cent of preferential trade agreements) and maintaining and creating policies protecting persons with disabilities (69 per cent of preferential trade agreements). [598] A similar analysis but focusing on free trade agreements currently in effect notified to the World Trade Organization found that almost a third — 27 per cent — of these agreements contain provisions on trade and disability (as opposed to only 20 per cent on gender).[599]

Figure 240. Total value of exports of assistive products, in billions of US dollars, from developing countries and developed countries, from 2014 to 2021.



Source: Data provided by the PAHO/WHO Collaborating Center on Rehabilitation and Assistive Technology (on the basis of data from the International Trade Centre's Trade Map[600]).

Figure 241. Total value of imports of assistive products, in billions of US dollars, to developing countries and developed countries, from 2014 to 2021.



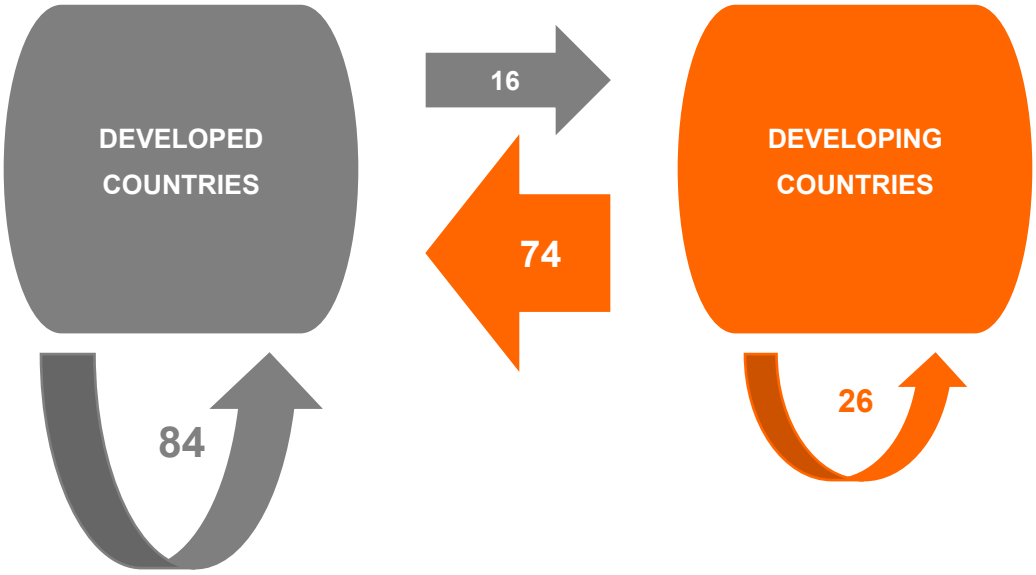
Source: Data provided by the PAHO/WHO Collaborating Center on Rehabilitation and Assistive Technology (on the basis of data from the International Trade Centre's Trade Map[600]).

Trade liberalization and trade agreements can also empower persons with disabilities to have more affordable access to assistive devices. Internationally comparable data is available to analyse the international trade of a selected list of assistive products: (i) glasses and lenses, (ii) hearing aids, (iii)

orthotics and prosthetics, (iv) wheelchairs and (v) other articles used by persons with disabilities to compensate for an impairment. Exports of these assistive products grew 33 per cent between 2014 and 2021, from 63 billion US dollars in 2014 to 84 billion US dollars in 2021, showing a consistent increase in trade flow throughout this period, with the exception of 2020, the first year of the COVID-19 pandemic in which there was a drop of more than 10 per cent in these exports (Figure 240). For glasses and lenses, orthotics and prosthetics, and wheelchairs, the total value of exports increased by 25 to 40 per cent from 2014 to 2021; for hearing aids, the total value of exports showed a much larger increase in the same period (82 per cent), mainly due to a sharp increase in 2021.

Globally, in 2021, the total value of imports of assistive products was 88 billion US dollars (Figure 241). The difference between import and export values (4 billion US dollars), which is attributed inter alia to freight and insurance costs,[601] is much higher for orthotics and prosthetics (10 per cent of the cost of exports) than for other assistive products.

Figure 242. Percentage of the exported values of assistive products from developing and developed countries to developing and developed countries, in 2021.



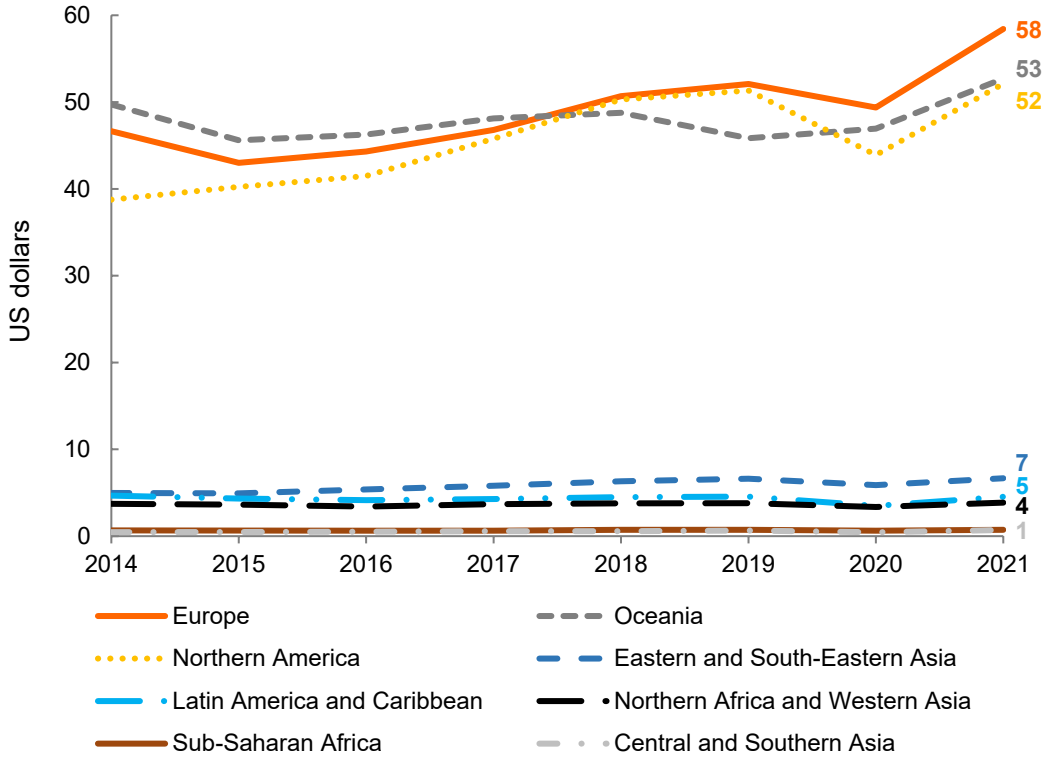
Source: Data provided by the PAHO/WHO Collaborating Centre on Rehabilitation and Assistive Technology (on the basis of data from the International Trade Centre's Trade Map[600]).

The participation of developing countries in the global market of assistive technology is low, both as importers and as exporters. As exporters, developing countries have a small share of the global market of assistive technology, and this share has changed minimally from 2014 to 2021. In 2021, their share for various assistive products was between 14 per cent and 48 per cent of the world's export values. As importers, developing countries have also a small share of the market. In 2021, the share of developing countries in the global value of imported assistive technology was only 18 per cent, a value that has

remained stagnant since 2014. Developing countries had a smaller share of the market in 2014-2021 for every assistive product: the shares by type of assistive product were three to six times less than the share of developed countries. The share of developing countries was especially low for hearing aids, orthotics and prosthetics and wheelchairs.

International trade of assistive products happens mostly among developed countries and to developed countries (Figure 242). In 2021, 84 per cent of the exported value of assistive products (93 per cent in the case of wheelchairs) was exported from developed countries to other developed countries, a situation that has not changed much since 2014. Also in 2021, 74 per cent of the exported value of the assistive products exported by developing countries also went to developed countries – with little variation by type of assistive product (ranging from 69 per cent to 86 per cent). These percentages have grown for all assistive products since 2014, indicating that developed countries are getting an increasing share of exports of assistive products from developing countries.

Figure 243. Per capita value of imports of assistive products, by region, from 2014 to 2021.



Source: Data provided by the PAHO/WHO Collaborating Center on Rehabilitation and Assistive Technology (on the basis of data from the International Trade Centre's Trade Map[600]).

Both the export and import values of assistive technology in developing countries grew between 2014 and 2021: from 13 billion to 22 billion US dollars for exports and from 12 billion to 16 billion US dollars for imports (Figure 240 and Figure 241). However, this growth has not been enough to change the overall

share of developing countries in world export and import values. For exports, the share of developing countries increased slightly from 21 per cent in 2014 to 26 per cent in 2021; for imports it remained at 18 per cent in 2014 and 2021.

In the period from 2014 to 2021, the total value of imports of assistive technology to Central and Southern Asia grew by 64 per cent, followed by Northern America (41 per cent), Eastern and South-eastern Asia (40 per cent) and sub-Saharan Africa (33 per cent). In all other regions growth was below 30 per cent. Despite the growth in imports to Asia and sub-Saharan Africa, the imported value per capita in these regions in 2021 was still considerably lower than the world average of 12 US dollars per capita (Figure 243), with Europe, Northern America and Oceania showing the highest imported values per capita (above 50 US dollars per capita). The per capita value of imports in these regions was almost five times the world average in 2021.

Box 15. Types of tariffs

There are three types of tariffs: *bound rates*, *most-favoured nation (MFN) tariffs* and *preferential tariffs. Bound rates* are specific commitments made by individual World Trade Organization (WTO) member states, acting as a maximum for any applied tariff on an import from another country, that is, the country commits to never apply more than the bound rates to an imported product. By binding their tariffs, countries improve the predictability of the market. *Most-favoured nation (MFN) tariffs* are tariff rates a country applies on imports from countries that are members of the WTO. MFN tariffs are always lower than the bound tariffs and are the tariffs that are usually applied in practice. MFN tariffs are not imposed on imports if the countries are part of a preferential trade agreement, in which case mutually agreed *non-MFN (preferential) rate*s – lower than MFN tariffs – apply. These agreed *non-MFN (preferential) rate*s are not necessarily reciprocal.

A key factor in the international trade of assistive technology are tariffs, which are taxes on imports or exports of goods between countries. Tariffs are usually calculated as a percentage of the value of the product. They are not paid by the exporting country but are passed on to the consumers in the importing country thus raising the prices of imported products. Analysing customs tariffs is important as they inform the predictability of the market and assist in identifying areas for international orchestrated action and negotiation in order to reduce barriers to trade and facilitate and improve the supply and availability of imported assistive products.

Assistive products are subject to several different types of tariffs – bound, most-favoured nation (MFN), and non-MFN preferential tariffs – see Box 15. By committing to bound tariffs, countries set a maximum tariff value that can be imposed on the traded product, hence improving market predictability. Bound tariffs are rarely applied in practice, as the de facto applied tariffs are MFN tariffs and, for countries in trade agreements, the tariffs applied are (non-MFN) preferential tariffs.

The percentage of countries that bind their tariffs on assistive products is lower for least developed countries (LDCs) than for other countries or areas: depending on the type of assistive product, 40 per cent to 50 per cent of LDCs but 80 per cent to 90 per cent of other countries or areas bind their tariffs. The number of LDCs that choose to bind their tariffs at 0 per cent is close to zero, while 30 per cent to 40 per cent of other countries or areas choose to do it. Spectacles and their components are the most significant exception, with only a few countries (less than 10 per cent of reporting countries with bound tariffs) choosing to bind their tariffs at 0 per cent. When not zeroed, the median average of the bound tariff for LDCs is slightly higher than that of other countries or areas. For wheelchairs, the median average bound tariff for all countries is 35 per cent; for orthotics and prosthetics, it is 45 per cent for LDCs and 35 per cent for other countries or areas; for spectacles and lenses, it is 30 per cent to 45 per cent for LDCs and 20 per cent to 30 per cent for others; and for hearing aids, it is 50 per cent for LDCs and 35 per cent for other countries or areas.

In both groups (LDCs and other countries or areas), for hearing aids, wheelchairs, orthotics and prosthetics, and other articles used by persons with disabilities to compensate for an impairment, about 60 per cent to 70 per cent of countries reporting MFN tariffs chose to set them at 0 per cent (Table 8). For glasses and spectacles, the percentage is much lower for both groups of countries, less than 30 per cent among LDCs and less than 50 per cent among other countries or areas. The median average duty used as an MFN tariff is low in both groups (between 5 per cent and 10 per cent), with a slightly broader range among LDCs. Again, spectacles and their components are different from other groups of assistive products, with slightly higher median average tariffs and broader tariff ranges. Overall, LDCs often have a broader range of MFN tariffs, lower binding status and higher bound tariffs, indicating that they have more flexible and less predictable trade policies on assistive products.

While only a few countries or areas report preferential tariffs resulting from trade agreements (circa 15 per cent to 20 per cent for both LDCs and other countries or areas), the tariff values set in these agreements are often 0 per cent (frequently, more than 80 per cent of the preferential tariffs reported by both LDCs and other countries or areas).

Table 8. Percentage of countries that do not impose tariffs on the imports of various assistive products (i.e., with MFN tariffs set at zero for these products), median tariff and tariff range for countries with MFN tariffs not set at zero, for least developed countries (LDC) and other countries, in 2021.

Assistive product	Countries with MFN tariffs at 0 per cent	Median MFN tariff for countries with MFN tariffs not set at zero (per cent of the value of the product)	MFN tariffs range for countries with MFN tariffs not set at zero (per cent of the value of the product)
Wheelchairs, not mechanically propelled[602]	LCD: 71 Other: 78	LCD: 5 Other: 5	LCD: 3-26 Other: 2-12
Wheelchairs, motorized or mechanically propelled[603]	LCD: 69 Other: 79	LCD: 5 Other: 5	LCD: 3-26 Other: 2-10
Parts and accessories of wheelchairs[604]	LCD: 63 Other: 77	LCD: 5 Other: 6	LCD: 3-26 Other: 2-20
Hearing aids[605]	LCD: 71 Other: 71	LCD: 5 Other: 5	LCD: 1-26 Other: 1-20
Orthopaedic appliances[606]	LCD: 66 Other: 63	LCD: 5 Other: 5	LCD: 1-26 Other: 0-14
Artificial joints for orthopaedic purposes[607]	LCD: 66 Other: 67	LCD: 5 Other: 5	LCD: 1-26 Other: 1-10
Artificial parts of the body[608]	LCD: 71 Other: 67	LCD: 5 Other: 5	LCD: 1-26 Other: 1-30
Glasses for corrective spectacles[609]	LCD: 20 Other: 50	LCD: 5 Other: 5	LCD: 3-26 Other: 1-20
Contact lenses[610]	LCD: 20 Other: 41	LCD: 5 Other: 5	LCD: 2-26 Other: 1-20
Spectacle lenses of glass[611]	LCD: 29 Other: 40	LCD: 8 Other: 7	LCD: 2-26 Other: 0-32
Spectacle lenses of materials other than glass[612]	LCD: 23 Other: 43	LCD: 8 Other: 7	LCD: 2-26 Other: 0-32
Frames and mountings for spectacles, goggles or the like, of plastics[613]	LCD: 9 Other: 31	LCD: 10 Other: 8	LCD: 2-30 Other: 0-35
Frames and mountings for spectacles, goggles or the like (excluding of plastics)[614]	LCD: 3 Other: 33	LCD: 10 Other: 8	LCD: 2-30 Other: 2-35
Parts of frames and mountings for spectacles, goggles or the like[615]	LCD: 3 Other: 32	LCD: 5 Other: 5	LCD: 2-30 Other: 1-35
Spectacles, googles and the like, corrective, protective or other[616]	LCD: 6 Other: 20	LCD: 8 Other: 8	LCD: 2-26 Other: 2-30
Other articles used by persons with disabilities to compensate for an impairment[617]	LCD: 63 Other: 67	LCD: 5 Other: 5	LCD: 0-5 Other: 0-10

Source: Data provided by the PAHO/WHO Collaborating Centre on Rehabilitation and Assistive Technology (on the basis of data from International Trade Centre's Trade Map).[600]

Among the various assistive products, spectacles and their components have the highest percentage of countries in both LDCs and other countries or areas reporting preferential tariffs, including by zeroing them, showing that trade agreements are used as an alternative to bound and MFN tariffs for this group of assistive products. In general, for all assistive products, LDCs show a narrower range of preferential tariffs than other countries or areas.

The lack of internationally comparable data hampers a comprehensive analysis of exports and imports for all assistive products. The Priority Assistive Products List, released by WHO in 2016, includes 50 priority assistive products selected on the basis of their widespread need and impact on a person's life. Yet, available data on international trade only allow for the trade analysis of 30 per cent of these products. It is not possible to track priority assistive products such as Braille writing equipment, deafblind communicators, handrails and grab bars, personal digital assistants, screen readers and ramps, among others.

Tariffs are just one aspect regulating the international trade of assistive products. Without adequate trade policies and agreements, the promised benefits that eliminating tariffs will lead to wider availability and reduced costs of assistive technology will not materialize. For instance, to ensure fair trade practices and harmonization of trade policies, trade agreements have obligated countries to harmonize their policies and eradicate subsidies. But the elimination of subsidies has had a negative impact on the availability and cost of assistive products, as it has deterred governments from offering financial benefits for the manufacturing or sale of assistive devices. Trade agreements have also exerted pressure that has resulted in a greater privatization of the assistive technology industry. This has resulted in higher prices of assistive devices to allow private companies to increase their share of profits. Moreover, trade agreements have also pushed acceleration towards private insurance systems and reduced the policy space for governments to provide publicly funded medical and social protection benefits, leading to the absence of the social programmes and schemes that previously provided persons with disabilities with subsidized or cost-free access to assistive technology. This left persons with disabilities relying on private insurance coverage, their own incomes or that of their families, which in many cases are insufficient to pay for the assistive technology that persons with disabilities require.[618]

The WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights, and similar intellectual property rights' commitments in preferential trade agreements, have further increased the cost of access to assistive technology as they have enabled private stakeholders to retain ownership of the intellectual property of the technology they design and manufacture. Intellectual property provisions in trade agreements ensure protection for the creation of innovative assistive products. The creation of these products sometimes requires a high sunk cost in the form of investment in research and development. This is the case with assistive products such as wheelchairs, Braille printers, portable note-taking devices, and screen reading software. Intellectual property provisions restrict the production and marketing of such products by other companies and provide exclusive rights to the investors and creators to offset the sunk

cost. This is done to encourage more research and development investment by private stakeholders, which can lead to more innovation in the creation of new assistive products. Therefore, intellectual property rights' protections can help persons with disabilities gain access to new innovative equipment that can further enhance their standard and quality of life. However, this protection may also lead to higher prices for such equipment as it allows the owners of the patented products to price them at their choice. As a result, trade agreements may have negative consequences on the affordability and availability of assistive products for persons with disabilities. In these situations, the promised benefit of trade liberalization for persons with disabilities of lower prices through the elimination of tariff barriers is not materialized. On the contrary, extended patent protection on assistive products can increase their cost in some countries.[618] Yet, if designed based on evidence to address these challenges, trade agreements can be an effective tool to overcome these barriers.

Summary of findings and the way forward

Some 80 per cent of persons with disabilities live in developing countries. Yet, the international trade of assistive products is concentrated in developed countries: they dominate this trade as exporters and as importers. The developed countries combined account for 74 per cent of the value of exports of assistive technology in the world and developing countries account for 26 per cent. Imports are similarly concentrated: developed countries as importers account for 82 per cent of the value of imported assistive technology and developing countries account for 18 per cent. Most exports go from developed countries to developed countries. The per capita value of imports of assistive products varies by region, with Europe, Northern America and Oceania importing more than 50 US dollars of assistive products per capita, and Asia, Latin America and the Caribbean, and sub-Saharan Africa importing less than 10 US dollars of assistive products per capita.

Despite the growing value of exports from developing countries and imports to developing countries since 2014, their global share in imports and exports remained stagnant. The per capita value of imports to Europe, Northern America and Oceania has been consistently five times higher than in other regions since 2014. The COVID-19 pandemic had a marked impact on the international trade of assistive products, causing a 10 per cent drop in the value of exported assistive products, a factor that may have impacted access to assistive technology during the pandemic (see the chapter on Goal 10).

Barriers to trade persist in assistive technologies. Many assistive products have taxes imposed at the border in the form of tariffs. Tariffs on some assistive products remain high. Depending on the type of assistive product, 29 to 97 per cent of least developed countries apply non-zero MFN tariffs; and 21 to 80 per cent of other countries apply non-zero MFN tariffs.

For wheelchairs, the median average bound tariff — that is, the maximum tariff that a country pledges to apply in its WTO agreements — is 35 per cent; for orthotics and prosthetics, it is 45 per cent for LDCs and 35 per cent for other countries or areas; for spectacles and lenses, it is 30 per cent to 45 per cent for

LDCs and 20 per cent to 30 per cent for others; and for hearing aids, it is 50 per cent for LDCs and 35 per cent for other countries or areas. The average “applied” tariff on assistive products (MFN tariff) — the tariff typically used in practice — is considerably lower, at 5 per cent for wheelchairs, orthotics and prosthetics and hearing aids; and 5 per cent to 10 per cent for spectacles and lenses. Behind these average values, lies a wide range of tariffs applied, sometimes as high as 35 per cent. Moreover, the gap between the bound tariff rates and the applied tariff rates leaves ample legal room for increasing tariffs on these assistive products without violating WTO rules.

Only about 20 per cent of countries or areas report being part of trade agreements with preferential tariffs on assistive products and only about 80 per cent of the tariff values set in these agreements are set to 0 per cent. For these trade agreements, LDCs tend to apply higher tariffs on imports than other countries. The latter may pose challenges for persons with disabilities in LDCs to afford assistive products, especially as persons with disabilities in these countries are at higher risk of poverty and may be more likely to face challenges affording assistive technology than persons with disabilities in other countries. Moreover, only about 20 per cent of LDCs have preferential trade agreements resulting in tariffs of 0 per cent.

Goal 17 calls for favourable terms for exports for least developed countries, namely duty-free access to markets in other countries. For assistive products and their vital role to leave no person with disabilities behind, duty-free access worldwide can assist in eliminating the unmet needs for assistive technology in all countries.

Apart from its role in ensuring the wider availability of assistive technology, trade can also serve as an incentive to promote laws and practices to ensure the realization of the rights of persons with disabilities and their inclusion in society. Among preferential trade agreements negotiated from 2010 to 2020, 27 per cent included such clauses. Before 1970, none of the negotiated preferential trade agreements included such clauses. At this rate of progress, about a third of preferential trade agreements is expected to include such clauses by 2030. To achieve an inclusion of these provisions in all trade agreements by 2030, the current rate of progress should accelerate four times.

To ensure that international trade acts as an effective means of improving access to assistive technology, thus supporting the implementation of the SDGs by, for and with persons with disabilities, it is recommended:

1. Monitor and promote the incorporation of disability-inclusion provisions in trade agreements and ensure that international trade agreements do not perpetuate or exacerbate the inequalities experienced by persons with disabilities. The integration of disability-inclusion concerns, including for women with disabilities, in trade agreements can help maximize the positive impact and minimize the negative impact that trade agreements can have on the rights and needs of persons with disabilities.

2. Reduce barriers to the international trade of assistive technology to help make this technology available for all persons with disabilities who need it. Import tariffs, export restrictions, and other limitations on international trade in assistive technology continue to confound the hopes for eliminating the unmet need for assistive technology. Governments can work together at the WTO to help meet this need, with the aim of finalizing new rules to support trade for assistive technology by eliminating duties and tariffs on assistive technology, extending this to cover all assistive technology, and to be applicable to all WTO members. They must ensure that WTO obligations that prohibit export restrictions are effectively applied in the trade of assistive technology. Ideally, these reforms could be included in a new trade agreement that would be fully multilateral. Another way trade can support the needs of persons with disabilities is through trade agreements containing waivers on intellectual property rights protection concerning assistive products to bring down their costs. Persons with disabilities and their representative organizations should be consulted and involved in the development and negotiation of trade agreements on assistive products.

3. Keep commitments on imports and exports of assistive technology during global health emergencies and other crises. Countries can agree to limit the duration of restrictions on exports of critical assistive products during a pandemic or other global or regional crises and ensure that trade is not interrupted for countries in need. Reducing trade barriers for assistive technology can expand access to this technology in normal times while also bolstering preparedness for pandemics and other global or regional crises.

4. Promote trade of assistive technology among developing countries. Cut tariffs and remove other trade barriers on assistive technology they import from each other. Apart from promoting trade, such cuts reduce the final price to consumers in developing countries. Trade among developing countries can also facilitate manufacturing knowledge sharing, foster innovation, diversify import sources to improve resilience and build supply chains among developing countries.

5. Improve the availability and quality of internationally comparable data on exports and imports of assistive products and on the tariffs applied to these products. Exploring data on international trade and tariffs depends on a harmonized system of coding of products. However, current codes are not directly applicable to many assistive products. Furthermore, the available codes for assistive products correspond to very broad categories: there is a need for further detail in the classifications and codes of assistive products. The international community would benefit if these codes could be aligned with other references such as ISO 9999:2016 (Assistive products for persons with disability), which establishes a widely accepted classification and terminology of assistive products, increasing data comparability internationally.

6. Conduct research on the impact of trade and trade agreements on the inclusion and participation of persons with disabilities in society and development. More data are needed to

understand the impact of existing trade agreements on persons with disabilities, and to evaluate differences in impact for men versus women with disabilities.

Increasing the availability of data (target 17.18)

This section will discuss the collection and availability of statistical data on persons with disabilities, including data disaggregated by disability, and reflect on the impact of the COVID-19 pandemic on the collection and availability of these data.

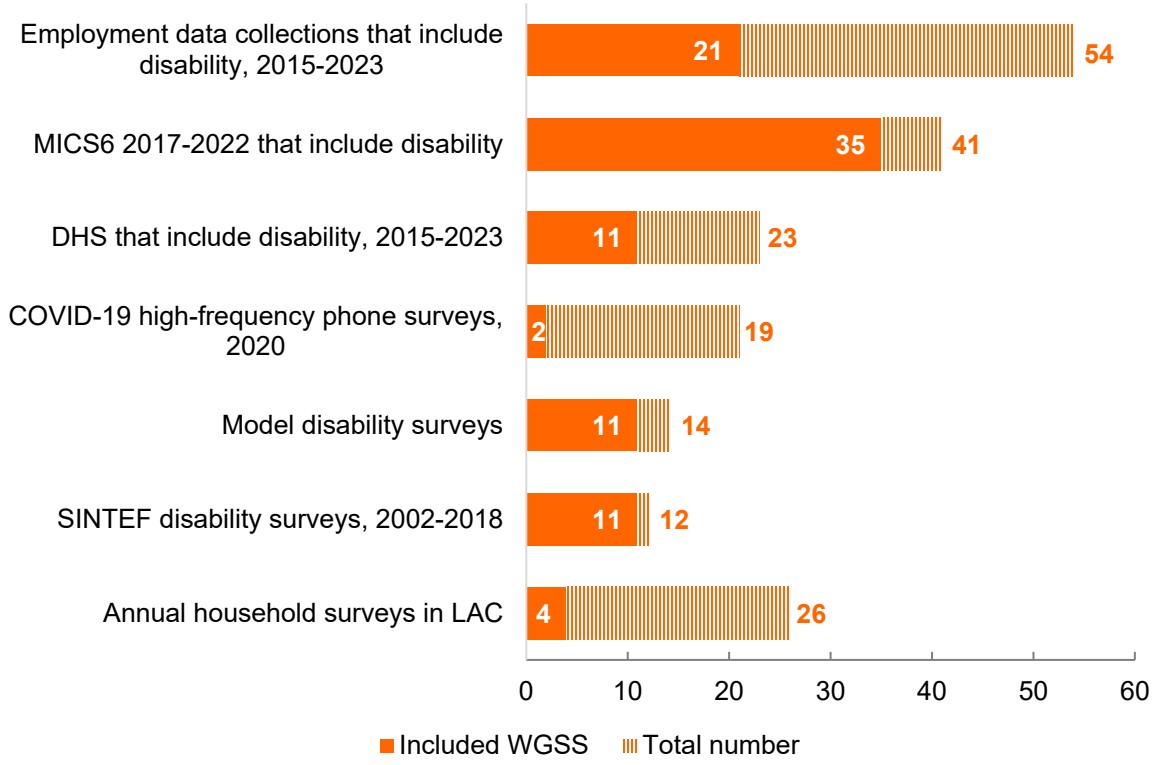
Target 17.18 calls for, by 2020, enhanced capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated, inter alia, by disability status. 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 CRPD and to identify and address the barriers faced by persons with disabilities in exercising their rights (Article 31). States Parties are encouraged to disseminate the statistics and ensure their accessibility to persons with disabilities and others.

Since then, there have been further calls from the United Nations General Assembly and the World Health Assembly for countries to collect data on persons with disabilities and for United Nations entities and relevant international organizations to support countries in collecting, processing, analysing and disseminating data on disability.[619]

Current situation and progress so far

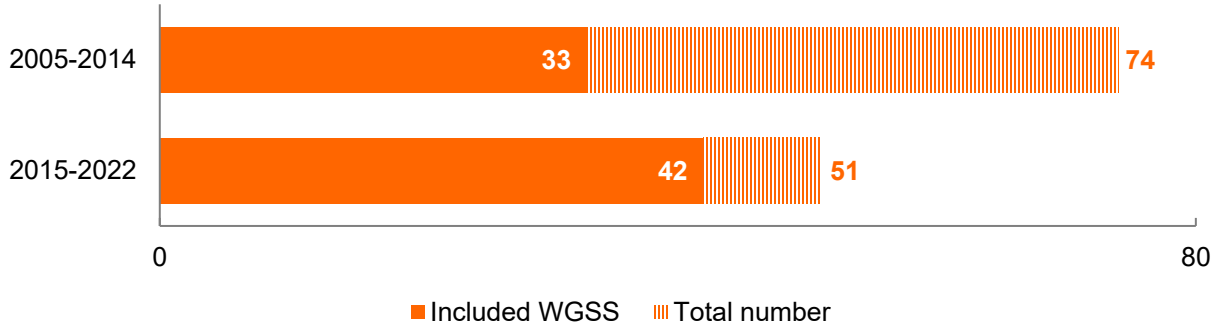
Major international efforts to increase the availability of disability data date as far back as the 1980s, and these efforts were further intensified with the adoption of the CRPD in 2006 and the 2030 Agenda in 2015, promising to “leave no one behind”. An increasing number of countries have been including disability questions in their data collections in order to assess the gaps between persons with and without disabilities and to understand the enablers and the barriers persons with disabilities face in participation in society and in their daily lives. In 2015-2023, 54 compiled information on persons with disabilities in data collections on employment, 41 countries in multiple-indicator cluster surveys (MICS), 23 countries in demographic and health surveys (DHS) and 19 countries in COVID-19 high-frequency phone surveys (Figure 244). Model Disability Surveys have been conducted in 14 countries; and the SINTEF disability surveys have been conducted in 12 countries. Also, since 2005, many countries have included disability questions in their national censuses (Figure 245): 74 countries in 2005-2014 and 51 countries in 2015-2022.

Figure 244. Number of countries with selected data collections and number of those that included the Washington Group short set of questions on functioning (WGSS).



Note: Employment data collections refer to the most recent data available in ILO records. LAC refers to Latin America and the Caribbean.
Source: DHS,[6] DDI 2021,[620] ILO, Inter-American Development Bank, IPUMS,[8] SINTEF,[9] UNDESA and WHO.

Figure 245. Number of countries that collected data on persons with disabilities in their censuses, and those that included the Washington Group short set of questions on functioning (WGSS), in 2005-2014 and in 2015-2022.



Source: DDI Collective (2024),[621] ECLAC,[13] ESCWA, IPUMS,[8] Mitra and Yap (2022)[626] and UNDESA.

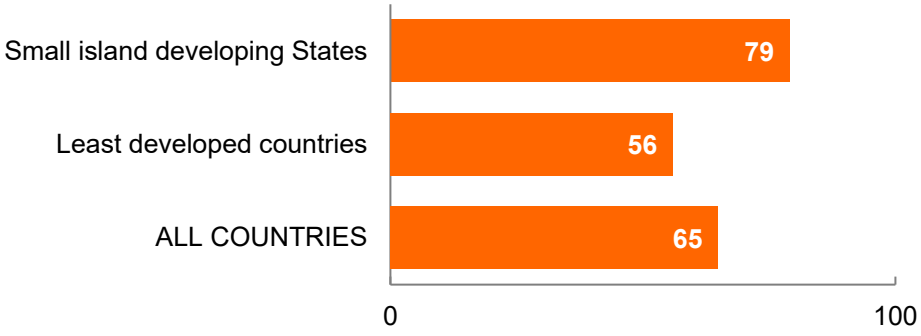
A variety of different methodologies is in place to collect data on persons with disabilities. Different questions are asked depending on the country. Within the same country, these questions may also differ across censuses, surveys and other data collection efforts. These differences prevent the comparison of data from country to country and within the same country.

Table 9. Tools developed to produce internationally comparable data on persons with disabilities, including data disaggregated by disability.

Use	Tool	Developed by
Population-based household survey on persons with disabilities	Model Disability Survey	World Health Organization
	Surveys on the living conditions of persons with disabilities	SINTEF
To integrate into an existing survey/census to disaggregate data by disability	Short set of questions on functioning (WGSS)	Washington Group on Disability Statistics
	Functioning and Disability Disaggregation Tool (11 questions)	World Health Organization
	Short set on functioning – enhanced (12 questions)	Washington Group on Disability Statistics
	Extended set on functioning (37 questions)	Washington Group on Disability Statistics
In labour force surveys	Labour force survey module on disability	ILO in collaboration with the Washington Group on Disability Statistics
To compile information on children/youth with disabilities	Child Functioning Module	UNICEF and the Washington Group on Disability Statistics
To measure the impact on women of environmental challenges	Model questionnaire: measuring gender and the environment	UN Women
In demographic and health surveys	Disability module with the WGSS	DHS Program

Since the early 2000s, a number of initiatives have delivered internationally comparable methods (that is, questions) to obtain disability data (Table 9). Among these methods, the Model Disability Survey has been conducted in 14 countries and the Washington Group short set of questions has been used in multiple countries and in various data collections (Figure 244 and Figure 245). For instance, these questions have been used in 33 countries for censuses in 2005-2014, 21 countries for employment data collections in 2015-2023, 35 countries for MICS, 11 countries for DHS, 11 countries for the SINTEF disability surveys, 4 countries for annual household surveys in Latin America and the Caribbean and 2 countries for the COVID-19 high-frequency phone surveys. In 2005-2014, 45 per cent of censuses that included disability questions used the WGSS. In more recent years, 82 per cent did so but the true percentage for the 2015-2024 census round remains unknown as this census round is not yet finalized (Figure 245). Since 2005, 79 per cent of small island developing States and 56 per cent of least developed countries have used the WGSS in their last census (Figure 246). Moreover, as of January 2023, 54 MICS surveys collected data on children and youth with disabilities using the child functioning model, which also provides internationally comparable data.[622]

Figure 246. Percentage of countries that used the Washington Group short set of questions on functioning, among countries that included disability in their last census, 2005-2022.



Source: UNDESA.

In addition to their use in censuses and surveys, the tools to produce internationally comparable data have been included in administrative systems, education contexts, program registration systems, disaster risk reduction and other humanitarian contexts, as well as in general program planning by civil society organizations.

From 2018 to 2022, several organizations have organized capacity-building activities on disability statistics, including the DHS Program, ILO, SINTEF, UNICEF, UNPRPD, the Washington Group and WHO. These activities include, among others, capacity building to governments. In particular, 59 per cent of the least developed countries and 45 per cent of small island developing States received this support.[623]

Many national online data portals are not accessible for all persons with disabilities because they lack accessibility features. This follows the trend of online governmental portals (see the chapter on Goal 16) – in 2020, only 37 per cent of countries had online governmental portals accessible for persons with disabilities according to W3C guidelines. Awareness of the need to make data accessible to all, including persons with disabilities, has been rising and online portals on internationally recommended methods to collect disability data have increasingly included disability features. For example, the WHO data webpage includes accessibility features, such as alternate text for graphic elements, use of plain language, logical heading structure and large links, buttons and controls. The website of the Washington Group on Disability Statistics, which includes guidelines on internationally comparable methods to collect data on persons with disabilities, includes various accessibility features, such as a colour scheme avoiding colours that do not offer enough contrast for common forms of colour blindness, the possibility of navigating the website by keyboard alone, and that the website can be used with common assistive technology – these accessibility features were developed in consultation with organizations of persons with disabilities.

Most data visualization guidelines still focus on persons without disabilities or blind and partially sighted persons, for which data visualisation descriptions are recommended, or persons who are colour blind, for whom the use of colour-independent patterns is recommended. Recently, new research has emerged on identifying accessible data visualizations for persons with intellectual and development disabilities, but this research remains scarce.[624] In particular, more research on universal designs of data visualizations that are accessible to all, including persons with intellectual and developmental disabilities, is needed.

One of the barriers to using disability data for policy guidance and for the assessment of progress towards the SDGs and the CRPD, is the lack of a centralized online portal with disability data from countries all over the world and for relevant indicators to monitor the SDGs and the CRPD. The lack of such a centralized portal has been recognized since the 1980s. Despite several initiatives, such a portal still does not exist. Four online portals focusing on disability data and with a global scope have been produced since the 1990s (Table 10), but they have remained limited in the indicator coverage and use only a small portion of the disability data available worldwide. All except one have been discontinued as of 2023, due to lack of regular and sustainable funding.

Since 2015, more United Nations entities and other stakeholders have started to compile disability data. As of early 2023, various actors held substantial global and regional disability data compilations, including ECLAC, ESCWA, ESCAP, Fordham University (United States), ILO, Leonard Cheshire (United Kingdom), SINTEF, UNDESA (including UNSD), UNESCO, UNICEF, WHO and the World Policy Analysis Center (United States). Many of these data are not publicly available online.

Progress has been made in the availability of data disaggregated by disability in the United Nations SDG Indicators Database. In 2024, this database contained seven indicators with country data disaggregated by disability, up from zero in 2018. Three of these indicators have data for more than three countries. This

progress however falls short of covering the 10 SDG indicators for which the 2030 Agenda explicitly requires disaggregation by disability (only two of these indicators have data for more than three countries).[625] Moreover, this also falls short of the general call in the 2030 Agenda for SDG indicators to be disaggregated, where relevant, by sex and disability. Disaggregation by sex is more widely available than disaggregation by disability: 49 indicators have data disaggregated by sex but only 7 have data disaggregated by disability. Only three indicators in the database have data disaggregated by both sex and disability.

Table 10. Examples of disability data portals with global scope and that are publicly available online.

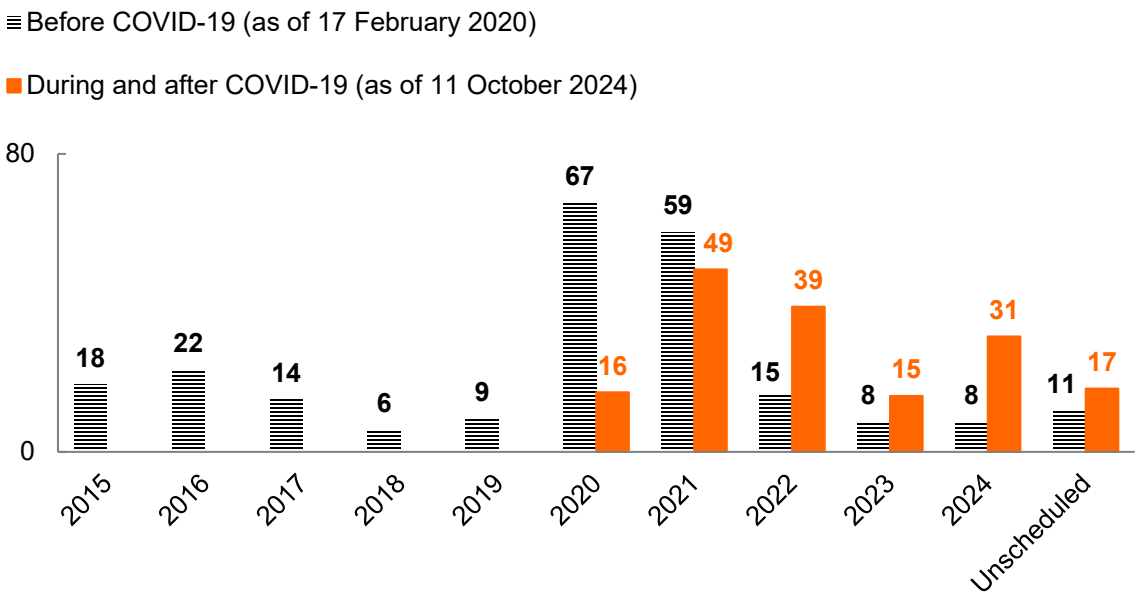
Name of portal	Host	Scope	Period of regular updating
DISTAT	UN Statistics Division	Disability prevalence in various countries	1990s
United Nations Disability Statistics Data Portal	UN Statistics Division	Disability prevalence in various countries	2017-2019
Disability Data Portal	Leonard Cheshire	Poverty, social protection, education, employment, empowerment of women and girls, violence – in various countries	2018-2022, discontinued in December 2022
Disability Data Initiative	Fordham University, United States	Poverty, health, education, standard of living – in various countries	Since 2021 and ongoing

Impact of the COVID-19 pandemic

The COVID-19 pandemic has disproportionately affected persons with disabilities (see the chapter on Goal 3) and yet, few countries collected data on persons with disabilities or disaggregated data by disability at the national level since the start of the pandemic. For example, only two countries have disaggregated the national COVID-19 mortality data by disability – the United Kingdom and the Republic of Korea. To monitor the impact of the COVID-19 pandemic, COVID-19 high-frequency phone surveys were conducted in 55 countries, but questions to identify persons with disabilities were only included in 19 of those countries.[626]

Furthermore, the pandemic also impacted the availability of statistics on disability collected through population and housing censuses, which are a principal source for producing statistics on persons with disabilities in most countries. Countries usually conduct their censuses every ten years. The onset of the COVID-19 pandemic in the middle of the 2020 census round[627] (that is, the period from 2015 to 2024) had a significant and adverse impact on its implementation. National statistical offices or census agencies were challenged to produce timely, accurate and reliable statistics during the pandemic. The pandemic circumstances, with social distancing measures, impacted on the implementation of censuses, particularly in countries conducting their censuses fully or partly with the traditional method, whereby every household in the country is approached with a request for information.

Figure 247. Number of countries by the year their census was scheduled, before and during/after the COVID-19 pandemic.



Source: United Nations Statistics Division.

Consequently, the collection and dissemination of data, including on persons with disabilities, were affected, resulting in at least one- or two-year delays (Figure 247). Before the pandemic, 67 countries were planning to conduct the census in 2020 but only 16 of them were able to conduct the census as scheduled. The others had to postpone to later years. As a result, while before the pandemic only 15 countries had planned to conduct their census in 2022, this number increased to 39 countries after the pandemic. Another 15 countries delayed their census to 2023; and 31 countries to 2024.

Census operations also took longer than usual during the pandemic, resulting in further delays. Among the countries that managed to conduct their census in 2020 in the middle of the pandemic and social

distancing restrictions, a few of them had to extend the enumeration period for more than six months to increase response rates and ensure completeness.

Conducting the 2020 round of censuses under the pressure of the COVID-19 pandemic has also raised concerns about the quality of census results. Many people moved to different addresses when schools and workplaces were closed or changed their place of residence to join another household. All these circumstances have created difficulties in counting people in their place of usual residence. In addition, due to constrains on time and resources, some countries had to shorten their census questionnaires, which may have affected disability-related questions and resulted in the loss of time series data and intertemporal comparability.

Compared to previous census rounds, the availability of detailed statistics on persons with disabilities coming from censuses is delayed, and in some countries not yet available at all. As a positive development, the pandemic has been a catalyst for more innovative and agile ways of data collection, like remote or online data collection, with the potential for increasing both the quality and availability of data on persons with disabilities.

Summary of findings and the way forward

In the context of the 2030 Agenda and the promise to “leave no one behind,” substantial efforts have been made to generate data and information to monitor the situation of persons with disabilities. An increasing number of countries is collecting data on persons with disabilities, and using established internationally comparable methods to do so, ensuring progress towards the achievement of target 17.18. Since 2015, 42 countries have used the Washington Group questions out 51 countries collecting disability data in censuses and 14 countries have conducted Model Disability Surveys. However, capacity to use internationally recommended methods is still lacking in many countries, particularly in least developed countries. To achieve target 17.18, it is crucial to direct more capacity-building efforts towards countries that need them the most.

The onset of the COVID-19 pandemic resulted in less data on disability being available than expected, due to disrupted data collections, particularly censuses and surveys. Moreover, although rapid emergency data collections were conducted in some countries during the pandemic to understand its impact and guide policy formulation, those data collections rarely compiled data disaggregated by disability status.

Only a minority of developing countries have comparable data across time that would allow for the tracking of progress towards the realization of the SDGs for persons with disabilities. The lack of standardized methods along time prevents measuring this progress for many topics covered by the SDGs.

Accessibility features are still lacking in many data disseminations. And the lack of a centralized, accessible, publicly available and global online platform for data on persons with disabilities causes

barriers to a sustainable and regular monitoring of progress for persons with disabilities towards the SDGs and the realization of the CRPD.

The availability of data disaggregated by disability in the United Nations SDG Indicators Database has increased since 2018, but progress has been too slow. With current trends less than half of the indicators for which the 2030 Agenda explicitly requires disability disaggregation will have data by 2030. The rates of progress will need to be four times faster in order to achieve, by 2030, availability of data disaggregated by disability for these 10 indicators. To achieve a level comparable to the current availability of gender disaggregated data, rates of progress will need to increase six-fold.

To increase the availability of relevant and high-quality data on persons with disabilities, the following actions are recommended:

1. Integrate and harmonize disability data collections in all relevant national information systems. Integration of disability in the national information systems implies collecting and disaggregating population data by disability as well as collecting data on persons with disabilities in relevant national information systems – for instance, for national health information systems, to collect health facilities-based data disaggregated by disability; similarly for education information systems, collect data on disability across educational facilities.

2. Encourage the use of internationally comparable methods. The most effective way of understanding disability is to use valid and reliable tools assessing functioning difficulties in undertaking specific activities like walking, seeing, or hearing as well as barriers in the environment that may contribute to those limitations. The selection of a specific tool will depend on the resources that countries have, their objectives and specific contexts. Statistical methods to harmonize data from different functioning tools already exist for comparability and countries should be encouraged to use them, including the newest revision of the United Nations Principles and Recommendations for Population and Housing Censuses.

3. Establish regular and standardized data collections across time. Data collected with the same methods in different time periods are essential to measure progress. While many countries currently have only one point-in-time data on persons with disabilities, population data systems that continuously produce such data are key to effectively inform policy and decision-making. Countries may consider establishing a register of persons with disabilities to produce timely, frequent and accurate data; as well as enhancing the frequency and the quality of disability-related data by using various data collection methods.

4. Invest in collecting and disseminating data on women and girls with disabilities. More investments in data collection on women and girls with disabilities are needed. Data disaggregation and collection of individual-level data must be prioritized to ensure that everyone is included in policy formulation and programme design. When such compelling evidence is available, policymakers cannot turn a blind eye. Ignoring such data will leave women and girls with disabilities behind.

5. Make all data, in online websites and printed formats, accessible for persons with disabilities. Many websites lack accessibility features, like audio versions, captioning of data charts and alternatives to mouse use. Data is an important tool for participation and all persons with disabilities should have access to data in accessible formats.

6. Build capacity of developing countries, particularly least developed countries and small island developing States. The use of standardized and internationally comparable methodologies to collect disability data remains particularly low in least developed countries.

7. Promote partnerships to coordinate for the production of a centralized global, online, publicly available and accessible repository for data on persons with disabilities. Previous efforts have been hampered by lack of regular and sustainable funding and lacked coordination among relevant stakeholders. Many actors are involved in the production of data on persons with disabilities covering the scope of the CRPD and the SDGs, and they should all be engaged in this effort.

8. Involve persons with disabilities and their representative organizations in all stages of data production, from planning to dissemination, and data utilization, especially in census planning and operations. It is key to involve a diversity of persons with disabilities, including persons with various types of disabilities and gender, and their representative organizations to ensure that data are fit for purpose and accessible to all.

9. Increase the number of indicators with data disaggregated by disability in the United Nations SDG indicator database. Data disaggregated by disability has increased substantially in the past five years, but this has only partially been reflected in the SDG Indicator database. Making these data available in the SDG indicators database will provide a solid evidence base to inform on the progress towards the SDGs for persons with disabilities.

10. Invest in research to identify the best visualizations for data accessibility for persons with disabilities, including for persons with intellectual and developmental disabilities, focusing on universal design visualizations accessible to all. With the proliferation of data-driven reasoning and decision-making increasing across all aspects of life, making data accessible to all is crucial. Without data accessibility, many persons with disabilities will need to rely on others to relay relevant information and to make decisions using that data and not be able to access and use the data independently.

Conclusion: SDG progress by, for and with persons with disabilities at a glance

The *Disability and Development Report 2024* provides an updated comprehensive analysis to address the needs of the international community to achieve the Sustainable Development Goals for persons with disabilities. As a follow up to the *Disability and Development Report 2018*, the *Report* presents the most recent global analysis based on data, legislation and policies from all countries to understand the socio-economic circumstances of persons with disabilities worldwide and the challenges and barriers they face in their daily lives, including the exacerbated impacts caused by the COVID-19 pandemic. *Annex 1* presents a summary of the findings, providing a snapshot of progress by Goal.

The analysis shows that, since the adoption of the 2030 Agenda for Sustainable Development, nine years ago, there has been much progress, despite the setbacks posed by COVID-19. But many persons with disabilities still fall behind and continue to face barriers and discrimination. Gaps between persons with and without disabilities persist in the implementation of all the Sustainable Development Goals.

Among the 119 indicators used in this *Report* to assess progress towards the 63 targets of the 2030 Agenda identified as relevant for persons with disabilities, five indicators suggest progress consistent with achieving the targets of the 2030 Agenda for persons with disabilities. These include remarkable progress made in increasing the number of countries with laws on equal access to education for students with disabilities (target 4.1), with disaster early warnings in accessible formats (target 13.b), with online services for persons with disabilities (target 16.6), with government ministries accessible to wheelchair users (target 16.7) as well as notable progress made in increasing the number of donor countries reporting on the disability marker in their bilateral aid (target 17.2). If the trends observed so far continue, these achievements will reach all countries by 2030.

Some 31 indicators, corresponding to 21 targets, show progress but with moderate or severe deviations from the desired trajectory. These include progress on the provision of universal disability benefits and of cash benefits (target 1.3); on the health of persons with disabilities (targets 3.3 to 3.6); on legal protections for women with disabilities and against discrimination in the labour market for all persons with disabilities (targets 5.c and 8.8); on accessible and inclusive banks, food banks, restaurants, supermarkets, healthcare facilities, schools, public toilets and showers, employment agencies, public Internet cafes, bus and train stations, playgrounds, recycling premises and shops for sustainable products (targets 1.4, 2.1, 3.8, 4.a, 6.1, 6.2, 8.5, 8.10, 9.c, 11.2, 11.7, 12.2 and 12.5); on providing assistance during blackouts to persons with disabilities using electricity-run assistive technology (target 7.1); and on the safe evacuation of persons with disabilities during disasters (target 13.1).

For 10 indicators, there has been stagnation, regression or the target has been missed – these include insufficient progress in making ATMs (targets 1.a and 8.10), hospitals (target 3.8) and public drinking water sources (target 6.1) accessible for persons with disabilities; in providing access to persons with

disabilities living in least developed countries to the Internet (target 9.c was missed in 2020 for persons with disabilities), in preparing persons with disabilities for disasters (target 13.1), in providing policies on climate change in easy-to-understand formats (target 13.3), in including the perspective of persons with disabilities in environmental discussions (targets 14.2 and 15.5), and in involving persons with disabilities in decision-making on disaster risk reduction and response (target 16.7).

For 67 indicators, the data available can provide a snapshot of the current situation, but there is not enough data to assess trends over time and evaluate progress since 2015. For six indicators, corresponding to six targets, there is not even enough data to analyse the current situation for persons with disabilities – these include targets on extreme poverty, child mortality, health impact of pollution, early childhood development, child labour and impact of corruption and bribery.

Gaps persist between persons with and without disabilities, even for targets and indicators with progress. For many indicators, progress for persons with and without disabilities run parallel to each other and have not reduced the gap. The gaps are particularly large on food insecurity, health, access to energy and ICT, with gaps above 10 percentage points, and on multidimensional poverty and employment, with gaps above 20 percentage points. For women with disabilities, Indigenous persons with disabilities, persons with intellectual or psychosocial disabilities and persons with disabilities living in rural areas, the gaps are even wider.

The COVID-19 pandemic exacerbated the inequalities experienced by persons with disabilities. The response to the pandemic was largely not inclusive of persons with disabilities, especially in the early stages of the pandemic, with discriminatory practices in COVID-19 treatment, lack of information in accessible formats and reduced access to COVID-19 testing. Evidence suggests that half of COVID-19 deaths occurred among persons with disabilities. Moreover, persons with disabilities lost jobs and income at higher rates than others and struggled with the rising costs of goods and services, including the increased costs of assistive technology. In the early stages of the pandemic, about a third of persons with disabilities lost access to personal assistance, assistive technology or accessibility services – a trend that continued throughout the pandemic driven by inflation and disruptions in the supply chains. Persons with disabilities faced more difficulties than others accessing and affording food, water, energy, housing, healthcare and personal protective equipment, like masks and sanitizers. One in five students with disabilities dropped out of school during the pandemic and nine in ten did not have the ICT needed to participate in remote learning. Half of workers with disabilities faced barriers working remotely, such as inaccessible online platforms. The isolation created by lockdowns put persons with disabilities, and particularly women with disabilities, at an increased risk of violence, with a quarter of persons with disabilities experiencing violence at home and almost half of women with disabilities not feeling safe at home. Lockdowns also disrupted the regular data collections creating a lack of evidence to guide pandemic responses for persons with disabilities.

Although various countries put in place measures to provide support for persons with disabilities to face

these challenges, others were not able to do so: more than 90 per cent of countries prioritized persons with disabilities in COVID-19 vaccination campaigns, but only half of households with students with disabilities received financial support during school closures to cover the cost of personal and technological support for remote learning, less than half of countries targeted persons with disabilities in their COVID-19 social protection measures and only 10 per cent of countries conducted rapid emergency data collections on persons with disabilities during the pandemic.

Although countries worldwide have been taking measures to build back better and the negative impacts have been steadily reversing since the end of the pandemic, in the current trajectory, the world will not achieve the Sustainable Development Goals for persons with disabilities by 2030. Progress needs to be accelerated. Depending on the target, its achievement will require accelerating the rate of progress from 2 to 65 times faster than the rates of progress observed so far. Accelerations are particularly needed in making physical and virtual environments accessible for persons with disabilities, in adopting anti-discrimination legislation, in expanding social protection and in implementing measures to guarantee the safety and protection of all persons with disabilities when a disaster or other emergency hits.

Compared to the 2018 *Disability and Development Report*, this time around there are much more data on persons with disabilities. The gains in data availability are attributed to the strong commitment of countries and national, regional and international organizations to collecting, compiling and disseminating disability data as well as to the advocacy and efforts of civil society, especially representative organizations of persons with disabilities. The availability of disability data for monitoring progress towards the realization of the Sustainable Development Goals and the Convention on the Rights of Persons with Disabilities (CRPD) is at its highest levels since the CRPD was adopted in 2006. The international community can be more confident where they are, where they need to go and what needs to be done. The disability markers recently developed for tracking bilateral and multilateral aid are a major breakthrough that can inform development efforts. As the international community prepares for the Second World Summit for Social Development in 2025, all need to step up to rescue the Sustainable Development Goals and disability inclusion is part of the solution. This *Report* includes concrete steps that global leaders and relevant stakeholders can take right now to speed up the implementation of the Sustainable Development Goals by, for and with persons with disabilities.

Annex 1. SDG progress by, for and with persons with disabilities by goal

The chart in this annex presents an overview of global progress by, for and with persons with disabilities regarding the targets outlined in the 17 Goals of the 2030 Agenda for Sustainable Development, using trend data between the baseline year of 2015 and the most recent year with available data.

For each target, a list of indicators is included. Some of these indicators are from the 2030 Agenda for Sustainable Development, other indicators provide essential information to contextualize the Sustainable Development Goals (SDGs) for persons with disabilities, such as accessibility of the environment for persons with disabilities, availability and use of assistive technology and existence of laws, policies and mechanisms supporting the inclusion of persons with disabilities. When there is no data disaggregated by disability for a particular SDG indicator, proxy indicator(s) with available data are used when available. Additional information about these indicators is given in the individual chapters of this *Report*.

Legend:

- On track or target met
- Fair progress but acceleration needed
- Stagnation or regression or target missed
- Insufficient data
- % All percentages in the table show latest data available on the indicator
- × Number of times rates of progress observed so far need to be accelerated to meet the target
- D Data for developing countries

		Latest data	Acceleration needed	Progress so far
1 NO POVERTY				
1.1 International poverty	*Insufficient data*			
1.2 Multidimensional poverty	Persons with disabilities living under the national poverty line	20%		
	Persons with disabilities multidimensionally poor[D]	80%		
1.3 Social protection	Persons with severe disabilities receiving cash benefits	34%	3×	
	Countries with universal disability benefits	17%	10×	
1.4 Access to financial services	Banks accessible to wheelchair users	70%	6×	
	ATMs accessible to wheelchair users[D]	48%		
1.a Resources to end poverty	Government spending on social programmes for persons with disabilities as a share of GDP	1%		



2.1 Food security	Persons with disabilities without enough food[D]	55%		
	Food banks accessible to wheelchair users	34%	2×	
	Restaurants accessible to wheelchair users[D]	46%	2×	
	Supermarkets accessible to wheelchair users[D]	68%	10×	
2.2 Children malnutrition	Children with disabilities who are wasted[D]	7%		



3.1 Maternal mortality	Births from mothers with disabilities with skilled personnel[D]	79%		
3.2 Child mortality	*Insufficient data*			
3.3-6 Diseases, substance abuse, traffic accidents	Persons with disabilities self-reporting bad health[D]	33%	5×	
3.7 Sexual & reproductive health	Women with disabilities with family planning needs met[D]	46%		
	Women with disabilities receiving timely post-natal checks[D]	49%		
	Women with disabilities with knowledge on HIV/AIDS[D]	26%		
	Men with disabilities with knowledge on HIV/AIDS[D]	27%		
3.8 Universal health coverage	Persons with disabilities with unmet need for healthcare in developed countries	12%		
	Persons with disabilities with unmet need for healthcare because of cost[D]	56%		
	Healthcare facilities accessible to wheelchair users	58%	3×	
	Hospitals accessible to wheelchair users	85%		
3.9 Health impact of pollution	*Insufficient data*			
3.a Tobacco control	Persons with disabilities who smoke	10%		



4.1 Equitable education	Countries with laws on equal access to learners with disabilities	87%		
	Children with disabilities aged 7-14 with reading skills[D]	30%		
	Children with disabilities aged 7-14 with numeracy skills[D]	23%		
	Primary completion rate for children with disabilities[D]	69%		
4.2 Early childhood development	*Insufficient data*			
4.3 Tertiary education	Persons with disabilities who completed tertiary education	6%		
4.4 Skills for employment	Persons with disabilities who can copy/move folder in ICT[D]	8%		
	Persons with disabilities who can create an electronic presentation[D]	4%		
	Persons with disabilities who can install software[D]	5%		
	Persons with disabilities who can connect a new ICT device[D]	5%		
	Persons with disabilities who can send an email with attachment[D]	7%		
	Persons with disabilities who can write a computer program[D]	2%		
4.a Education facilities for all	Countries with physical spaces in schools inclusive of persons with disabilities	38%	3×	

	Countries in which students with disabilities are taught in the same classrooms as others	17%	



5.1 Discrimination	Women with disabilities who felt discriminated due to disability	8%	
	Women with disabilities who felt discriminated due to gender	9%	
5.2 Violence	Women with disabilities who suffer sexual violence[D]	13%	
5.3 Early marriage	Girls with disabilities aged 15-18 who are or have been married	7%	
5.4 Unpaid work	Women with disabilities in unpaid work	10%	
5.5 Leadership	Women with disabilities working as legislators, senior officials and managers	3%	
	Countries with quotas for women with disabilities in local deliberative bodies	1%	
5.6 Reproductive rights	Women with disabilities exercising their reproductive rights[D]	46%	
5.a Access to financial services	Women with disabilities using mobile phones for financial transactions	15%	
5.b Technology	Women with disabilities using the Internet	26%	
5.c Equality laws	Countries with legal protections for women with disabilities in their disability law	27%	3×



6.1 Safe drinking water	Households of persons with disabilities with safe drinking water	70%	
	Public drinking water accessible to wheelchair users[D]	70%	
6.2 Sanitation & hygiene	Households of persons with disabilities with improved sanitation	53%	
	Public toilets accessible to wheelchair users[D]	67%	3×
	Public showers accessible to wheelchair users[D]	59%	25×



7.1 Access to energy	Households of persons with disabilities with electricity[D]	60%	
	Energy poor households of persons with disabilities in developed countries	38%	
	Households of persons with disabilities using cool/wood for cooking[D]	56%	
	Schools that can use electricity-run assistive technology	76%	
	Countries that assist persons with disabilities using electricity-run assistive technology during a power cut	39%	



8.5 Full employment	Persons with disabilities employed	27%	
	Unemployment rate for persons with disabilities	10%	

	Employment agencies accessible to wheelchair users	62%	2×	
8.6 Youth NEET	Youth with disabilities not employed, not in education or training	48%		
8.7 Child labour	*Insufficient data*			
8.8 Labour rights	Countries prohibiting discrimination against persons with disabilities in job hiring	79%	2×	
	Countries prohibiting indirect discrimination against persons with disabilities in the workplace	37%	8×	



9.c Access to ICT & Internet	Persons with disabilities using the Internet[D]	28%		
	Persons with disabilities in LDCs using the Internet	20%		
	Countries with regulations on ICT accessibility	69%		
	Public Internet cafes accessible to wheelchair users	20%	2×	



10.2 Inclusion	Persons with disabilities who indicate that joining community activities is problematic[D]	43%		
	Persons with disabilities who need but do not have any personal assistance[D]	44%		
	Persons with disabilities who make decisions about day-to-day life, where/with whom to live and how to spend money[D]	34%		
10.3 Eliminate discrimination	Persons with disabilities who felt discriminated	9%		
	Countries prohibiting discrimination against persons with disabilities in education	45%		



11.1 Housing & basic services	Persons with disabilities without modifications at home to make it accessible[D]	27%		
11.2 Public transport systems	Persons with disabilities considering transport not accessible	43%		
	Transit stations accessible to wheelchair users	69%	2×	
	Bus stations accessible to wheelchair users	75%	2×	
11.7 Urban green/public spaces	Persons with disabilities who need but do not have modifications in public spaces in the community	28%		
	Playgrounds accessible to wheelchair users	52%	10×	



12.2 Sustainable use of natural resources	Shops of sustainable products accessible to wheelchair users	67%	2×	
12.5 Waste prevention, reduction, recycling and reuse	Recycling premises accessible to wheelchair users	59%	65×	



13.1 Resilience to disasters	Persons with disabilities with preparedness plans for disasters	16%		
	Persons with disabilities aware of national disaster risk reduction plans	11%		
	Persons with disabilities aware of local disaster risk reduction plans	14%		
	Persons with disabilities who can evacuate when a disaster hits	61%	12×	
13.3 Climate change awareness	Countries with policies on climate change in accessible formats	78%		
	Countries with policies on climate change in easy-to-understand	0%		
13.b Climate change planning & management	Countries with early warnings in accessible formats	100%		
	Countries with early warnings in easy-to-understand	27%		



14.2 Take action on marine ecosystems **15.5 Take action to halt loss of biodiversity**	References to persons with disabilities in social media from youth environmental activism groups	0%		



16.1 Reduction of violence	Women with disabilities who suffer sexual violence[D]	13%		
16.2 Violence against children	Children with disabilities aged 0-18 who suffer violence	32%		
16.3 Justice for all	Courts and police stations accessible to wheelchair users	59%	4×	
16.5 Corruption & bribery	*Insufficient data*			
16.6 Effective institutions	Countries with online services for persons with disabilities	77%		
	Countries with online portals accessible to persons with disabilities	70%		
16.7 Inclusive decision-making	Governmental ministries accessible to wheelchair users	63%		
	Town halls accessible to wheelchair users	66%	4×	
	Persons with disabilities participating in decision-making on disaster risk reduction and response	14%		
16.9 Legal identity	Children with disabilities registered at birth[D]	58%		
16.10 Access to information	Countries with laws requiring public information in accessible formats	6%		
	Countries with at least one sign language as an official language	3%		



17.2 Aid by developed countries	Bilateral aid that is disability-inclusive	3%		
	Donor countries reporting on the disability marker	86%		
17.8 Enabling technology	Countries fully/partially covering costs of assistive technology	90%		
	Persons with disabilities with met needs for assistive technology in countries with low human development index	11%		
17.10 Multilateral trading system	Trade agreements that refer to persons with disabilities	27%	4×	

	Share of developing countries in global exports of assistive technology	26%	6×	
	Share of developing countries in global imports of assistive technology	18%	58×	
17.18 Statistics availability	Countries with Washington Group Questions in their censuses	22%	9×	
	Countries with a Model Disability Survey	7%		
	Countries with employment data disaggregated by disability	28%		
	Indicators disaggregated by disability in the UN SDG database	7	4×	
	LDCs that received disability data capacity-building	59%		
	SIDS that received disability data capacity-building	45%		

Explanatory notes

Average values shown in charts show the arithmetic averages of the values across countries. World and regional estimates are also calculated as arithmetic averages of country data.

(WG) indicates data in which persons with disabilities were identified using the six questions of the short set on functioning of Washington Group on Disability Statistics, that is, 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 show 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 on the basis of data from DHS, IPUMS and SINTEF data were calculated or commissioned by UNDESA, unless otherwise stated.

Endnotes

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