Department of Economic and Social Affairs

Global Status Report
on Disability and Development
Prototype 2015

UNEDITED VERSION

United Nations

New York, 2015

Department of Economic and Social Affairs

The Department of Economic and Social Affairs of the United Nations Secretariat is a vital interface between global policies in the economic, social and environmental spheres and national action. The Department works in three main interlinked areas: (i) it compiles, generates and analyses a wide range of economic, social and environmental data and information on which States Members of the United Nations draw to review common problems and to take stock of policy options; (ii) it facilitates the negotiations of Member States in many intergovernmental bodies on joint courses of action to address ongoing or emerging global challenges; and (iii) it advises interested Governments on the ways and means of translating policy frameworks developed in United Nations conferences and summits into programmes at the country level and, through technical assistance, helps build national capacities.

Note

The designations employed and the presentation of the material in the present publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country or territory or of its authorities, or concerning the delimitations of its frontiers. The term "country" as used in the text of this report also refers, as appropriate, to territories or areas. The designations of country groups in the text and the tables are intended solely for statistical or analytical convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process. Mention of the names of firms and commercial products does not imply the endorsement of the United Nations.

Contributors and acknowledgements

This report was drafted by the Secretariat for the Convention on the Rights of Persons with Disabilities (SCRPD) of the Division for Social Policy and Development (DSPD), UN Department of Economic and Social Affairs (DESA), with inputs from experts from academic institutions and international agencies.

Team from DSPD/SCRPD of UNDESA

Talin Avades, Fred Doulton, Miranda Fajerman, Kaisa Huovinen, Akiko Ito, Maria Martinho, Justin Meloche, Julie Pewitt, Robert Venne, Guozhong Zhang, Manou Zonderland

Contributors from UN and inter-governmental organizations

Stefan Tromel, Valentina Stoevska (ILO); Fredrik Ericsson (OECD); Arturo Requesens, Jean-Pierre Gonnot, Margaret Mbogoni, Keiko Osaki-Tomita (UNDESA); Irmgarda Kasinskaite, Mariana Kitsiona, Florence Migeon (UNESCO); Rosangela Berman Bieler, Anna Burlyaeva, Gopal Mitra, Tamara Rusinow, Lieve Sabbe, Megan T Tucker (UNICEF); Takashi Izutsu, Atsuro Tsutsumi (International Institute for Global Health, UN University); Maribel Derjani-Bayeh, Mary Keogh, Jeong Shim Lee, Sharon J. Taylor (UN-Women); Alarcos Cieza (WHO)

Contributors from academic institutions and non-governmental organizations

Mary Crock (University of Sidney); Rangita de Silva de Alwis (Wellesley Centers for Women, University of Pennsylvania); Roberto Foa (Harvard University); Daniel Mont (University College London); Victor Pineda (World Enabled)

Contents

Figures

Tables

Boxes

Acronyms and abbreviations

CRPD: Convention on the Rights of Persons with Disabilities

DESA: *see* UN DESA

DPO: disabled persons' organization

DSPS: Division for Social Policy and Development of UN DESA

ECOSOC: Economic and Social Council

ICF: International Classification of Functioning, Disability and Health

ICT: Information and communication technologies

ILO: International Labour Organization

ISO: International Organization for Standardization

IYDP: International Year of Disabled Persons

MDG: Millennium Development Goals

NGO: non-governmental organization

ODA: Official Development Assistance

SCRPD: Secretariat for Convention on the Rights of Persons with Disabilities

SDG: Sustainable Development Goals

UN: United Nations

UDHR: Universal Declaration of Human Rights

UN DESA: Department of Economic and Social Affairs

UNESCO: United Nations Educational, Scientific and Cultural Organization

UNICEF: United Nations Children's Fund

UNISDR: United Nations Office for Disaster Risk Reduction

WHO: World Health Organization

WPA: World Programme of Action Concerning Disabled Persons

Chapter 1. Introduction

Context

Disability is both a human rights issue and a development issue, a duality which has been recognized in the UN Convention on the Rights of Persons with Disabilities. Addressing the importance of disability inclusion for development, the 2030 Agenda for Sustainable Development includes several development targets for persons with disabilities and for accessible environments for them. In 2011, the World Health Organization (WHO) and the World Bank produced a report, using scientific evidence and available data, providing a portrait of the situation of persons with disabilities in various development aspects, such as health care, employment and education, as well as policies developed by countries to address the needs of persons with disabilities. However, since then, no other review of policies and the situation of persons with disabilities worldwide have been produced.

To address this gap, the General Assembly Resolution 69/142, 'Realizing the Millennium Development Goals and other internationally agreed development goals for persons with disabilities towards 2015 and beyond', requested the Secretary-General, in coordination with all relevant United Nations entities, "to compile and analyse national policies, programmes, best practices and available statistics regarding persons with disabilities, reflecting progress made in addressing the relevant internationally agreed development goals and the provisions of the Convention on the Rights of Persons with Disabilities (CRPD), to be submitted to the General Assembly in a flagship report during 2018 " (para 21b).

In preparation for the UN flagship report to be submitted to the General Assembly in 2018, the Secretariat for the Convention on the Rights of Persons with Disabilities (DSPD/DESA) produced this prototype Global Status Report on Disability and Development. This report uses available data and information on the situation of persons with disabilities in various aspects of economic and social development. It also presents policies and responses taken by

countries to promote the inclusion, participation and development of persons with disabilities. The Global Status Report on Disability and Development – Prototype 2015 is directed at governmental officials, policy-makers and other decision makers at all levels, development agencies, civil society and the public in general.

Aims

The overall aims of the Report are:

- To provide a preliminary assessment of available information, successful policies and key issues for persons with disabilities.
- To serve as a basis for decision on the outline and content of the UN flagship report to be submitted to the General Assembly in 2018.

Scope

This prototype report is a preliminary assessment of national policies, programmes, best practices and available statistics regarding persons with disabilities. The report covers selected development areas relevant to 2030 Agenda for Sustainable Development and the Convention on the Rights of Persons with Disabilities. Due to its preliminary nature, this report does not aim at reviewing comprehensively and thoroughly all policies and data available. Instead, the report provides illustrative data, analyses and policies.

For every topic discussed in this report, attempts were made to present the most recent data available. Preference was given to internationally comparable data showing the highest number of countries. When no internationally comparable data were available, selected country data were shown with a note alerting for the lack of internationally comparability. Although not comparable, it was judged pertinent to present these data because they show that the disadvantages experienced by people with disabilities are persistent across countries.

Since preference was given to internationally comparable data, some datasets presented are not recent, from the early 2000s and 1990s, and cannot be interpreted as the current situation. Nevertheless, these data sets can provide guidance on the situation experienced by persons with disabilities in the past and possibly still at present. These "old" data sets also highlight the need to produce new internationally comparable data to know the present situation and assess progress so far.

Due to changes in the methodology to identify persons with disabilities across time, there is a lack of data comparable over time, which hampers any assessment of progress. Therefore, this report focuses mainly on providing a snapshot in time of the situation of persons with disabilities.

Outline

Chapter 2 gives a historical perspective of the UN's work on disability and development and presents the international normative framework on disability. Chapter 3 gives an overview of the situation of persons with disabilities in development and discusses the definition, prevalence and data availability on the situation of persons with disabilities. It also explores accessibility to physical and information environments, by presenting UN mandates, reviewing best practices and available data on accessibility. Chapter 4 reviews the participation of persons with disabilities in education and employment, their health and their access to health care and to social protection. The chapter also reviews the status and participation of persons with disabilities who tend to suffer from double discrimination: women and girls with disabilities, children with disabilities, youth with disabilities, older persons with disabilities, indigenous persons with disabilities, refugees with disabilities as well as persons with mental and intellectual disabilities. Chapter 4 ends by discussing two examples of emerging issues in disability and development: (i) disaster risk reduction and humanitarian emergencies; and (ii) human settlements and urban development. Chapter 5

debates the way forward by identifying measures which can contribute to making the 2030 Agenda for Sustainable Development disability-inclusive. Most sections in the report end with a conclusion summarizing the section and recommendations on the way forward. These recommendations are based on each section findings and on expert advice.

Chapter 2. Historical overview of the UN's work on disability and development

"Persons with disabilities as beneficiaries and agents of change in society and development" - the central message of the work of the United Nations in disability[1] is increasingly taking concrete forms in global, regional national development agenda. Persons with disabilities are advocating for their rights to actively participate in and lead their communities and building new communities of stakeholders in disability-inclusive development. An historical reflection on the situation for persons with disabilities, however, demonstrates that this has not always been the case. Recent advancements of the rights of persons with disabilities in society and development emerge as a result of the adoption, progression and promotion of the international norms and standards relating to disability. An increasing international focus on the situation of persons with disabilities in development has also led to successful mainstreaming of the disability perspective and the rights of persons with disabilities in global development processes and their resulting frameworks, including the 2030 Agenda for Sustainable Development. Over the past decade in particular, the General Assembly[2] has reiterated its commitment to include the disability perspective in the global development agenda, calling for urgent action toward inclusive, accessible and sustainable society and development. The aim of this chapter is to highlight the achievements of the international community and to set its course for advancement of the rights of persons with disabilities.

Establishment of the United Nations

Prior to the establishment of the United Nations, the League of Nations discussed the nascent ideas for basic human rights, including promoting rights for minorities, religious freedoms, women and labour, but the international community definitively saw the beginning of the new era for universal human rights in the United Nations (UN) Charter – a result of an International Organization Conference in 1945, placed human rights at the core of the organization, committing to uphold the dignity and worth of all human beings. The commitment of the international community to promote the full and effective participation of persons with disabilities in all aspects of society and development is deeply rooted in the goals of the United Nations' Charter. [3] In 1948, the General Assembly of the UN adopted the Universal Declaration of Human Rights (UDHR)[4] which promoted the right to life, liberty and security of all persons in society, including the fostering of all such rights in the event of, among other circumstances, disability. Although it conceptualised disability as a condition, as opposed to a status or a result of a person's interaction with the way in which society is organized, the UDHR is widely recognised for establishing the core principle of equality for all.

The reference to disability in the UDHR as early as 1948, though overdue, provided positive and progressive steps to the advancement and rights of persons with disabilities. Global recognition of persons with disabilities as equals has progressed significantly since then. In 1976, the UN adopted the International Covenant on Civil and Political Rights[5] and the International Covenant on Economic, Social and Cultural Rights[6], which alongside the UNDHR formed a triad of international human rights treaties, and what is called the International Bill of Human Rights. The "International Bill of Human Rights" is applicable to all and provided a basis for the universal human rights of persons with disabilities.

A shift in perspective

While there was a major progress in the corpus of international human rights law and expansion of the United Nations human rights treaty system, disability largely remained as a social protection and welfare issue. The General Assembly, Economic and Social Council (ECOSOC) and its subsidiary organ, the Social Commission promoted well-being and welfare of persons with disabilities through technical cooperation, rehabilitation and vocational programmes. For example, the Social Commission during its sixth session in 1950 adopted the reports entitled "Social rehabilitation of the physically handicapped" and "Social rehabilitation of the blind",[7] leading the ECOSOC to establish rehabilitation programmes for persons with physical disabilities and blindness respectively. Following the decisions by the United Nations entities 1950, there was consensus formed among the United Nations and its entities (including the ILO, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF)) to establish international standards for education, treatment, training and placement of persons with disabilities. This, in turn, led a shift in focus in the way disability was conceptualised, moving away from defining the role of persons with disabilities as recipients of welfare and services to those who are entitled to exercise their basic human rights. In 1969, the General Assembly adopted a declaration, emphasising the need to protect the rights and welfare of persons with disabilities[8], thus calling for their full participation in society. The international recognition that it is the society that creates barriers for participation of persons with disabilities emerged during this period, leading to the adoption of the two international instruments on the rights of persons with disabilities.

The first was the Declaration on the Rights of Mentally Retarded Persons, adopted by the General Assembly in 1971[9], representing a significant step in raising awareness on the rights of persons with intellectual disabilities and the importance of the role of education for persons with intellectual disabilities to reach their full potentials. At the time, this Declaration

was an important tool to advance disability as part of a global agenda– particularly the issue of intellectual disabilities. The Declaration, however, still retained a 'medical/social welfare model' approach to disability in some parts, referring to persons with disabilities as reliant on social security and welfare and requires separate services and institutions.

A second declaration on disability followed in 1975 - the Declaration on the Rights of Disabled Persons[10], promoted social integration of persons with disabilities, on the basis of their inherent dignity and human rights, setting standards for equal treatment and accessibility to services. From the 1971 declaration, it reflected the transition from the 'medical/social welfare model' approach to disability to "social/human rights" model of promoting the equal rights and opportunities for persons with disabilities.

Building momentum

By 1980s the United Nations has garnered support from the Member States to take further steps for the full participation of persons with disabilities in society and development, which resulted in the designation of 1981 as the International Year of Disabled Persons (IYDP).[11] The IYDP promoted the full integration of persons with disabilities into society, increasing awareness and encouraging the formation of disability organizations to give an active voice to persons with disabilities worldwide. During the year, great many conferences, symposiums and events at global, regional and national levels were held to commemorate the progress made in inclusion of persons with disabilities in society and to strengthen the policy innovation. The IYDP was therefore a pivotal year for the advancement of the rights of persons with disabilities in society and development.

In 1982, the General Assembly adopted the World Programme of Action Concerning Disabled Persons (WPA)[12], to achieve the goal of the full and effective participation of persons with disabilities, rehabilitation, and the equalization of opportunities. The central theme of the WPA was the equalization of opportunities for persons with disabilities, and the

effective measures for the prevention of disability and rehabilitation. The WPA was thus an important and pivotal shift towards a rights-based approach to disability as a global issue. It focussed on how the societal and other barriers - be they environmental or attitudinal - should be removed so that persons with disabilities can participate in society as agents of change and beneficiaries of development gains. To advance the goal of the WPA, the United Nations General Assembly designated the decade for Disabled Persons, spanning from 1983 to 1992[13], which spurred a number of activities designed to improve the situation and status of persons with disabilities, including improving education and employment opportunities, and increasing their participation in communities and countries. During the Decade, a number of conferences and related activities took place, including an expert group meeting in 1987[14] and the adoption of the "Tallinn Guidelines for action on Human Resources Development in the Field of Disability" in 1989. The Decade resulted in the establishment of the International Day of Disabled Persons, to be observed on 3 December. It also resulted in establishment of the first global network of persons with disabilities, Disabled People's International, and subsequent formation of national and local organizations of persons with disabilities. The message of "persons with disabilities as agents and beneficiaries of development" thus started to take concrete forms in the international normative framework on disability and development as well as in global, national and regional policy frameworks and global networks of persons with disabilities to define their own rights, well-being and perspectives in society.

The Standard Rules on Equalization of Opportunities for Persons with Disabilities was one of the main results of the UN Decade of Persons with Disabilities, bringing the importance of equalization of opportunities to the forefront of a global development agenda. The Standard Rules were adopted in 1993 by the General Assembly to advance the central objective of the World Programme of Action concerning Disabled Persons as a set of rules

for action by the Governments and other stakeholders. The monitoring mechanism of the Standard Rules included the appointment of a Special Rapporteur to report to the Commission for Social Development to the implementation of the rules.[15]

Box 1. Key world conferences in the 1990s

In order to emphasise the need for a "society for all", and advocate the participation of all citizens - including persons with disabilities - in every sphere of society, the UN hosted five key world conferences in the 1990s.

i)   In 1992, the Rio de Janeiro Conference on Environment and Development encouraged Governments to give more attention to *"demographic trends and factors ... that have a critical influence on consumption patterns, production, lifestyles and long-term sustainability."* The Rio document mirrored this trend and dedicated an entire section of the final report to "strengthening the role of major groups."

ii)   The World Conference on Human Rights, held in Vienna in 1993, reconsidered universally recognized human rights instruments in the light of contemporary issues and produced a Programme of Action to guide human rights efforts forward in light of today's realities. The Conference recognized that "all human rights and fundamental freedoms are universal and thus unreservedly include persons with disabilities."[16] It recognized that any discrimination, intentional or unintentional, against persons with disabilities is per se a violation of human rights.

iii) The International Conference on Population and Development, held in Cairo in 1994, recognized the importance of the equalization of opportunities for people with disabilities. The objectives endorsed by the Conference included "ensuring realization of rights...and participation in all aspects of social, economic, and cultural life ...to

create, improve, and develop necessary conditions...[to] ensure equal opportunities ...and dignity [while] promot[ing] self-reliance"[17] of persons with disabilities.

iv) In March 1995, the United Nations held the World Summit for Social Development in Copenhagen, Denmark. The Summit adopted the Copenhagen Declaration on Social Development and the Programme of Action of the World Summit for Social Development. The Declaration attempts to respond to the material and spiritual needs of individuals, their families and communities. It stipulates that economic development, social development and environmental protection are interdependent and mutually reinforcing components of sustainable development, and it cites disadvantaged groups such as disabled persons as deserving special attention.[18] -- Copenhagen Declaration

v) In September 1995, the Platform for Action, was adopted by the Fourth World Conference on Women in Beijing, China. It stipulates areas of special concern and recognizes that barriers to full equality for women can include factors such as their disability. Concerns relating to disability are also raised in the Beijing Declaration when the parties to the Conference commit to "intensifying efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of factors such as...disability"[19]

UN development conferences

As well as key milestones reached by the UN in advancing disability rights and development, international and world conferences held during the 1990's following the decade for disabled persons emphasised the need for a 'society for all', thus providing scope to advocate participation of persons with disabilities in all spheres of society (Box 1). Conferences

advocated initiatives to improve health care, education, elimination or reduction of violence and the lessening of the poverty rate for persons with disabilities, thus realising their rights in all aspects of social, economic and cultural life. The World Conference on Human Rights in 1993 saw the generation of the Vienna Declaration and Programme of Action[20], adopted by the General Assembly to advance the human rights in line with the changing scope of society. It recognised that the human rights and freedoms granted to all members in society unreservedly include persons with disabilities[21], and for this reason, discrimination against them is a violation of human rights.

Additionally, the World Summit for Social Development in 1995 adopted the Copenhagen Declaration on Social Development[22], which stipulates that developments in economics, social and environmental are mutually reinforcing components of sustainable development. The declaration also noted that development cannot be accomplished in the absence of all human rights and without participation from all groups and representations in society. Though core human rights treaties were certainly universal in their coverage, they did not address the specific barriers, needs and concerns that persons with disabilities faced, toward an international convention on disability.

The United Nations, in collaboration with Member States, organizations of persons with disabilities and academic institutions were exploring further how the Standard Rules and the existing international normative framework on disability – consisting of international instruments on human rights and development- could advance the rights of persons with disabilities. For this objective, a number of technical meetings were organized throughout the late 1990s to early 2000. A pivotal meeting was the UN Consultative Expert Group Meeting on International Norms and Standards relating to disability (1998), which explored specific ways to utilize the existing norms and standards for advancement of the rights of persons with disabilities, including specific recommendations for mainstreaming disability in

the UN development and human rights agenda, mechanisms, processes and resulting documents. The following year, an UN inter-regional conference on international norms and standards relating to disability was held in collaboration with the Equal Opportunities Commission of Hong Kong, SAR, China, which brought together global, regional and national leaders and experts in the field of disability, development and human rights. The Conference adopted a set of recommendations for advancement of the rights of persons with disabilities at global, regional and national levels, including a possibility for promoting an international Convention on the rights of persons with disabilities.[23]

At the 56th session of the General Assembly, the Government of Mexico at its highest level proposed an international convention on disability to be considered by the General Assembly, based on the programme of action adopted by the World Conference on Human Rights in Durban (South Africa, 2001). The consultations on this proposal involved many new and traditional stakeholders in the field of disability, gaining a momentum for a new era of "disability movement" within and outside the United Nations. The General Assembly established the Ad Hoc committee in 2001, which was initially proposed for "considering proposals for an international convention to uphold the dignity and rights of persons with disabilities." The committee engaged civil society (in its meeting in 2002), establishing a working group to prepare a draft text of a convention (in 2003)[24], with final negotiations on the draft text and its Optional Protocol, which were both adopted by the General Assembly in December 2006[25].

The Convention on the Rights of Persons with Disabilities (CRPD) was envisaged from the very beginning as the instrument for inclusive development and for advancement of the universal human rights of persons with disabilities. It entered into force in 2008 and has established two monitoring mechanisms: i) the Committee on the Rights of Persons with Disabilities and ii) the Conference of States Parties. While the Committee is part of the UN

human rights treaty monitoring system, the Conference of States Parties to the CRPD is a unique mechanism which has no parallel entities in other human rights conventions. The Conference is established as a unique forum to exchange views and new ideas for the implementation of the Convention and to improve policies and programmes, with a focus on practical solutions to the obstacles encountered by persons with disabilities on the ground.

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

Broadly speaking, there are two core aspects to the implementation of the Convention: (a) harmonization of laws relating to disability and adaptation of policies and programmes; and (b) non-legal strategies in innovative use of an international convention for advocacy and social change. Implementation of the Convention calls for the formulation of

strategic options for policies, programmes and evaluation measures that promote the full and equal participation of persons with disabilities in society and development.

While the international normative framework on disability was further strengthened by the Convention, the international community was facing the lack of information in the data, statistics and analysis of the situation of persons with disabilities in development for mainstreaming disability in the development goals, including the Millennium Development Goals. As a response to such need, a flagship report published by the World Health Organization and the World Bank in 2011, the World Report on Disability,[26] contributed to the available data and statistics, information and analysis of the situation of persons with disabilities. The Report estimated that there are one billion persons living with some forms of disability worldwide and included its analysis, which correlated disability with poverty, a lack of education, and increased likelihood to harmful practices to health. The Report articulated that disability is a critical developmental issue, and that the global development agenda must include persons with disabilities in all sectors of development.

UN General Assembly High Level Meeting on Disability and Development and toward disability-inclusive 2013 global agenda for sustainable development

As the international community were beginning dialogues to develop the 2030 Agenda for Sustainable Development, the General Assembly called for a High-Level meeting on Disability and Development to be held at the level of Heads of States and Governments in 2013[27], under the theme: "The Way Forward: a disability inclusive development agenda towards 2015 and beyond". At this meeting, Member States adopted an outcome document,[28] stressing the importance of giving due consideration to all persons with disabilities in the 2030 Agenda for Sustainable Development. The outcome document *"encourages the international community to seize every opportunity to include disability as a cross-cutting issue in the global development agenda"* and the need to translate these international

commitments into concrete actions and results for persons with disabilities was also emphasised by Members States in the Meeting.[29]

The international community, on the basis of the outcome of the High Level Meeting on Disability and Development, specifically addressed the inter-linkages between disability and sustainable development in the course of the negotiation of the 2030 development agenda for sustainable development. It underscored the importance of a disability-inclusive global development agenda and successfully included references to disability in the draft document of a 2030 global agenda. For the adoption in March 2016, the international community will continue its review of and consideration for disability-inclusion in the indicators for the monitoring and evaluation of the 2030 development agenda

Box 2. Timeline of disability and the United Nations

1945: The United Nations is established

1948: Universal Declaration of Human Rights (UDHR) is adopted

UDHR promotes the right to life, liberty and security of all persons in society

The 1950's and 1960's

The Social Commission Reports: "Social rehabilitation of the physically handicapped" and "Social rehabilitation of the blind" establishes rehabilitation programmes for persons with physical disabilities and blindness.

1969: Declaration on Social Progress and Development is adopted

The declaration emphasises the need to protect the rights and welfare of persons with disabilities, thus calling for their fuller participation in society.

1976: International Bill of Rights

The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, and the UNDHR form a triad of treaties

covering human rights, known as the International Bill of Human Rights.

1981: International Year of Disabled Persons (IYDP)

Conferences and symposiums are held to celebrate persons with disabilities and strengthen policy innovation.

1982: World Programme of Action Concerning Disabled Persons (WPA)

Encourages national level programmes to achieve and enhance rehabilitation, and the equalization of opportunities.

1983 to 1992: Decade for Disabled Persons

A number of programmes around the world improve the situation and status of persons with disabilities enhancing education and employment opportunities, and increasing their participation in society.

1993: Standard Rules on the Equalization of Opportunities for Persons with Disabilities

The Standard Rules (1993) encourage States to take action to remove obstacles that would prevent persons with disabilities from exercising their rights.

1995: The World Summit for Social Development in 1995

The Copenhagen Declaration on Social Development notes that economic, social and environmental developments are mutually reinforcing components of sustainable development.

2001: General Assembly establishes an Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities

The Ad Hoc committee considers the barriers encountered by persons with disabilities in society and drafts a treaty.

2006: The Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD is adopted on 13 December 2006, making it the first international human rights treaty of the new millennium.

2013: UN General Assembly High-Level Meeting on Disability and Development

An action-orientated outcome document is adopted by the Meeting, stressing the need for society to ensure accessibility for and inclusion of persons with disabilities. Disability is seen as a cross-cutting issue in the global development agenda.

2015: 2030 Agenda for Sustainable Development

Disability is incorporated as a cross-cutting issue and is specifically targeted areas related to education, growth and employment, inequality, accessibility of human settlements and means of implementation (in relation to availability and disaggregation of data.

Conclusion

Since its inception, the United Nations has been taking a lead in advancement of the rights of persons with disabilities in society and development, working closely with Member States, organizations of persons with disabilities and other civil society organizations, academic communities and the private sector, at local, national and global levels. There has been remarkable progress and achievements over the past decades in this endeavour for the full and effective participation of persons with disabilities as agents of change and beneficiaries of development. There are a number of landmarks, including the adoption of an international treaty, the disability-inclusion in the global development agenda, their processes, mechanisms, and monitoring and evaluation, including the 2030 global agenda for sustainable development (Box 2). Nonetheless, persons with disabilities still face great many challenges in their quest for equal and full participation in society and development. On the way towards the implementation of a new 2030 Agenda for Sustainable Development, the

international community has the extraordinary opportunity to translate the long-standing commitment of the United Nations to advancement of the rights of persons with disabilities into concrete development action and practice. This is all for the goal of creating an inclusive, accessible and sustainable world, which is peaceful and prosperous world for all.

Chapter 3. Overview of the situation of persons with disabilities in development

3.1   Defining disability

In line with the approach taken in the International Classification of Functioning, Disability and Health (ICF),[30] disability can be defined as a limitation in a functional domain that arises from the interaction between a person's intrinsic capacity, and environmental and personal factors. In ICF terms, this is the level of a person's *performance* in a domain, taking in account the impact of his or her environment and personal factors (Bostan et al 2015). Along similar lines, the United Nations' Convention on the Rights of Persons with Disabilities *recognized "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"* (UN, 2007: Preamble).

The ICF defines functioning as occurring at three levels: body function and structures, activities and participation. For example, if an individual cannot move their legs, he/she experiences a limitation in functioning at the body function level. If an individual has difficulty walking, he/she experiences a limitation at the basic activity level, in other words difficulty combining body functions to perform a particular task. If an individual cannot work, i.e. combine a group of activities in order to fulfil a social function or role, because of environmental barriers (e.g. an inaccessible work place), then he/she is restricted at the participation level.

The overall experience of disability is diverse as it is the aggregate of limitations in functioning across multiple domains (e.g. walking, seeing), each on a continuum, or a spectrum, from little or no disabilities to severe disabilities, either within a particular domain or across multiple domains. For each domain, the level of functioning a person experiences

depends both on the intrinsic capacity of the individual's body and the features of his or her environment that can either lower or raise, the person's ability to participate in society. For example, a wheelchair user living in an environment where buildings and public transportation are wheelchair accessible, will experience less disability than a comparable wheelchair user living in an inaccessible environment. 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". Although there is no universal standard for this threshold, countries and international organizations have adapted practical thresholds for their own data collections on the basis of their policy needs.

3.2 Measuring disability and data collection

Why do we need data?

In order to develop policies and programs to achieve internationally agreed development goals and to implement the Convention on the Rights of Persons with Disabilities (CRPD), it is essential for countries to have a clear understanding of the situation of persons with disabilities and the nature of the barriers to participation that they face. To ensure those policies and programs are properly implemented, their outcomes need to be effectively monitored and evaluated. Such activities require timely, high quality data on people with disabilities and on the nature of the environment, namely on environmental barriers faced by persons with disabilities. In addition, collecting and disseminating data on disability provides information on the functioning of the population, on inequality of opportunities and the existing provision of services for persons with disabilities (e.g. see Box 3 for data needed to support evidence-based policy on inclusive education).[31]

The importance of data collection has been reinforced by article 31 on Statistics and Data Collection in the CRPD. The article states that governments need to undertake appropriate data collection "to enable them to formulate and implement policies to give effect" to the CRPD, and to help assess its implementation. SDG target 17.18 aims at enhancing capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by disability, in five years, i.e. by 2020, well- ahead of the target-year of the 2030 Agenda for Sustainable Development.

Box 3. Data needed to support evidence-based policy on inclusive education

Developing effective policies promoting inclusive education requires an accurate assessment of needs and gaps. However, data are generally lacking. Collecting data on children with disabilities poses its own challenges as it is difficult to distinguish a disability from a delay in

development which may not result in a disability. But without data on the number of children with disabilities, by type of disability, it is difficult for policy makers to estimate and plan for the educational needs. To increase the chances of access to schooling for all children and ensuring their retention, knowledge on the different types of disabilities will help formulate targeted interventions because availability of services and infrastructure to accommodate children with disabilities in inclusive education or other settings may depend on the type of disability.

Without data on children with disabilities, it is also not possible to disaggregate educational attainment and school attendance for children with and without disabilities, which is essential to determine inequalities in the educational system and estimating the number of children falling behind. In the absence of data on children with disabilities and their access to education, identifying barriers to learning, such as the number of inaccessible schools and the number of schools without accessible educational materials, will be helpful in assessing the inclusiveness of the education system (see table below).

Purpose	Data are needed to support evidence-based policy
Identify educational needs	Number of children with disabilities, by type of disability
Identify inequality gaps; estimate the number of children with disabilities that may be falling behind in education	Educational attainment, disaggregated by disability School attendance, disaggregated by disability
Identify barriers in the education system and design measures to improve the inclusiveness of education systems[1]	Barriers to learning, including inaccessible schools and educational materials
Assess the inclusiveness of education systems	Number of students with special education needs enrolled in regular schools[32]

Assess the inclusiveness of education systems	Number of students with disabilities who benefit from resources, expertise, and equipment[32] 32intended for special needs education

Different approaches to disability data collection

Countries have typically collected data on persons with disabilities through three data sources: administrative registers of persons with disabilities; censuses; and surveys. Administrative registers generally identify persons with disabilities on the basis of conditions determined by law, which usually correspond to the conditions needed for people to receive disability benefits. As such, administrative registers tend to be limited in their coverage and lead to low prevalence of disability, typically omitting people with mild or moderate disabilities, or people who lack access to registering for disability benefits.

In censuses and surveys, three main approaches have been used by countries to collect data on disability: (i) the approach which asks persons if they have a disability; (ii) the approach which asks about a list of diagnosis and (iii) the functioning based approach.

The first approach relies on asking the question "Do you have a disability?" with a categorical yes or no answer. Although this method may seem straightforward, it does have limitations. The term "disability" is often associated with shame and stigma, and therefore respondents may not wish to disclose that they or a family member has a disability. Additionally, as the word "disability" is often considered to only apply to very severe conditions, people with mild or moderate impairments may not identify themselves as having a disability.

The second approach of list-of-diagnosis presents respondents with a list of particular diagnoses, such as paralysis, epilepsy, blindness, autism, etc. This approach may miss many people with disabilities as no list of diagnoses is complete. Moreover, the terminology of the list may mean that individuals may not understand or may not even know their own

diagnosis. Since knowledge of one's diagnosis is correlated with one's education and access to health care, this approach may be subject to bias

The third approach, the functioning based approach, relies on asking people about the difficulties they face while undertaking basic activities, such as seeing, hearing, walking, concentrating and communicating. This approach tends to identify higher rates of disability prevalence than the first two (Table 1). The functioning based approach is the basis of the UN recommendations for questions collecting data on people with disabilities in censuses. These recommendations consider four domains essential in determining disability status: walking; seeing; hearing; cognition; and identify two other domains for inclusion if possible: self-care and communication.[33] Six questions for censuses on these six domains have been adopted by the Washington Group on Disability Statistics (Box 4).

Table 1. Census-based disability prevalence by type of question

| Country | "Do you have a disability?" Yes/No | | List of diagnoses/conditions | | Functioning/activity based | |
	Year	Disability prevalence (%)	Year	Disability prevalence (%)	Year	Disability prevalence (%)
Brazil			1991	0.9	2000	14.5
Mexico			2000	1.8	2010	5.1
Uganda	1991	1.2			2002	3.3

Source: Uganda 1991 and Brazil 1991: DISTAT;[34] Brazil 2000, Mexico 2000 and Uganda 2002: Mont (2007);[35] Mexico 2010: Velázquez Lerma (2015).[36]

Box 4. Washington Group of Short Questions on Disability

The next questions ask about difficulties you may have doing certain activities because of a

HEALTH PROBLEM.

1. Do you have difficulty seeing, even if wearing glasses?

2. Do you have difficulty hearing, even if using a hearing aid?

3. Do you have difficulty walking or climbing steps?

4. Do you have difficulty remembering or concentrating?

5. Do you have difficulty (with self-care such as) washing all over or dressing?

6.Using your usual (customary) language, do you have difficulty communicating, (for example understanding or being understood by others)?

Each question has four response categories: (1) No, no difficulty, (2) Yes, some difficulty, (3) Yes, a lot of difficulty and (4) Cannot do it at all.

Status of internationally comparable disability data

Out of selected 166 countries/territories that conducted censuses in 2005-2014,[37] 75% of them – or 125 countries/territories – collected data on disability.[38] More than one quarter, or 39 countries/territories, included the four essential domains of the UN recommendations/Washington Group questions,[33] that is, asked about difficulties in walking, seeing, hearing and remembering/concentrating and included the Washington Group response categories of Box 4.[39] Countries also included disability modules in special surveys – like labour force surveys,[40] demographic and health surveys[41] or living standard measurement surveys[42] – in order to obtain information on the participation of persons with disabilities in diverse areas of life. Several sources are used for collecting data on employment for persons with disabilities. A total of 112 countries have collected this information through censuses, surveys or administrative records since 2000. While this information is mostly publicly available online, 7% of these data sources have not been disseminated freely online.[43]

Although more and more disability data have been generated in recent years, these data are not always comparable because different approaches to data collection are still in use (see section above), even in censuses for which UN recommendations exist.[33] But

encouraging international initiatives have produced multi-country sets of internationally comparable data. The WHO conducted World Health Surveys in 2002-4, with more than 50 countries collecting data on disability using a common survey.[44] These data permitted the assessment of the situation of persons with disabilities in a number of areas, including education, employment and health care. The ILO's School-to-Work Transition Surveys, which were conducted in 2012-3 in 28 countries, used the Washington Group questions (Box 4) and produced a wealth of data on the experience of youth with and without disabilities as they are transitioning from school to work.[45] In 2013, the United Nations Office for Disaster Risk Reduction (UNISDR) conducted a first-ever United Nations Survey on Living with Disabilities and Disasters which surveyed more than 5,000 persons with disabilities in 137 countries. This survey looked into factors related to how persons with disabilities cope with disasters – the survey used the Washington Group questions to identify the types of disabilities that persons with disabilities live with every day.

3.3 Prevalence of disability

3.3.1 Global prevalence for adults

Due to the use of different approaches to measure and identify persons with disability during data collection exercises, there are several distinct estimates of disability prevalence. In addition, as disability is a continuum (see section 3.1 'Defining disability'), even if the same questions are used to identify persons with disabilities different cut-off thresholds used to identify people with disabilities will lead to different estimates of disability prevalence.

In 2011, the WHO/World Bank's World Disability Report gathered data from 59 countries collected through the World Health Surveys in 2002-2004 that included a functioning approach. The report found that the global prevalence of disability was 16%, ranging from 12% in higher income countries to 18% in lower income countries (Table 2). A third set of estimates derived from the Global Burden of Disease Study 2004 update used a different

methodology that yielded an estimate of 19%.[26,46] The Washington Group questions (see section 3.2) tend to lead to lower estimates at the country level (Table 3). Research has shown that these questions leave out those with minor or moderate disabilities, but they identify those with significant disabilities.[47]

Table 2. Estimates of global disability prevalence for adults

Data source	Global prevalence
World Health Surveys, 2002-2004[26]	16%[48]
Global Burden of Disease Study, 2004[46]	19%[49,50]

Table 3. Disability Prevalence Using the Washington Group Questions, by Data Instrument and Year

Country	Type of source	Year	Prevalence Rate
Aruba	Census	2010	7%
Israel	Census	2008	6%
Maldives	Survey	2009	10%
United States	Survey	2013	10%
Zambia	Survey	2006	9%

Source: Loeb (2015).[51]

3.3.2 Prevalence in children

Estimating disability prevalence for children poses even greater challenges than for adults as it is difficult to differentiate between natural development delays and disabilities. Some global and country studies point to prevalence estimates around 6% (see Table 4), but estimates vary widely depending on the method used. A detailed study in the United States that took a functional approach to defining disability found that the disability prevalence rate

of the under age 18 population was 7%.[52] A more recent study in the United Kingdom pointed to 7% disability prevalence among those aged 18 or under.[53] In six countries included in the Developmental Difficulties in Early Childhood Survey, the prevalence of developmental difficulties in young children ranged from 5% to 12%.[54]

Although at the global level, disability prevalence was found to be similar for girls and boys,[46] some national studies point to higher prevalence in boys than in girls (Figure 1). In the United States, boys had a higher rate of disability, 8%, than girls, 5%. Similarly, in the United Kingdom, 9% of boys and 6% of girls had a disability; in New Zealand, 13% of boys and 9% of girls had a disability and in Australia, 10% of boys and 6% of girls had a disability.

Table 4. Estimates of disability prevalence for children

Geographical coverage	Data source	Year	Age group	Prevalence Rate
World	Global Burden of Disease Study, 2004[46]	2004	0-14	5%[55]
Australia	Survey of Disability, Ageing and Carers[56]	2003	0-14	8%
New Zealand	National household surveys[57]	2001	0-14	11%
United Kingdom	Blackburn et al (2010)[53]	2004-5	0-18	7%
United States	Newachek and Haflon (1998)[52]	1992-4	0-17	7%

Note: As the data from the different sources used different methods to collect data on persons with disabilities, these data are not internationally comparable.

Figure 1. Disability prevalence among boys and girls
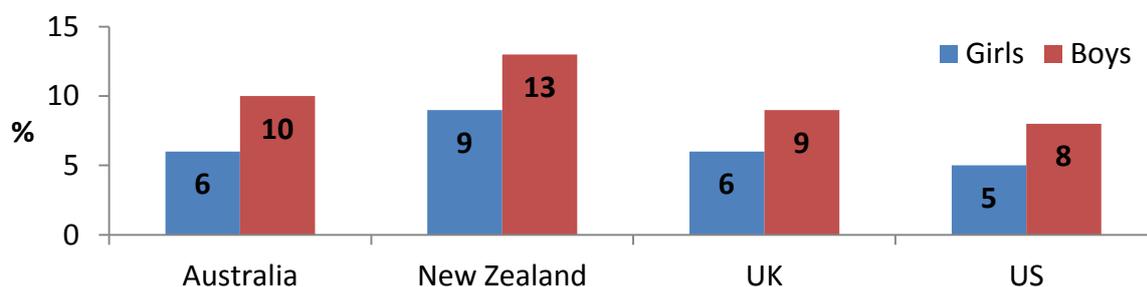
Note: As countries use different methods to collect data on persons with disabilities, these data are not internationally comparable. Despite these differences in methodology, there is a consistent gap across countries on school attendance for youth with and without disabilities.

Sources: Australia: Survey of Disability, Ageing and Carers, 2003;[56] New Zealand: National household surveys;[57] UK: Blackburn et al (2010);[53] US: Newachek and Haflon (1998).[52]

3.3.3 Prevalence among older persons

The highest rates of disability are among older persons. For example, in Sri Lanka in 2001 only 7% of the general population is 65 years or older but they make up 23% of the disabled population.[58] In Australia, in 2003, those percentages are 11 and 35, respectively.[58]

Overall, age is associated with disability and the age/disability gradient becomes quite steep as people age in both higher and lower income countries (Table 5).[26,59] Data from Canada, shows how fast disability prevalence can increase as people get older (Figure 2). Older women tend to have higher rates of disability than older men. In 59 countries, in 2002-4, the differences between disability rates of those ages 65+ were ten percentage points higher for women than for men.[58]

Table 5. Disability prevalence, by age and income level, in 59 countries, 2002-4
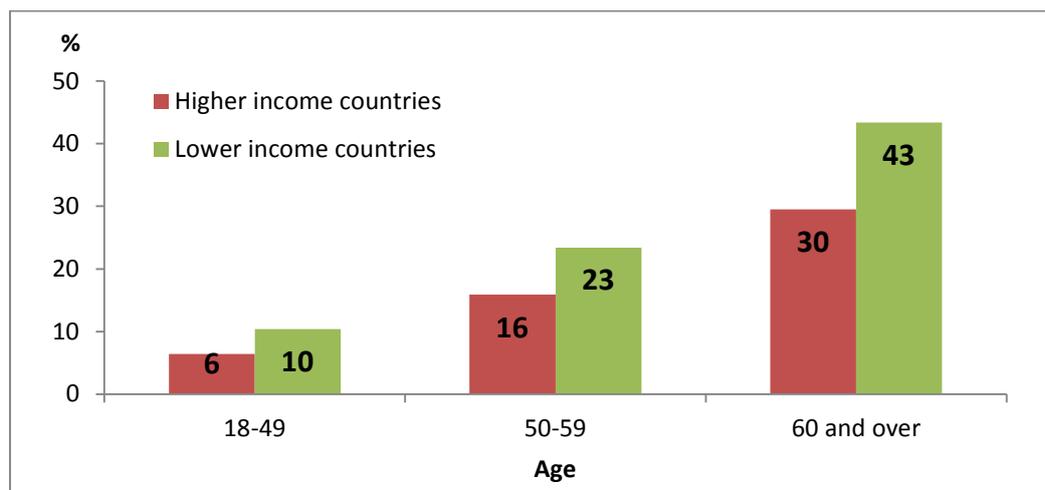
Source: WHO and World Bank (2011),[26] p. 28.

Figure 2. Disability prevalence, by age, Canada, 2006
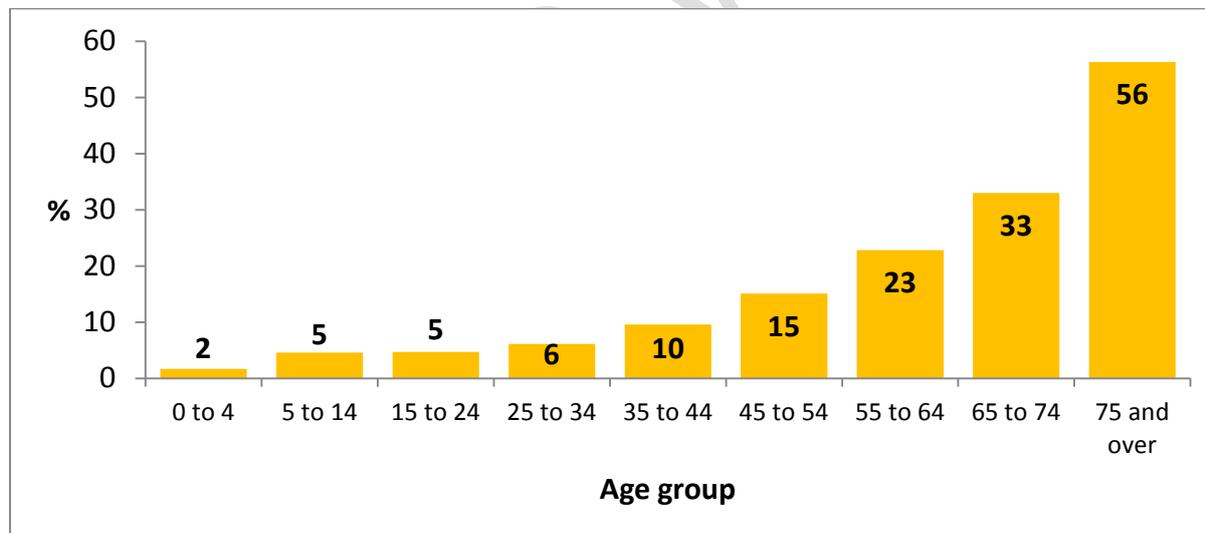
Source: Stone (2014).[60]

3.3.4 Prevalence by sex

While studies have suggested that disability prevalence is higher among boys than girls (see section above on prevalence for children), for adults the inverse is observed: 12% of women

aged 18 or over have at least one severe functional limitation compared to only 8% of men.[61] Even looking at moderate limitations, there is still a gender gap of 14% to 11%. Sometimes the gender gap is attributed at least in part to the fact that women live longer and are thus more likely to become disabled in old age, but looking only at working age adults the gap remains: 10% to 7% for a severe limitation and 13% to 10% for a minor one. The gender gap in disability prevalence is highest for the older population, where 44% of women have a disability, compared to 34% of men.

3.3.5 Urban versus rural

Evidence suggests that the rate of disability is slightly higher in rural areas than in urban areas, probably because poverty rates are higher and access to health care is lower. Using data from 59 countries, in 2002-4 the prevalence rate in rural areas has been estimated at 16% and in urban areas at 15%.[26] Some individual country studies support these findings. In a study in Bangladesh, it was found that after controlling for wealth, age, sex, education, marital status, and district, people in rural areas were about 12% more likely to have a disability[62]. A 2009 study showed disability was higher in rural areas of India, as well.[63] However, country data suggests that in some countries prevalence is higher in urban areas while in others prevalence is higher in rural areas (see Figure 25 in section 4.3.2 'Persons with disabilities in human settlements and urban development').

3.3.6 Prevalence by type of disability

People with different types of disability – for example physical disabilities versus cognitive disabilities – may experience different barriers, and also different causes of disability. Therefore, it is useful to have a breakdown by type of disability. Figure 3 shows data on type of disability for working age adults[64]. Difficulties with self-care are the least prevalent, as expected, because they represent the people with the most severe limitations. Across regions, difficulties with mobility and mental functioning (concentrating and remembering) are more prevalent than difficulties with seeing, except for the Americas where the prevalence is similar.

Figure 4 shows the prevalence of different types of disabilities for older adults. The prevalence rates across all categories of disability are higher than for working age adults, including for severe disabilities associated with difficulties in self-care. Compared to people who are working age, seeing difficulties become more prominent in old age in all regions except Europe.

Figure 3. Disability prevalence for working age adults, by type of disability, in 54 countries, 2002-4[65]
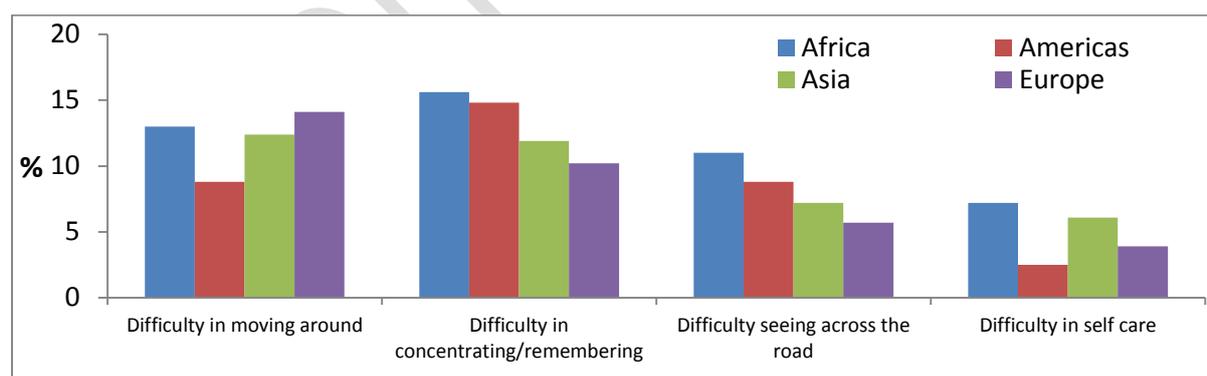
Source: Author's elaboration based on data in Mitra and Sambamoorthi (2013).[61]

Figure 4. Disability prevalence for older persons, by type of disability, in 54 countries, 2002-4[65]
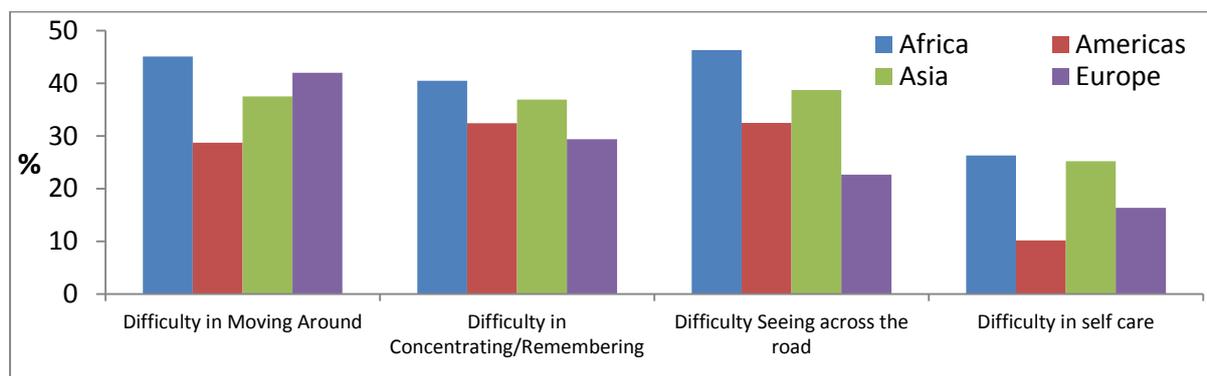
Source: Author's elaboration based on data in Mitra and Sambamoorthi (2013). [61]

3.4   Overview of the socio-economic status of people with disabilities

Much attention has been paid to the relationship between disability and poverty.[66] In fact, that relationship is usually described as a vicious circle where poverty creates conditions that lead to the onset of disability, and then once having a disability, a person is trapped in poverty because of less access to education, employment, health care, and most other aspects of society.[67]   However, the relationship between disability and poverty is more complex. Indeed, some factors make disability and poverty negatively correlated.

Clearly, poor nutrition, lack of access to health care, unsafe living and working conditions and other conditions associated with poverty can lead to disability. However, people who are richer have been shown to live longer[68], and disability is associated with ageing. Also, people who become disabled later in life are more likely to have assets and children who can help support them. Moreover, richer people who are injured or experience the onset of an illness – or even have a congenital disability – are more likely to get the care and services they need to live longer. That is, poorer people with disabilities are more likely to die and thus disappear from prevalence rates while richer people with disabilities remain. Studies from Vietnam and Indonesia show that the link between disability and poverty weakens as the age of onset of disability increases,[69,70] helping to explain why a strong relationship between consumption measures of poverty and disability has not always been found, especially when age of onset of disability is neglected. Out of 15 developing countries, one study found that only four countries showed a significant relationship between consumption based poverty and disability. [61] However, when multidimensional measures of poverty are used, the relationship between disability and poverty is stronger. The same study of 15 developing countries found a significant correlation between disability and various measures of exclusion, such as deficits in education, employment, life expectancy, etc. These results are mirrored in a study of disability and poverty in Afghanistan and Zambia[71] which

did not find significant differences between the assets of people with and without disabilities, but found that people with disabilities were associated with other forms of exclusion, when it came to domains such as education, employment, and health care.

In addition, one study in Vietnam found that the relationship between disability and poverty varied significantly by district, with some districts showing a big gap in poverty rates (as measured by consumption) between people with and without disabilities but some districts showing much smaller ones.[72] That study found that those gaps were correlated with lower levels of infrastructure, suggesting that improved infrastructure can help weaken the link between disability and poverty. Even though improved infrastructure may remove some barriers keeping people with disabilities poor, the link between disability and poverty can also be observed in developed countries with more advanced infrastructure. In the United States, for example, people with disabilities made up 47% of those in poverty and 65% of those in long-term poverty.[73]

Many of the studies looking at disability and poverty do not account for the extra costs of disability. People with disabilities have costs associated with health care, transportation, personal assistance or assistive devices, modified residences, etc.[74] The result is that two households with the same level of consumption (or income) – one with a member with a disability and one without – are not enjoying the same standard of living due to the extra costs associated with reasonable adjustments for persons with disabilities.

Table 6 presents the estimated costs of living with a disability. While the estimated costs of living with a disability range significantly, a rough estimate would be that having a disability increases the cost of living by about a third of average income. [75]

Another way that the poverty rates for people with disabilities can be understated is that poverty rates are usually reported for households and not individuals. The assumption is that all individuals in the household receive an equal share of family resources, yet, it can be

posited that persons with disabilities are de-valued or discriminated against in their own households and may receive a lesser share. Studies show that family investment in children with health conditions is significantly lower than for children without disabilities.[76]

Poverty is only one measure of deprivation, though. The rates of employment and education are also lower for persons with disabilities. Studies also show that people with disabilities have less access to health care[26,61] and less access to basic water and sanitation (Box 5).

Table 6. Estimates of the cost of disabilities, by degree of disability

Country	Data source	Cost of disabilities as percentage of average income
Spain[77]	Survey of Life Conditions 2007	*Moderate disability:* 40% *Severe Disability:* 70%
Ireland[78]	Several surveys from 1995-2001	*Any Disability:* 23% *Moderate:* 30% *Severe:* 33%
Ireland[79]	Living in Ireland survey for 2001	*Any Disability:* 40%
China[80]	2006 Second National Survey of Disabled Persons	*Households with disabled adults:* 8% to 43% *Households with disabled children:* 18% to 31%
Vietnam[69]	2006 Vietnam Household Living Standards Survey	*Any Disability* 12%
UK[81]	2007-8 Family Resources Survey	*Older people below median disability level:* 21% *Older people above median disability level* 39%
UK[82]	1998-99 Household Expenditure Survey	*Any Disability* 29% *Moderate:* 30% *Severe:* 40%
UK[75]	1996/97 Family Resources Survey; 1999-2000 British Household Panel Survey	*Mild:* 11% *Moderate:* 34% *Severe :* 64%

Box 5. Access to water and sanitation for persons with disabilities in Uganda and Zambia

There are differences in access for persons with disabilities to fundamental services such as water and sanitation. For example, 32% and 48% of people with disabilities in Uganda and Zambia, respectively, are able to get help fetching water. In both countries, about 70% of those who did report difficulties in doing so explained that the difficulties were due to barriers such as the distance of the water source to home, the heaviness or unreachability of pump handles, time spent waiting in line (for those who have difficulty standing), and the weight of water containers.[83] In addition to physical barriers, attitudes undermined their ability to obtain water. In Uganda, 19% were told they should not touch the water that other people drink, presumably for fear of contagion.

People with disabilities also found barriers in using the same toilets as household members used in their home (24% in Uganda, 16% in Zambia). Toilets in public places were even more inaccessible with 39% of people in Uganda reported having trouble finding an accessible toilet in their community. Persons with disabilities also reported that when they used the toilets, they were often mocked or laughed at by non-disabled people. People with disabilities in these countries were nearly 25% less likely to bathe, and reported feeling ashamed because they were unclean or smelled.

3.5   Accessibility as a pre-condition for inclusive and sustainable development

The 2030 Agenda for Sustainable Development highlighted the importance of leaving no one behind.[84] Yet, due to inaccessible physical and virtual environments, inaccessible communication devices and transportation, persons with disabilities often cannot fully enjoy the opportunities and services that are available to all. Forms of transportation without ramps, schools and workplaces only accessible by stairs, and websites which cannot be read by assistive devices prevent persons with disabilities to fully participate in society, access information and education, attend to education or obtain a job. Accessibility is not merely a fundamental right for persons with disabilities; it is also conducive of inclusive and sustainable development as it allows persons with disabilities to become active and productive participants in society. Accessibility is therefore key to empowering persons with disabilities to live independently, be integrated in their community, and to access basic information. In essence, accessibility acts as the medium and facilitator for the full integration of all persons in society, regardless of disability.

Despite the existence of the CRPD since 2006 as a vehicle promoting accessibility,[85] there remain gaps in creating accessibility for all. This section will discuss definitions of accessibility and the accessibility requirements for inclusive and sustainable development. It will review existing international mandates on accessibility, provide an overview of the current situation of accessibility for persons with disabilities, and identify actions which can promote accessibility.

What is accessibility?

Accessibility has been defined as the provision of flexible facilities and environments, either virtual or physical, to accommodate each user's needs and preferences. For persons with disabilities, this may be any place, space, item or service, that is easily approached, reached, entered, exited, interacted with, understood or otherwise used.[86]

Although accessibility was initially seen as a concept to be applied only for environments devoted to persons with disabilities, by the 1960s the idea of having environments accessible to all, independently of their functional abilities, started to spread.[87] In the 1990s, the term *universal design*[88] appeared, and was defined as a framework for the design of places, objects, information, communication and policy to be usable by the widest range of people operating in the widest range of situations without special or separate design. Universal design is not a design style but an orientation to any design process that starts with a responsibility to the experience of the user.[89] Achieving this requires a shift in orientation for design – whether virtual or physical - to be more inclusive and appropriate to all groups in society (Box 6). In the CRPD, universal design has been defined as "the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design". The CRPD states that "*Universal design* shall not exclude assistive devices for particular groups of persons with disabilities where this is needed." The concept of accessible design ensures both "direct access" (i.e. unassisted) and "indirect access" meaning compatibility with a person's assistive technology (for example, computer screen readers).

Box 6. Universal Design

Universal design is based on seven principles:[90]

Equitable Use: The design does not disadvantage or stigmatize any group of users.

Flexibility in Use: The design accommodates a wide range of individual preferences and abilities.

Simple, Intuitive Use: Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

Perceptible Information: The design communicates necessary information effectively to the user, regardless of the user's sensory abilities.

Tolerance for Error: The design minimizes hazards and the adverse consequences of accidental or unintended actions.

Low Physical Effort: The design can be used efficiently and comfortably, and with a minimum of fatigue.

Size and Space for Approach & Use: Appropriate size and space is provided for approach, reach, manipulation, and use, regardless of the user's body size or mobility.

UN mandates on accessibility

Accessibility within the UN policy framework has primarily been guided by three documents to date: The World Programme of Action (1982)[91], the UN Standard Rules on the Equalisation of Opportunities for Persons with disabilities (1993)[92] and the Convention on the Rights of Persons with Disabilities (CRPD)[93]. Together, these documents encourage governments and stakeholders alike to recognise the importance of equalization through means of accessibility, be it through the physical environment or information and communication technologies (ICT). Although the emphasis of the World Programme of Action was on physical environments – as information and communication technologies were

not yet as widespread at the time – the Standard Rules and the Convention emphasized the need to make both physical and virtual environments accessible. Apart from these three instruments, accessibility has also been clearly defined as a means and goal to disability-inclusive development by the United Nations General Assembly through a series of resolutions.[94]

The CRPD promotes accessibility in Article 9 and encourages universal design in Article 4 as a way to enable persons with disabilities to live independently and participate fully in all aspects of life. In particular, Article 9 of the Convention[95] on 'Accessibility' calls on State Parties to take measures to promote accessibility of facilities and services which are open to the public, to provide provisions for Braille and easy to read forms, to facilitate accessibility to buildings and to promote the design and production of accessible ICT's, including the internet. On universal design, CRPD calls on States "to undertake or promote research and development of universally designed goods, services, equipment and facilities, (…) which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines" (Article 4, General Obligations).

During the UN General Assembly High-Level Meeting on Disability and Development, held in 2013,[96] heads of states stressed the importance of ensuring accessibility for the inclusion of persons with disabilities in all aspects of development. The outcome document highlighted the need for information and communications technologies to be developed and used to their fullest potential by persons with disabilities.[97]

Recently, the 2030 Agenda for Sustainable Development highlighted the importance of accessibility through the Sustainable Development Goals (SDG), and their targets, calling for disability sensitive education facilities and expansion of public transport with special

attention to persons with disabilities. Inclusive and accessible green and public spaces for persons with disabilities were also highlighted.[98]

Approaches to increase accessibility

a.   Mainstreaming accessibility

In a bid to provide equal opportunities for persons with disabilities, many national policies tend to apply a special-needs approach to accessibility, predominantly establishing services specialized for persons with disabilities, as opposed to a general integrative approach. Establishing integrated services, accessible to all regardless of disability, will contribute to enhanced inclusion and reduce gaps between services available to persons with disabilities and the rest of the population (Box 7).

Moreover, the provisions of accessibility can benefit all persons in a given population, not only persons with disabilities. For instance, the cell phone vibration mode and the SMS services are not only useful for persons with hearing loss but to a larger population who may benefit from sensory alteration. Furthermore, as well as being useful to persons with visual impairments, magnifying application in smartphones, which increase the size of the text, can enhance usability for older persons who find increasingly difficult to read small text fonts. In an aging population, and with advancements in modern medicine, which allow longevity in life, the provisions for accessibility will be applying to a wider sector of society, for example, to older persons with mobility concerns.[99]

Box 7. Building an accessible school

Converting an existing school into an accessible building for all students, staff and community, with and without disabilities, presents one of the most unique challenges for a school district. It has been argued that designing a user-friendly school building for all, and designing one for those without disabilities, should be one and the same[100]. Conceptually, there should be no visible difference if the design is developed in a sensitive and sensible manner. Aesthetically, the building's exteriors and interiors should not create the appearance of a school building designed for specific types of users.

Accommodations that can benefit persons with diverse capacities and functional abilities include[101]:

- ✓ Ensuring space utilization is orderly and clearly defined;
- ✓ Orienting users with good and universal graphics;
- ✓ Eliminating sharp projecting objects from the wall;
- ✓ Providing adequate-width doors from connecting corridors to the central commons to ensure easy traffic flow;
- ✓ Visual graphics can provide orientation and directional movement for students and adults by incorporating color contrasts to identify a change in floor material, or ramps;
- ✓ Consideration (by planners) of spaces and furnishings that are adaptable for wheelchairs to manoeuvre into each room and up to the furniture;
- ✓ Mechanical heating, ventilation and air-conditioning systems that are designed for more individual room control;
- ✓ Floor-to-ceiling chalkboard and tack board to accommodate students on the floors, in wheelchairs, or upright;
- ✓ Special subdued lighting to accommodate children who are lying on the floor;
- ✓ Assisting the visually impaired with colour schemes.

b.   Mixing bottom-up with top-down approaches

The creation of accessible services can be achieved from either a top-down or a bottom-up approach. Table 7 highlights the fundamentals of both approaches. By combining the principles of both top-down and bottom-up approaches, the principles of universal design can be brought to fruition (see section Accessibility). Feedback from local communities on accessibility needs and capacities can inform national and international legislation on accessibility standards[102], which in turn, can promote the application of accessibility at the local levels, basing accessibility policies on the user experience. Public servants can be sensitized to solicit this feedback from communities and processes can be established to integrate it in decision-making. Such practices, which incorporate user experience, can help to identify the barriers to accessibility in the local community, enhancing user experience and driving the concept of universal design.

Table 7. Bottom-up with top-down approaches to accessibility

Approach	Fundamentals	Example
Top-down	Implement accessibility through the lens of the CRPD, other internationally agreed frameworks and national legislation. Such legislations are regulated by standard-setting specifications.	In Cambodia, the Law on the Protection and the Promotion of the Rights of Persons with Disabilities[103] (2009) refers to accessibility in the integration, protection and establishment of provisions and services which are accessible to persons with disabilities.
Bottom-up	Driven by local initiatives which identify requirements and minimum accessibility standards appropriate to	During the first Asian and Pacific Decade of Disabled Persons (1993-2002), governments, civil society

	local capacities and communities. Such initiatives provide information on accessibility needs on a local scale and eventually assist in developing guidelines and standards at the national level.	organizations and other stakeholders convened to share experiences around accessible urban and pedestrian features in the region. Experiences were compiled into a report which provided guidance on key concept, planning and design principles, leading to guidelines for promoting accessible environments (UNESCAP, 1995)[104].

Accessibility: status and trends

a.   Physical environment

In 2011, the International Organization for Standardization (ISO) set international standards for the built environment, reflecting aspects of accessibility management in buildings[105] in order to enable all persons regardless of disability to reach, enter, use and safely evacuate a building independently. Various countries produced legislation requiring accessibility to the physical environment (Table 8 and Box 8).

Table 8. National legislation on accessibility of the physical environment

Country	Legislation	Provisions for physical environment	Year of enactment
US	Americans with Disabilities Act[106]	New public and private business construction generally must be accessible. Existing private businesses are required to increase the accessibility of their facilities when making any other renovations in	1990

		proportion to the cost of the other renovations	
Australia	Disability Discrimination Act[107]	The Act calls for the elimination of discrimination against persons with disabilities in accesses to premises. Article 23 (Access to Premises) states it unlawful to refuse persons with disabilities use of any premises that the public is entitled to	1992
Canada	Canadian Human Rights Act,[108] the Employment Equity Act[109], and the Canadian Labour Code[110]	Canadian Human Rights Act (1985) encourages the Governor in Council to prescribe standards of accessibility that make it a discriminatory practice to deny access to any service or facility to any individual. The Canadian Labour Code (1985) calls for reasonable care to ensure that all of the persons granted access to the work place.	1985, 1995, 1985
Norway	Discrimination and Accessibility Act[111]	The Act defines lack of accessibility as discrimination and obliges public authorities to implement universal design in their areas. The Act refers to issue-specific legislation regarding accessibility in built environment and transport	2008
France	Law nr 2005-102 dates 11 Feb 2005 on the equalities of rights and opportunities, participation and citizenship of persons with disabilities[112]	Establishments open to the public, whether public or private, must be accessible for persons with disabilities, regardless of the type of disability	2005
UK	Equality Act[113]	The Act calls for the improvement of physical environments schools for the	2010

		"purpose of increasing the extent to which disabled pupils are able to take advantage of…facilities or services provided or offered by the school". The Act also calls for participating authorities to prepare accessibility strategies for Schools and Public Service Vehicles (such as rail vehicles and taxis)	
South Africa	Promotion of Equality and Prevention of Unfair Discrimination Act[114]	Prohibits unfair discrimination on grounds of disability by contravening the code of practice or regulations of South African Bureau of Standards that govern environmental accessibility	2000
Sri Lanka	Supreme Court order[115]	Landmark order to boost the inherent right of disabled persons to have unhindered access to public buildings and facilities	2011

Nevertheless, physical barriers remain even in countries with legislation. For many countries, the degree to which governmental, public and private spaces are accessible is unknown. Still, some countries have available data. In France, for instance, as of 2012, only 15% of establishments that are open to the public, whether public or private, were accessible. In Greece, only 9% of all public services, public law legal entities and local governments were accessible, as of 2008. In Hungary, non-official sources reported 65% of public authority national and municipal buildings accessible.[116] Even when the buildings are accessible, other physical barriers may be encountered. For instance, in medical facilities, the medical equipment may be inaccessible for persons with disabilities.[117] Mobile and smart phones have been reported to increase the confidence of people with disabilities to venture into physical environments, as mobile phones can be used to ask for assistance or, for persons with visual and cognitive facilities, to navigate through GPS.

Box 8. Promoting accessibility in the built environment in the European Union

The European Committee for Standardization (CEN) adopts and sets European Standards and union-wide performance requirements to promote accessibility in the built environment. This involves inputs from the evaluation of policies and legislation, expert groups and professionals in the field. In fulfilling such obligations, the European Commission (EC) issued a mandate in 1999[118], which outlines guidance for developers on building accessible environments. In its 2000 Directive[119], the EC included articles on reasonable accommodation to enable a person with a disability to have access to or advance their participation in employment or further training.

In a bid to enhance accessibility and sufficient provisions for persons with disabilities, the EC conducted an inventory assessment of accessibility standards in member countries in 2011[120]. Despite clear examples of environmental accessibility provisions, gaps and weaknesses concerning functional accessibility remained. While there is no statistical data on accessibility of buildings for persons with disabilities in the majority of the European Countries presented, in France, only 15% of 'establishments open to the public' (ERP's) complied with universal standards[121]. In Sweden, 93% of the municipalities and County Council offices were equipped with hearing requirements which cover all or parts of the room where the council meets[122] and there is also support for persons with cognitive disabilities in accessing and participating in meetings.

Cost and benefits of accessibility

Altering the standards and accessibility in buildings or public transport, and retrofitting existing infrastructure and facilities creates cost implications, making progress in accessibility a challenge in many countries. However, accessibility should be seen as an investment decision by governments,[123] as the expected returns will be high compared to the

costs. Long term benefits include enhancement of the workforce, with more people with disabilities progressing as equal, active, productive and contributing employees or business owners.

In Sweden, for instance, norms in place specifying accessibility in newly constructed public buildings and workplaces since the 1960's and in new multi-family housing since 1977 have incurred additional costs of less than 1 % of the total cost. The returns included fewer accidents, fewer hospital days and institutional care as more people can live at home. Furthermore, more accessibility in work places means more participation of persons with disabilities in the labour maker and, consequently, more diversity in society capturing persons of all talents and abilities[124].

Accessible information and communication technologies

Information and communication technologies (ICT), such as web services, mobile devices, television and computers, are becoming more and more essential for daily participation in work, education and in social and cultural spheres. In addition, computers and the internet can decrease the sense of isolation for persons with disabilities who may be homebound or have limited mobility.[125] In the context of global policy discourse on disability and development, accessible ICT has been a major policy objective in international normative frameworks concerning the advancement of persons with disabilities and development since the 1990s.

a. Web accessibility

Web content accessibility reflects the degree to which a web site is accessible to the largest possible range of people, especially for persons with disabilities. Web pages that use small fonts or particular colour combinations may be unreadable for the visually impaired. Similarly, audio or video content on web pages may not be useful for the hearing impaired. Those with motor impairments may require special features on websites so that they can be

navigated without a pointing device. ISO standards for web accessibility, also known as the Web Content Accessibility Guidelines (WCAG) 2.0, do exist[126] and e-accessibility checker software has been developed to assist those who wish to verify if their websites satisfy the ISO accessibility criteria (Box 9).[127] The WCAG 2.0 forms the basis of national guidance documents and legislation on accessible web sources in many countries, including countries of the European Union, Australia, Hong Kong (SAR, China), Japan, New Zealand and the United States.[128] In addition, the European Commission has adopted the WCAG 2.0 as an objective to attain for all its websites.[129]

Box 9. Web Content Accessibility Guidelines (WCAG) 2.0

The WCAG 2.0 guidelines[130], also known as the ISO/IEC 40500:2012 standards, provide guidance on making web content more accessible to persons with disabilities. Its four principles offer the means to making the web more accessible:

1) Perceivable – information to be presented in a way that users can perceive them

2) Operable[131] – interface and navigation to be operable

3) Understandable – operation of user interface to be understandable

4) Robust - content to be interpreted reliably by a variety of users, and a range of assistive technologies

Despite the existence of international standards, the large majority of websites do not follow them. This includes governmental websites. Among governmental portals of the 193 UN Member States, the fonts and colours in the portals can be reconfigured in only 32% of countries, although this feature is helpful for those with visual disabilities[132]; a feature reading the website content - which is helpful for those with severe visual difficulties - is included in portals of a mere 7% of countries. Only 4% of governmental websites include video in sign language, which makes information and a website accessible for persons with hearing difficulties (see Figure 5). Moreover, people with disabilities will encounter

additional barriers in many national portals: in 35% of countries the national portals included features that can only be used with a mouse, which poses difficulties for persons with hand mobility disabilities; in 48% of countries form elements[133] were not labelled and in as many as 63% of countries graphical elements were lacking descriptive text, all of which create difficulties for persons with visual disabilities (see Figure 6). Although more recent data on all these features are not available, it is known that there has been progress on the number of governmental websites that allow for changes in font type and size, a feature which is useful for persons with visual disabilities. While in 2012, 31% of countries allowed for flexible font size and type, this percentage has increased to 40% in 2014.[134]

Figure 5. Countries with online national portals offering features which promote accessibility, 193 countries, 2012
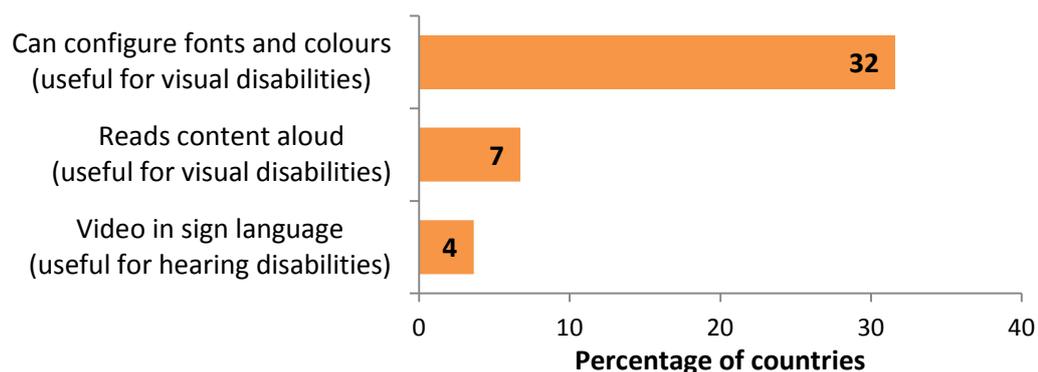
Source: 2012 UN E-Government Survey[135]

Figure 6. Countries with accessibility barriers in their online national portals, 193 countries, 2012
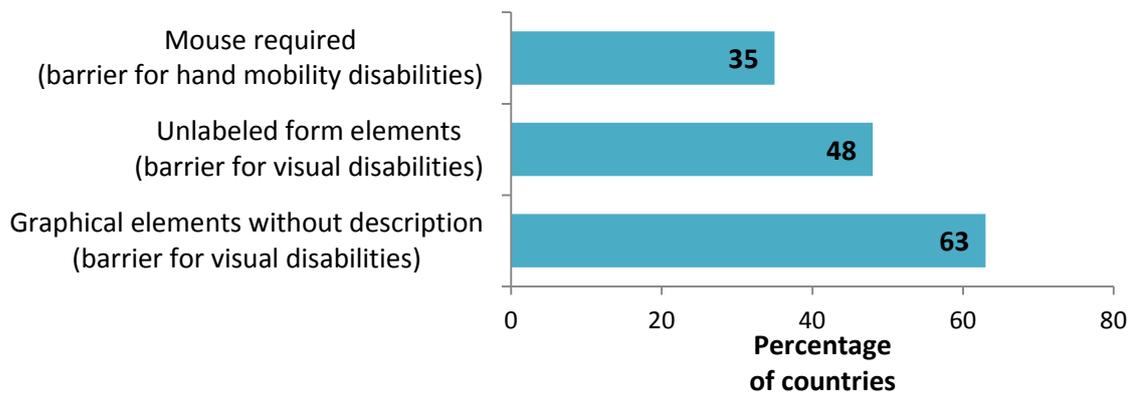
Source: 2012 UN E-Government Survey[135]

b.   Accessible mobile phones and services

Enhanced accessibility of mobile phones and services remains a relatively underdeveloped segment of the ICT market, yet the technology supporting accessibility is becoming more developed with a growing number of accessibility applications for smartphones (Table 9). Some applications, like screen readers, do make the tool accessible; others, like GPS, can increase the accessibility for persons with disabilities in their physical environment. Although many features and applications are available free of charge, affordability remains a major issue, especially for smartphone.[136] In 2012, screen readers and text-to-speech applications cost several hundred US dollars on some mobile platforms.[137] Another issue limiting usage of accessibility features and applications is language, as they tend not to be available in local languages. For instance, in India, there are 22 official languages yet the applications only exist in Hindi. Other countries where many languages are used, such as several African countries, suffer from a similar situation. Progressively, many countries have introduced legislation promoting accessibility of information and communication technologies.[138]

Table 9. Mobile phone and platform features which enhance accessibility

Mobile phone and platform features	Enhances accessibility for persons with:
Screen readers (into speech or Braille), tactile markers[139], audible feedback on pressed buttons, adjustable font sizes, audible cues, adjustable brightness/contrast, screen magnifiers, digital access to "talking" books, GPS	Visual disabilities
Visual and vibrating alerts, relay services,[140] hearing aid compatible device, volume adjustment, SMS text messaging, SMS-based emergency service, mono audio[141], captioning of	Hearing disabilities

videos	
Voice recognition, auto text[142], head movement recognition[143]	Arms/hands/fingers mobility disabilities
Predictive texting, speech recognition, text-to-speech, built-in calculator, schedule reminders, large and simple display screens	Cognitive disabilities

Source: Author's elaboration on the basis of information from International Telecommunication Union and G3ict (2012)[144] and Sesame.[143]

Barriers

Identifying the current obstacles to making ICTs more accessible is essential to design solutions leading to the development of inclusive technologies, at minimal cost and with wide benefits. These obstacles include:

- insufficient national regulation setting guidelines and standards for accessibility;

- poor implementation of policies to promote the creation of accessible ICTs[145];

- the cost of making ICTs accessible to all[145];

- lack of awareness by the ICT industry on the economic benefits the development of accessible technology can generate;[146,147]

- lack of purchasing power by persons with disabilities to buy, access and use ICT[148,149];

- the higher cost of ICT equipment especially designed for persons with disabilities, which tends to be more expensive as it is adapted to their impairments[150,151];

- reduced access to higher education among persons with disabilities, which in turn, reduces awareness of the advantages of access to information and communication technologies.[152]

Conclusion and the way forward

This chapter has provided an overview of the status and trends of international and national policy legislation and practices concerning accessibility. Standards, guidelines and national legislation can promote accessibility of the physical and virtual environments. Although there are encouraging examples of national legislation, this remains limited to a small set of countries and, even in those countries, the legislation has not yet fully turned into practice. The little existing data on the accessibility of public physical environments suggests they are largely not accessible. A similar situation is found in accessibility of the virtual world, with most national online portals inaccessible. On the positive side, there is an increase in the accessibility of ICT tools and a growing trend in creating tailored ICT tools to improve accessibility for certain disabilities.

Seeing accessibility as an investment, as opposed to a cost issue, can support its implementation within the context of the 2030 Agenda for Sustainable Development. Being cognizant of accessibility during the planning, designing and developing stages of any virtual or physical environment will lead to final products and services with a higher chance of being accessible to all. This in turn will avoid retrofitting, which can be more costly.

Chapter 4. Disability as a cross-cutting issue for sustainable and inclusive development

4.1   Participation of Persons with Disabilities in Political, Economic, Social and Cultural Spheres

4.1.1 Education

The right to education is a well-established universal human right, underpinned by international human rights treaties and conventions[153]. The international community acknowledges that education is central to building inclusive societies and to ensuring that all persons participate on an equal basis and are able to reach their full potential. The development and adoption of international legal instruments in the past decades demonstrates that the rights of persons with disabilities, including the right to education, cannot be compromised[154]. It is undeniable that when education is guaranteed, access to all other civil, political, social, economic and cultural rights is enhanced.

UN mandates

From the Universal Declaration of Human Rights that upholds the right to education for all persons (1948), to the most recent UN Convention on the Rights of Persons with Disabilities (CRPD) adopted in 2006 that recognizes the principle of equality in education for persons with disabilities, education is seen as a means and a condition to enhance individual development, life chances and effective participation in society for persons with disabilities (Table 10). The Convention against Discrimination in Education (1960) and Article 23 of the Convention on the Rights of the Child (1989) assert strongly the principle of non-discrimination in education. The CRPD additionally, as a legally-binding standard setting instrument specific to the disability context, is a milestone in that it elaborates and clarifies existing obligations of countries with regard to education. Specifically, article 24 of the

CRPD calls on State Parties to ensure an inclusive education system at all levels and lifelong learning.

In addition, the adoption of the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities in 1993, which was a result of the United Nations International Year of Disabled Persons (IYDP) in 1981 and the World Programme of Action Concerning Disabled Persons (1983-1992), also represents a strong moral and political commitment of Governments to take action to attain equalization of opportunities for persons with disabilities in the field of education[155]. The Standard Rules, although not a legally binding instrument, urge governments to adopt the principle of equal educational opportunities, but by placing focus on the integration model rather than the inclusive education paradigm.

Table 10. Key international legal documents relevant to the education for persons with disabilities

Key international legislation relevant to the education for persons with disabilities				
Instrument	**Year**	**Components relevant to the education for persons with disabilities**	**Number of signatory states**	**Number of state parties**
Universal Declaration of Human Rights	1948	Article 2, 25 and 26	-	-
International Covenant on Economic, Social and Cultural Rights	1966	Article 2 and 13	5	164
Convention against Discrimination in Education	1960			100
Convention on the	1989	Article 2, 23, 24, 28	2	195

Rights of the Child		and 29		
Convention on the Rights of Persons with Disabilities	2006	Article 24	29	154

The World Conference on Education for All (1990)[156] resulted in the World Declaration on Education for All, which stimulated the international community to adopt a new, more forward-looking vision towards basic education. The document calls for commitment in meeting the basic learning needs of all, to equipping people with the knowledge, skills, values and attitudes they need to live in dignity, to provide continuing education, to improving their own lives and contributing to the development of their communities and nations. The Declaration and Framework for Action, while stressing the importance of equity and equal access to basic education for all, including for persons with disabilities, provided scarce indications as to how this could be materialized.

Greater impetus to the right of education for persons with disabilities was given four years later, with the World Conference on Special Needs Education: Access and Quality. [157] The subsequent adoption of the Salamanca Statement and Framework for Action on Special Needs Education identified the barriers to learning for all children and by making an unequivocal call to inclusive education. The Framework laid out some key principles, such as the '*principle of the inclusive school[158] where all children should learn together, wherever possible*' and the school-level responsibility. i.e. '*responding to diverse needs of students, accommodating different styles and rates of learning and ensuring quality education to all through appropriate curricula, organizational arrangements, teaching strategies, resource use and partnerships with their communities[159]*'. The Framework also encouraged countries to adopt complementary legislative measures in fields such as health and social welfare in order to give full effect to education legislation and urged for better coordination at national

level among educational authorities and stakeholders from other fields to ensure alignment and maximize results.

In 2000, the global community reaffirmed its commitment to the Education for All movement by adopting the six Dakar goals and the Dakar Framework for Action, Education for All: Meeting our Collective Commitments at the World Education Forum). The Dakar Framework[160], while lending continuity to the previous efforts and commitments of the international community to progress education for all, including pledges made in Salamanca, did not place specific focus on inclusive education for children with disabilities. The Framework did not set forth an explicit articulated strategy on how to deliver access and quality of education to children with disabilities, but addressed the issue more broadly, by referring to the learning needs of the poorest and most marginalized, which includes children with disabilities.

The post-2015 discussions in the past few years have reinforced the debate on ensuring an inclusive approach to development by addressing inequalities and the needs of the most marginalized, including those of persons with disabilities[161]. The 2030 Agenda for Sustainable Development includes as a goal the inclusive quality approach to education '*Ensure inclusive and equitable quality education and promote life-long learning opportunities for all* (Goal 4)'. It also includes two targets focusing on persons with disabilities: target 4.5. '*by 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples, and children in vulnerable situations*'; and, under means of implementation, target 4.a '*build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all*'.

What is inclusive education?

In the past few decades, the inclusive education paradigm has been gaining ground, as a valid educational approach that can advance the right to education for children and persons with disabilities (Table 11). Inclusive education is described as the process of strengthening the capacity of the education system to reach out to all learners. As an overall principle, inclusive education should guide all education policies and practices, by providing equal opportunities in education for all learners, by respecting diverse needs, abilities and characteristics of learners and by eliminating all forms of discrimination in the learning environment[162].

The fundamental principle of the inclusive school as defined in the Salamanca Framework for Action is that '*all children should learn together, wherever possible, regardless of any difficulties or differences they may have. Inclusive schools must recognize and respond to the diverse needs of their students, accommodating both different styles and rates of learning and ensuring quality education to all through appropriate curricula, organizational arrangements, teaching strategies, resource use and partnerships with their communities*'[163].

The concept of inclusive education is a broad one, and not limited to scope in terms of target groups, as it is meant to secure the conditions that can advance the right to education for all vulnerable and marginalized groups who are being excluded from equal education opportunities on the grounds of ethnicity, gender, ability and socio-economic status. At the same time, the inclusive education debate has put in the spotlight the question around the right to education for persons with disabilities in particular, by looking at the barriers that keep excluding children with disabilities from benefitting from access to quality education at all levels.

a.   Inclusive curriculum

The International Bureau of Education of UNESCO defines curriculum as both a political and a technical issue, which is well embedded within the complex interfaces of society, politics and education. Within the scope of this definition the content of curricula is very much dependent on the political position of each country vis-à-vis equity and inclusion issues. An inclusive curriculum requires a single curriculum that can be taught to all learners, including those with mixed abilities and with provisions for additional instruction support to students with learning difficulties. In addition, it should be complemented by inclusive assessment processes to ensure that the progress of all students is followed.

b.   Inclusive assessment

Inclusive assessment is 'an approach to assessment in mainstream settings where policy and practice are designed to promote the learning of all pupils as far as possible; its overall goal is that all assessment policies and procedures should support and enhance the successful inclusion and participation of all pupils vulnerable to exclusion, including those with special education needs'[164]. Inclusive assessment which may include formative evaluations, summative assessments, initial identification of special education needs or monitoring of educational standards, is meant to promote learning for all and implies that assessment processes are the same for all learners.

Table 11. An inclusive approach towards the education for children with disabilities[165]

Traditional approach	Inclusive approach
The focus is on the needs of 'special students'	The focus is on the rights of all students
The focus is on the student	The focus is on the classroom
The aim is to change/remedy the students	The aim is to change the school
The student is assessed by a specialist	Teaching/learning factors are assessed
Programmes are diagnostic/prescriptive	The emphasis is on collaborative problem solving
The student is placed in an appropriate programme	The regular classroom is adaptive and supportive
The premise is that the student with special needs will benefit from being integrated	The premise is that all students benefit from full inclusion
The interventions are technical (specialist teaching)	The emphasis is on good quality teaching for all

Status and trends

An estimated 93 to 150 million children (0-14 years) live with some form of disability[166]. Mounting evidence suggests that children with disabilities are less likely to attend school[167] and those who attend school are less likely to complete the full education cycle compared to their non-disabled peers. Figure 7 shows that in 14 out of 15 countries, the percentage of children attending school is lower for those with disabilities than for those without disabilities. Children and young people with disabilities (6 to 17 years old) are also less likely to start school and have lower transition rates among grades in some countries[168]. In 2002-2003, among 51 countries, only 53% of the people aged 18-49 with disabilities had completed primary education, compared to 67% of those without disabilities. A similar gap, of 15 percentage points, exists for those aged 50-59. Although smaller, the gap for those aged 60 or over is still significant, with a difference in 9 % (Figure 2). School enrolment rates tend

to depend on the type of impairment of each child; on average children with physical disabilities have more chances of being in school than children with intellectual or sensory impairments[169]. On average, persons with disabilities are also likely to spend fewer years in schools, usually one or two years less than their non-disabled peers (Figure 3). As a result, adults with disabilities, typically have lower educational attainment[170,171].

The reasons of low attendance are multi-fold, including inaccessibility of schools and educational materials[172], lack of training of teachers on teaching students with special needs as well as low expectations from families about the potential of people with disabilities. Parents of children with disabilities are often discouraged from enrolling their children in school for fear of abuse or bullying, while others refrain because of the shame and stigma associated with having a child with disabilities[173]. Even in cases where children with disabilities are enrolled in schools, the chances of dropping out may be higher as children with disabilities often suffer from bullying, rejection and isolation from their peers, and even sometimes violence. They may also experience feelings of low-self-esteem and isolation in the classroom due to lack of targeted support from teachers, who either lack training themselves[174,175] or have biased perceptions about the potential and abilities of disabled children. Studies in developing countries have pointed out to lack of resources – including unsuitable classroom infrastructure, non-adapted curriculum and learning materials, lack of materials in Braille for students with visual difficulties - as key barriers to inclusive education. [176,177,178]

Teachers play a key role in promoting positive attitudes towards disability and incorporating the principles of inclusive education in the learning environment. Being trained on teaching students with special needs, [179] length of experience,[180, 181] holding a university degree[182] and the level of school support[183] can positively affect teacher attitudes to include children with disabilities in mainstream classrooms. Evidence suggests that inclusive

education can lead to better social, communication and behavioural skills for children with disabilities.[184]

Figure 7. Percentage of children 5 to 14 years of age, with and without disabilities, attending school, in 15 countries, 2000-5
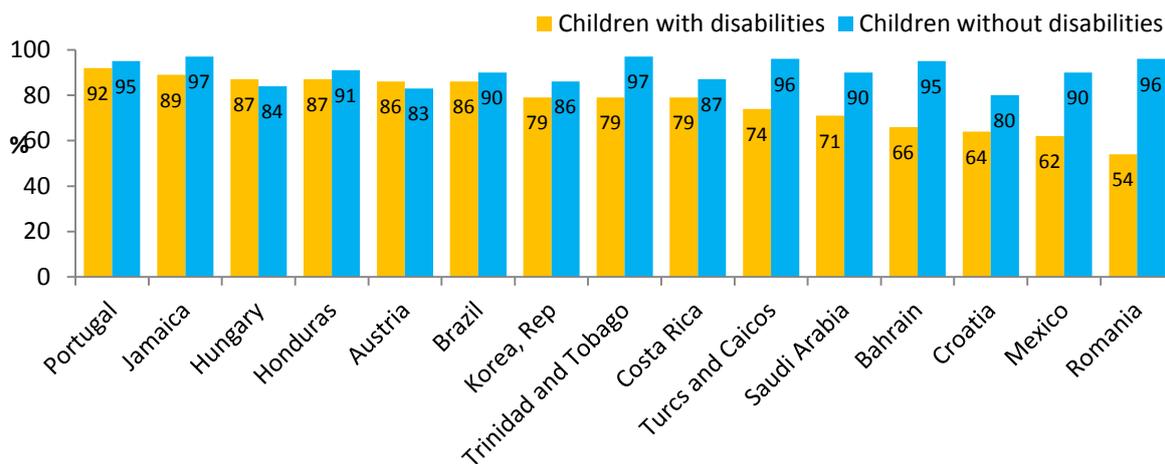
Note: As countries use different methods to collect data on persons with disabilities, these data are not internationally comparable. Despite these differences in methodology, there is a consistent gap across countries on school attendance for youth with and without disabilities.

Source: Censuses, surveys and administrative sources from the countries.[185]

Figure 8. Percentage of the population with and without disabilities who completed primary school, by age, 51 countries, 2002-4
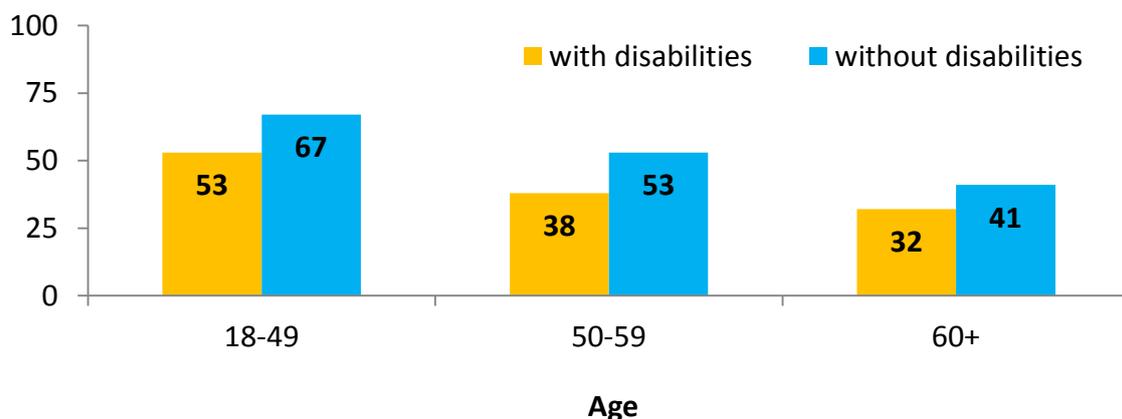
Source: WHO (2011),[186] p. 207.

Figure 9. Mean years of schooling for persons with and without disabilities, by age, 51 countries, 2002-4
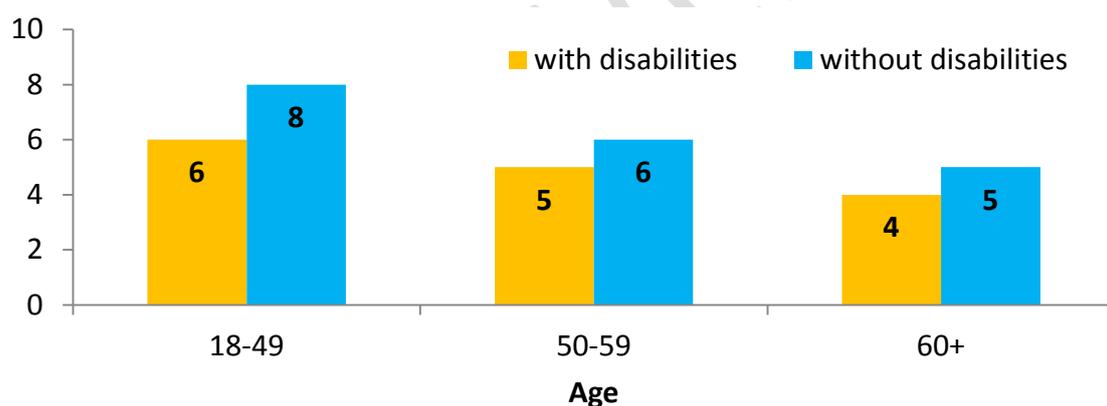
Source: WHO (2011),[26] p. 207.

Economic benefits from educating children with disabilities and promoting inclusive education

Empirical evidence suggests that schooling has a positive effect on generating employment and income opportunities for individuals with disabilities,[187] thus making the case for promoting inclusive education as a means of increasing livelihood opportunities for persons with disabilities. In 2008 in Nepal, returns to investment in the education of persons with disabilities have been estimated at around 20%, two to three times higher than that of

persons without disabilities.[188] This means that, for persons with disabilities, an additional year of schooling increases their future earnings by 20%.

Continuing to support only segregated schools is not only contrary to what is known to be good practice, but may also be inefficient. In Bulgaria, it was found that the budget per child educated in a special school can be up to three times higher than for a similar child in a regular school.[189] This shows that segregating is not necessarily cost effective compared with inclusive education.

Measures taken to promote inclusive education

a.   Legislation and policies

While national legislation and policies in most countries has progressively come to recognize the right to education in line with human rights frameworks (see e.g. Box 10), related education policies often do not reflect this commitment. Even when governments recognize that inclusive education is the most effective means to overcome discriminatory attitudes and to build socially just societies, inclusive education policies are yet to be effectively implemented[190]. Depending on the context, policies may sometimes misinterpret the principles of inclusive education; namely that inclusive education is meant to recognize and accept difference across the whole spectrum of learners; and that radical reforms are needed in order to align policy directions with what is actually happening in the schools and in the classroom. Such misinterpretations may result in the redirection of resources, teacher training, curriculum development, modes of learning assessment, building capacity and working collaboratively with stakeholders at different levels.

Even when unambiguous inclusive policies are in place, physical barriers and lack of appropriate services and resources are at sway. Particularly in contexts where there are inadequate human and financial resources, the implementation of inclusive education at the classroom level that should normally be redressing injustices for the whole school population,

becomes even more challenging. In relation to this point, the universalization of primary education introduced in many countries in 2000, found countries unprepared in dealing with large numbers of newly entrants; this was especially the case in low resource settings, which faced significant difficulties with keeping up with large classroom sizes, insufficient spaces and lack of furniture and/or learning materials. In such settings, which were already hindered by the lack of basic resources, inclusive education provisions and practices were almost made impossible, even for qualified teachers, who experienced difficulties in controlling pedagogical practices or providing individual support to learners with diverse needs.

Box 10. Policies in Namibia for curriculum adaptation and flexibility of assessment processes

Namibia recently adopted its Sector Policy on Inclusive Education that seeks to ensure that all learners are educated in the least-restrictive education setting and in schools in their neighbourhood to the fullest extent possible[191]. One of the main strategies of the policy in achieving its stated objectives is the review of the National Curriculum for Basic Education, through the modification/adaptation of the subject content with relevant methodologies and materials, and through the review of examinations and assessment processes so as to better reflect the diversity of learners without impacting quality. Some of the activities that are outlined in the Policy with regard to curriculum and assessment include the expansion of subject options that are provided in Resource schools, to vocational subjects and subjects for independent living with a view of enhancing the autonomy of learners with disabilities. In addition, the policy recommends strengthening school inspection as an effective mechanism to promote inclusive education at the school level by inspecting aspects of the curriculum. As far as assessment processes are concerned, the aim is to reconceptualize formal examinations and their formats to provide fair opportunity to all learners to demonstrate their achievements

and to make available examinations centres equipped with technology, assistive devices and support staff to help learners with disabilities.

b.   Approaches and models that promote inclusive education

Subject to the context, availability of resources and engagement towards fostering more inclusive societies, countries are adopting different strategies to progress towards inclusive education that are closely linked to the financing of educational services. As there is no single model that can be relevant to all contexts, there are different mechanisms being employed by countries to promote inclusive education,[26] and some are considered to be more inclusive and viable than others. In some countries segregated educational provision is still prevalent,[192,193] while others opt to follow models more geared towards inclusion, such as the inclusive model, the 'twin track' approach and the resource-based service model:

- The **inclusive approach** involves the reduction of special school provision by employing whole school policies and planning to develop inclusive schools that respond to a wide range of learning needs.

- The **'twin track' model** is based on the premise of the development of inclusive regular schooling, while keeping some separate specialized provision particularly for some specific types of impairments, until provisions to support whole school inclusive policies in regular schools can be provided.

- The **resource-based service model** is meant to provide additional funding for schools that include children with disabilities by allocating more resources and increasing incentives for enrolment[194].

For example, the UK has adopted an inclusive approach to ensure the effective transition from separate special schools to more inclusive school environments through the co-location of special and mainstream schools as a way to strengthen the interaction among

students with mixed abilities and non-disabled students, as well as teachers; the development of a cluster of special schools that support regular schools; appointing teaching assistants and specialist teachers to support individual students and help mainstream teachers adapt curriculum, teaching methods and forms of assessment that cover a wide range of learning needs.[194] In the United States a twin track approach exists, aiming at placing children in the most integrated setting possible, while providing for more specialized placement where this is considered necessary.[195]

Some OECD countries are employing the resource-based service model. For instance, in Australia, under the 'More support for students with Disabilities' short term initiative (2012-2014), government and non-government education authorities were provided with additional funding to support students, teachers and schools in their jurisdiction. Some of the activities that were supported, with sustainable results even upon their completion and termination of funding, include the creation of centres of excellence, the provision of assistive technology to support students' learning, curriculum adaptation and online professional learning modules[196].

Apart from national legislation and policy, the negative attitudes of parents of non-disabled children can also affect the mainstreaming of children with disabilities into regular schools because of fear that children with disabilities may hold back the class. However, most studies that have examined the academic effects of inclusive education on children without special education needs have shown neutral or positive effects, signifying that inclusive education does not prevent the academic achievement of students without special needs[197,198,199,200]. Far less research has been done on the socio-emotional effects of inclusive education on children without special needs, but the few studies available mostly show positive effects on the attitudes of children without special needs towards children with special needs, less prejudice, and greater interaction among them[201,202,203].

Conclusion and the way forward

Children with disabilities are typically less likely to attend school. As a result, adults with disabilities tend to have lower educational attainment levels than the rest of the population. Many barriers and challenges have prevented children with disabilities to gain education more widely including lack of accessible schools and educational materials, negative attitudes from society as well as low expectations from family members regarding the potential of children with disabilities.

In the past few decades, the inclusive education approach has been gaining ground. This approach aims at full participation of children with disabilities in education side-by-side with their peers. This integration of all in "one classroom" leads to better social outcomes for children with disabilities. However, the success of inclusive education is dependent on appropriate training of teachers and availability of adapted learning materials. Inclusive education has been adopted typically in developed countries and with various degrees of implementation. Some countries opt for a twin-track system with both inclusive schools and segregated schools.

Multi-sectoral responses towards disability-inclusive strategies should be promoted to ensure convergence and complementarity of efforts of all relevant stakeholders. Strong political will is necessitated to ensure that a culture of acceptance and inclusion trickles down to the community, school and classroom level. Political will should also be directly reflected in the establishment of inclusive education policies, the selection of inclusive service-delivery models, and in the allocation of resources in relation to infrastructure.

Access to inclusive early childhood interventions and services is crucial in ensuring better health outcomes, in improving school readiness, and fostering a culture of inclusion. Inclusive curricula, diversified pedagogical methods, as well as forms of assessment

recognizing the diversity and abilities of all learners should be instituted. Pre-service and in-service training for teachers to enhance professional expertise and confidence and to provide positive orientation towards learners with different abilities is central for delivering inclusive education. The recruitment of qualified teachers and other educational personnel with disabilities, serving as role models and providing peer support where relevant is also a viable strategy to minimize prejudice towards disabilities. Availability of inclusive ICTs along with assistive technology that is relevant and affordable, are indispensable means for ensuring equal learning, communication and mobility opportunities for learners with disabilities[204].

4.1.2 Health and well-being

Health and well-being are as important for persons with disabilities as for all, as they affect the capacity to learn, to work and to socialize. Healthy persons with disabilities can also make more important contributions to economic progress, as they can live longer, be more productive, and save more. Many factors influence the health status of persons with disabilities and a country's ability to provide quality health services for them. Socio-economic conditions and access to health care services play an important role in determining health status. Yet, persons with disabilities tend to have lower socio-economic conditions – like higher poverty, lower access to education and employment – and more barriers in accessing health care than their non-disabled peers.

This section discusses definitions of health and well-being, lists the international mandates in these areas, presents available evidence on the status of health, access to health-care and well-being of persons with disabilities, and outlines measures which can improve health and well-being for persons with disabilities.

What is health and well-being?

The World Health Organization (WHO) defined health, in its 1948 Constitution, as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Although criticized for its extreme breadth, the definition made the point that health has social as well as physical and psychological dimensions. For data collection and measurement purposes WHO has more recently adopted an operational definition, in which health is an intrinsic attribute of the individual, variable over time, and comprised of states or conditions of functioning of the human body and mind.[205] This conceptualization of health is based on the model of functioning found in WHO's *International Classification of Functioning, Disability and Health* (ICF),[206] and in particular the conception of health as

intrinsic capacity. This approach to health has strong intuitive appeal, confirmed by a study showing that when people are asked to make a judgment about their level of health, they tend to refer to features of their bodies rather than to what their health makes possible in terms of social activities or state of wellbeing.[207]

As the original 1948 WHO definition of health suggests, however, the ultimate goal is not just better health but also increased wellbeing. Although health may not equate with wellbeing, health is both an intrinsic component of wellbeing, and, instrumentally, a determinant of wellbeing.

The current consensus on the conceptualization of wellbeing, or '*subjective wellbeing*' as it is also called, relies on two perspectives: the *hedonistic* perspective on wellbeing emphasizes the direct experience of pleasure or positive emotions or affect (or alternatively, the absence of negative emotions); the *eudemonic* perspective by contrast points to the higher values of life, and is often expressed in terms of the extent to which an individual has acquired self-actualization or discovered the purpose in life. As both of these perspectives are subjective, data about *subjective wellbeing* can only come through self-report from individuals. The challenge is to operationalize subjective wellbeing in a manner that makes it possible to validly and reliably collect this information.

Because of the challenges of doing so, many researchers set subjective wellbeing aside and look at a different notion, namely *objective wellbeing*, which is essentially based on those intuitively good things in life – income, family life, education, and health.. The empirical assumption is that these objectively 'good' things in life are probably very good proxies for hedonistic and eudemonic wellbeing. The fact that objective conditions of wellbeing are easier to collect data about, and measure, has made them popular as research objectives. However, the presumed association between objective conditions of wellbeing such as income levels and subjective states of positive affect, such as happiness or life

satisfaction, has been exceedingly difficult to substantiate empirically, for a wide variety of reasons. This has led to the practice of merging both objective and subjective wellbeing into a single notion. [208]

Much of the recent work in wellbeing has focused on subjective wellbeing, and in particular on analyses of human happiness.[209,210] Contemporary accounts tend to try to bring together the two historical perspectives of hedonistic and eudemonic wellbeing into a single metric, operationalizing the two notions in terms of affect and a cognitive component of life satisfaction and have developed a variety of tools[211,212,213] to be able to successfully measure the phenomena individually and in the general population.

Although there has been much attention recently given to the policy applications of subjective wellbeing,[214,215] and in developing a well-being index that could augment economic indicators such as GDP, the issues mentioned above on subjective wellbeing need to be resolved before such a concept can be successfully used as a tool for assessing the effectiveness of policy on population happiness.

UN mandates

The CRPD covers health and rehabilitation services, in articles 25 and 26 respectively, for persons with disabilities. Article 25 focuses on the recognition that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability and calls on States Parties to take all appropriate measures to ensure access for persons with disabilities to health services, including health-related rehabilitation. Article 26 calls for comprehensive habilitation and rehabilitation services and programmes, provision of trained professionals in habilitation and rehabilitation services and availability of assistive devices and technologies helpful for habilitation and rehabilitation designed for persons with disabilities.

WHO's activities in the arena of disability and health are currently structured by the Global Disability Action Plan 2014-2021.[216] This Plan focuses on three primary objectives:

1) addressing barriers and improving access to health care services and programmes;

2) strengthening and extending habilitation and rehabilitation services, including community based rehabilitation, and assistive technology; and

3) supporting the collection of appropriate and internationally comparable data on disability, and promote multi-disciplinary research on disability.

Each of these objectives, and the anticipate range of actions associated with them, reflects the two dimensions of the relationship between environmental factors and social determinants and disabilities: namely, i) reducing the health risks that lead to health conditions; and ii) removing or moderating the impact of environmental factors that, in interaction with the impairments a person experience, lowers levels of access to health care.

Status and trends

a.   Health status of persons with disabilities

People with disabilities experience significantly greater vulnerability to secondary health conditions, co-morbid conditions, age-related conditions, and higher rates of premature death. For example, depression is a common secondary condition in people with disabilities ,[217,218,219] and the prevalence of diabetes in people with schizophrenia is nearly ten times higher than in the general population.[220] As they age, people with developmental disabilities have far higher rates of dementia than the general population.[221] In general, people with disabilities have increased rates of health risk behaviours, such as being overweight, smoking or not engaging in adequate physical activities,[222,223,224] and have a greater risk of being exposed to violence.[225,226] Because of all these factors, the mortality rates for persons with disabilities, although they vary depending on the underlying health condition, tend to be

higher than for the general population.[227] Evidence shows that people with learning disabilities on average die 5 to 10 years younger than other citizens.[228]

b.   Access to health care

Persons with disabilities have more health care needs compared to people without disabilities, but they are more often unsuccessful in getting care when needed (Figure 10). People with disabilities are more likely to not be able to afford the medical visit or the transportation to the medical facility, and to not have transport to reach health care locations. People with disabilities have also more difficulties in finding health-care providers with adequate equipment and skills (Figure 11).

Figure 10. Percentage of persons with and without disabilities, seeking health care needs and having those needs unmet, by sex, in 51 countries, 2002-4
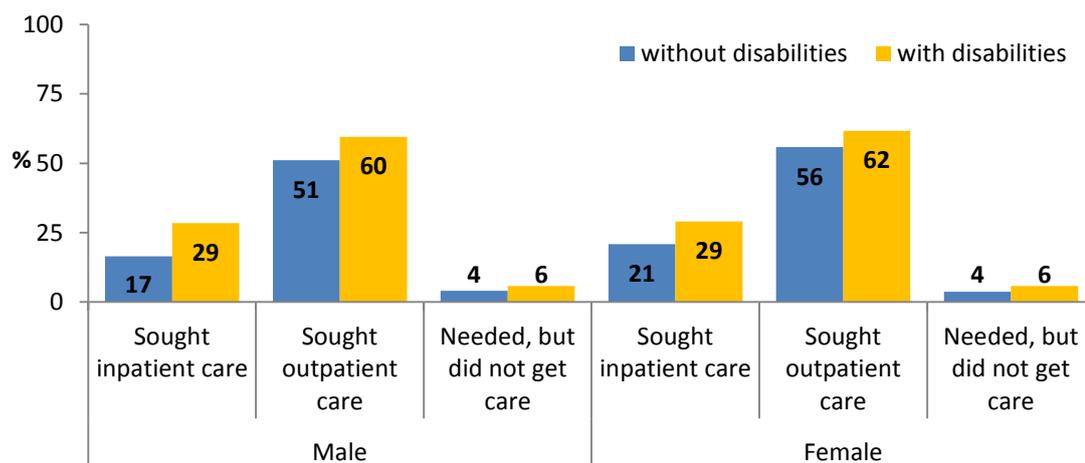
Source of data: WHO (2011),[229] p. 62.

Figure 11. Reasons for lacking care for persons with and without disabilities, by sex, in 51 countries, 2002-4
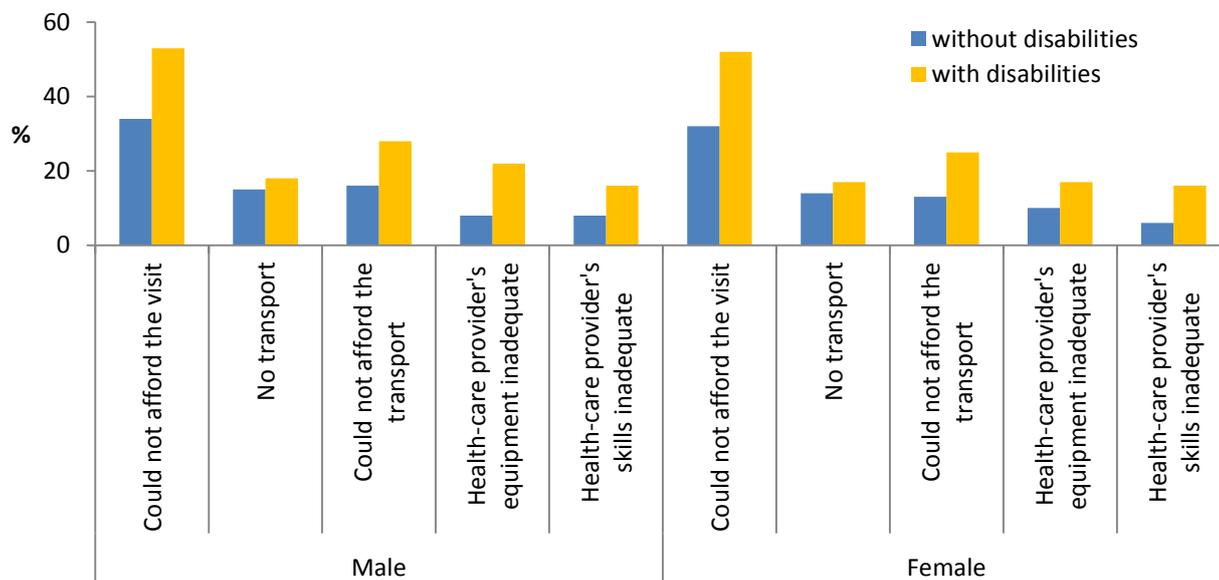
Source of data: WHO (2011),[229] p. 63.

c.   *Social determinants of health*

Health is closely associated with what has come to be called the *social determinants of health*, i.e. the physical, social, economic, political and cultural factors and conditions that are closely associated with health decrements.   Social determinants which can affect health include income, stress, early childhood development, social exclusion, unemployment, social support networks, addiction, availability of healthy food, and availability of transportation. Empirical findings show a striking relationship between the distribution of these social conditions and the health levels of individuals.[230] Since persons with disabilities are more likely to be poor, unemployed, and under-educated (see section 4.1.1 on Education and section 4.1.3 on Employment), their health is more vulnerable than for those without disabilities.

d.   *Well-being*

Many studies have reported that people with serious and persistent disabilities report that they experience a good or excellent quality of life.[231] It is a well-established feature of subjective wellbeing that while people express low levels of affect in their lives, they can at the same time express relatively high levels of satisfaction of their life as a whole.[232,233] For many

people with impairments, the impact of these affect how day to day life is lived: more time may be required to do activities of daily living such as dressing and grooming, help may be required or pain moving around may make it unpleasant to carry out the simplest tasks. These features of living with a disability may have an impact on experienced levels of happiness or positive affect. But for most persons with disabilities, when they reflect on their lives overall, they tend to express levels of life satisfaction that are not different from the general non-disabled populations.[234,235,236] More significantly, life satisfaction is more strongly affected by environmental conditions rather than impairments. For example, persons with spinal cord injury rate their life satisfaction higher if their environments are facilitating and they can, as a result, experience higher levels of activity and participation levels in daily life.[237]

Conclusion and the way forward

Persons with disabilities tend to suffer from poorer health, have less access to health care and often find barriers in accessing health care, such as lack of accessible transportation, medical facilities or equipment. The poorer health is partly explained by their lower socioeconomic levels. However, in terms of well-being a different picture emerges. Despite all the barriers and challenges that people with disabilities face on a daily basis, they tend to report levels of life satisfaction similar to those for people without disabilities.

To improve the health of persons with disabilities, improvements in accessible health care, in accessible transport and in the socio-economic levels of persons with disabilities are needed. Several actions can contribute to this aim:

- Eliminating the barriers people with disabilities face in accessing primary and public health care services across the spectrum from promotion of health, prevention and treatment of health conditions.

- Making health facilities accessible for persons with mobility disabilities

- Changing the financing structure of health systems through universal health care.

- Recognizing differences in health care needs for persons with disabilities and therefore differences in how public health strategies are formulated. [238]

- Enhancing training programmes for health professionals to raise awareness about the often unique health needs of persons with disabilities.

- Addressing the impact of social determinants, which are more negative for persons with disabilities. Public health and other social interventions that target the social determinants of health and disability, especially those that open up the range and quality of the participation in the major areas of life – family and community life, education and employment – address not only the health and lived health of persons with disabilities, but also their subjective well-being. These should therefore be promoted. In particular, enhance the availability of assistive technology, workplace accommodations, and accessible buildings and public transportation.

- Promoting healthy life-styles among persons with disabilities, namely by encouraging physical exercise, healthy nutrition and discouraging health risk behaviours such as smoking and alcohol consumption.

- Increase the availability of high-quality data on the health and well-being of persons with disabilities, including:

    1. data on overall health status of persons with disabilities

    2. data on the use of health care services by persons with disabilities

    3. reliable information about the impact of social determinants on the health of persons with disabilities as well as on the impact on these determinants on their disabilities

    4. information about low and medium income countries, where, currently, very little is known, either about the health status and service usage of persons with disabilities

5. data on the wellbeing of persons with disabilities.

4.1.3 Employment

Employment and decent work are the most effective means to contribute to the social inclusion of people with disabilities by breaking the vicious cycle of poverty and marginalisation. The professional potential of people with disabilities often remains untapped due to misconceptions about their working capacity, negative societal attitudes and non-accessible physical and informational environments.

This section presents international legislation covering employment issues for persons with disabilities, provides an overview of the status of participation of persons with disabilities in the workforce, lists measures taken by developing countries to increase job opportunities for persons with disabilities and ends with a conclusion discussing the way forward.

UN mandates

The CRPD and the different ILO Conventions and Recommendations provide the global legal framework that should guide the design of national legislation and policies to create and promote equal employment opportunities of people with disabilities (Table 12). The CRPD as well as the ILO Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159)[239] and its accompanying Vocational Rehabilitation and Employment (Disabled Persons) Recommendation, 1983 (No. 168)[240] provide that representative organizations of persons with disabilities should be involved at every stage of the process of developing, implementing, monitoring and evaluating laws, policies and national strategies promoting the employment of persons with disabilities.

Article 27 of the CRPD is specifically devoted to work and employment for people with disabilities. States Parties are called upon to open up opportunities in mainstream workplaces, both in the public and private sectors. To facilitate this, the CRPD requires State parties to promote the access of disabled persons to freely-chosen work, general technical and

vocational guidance programmes, placement services and vocational and continuing training, as well as vocational rehabilitation, job retention and return-to work programmes. The CRPD provisions cover people with disabilities seeking employment, advancing in employment as well as those who acquire a disability while in employment and who wish to retain their jobs. The CRPD also recognizes that for many disabled persons in developing countries, self-employment or micro business may be the first option, and in some cases, the only option. States Parties are called on to promote such opportunities. Further, the CRPD requires State parties to ensure that people with disabilities are able to exercise their labour and trade union rights. States Parties are also called on to ensure that people with disabilities are not held in slavery or servitude and are protected on an equal basis with others from forced or compulsory labour.

A central requirement for labour market inclusion according to the CRPD is non-discrimination against people with disabilities in their search for work and employment. The CRPD emphasizes that the right to work applies to all forms of employment. Equality of opportunity and equality between men and women with disabilities are principles that are also present in the ILO Convention No. 159[241]. The ILO Convention No. 159, accompanied by the ILO Vocational Rehabilitation and Employment (Disabled Persons) Recommendation, 1983 (No. 168)[242], requires that member States formulate, implement and periodically review a national policy on vocational rehabilitation and employment of disabled persons.

Other ILO Conventions are also of particular importance to the promotion of the right of people with disabilities to decent work and employment, including the Human Resources Development Convention, 1975 (No. 142)[243], the Occupational Safety and Health Convention, 1981 (No. 155)[244] and the Private Employment Agencies Convention, 1997 (No. 181)[245].

The concept of reasonable accommodation is a key provision that is also referred to throughout the CRPD. In countries which have ratified the CRPD, it is now a requirement that legislation is enacted that requests employers to take steps to ensure that work environments are both generally accessible to people with disabilities and that reasonable accommodation is provided to enable a disabled employee or job-seeker to compete on an equal basis with others.

The SDGs of the 2030 Agenda for Sustainable Development include a target, target 8.5, aiming at achieving full and productive employment and decent work for persons with disabilities by 2030.[246]

Table 12. Key international legislation on employment and persons with disabilities

Key international legislation on employment and persons with disabilities
Article 27 of the CRPD - 2006[247]
ILO Human Resources Development Recommendation (No. 195) - 2004[248]
ILO Private Employment Agencies Convention (No. 181) - 1997[249]
ILO Convention No. 159 – 1983[250]
ILO Vocational Rehabilitation and Employment (Disabled Persons) Recommendation (No. 168) - 1983[251]
ILO Occupational Safety and Health Convention (No. 155) - 1981[252]
ILO Human Resources Development Convention (No. 142)- 1975[253]
ILO Discrimination (Employment and Occupation) Convention (No. 111) - 1958[254]

Status and trends

Working-age persons with disabilities are less likely to be employed than their non-disabled peers (Figure 12). According to results in 51 countries, in 2003-3, only 41% of the population aged 18 to 49 with disabilities is employed, compared with 58% for persons without disabilities. For those aged 50 to 59, the gap is slightly wider, with 40% of those with disabilities employed while 61% of those without disabilities are employed. Among those

over 60 years of age, the percentage of persons without disabilities employed, 27%, is almost three times higher than the percentage for persons with disabilities, 10%.

Figure 12. Employed to working-age population ratio,[255] by age, for persons with and without disabilities, 51 countries, 2002-2003
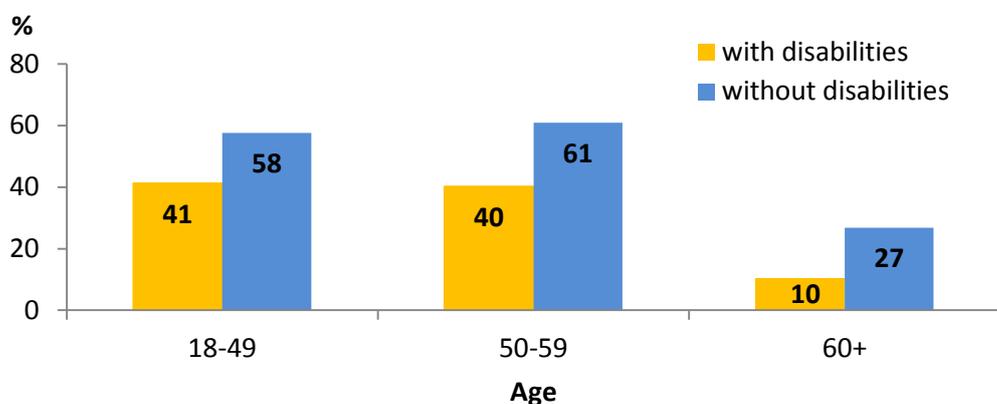
Source: WHO (2011),[186] p. 238.

In some countries, the employed to working-age population ratio for persons with disabilities is half or less than those without disabilities.[256] As persons with disabilities are often discouraged to look for a job, their participation in the labour market tends to be much lower than that of persons without disabilities; for those who look for work, employment opportunities are scarce due to inaccessible work places and information, discrimination, negative attitudes towards persons with disabilities and misconceptions about their capacity to work. Data from 1990-3 showed that in many countries most people considered unfair to give work to handicapped people when able-bodied people cannot find jobs (Figure 13).

Figure 13. Percentage of people who agree with the sentence "It is unfair to give work to handicapped people when able-bodied people can't find jobs", 1990-3
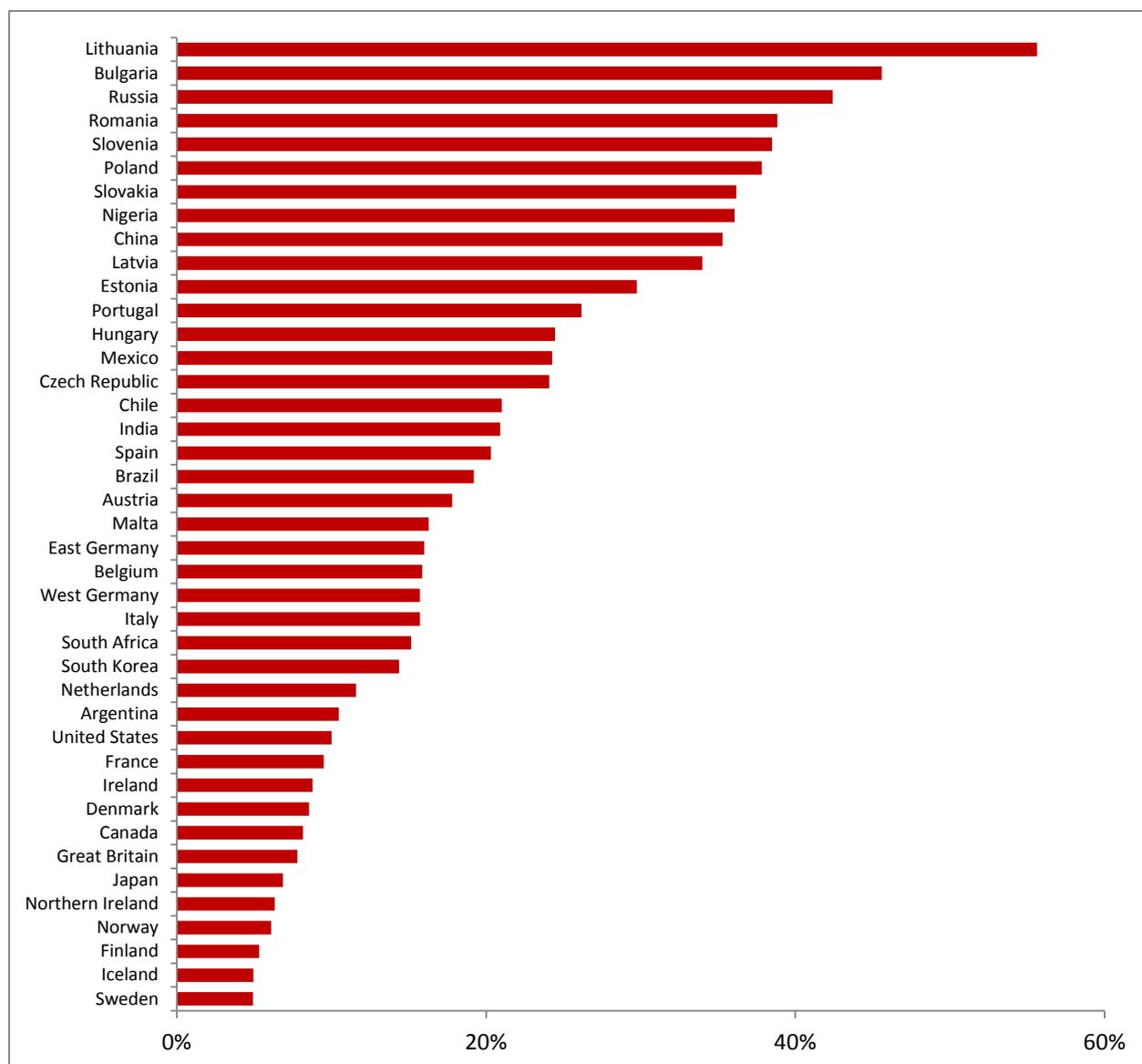
Source: World Values Survey (1990-3 wave).

However, when looking at self-employment the situation reverses (Figure 14). Among 16 developing countries, in all but one the self-employment rate is higher for persons with disabilities than for persons without disabilities. This has been attributed to the absence of wage employment options for people with disabilities as they are marginalized from the labour market due to inaccessible workplaces and transport, lower educational qualifications and discrimination. As a result, people with disabilities are pushed to generate income though

their own enterprises.[257] Self-employed workers tend to be in more vulnerable situations as they are more likely to experience sudden un- or underemployment and to lack social security.

When in employment, people with disabilities are more likely to be in part-time jobs. A 2010 study in 29 countries showed that in all of them the percentage of part-time employees among employed persons with disabilities was higher than for their non-disabled peers in all countries (Figure 15). A study in Nepal showed however that, for persons with disabilities, higher levels of job satisfaction are associated with full-time work.[258] Often disabled persons are limited to part-time employment because the full time employment does not give them the proper time to travel to and from work and to deal with health concerns. But people with disabilities have the potential to engage in full time work. Besides having reasonable accommodations at the workplace, like accessible equipment and facilities, it is also necessary to address other related issues such as transport.

Figure 14. Self-employment rate[259] for persons with and without disabilities, in 15 countries, 2002-2003
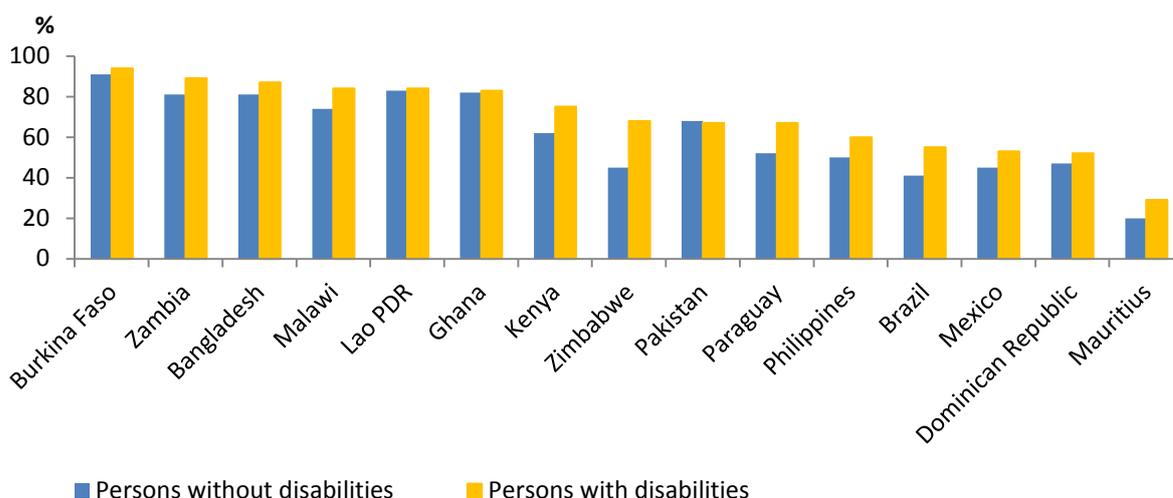
Source: Mizonoya and Mitra (2013).[260]

Persons with disabilities are also more likely to be in low-paid jobs with poor career prospects and working conditions,[261,262,263,264,265] especially as legislation in some countries[266] provides for the possibility of the reduction of the applicable minimum wage through exceptions for persons with disabilities.[267,268] Quota legislation for employment of persons with disabilities exists in a number of countries (see section below). Where it exists, it usually covers both the public and the private sector. However, there is little information available on employment of persons with disabilities disaggregated by public versus private sector. Existing data for Ecuador shows that, in 2010, 15 public companies were employing people with disabilities.[269]

Figure 15. Share of part-time employment in total employment by disability status, in 29 countries, 2003-2008
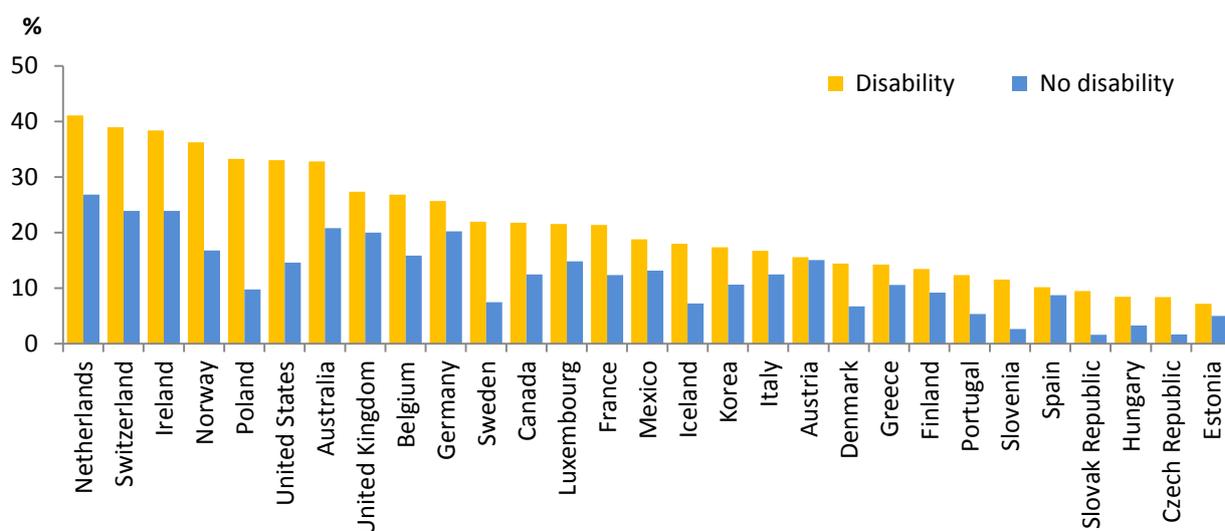
Source: Reproduced from OECD (2010).[270]

The economic costs of exclusion

The exclusion of people with disabilities from employment opportunities results in an economic cost for national economies. According to an ILO study covering Viet Nam, Thailand, China, Malawi, Namibia, Zambia, Zimbabwe, Ethiopia, South Africa and

Tanzania, the higher rates of unemployment and labour market inactivity among people with disabilities as well as the reduced productivity of employed disabled persons due to barriers to education, skills training and transport lead to a loss for countries worth up to 7 % of GDP[271].

Measures taken to promote employment among persons with disabilities

Governments, businesses as well as trade unions worldwide have been taking initiatives to promote employment among persons with disabilities on an equal basis with the rest of the population. Encouraging initiatives are also taking place in developing countries (Table 13). Some developing countries have introduced anti-discrimination laws both in the recruitment of and the salaries paid to persons with disabilities. At least eighteen countries also have introduced employment quota systems to ensure the participation of persons with disabilities in the labour force. While all quota systems call for employers to employ a set minimum percentage of disabled workers, there are variations between systems, particularly in relation to the obligatory or non-obligatory requirement, the size and type of enterprise affected and the nature and effectiveness of sanctions or levies in cases where an employer fails to meet the requirement. In some countries, the funds collected through the compensation levy are used exclusively to promote employment opportunities of persons with disabilities[272]. Acknowledging the importance of quotas in education and training is also important to ensure that persons with disabilities can develop skills to compete in the labour market. In Bangladesh, for example, 5% of seats in polytechnics and technical schools and colleges are reserved for persons with disabilities.

Table 13. Examples of measures adopted by developing countries aiming at promoting employment among persons with disabilities on an equal basis with others[273]

Measure promoting employment among persons with disabilities on	Examples of countries which have adopted such measures

an equal basis with others	
the creation of anti-discrimination legislation in employment;	Uganda: article 21 of Constitution Brazil: article 7 of Constitution Costa Rica: Law 7600 on equal opportunities for peoples with disabilities (1996) Ghana: Persons with Disability Act (2006) South Africa: Employment Equity Act (1998)
legal framework for equal pay for equal work	Cuba, Brazil, Mongolia
employment quota systems	China, India, Japan, Mongolia, the Philippines[274], Sri Lanka, Thailand, Indonesia[275], Ethiopia, Mauritius, Tanzania, Kuwait, Ecuador, Peru, Brazil, Azerbaijan, Mongolia, Turkmenistan
explicitly mentioning persons with disabilities in employment policies and programme	Sri Lanka: National Human Resources and Employment Policy, 2012 Ethiopia: National Employment Policy and Strategy, 2009
inclusion of persons with disabilities in public procurement policies, public employment programmes and other public works programmes	South Africa: Preferential Policy Framework Philippines: Executive Order 417, 2005 India: Mahatma Gandhi National Rural Employment Act
mainstreaming disability in technical and vocational education and training	Government initiatives: Bangladesh, Mongolia, Zambia, Uganda, Burkina Faso, Initiatives from private companies: Nigeria (L'Oreal), India (Tata Consultancy Services), Brazil (Extra and Pão de Açucar, Sodexo), Thailand (Novotel Bangkok), Egypt (cell phone operator Mobinil)
quotas for persons with disabilities in technical and vocational training	Bangladesh: 5% of seats in polytechnics and technical schools and colleges are reserved for persons with disabilities (Ministry of Education order, 2015)
creation of services that support the	Ethiopia (Ethiopian Centre for Disability and

employment of persons with disabilities	Development) Lebanon (Lebanese Physical Handicapped Union) Peru (Yanbal International)
creation of programmes to deal with return to work for persons who have acquired a disability	Malaysia (Return to Work Program, 2007)
establish business and disability networks[276]	Brazil (*Rede Empresarial de Inclusão Social*), Saudi Arabia (*Qaderoon*), Chile (*Red de Empresa Inclusiva*), South Africa (*South African Employers for Disability (SAE4D)*), Peru, Egypt, Zambia, Costa Rica, Sri Lanka
awards that recognize companies that apply disability-inclusive practices	Costa Rica
training trade union leaders on disability rights promotion	Ethiopia, Zambia

Source: Authors' elaboration on the basis of information provided by ILO.

Apart from legislation, a few countries – Ethiopia, India, Philippines, South Africa and Sri Lanka – explicitly mention persons with disabilities in employment policies and programmes and include them in public procurement policies, public employment programmes and other public works programmes.

Both governments and private companies have promoted the inclusion of persons with disabilities in technical and vocational education training (see Box 11). While government programs tend to cover a wider range of professional areas, private companies typically create training programmes oriented to their own professional needs.

Box 11. The Ágora programme: matching skills with jobs through training

Within the Ágora programme run by the ONCE Foundation for Latin America (FOAL) in 14 countries of Latin America, each beneficiary with a disability undergoes a personal interview to identify individual skills and professional ambitions. Based on this assessment and in

cooperation with employers, the Ágora programme designs tailor-made trainings and business plans. In 2014, 499 programme participants found employment; another 1,287 beneficiaries were supported in starting their own businesses.

Several countries - Brazil, Chile, Costa Rica, Egypt, Peru, Saudi Arabia, South Africa, Sri Lanka, Zambia - have established national business and disability networks to promote good practices of disability inclusion (see Box 12). As a result an increasing number of companies are creating initiatives targeting disabled persons. Costa Rica launched in 2014 an award to officially recognize companies in their work to apply disability-inclusive practices.[277]

Box 12. National business and disability networks: the example of Sri Lanka

The Employers Federation of Ceylon (EFC) established an Employers' Disability Network in 2000 with the goal of increasing employment opportunities for persons with disabilities. Since 2009, the EFC IT training courses that are the only ones available on IT for persons with visual impairments in Sri Lanka, has placed more than 400 persons with disabilities in employment. A number of leading IT institutes in Sri Lanka support the on-going IT courses. To increase the candidates' opportunities to be placed in suitable jobs, English lessons have also been launched for the trainees.

In addition to employers, trade unions have also been promoting the inclusion of people with disabilities in the labour market. For instance, in Ethiopia, the Confederation of Ethiopian Trade Unions (CETU) is working towards implementing a project on the inclusion of disability rights in trade unions activities.

A major shortcoming in many developing countries is the lack of adequate services that support the employment of persons with disabilities. Where they exist, they help identifying and providing information on job vacancies, assessing the aptitudes and interests of the job-seeker, providing career guidance and referring the job-seeker for further training,

if required, matching people to available jobs, as well as being able to provide advice to employers on reasonable accommodations or or promoting employment opportunities through approaches like supported employment (see Box 13). Services of the like have been established in Ethiopia, Lebanon and Peru and in Malaysia a program was started to assist the return to work for those who acquired a disability.

Box 13. Supported employment for people with disabilities in China

Hunan was the first province in China to pilot a supported employment model in 2014. This 'train and place' approach paved the way for 20 women and men with intellectual disabilities to be trained on the job. The Hunan Disabled Persons' Federation chose 10 NGOs and vocational training centres as pilot organizations to promote the approach. Subsequently, work opportunities at selected businesses – supermarkets, bakery shops and hotels, among others – were identified and matched to the interests of persons with disabilities. Through training and sensitization, their colleagues and department leaders learned how to support them adequately.

Conclusion and the way forward

People with disabilities are still not participating in the labour force on an equal basis with their peers. Among the working age population, fewer people with disabilities are employed and, for those who work, they are more likely to have vulnerable employment and lower pay than their non-disabled peers. It is important to remember that the barriers encountered by persons with disabilities in many other areas, including in education and access to transport, have a huge impact on the employment opportunities of persons with disabilities.

There is however an increasing number of good practices in promoting the right to decent work of people with disabilities by governments, businesses as well as trade unions. Governments in several countries have been playing a crucial role in creating an enabling

legal and policy environment, which both increases the employability of persons with disabilities and leads to more inclusive employment opportunities by private and public employers. Businesses are also becoming more aware of disability inclusion and have created training for persons with disabilities, often with the support of national business and disability networks. Trade unions are also playing a role in the inclusion of people with disabilities in the labour market.

However, in general, there is scope for expanding measures to promote persons with disabilities in the labour force. More countries need to create initiatives in this regard. Ultimately, achieving employment rates of persons with disabilities similar to those of the general population, and ensuring equal access to the labour market for persons with disabilities, requires a combination of measures. Key measures include:

- creation of anti-discrimination legislation in employment and legislation on equal pay for equal work

- employment quota systems for persons with disabilities

- explicit mentioning persons with disabilities in employment policies and programmes

- inclusion of persons with disabilities in public procurement policies, public employment programmes and other public works programmes

- creation of services that support the employment of persons with disabilities (placement services as well as services providing information for persons with disabilities on the job market and to employers on reasonable accommodations)

- creation of programmes to deal with return to work for persons who have acquired a disability

- supported employment for people with intellectual disabilities (provision of job coaches, funded by government, to accompany the worker in the early stages of his/her job)

- tax and other financial incentives for companies and persons who employ persons with disabilities

- mainstreaming disability in technical and vocational education and training

- quotas for persons with disabilities in technical and vocational training

- awareness campaigns for the business sector and the overall population highlighting the contributions people with disabilities make in the labour force

- creation of business and disability networks to promote disability inclusion and increase employment opportunities for persons with disabilities

- creation of awards that recognize companies that apply disability-inclusive practices

- recruiting, organizing and integrating people with disabilities in trade unions

- training trade union leaders on promoting disability rights.

4.1.4 Social Protection

Compared to their peers without disabilities, persons with disabilities are less likely to be in full-time employment and are more likely to be unemployed or economically inactive, both in developed and developing countries. In addition, persons with disabilities face significant extra costs related to disability, for instance, costs for support services, assistive devices, disability-related health care costs and opportunity costs linked to discrimination. These costs not only impact on persons with disabilities as individuals but also their families and the household they live in. Due to these costs, reduced economic resilience and repeated economic shocks are more often than not the situation people with disabilities experience. Therefore social protection systems play a key role in partially correcting some of the labour market inequalities and meeting the needs of persons with disabilities with regard to income security, health protection and social inclusion.

This section will list the UN mandates related to social protection for persons with disabilities and describe the various components and types of social security schemes for persons with disabilities. It will also provide an overview of the status of social protection for persons with disabilities and suggest measures to improve this status.

UN mandates

The international human rights framework contains a number of provisions ensuring the right to social protection of persons with disabilities. The Universal Declaration of Human Rights, 1948, and the International Covenant on Economic, Social and Cultural Rights, 1966, contain a general recognition of this right, while the Convention on the Rights of Persons with Disabilities (CRPD) provides more explicit guarantees. Together, they recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, to the continuous improvement of living conditions, to social security and to the highest attainable standard of health.

More specifically, article 28 of the CRPD provides for the realization of the right to social protection without discrimination on the basis of disability, providing access to (i) appropriate and affordable services and devices and other assistance with disability-related needs; (ii) social protection and poverty reduction programmes; (iii) assistance with disability-related expenses; (iv) public housing programmes; and (v) retirement benefits and programmes.

The CRPD also lays down the right of persons with disabilities to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. To this end, States must take all appropriate measures to ensure access for persons with disabilities to health services, including health-related rehabilitation.

In a complementary way, successive standards adopted by the International Labour Organization (ILO) set both basic minimum and higher standards of income protection which should be guaranteed to persons with disabilities as an alternative to income earned prior to disablement, or to income that would have been earned from employment had they been able to work. More specifically, the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102)[278] deals with the contingency of total disablement - not due to an employment injury - which results in a person's inability to engage in any gainful activity and which is likely to be permanent. In these circumstances, protection is to be provided through periodic cash benefits, subject to certain conditions. The ILO Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (No. 128)[279], in its Part II, deals with the same subject matter but sets higher standards for disability benefits schemes. Its accompanying Recommendation, No. 131[280], broadens the definition of the contingencies that should be covered under national schemes by including partial disability, which should give rise to a reduced benefit, and by introducing the incapacity to engage in an activity involving substantial gain among the criteria for disability assessments.

ILO Convention No. 128 also provides for rehabilitation services designed to enable persons with disabilities to either resume their employment or to perform another activity suited to their capacity and skills. Although medical care, including medical rehabilitation, is dealt with in separate provisions in ILO Convention No. 102 (Part II) and the ILO Medical Care and Sickness Benefits, Convention, 1969 (No. 130)[281], a comprehensive, coherent and integrated approach to disability benefits, such as the one set forth in the ILO's normative framework, requires that equal attention be given to the income support and medical needs of persons with disabilities. Hence, the standards set as regards the provision of medical care, including medical rehabilitation, are highly relevant. Such care should be "afforded with a view to maintaining, restoring or improving [their] health … and [their] ability to work and to attend to [their] personal needs". Convention No. 102 further requires an institution or government department administering medical care to cooperate with the general vocational rehabilitation services "with a view to the re-establishment of handicapped persons in suitable work" (Article 35).

The ILO Social Protection Floor Recommendation, 2012 (No. 202)[282] also puts forward an integrated and comprehensive approach to social protection and disability benefits, whereby persons with disabilities should enjoy the same guarantees of basic income security and access to essential health care as other members of society through national social protection floors. These guarantees can be provided through a variety of schemes (contributory and non-contributory) and benefits (in cash or kind), as is most effective and efficient in meeting the needs and circumstances of persons with disabilities to allow them to live in dignity. Some of the principles set out in the Recommendation are of particular relevance for persons with disabilities, including the principles of non-discrimination, gender equality and responsiveness to special needs, as well as respect for the rights and dignity of people covered by the social security guarantees.

Social protection for persons with disabilities

Social protection refers to preventing, managing and overcoming situations that adversely affect a person's wellbeing. It includes coverage and access to social security schemes as well as labour protection and dedicated programmes and activities that protect vulnerable groups, such as persons with disabilities from poverty and exposure to economic and social risks, by enhancing their capacity to manage these risks. Core components of social security systems that explicitly address the needs of persons with disabilities include (i) programmes that provide income support to persons with disabilities and their families, (ii) social health protection and (iii) other forms of protection such as universal health coverage. Programmes that actively support the (re-)integration of persons with disabilities in the labour market and their livelihoods also play a key role. Box 14 presents the different types of social protection schemes for disability.

Box 14. Types of social protection schemes for disability

Contributory social protection schemes: only protects persons who have made contributions during a qualifying period. It usually covers workers on formal wage-employment and, in some countries, the self-employed. The contributions requirement allows the proper financing of schemes to ensure the due payment of disability benefits on a long-term basis. However, it leaves out children with disabilities and persons with disabilities who have never formally worked.

Non-contributory social protection schemes: requires no direct contribution from beneficiaries or their employers. These schemes are usually financed through taxes or other state revenues. Non-contributory disability benefits play a key role in protecting those persons with disabilities who have not (yet) earned entitlements to contributory schemes or who have otherwise ceased involvement in a contributory scheme. They provide at least a

minimum level of income security for those disabled from birth or before working age, and those who for any reason have not had the opportunity to contribute to social insurance for long enough to be eligible for benefits. Contributory schemes can be mainstream schemes, e.g. those trying to alleviate poverty in general, or disability-specific schemes, i.e. targeting people with disabilities only.

Universal schemes: provide benefits to all under the single condition of residence and/or citizenship.

Means-tested schemes: provides benefits upon proof of need and targets persons or households whose economic means fall below a certain threshold.

Status of social protection for persons with disabilities

More and more countries have been adopting social protection programmes for persons with disabilities, using a variety of schemes (for definitions of different schemes, see Box 14). Most countries expanded their social protection programs to include disability in the 1960s and the 1970s.[283] As of 2012-3, in almost all countries, the national legislation provides for a social protection scheme with cash benefits for persons with disabilities (Figure 16). In 168 countries, these disability schemes provide *periodic* cash benefits to persons with disabilities, in another 11 countries there is only a lump-sum benefit.[284] In 81 countries, the periodic benefits are obtained through contributory social insurance schemes, which mainly cover workers and their families in the formal economy and thus leave out children with disabilities and persons with disabilities who had not the opportunity to contribute to social insurance for long enough to be eligible to benefits. In 87 countries, fully or partially non-contributory schemes are used, and thus have improved coverage as they do not focus only on previous contributors to social security. Among these 87 countries, these schemes are universal in 27 countries, i.e. they cover all persons with assessed disabilities without regard to their income

status; in 60 countries they are means-tested schemes, that is, they protect only persons or households whose economic means fall below a certain threshold.

Regional differences in the scope of coverage for persons with disabilities have been observed. Non-contributory or universal schemes tend to be provided in Northern and Eastern Europe and a few other countries, namely Bolivia, Namibia, Mauritius, Brunei, Hong Kong, New Zealand and Timor-Leste. In Western Europe and Latin America, contributory-based social insurance is complemented by non-contributory poverty-targeted schemes. In other regions, mostly Africa, Middle East and Asia and the Pacific, contributory-based social insurance benefits are provided for those engaged in formal employment.[285]

As long-term disability benefits can potentially provide disincentives for people to seek employment, a few countries[286] reformed their policies recently by removing disability benefits for persons with disabilities with significant capacity to work. However, these reforms have had only limited success in increasing the proportion of persons with disabilities in employment due to an unfavourable labour market situation and lack of measures to facilitate (re)integration into employment.[287] Evidence from a number of countries, including Hungary, Italy, the Netherlands and Poland indicate that imposing tight obligations on employers to provide occupational health services and to support reintegration of persons with disabilities in the work place, together with stronger work incentives for workers and better support for employment, can help persons with disabilities who are beneficiaries of social protection schemes to return to the workforce.[288]

Figure 16. Overview of cash disability benefit programmes anchored in national legislation, by type of programme and benefit, 2012/13, in 183 countries

183 countries | **100%**

Disability schemes with periodic cash benefits
168 countries | **92%**

Only lump-sum disability benefits
11 countries
6%

No cash disability benefits
4 countries
2%

Part or full non-contributory scheme
87 countries
48%

Contributory scheme only
81 countries
44%

Non-contributory scheme is universal
27 countries
15%

Non-contributory scheme is means-tested
60 countries
33%

Source: Author's elaboration using data from ILO (2014),[289] available for 183 countries.

Conclusion and the way forward

Social protection for persons with disabilities has been expanding, although many countries only provide coverage for workers who have previously contributed to social insurance and thus leave out children with disabilities and persons with disabilities who did not have an opportunity to previously work. In order to promote as most as possible participation of persons with disabilities in the labour force, social protection schemes and policies need to not only provide an adequate level of income security but also support active engagement in employment by persons with disabilities (through support for training and rehabilitation

among others). These policies should however be designed in such a way that they protect the rights of those who, for various reasons, are not able to find suitable employment, and for whom the introduction of such policies may result in a reduction of income security and potentially higher risk of poverty.

In general, social protection for persons with disabilities needs to extend beyond poverty alleviation or reduction. Additional support through disability-specific schemes is required in order to effectively address disability-related additional costs and promote greater participation, autonomy and choice of persons with disabilities. In addition, social protection should always promote social participation of people with disabilities and should not contribute to isolation and marginalisation, such as entitlements linked to staying in residential institutions.

There is still a lack of understanding on the best social protection policies for ensuring the full participation of persons with disabilities in society. Namely, more research is needed:

- To better understand the differences between mainstream and disability-specific schemes in terms of eligibility and impact in the lives of persons with disabilities.

- To identify better ways to assess eligibility for disability benefits, i.e. who is considered disabled in a country and which types of disabilities are included. The disability determination process used for eligibility purposes has to move away from being a strictly medical approach. The medical approach does not take into account the costs incurred due to disabilities not the real impact in participation resulting from acquiring disabilities. It may result in either over- or under-compensation from the economic point of view.

- To identify better ways of assessing the support needs of persons with disabilities, in terms of additional costs incurred due to disability (assistive devices, personal care, rehabilitation) and reduction of income due to disability.

- To identify the barriers that people with disabilities face in accessing and fully benefiting from mainstream and disability-specific social protection schemes.

Finally, financing social protection is not exclusively a disability question, but addresses broader challenges. Thus, disabled persons' organizations need to engage with non-governmental organizations (NGOs) engaged in advocating for mainstream social protection to jointly advocate for social protection in general, including for persons with disabilities.

4.2   Other disadvantaged groups

4.2.1 Women and girls with disabilities

Women with disabilities are often subjected to double discrimination, for being women and disabled. Women and girls with disabilities continue to be at higher disadvantage from receiving mainstream education, access to employment and participating in social activities, when compared to their male and non-disabled counterparts. While progress has been made in some areas for women and girls[290], there has been less progress made with regards to women and girls with disabilities, including in responding to the specific challenges they face, such as discrimination, risk of violence and abuse, economic empowerment, and civic and political participation[291].

Disability has an additional gender dimension. Women, including those with disabilities[292], are more likely to be caregivers for children, family members with disabilities and other family members[293]. This risks to result in poverty for women due the costs related to caring for persons with disabilities as well as reduced opportunities for women to participate, contribute further and benefit from the economy and the society beyond their home[294].

This section will identify key international mandates and measures taken to improve the participation of women and girls with disabilities, and illustrate the trends and remaining gaps. It will also make some recommendations of how women and girls with disabilities can become an integral part of all efforts to address gender equality and disability inclusion.

UN mandates

The CRPD emphasizes the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities. It also includes, as one of its general principles, the need to ensure equality between women and men; and a standalone article, Article 6, on women with disabilities. It also contains

several provisions with specific references to women, gender, or sex—including in the contexts of measures to be taken in the areas of awareness raising; freedom from exploitation, violence and abuse; and health. The CRPD's twin track approach—having gender equality as one of its principles and a separate article on women with disabilities—has galvanized the momentum for change in increasing the visibility of women with disabilities. To assist States Parties, and provide guidance, the Committee on the Rights of Persons with Disabilities is currently in the process of drafting a General comment on Article 6: Women with disabilities[295].

Women with disabilities are also protected by normative frameworks safeguarding and advancing the rights of women, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Beijing Declaration and Platform for Action[296]. While CEDAW does not make explicit reference to women and girls with disabilities, the Beijing Declaration and Platform of Action does so in the General Recommendation No 18 on disabled women--which recommends that States parties provide information on women with disabilities in their periodic reports, and on measures taken --, in the General Recommendation No 24 on health, which calls for increased attention and provides guidance on measures to promote and protect the rights of women with disabilities, and General Recommendation No. 33 on women's access to justice, which recommends that State parties give special attention to access to justice systems for women with disabilities.

The Beijing Declaration and the Platform for Action recognize disability as a barrier to full equality and advancement, and the enjoyment of human rights[297], and identify specific actions to ensure the empowerment of women with disabilities in various areas. Specific actions include, but are not limited to:

-   enhance the self-reliance of women with disabilities (paragraph 175 (d))

-   equal access to appropriate education and skills-training for their full participation in life (paragraph 280 (c)), and to improve their work opportunities (paragraph 82(k))

-   health programmes and services that address the special needs of women with disabilities (paragraph 106 c))

-   equity and positive action programmes to address systemic discrimination against women with disabilities in the labour force (paragraph 178 (f))

-   improve concepts and methods of data collection on the participation of women and men with disabilities, including their access to resources (paragraph 206 (k)).

Status and trends

Out of the estimated one billion persons living with a disability, women and girls with disabilities make up a significant proportion. The average disability prevalence rate in the female population 18 years and older is 19.2% compared to 12% for males.[298] This means that almost 1 in 5 women is likely to experience disability throughout their lifespan. Several factors explain the higher prevalence of disability among women and girls compared to men and boys. These include women's lower economic and social status, violence against women and harmful gender-discriminatory practices. Among women of reproductive age, complications during pregnancy can cause disability[299]. In all regions, women live longer than men[300], making up around 55 % of the total older population (60 years of age and above) in the world[301]. As disability prevalence increases with age, women are at an increased risk of acquiring a disability and may spend a longer time living with a disability.

While global trends show an increase in the enrolment of women and girls in education[302], including gender parity in secondary education[303], available data show that the educational attainment of women and girls with disabilities is lower than that of women and girls without disabilities, and of men and boys with disabilities[304]. The Figure 17 and Figure 18 demonstrate the disadvantage experienced by women and girls with disabilities, who are

less likely than their male and their non-disabled counterparts to complete primary education and to have less years of education. Other evidence shows that gender is one of the key factors that accentuates stigma and discrimination. Girls with disabilities are more likely to be socially excluded than boys with disabilities, with direct bearings on their educational trajectories[305].

Figure 17. Percentage of population who completed primary school, by gender and disability, in 51 countries, 2002-4[306]
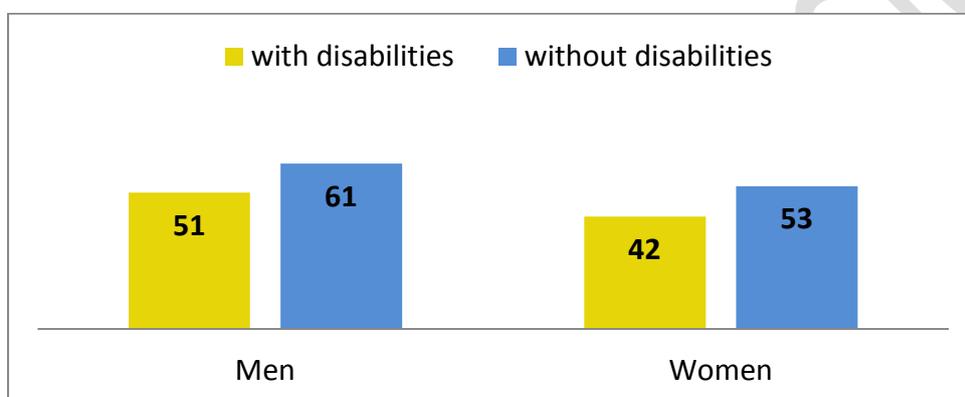
Source: WHO (2011),[186] p. 207.

Figure 18. Mean number of years spent in education, by gender and disability, in 51 countries, 2002-4[306]
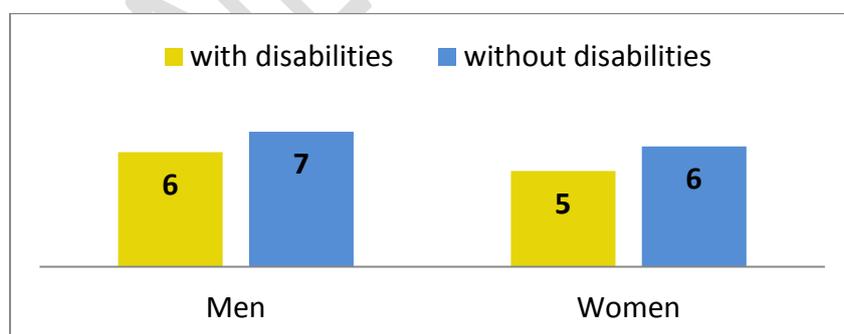
Note: t-tests suggest significant difference between the percentages above for persons with and without disabilities.

Source: WHO (2011),[186] p.207.[307]

Available national level data on literacy, support in early childhood education, and school attendance, including in special education, while not comparable across countries, persistently show a gender gap with females with disabilities lagging behind males with disabilities. In New Zealand, 29.7 % of girls with disabilities compared to 70.3 % of boys with disabilities receive support in early childhood education[307]; and participation rates of girls with disabilities in primary and secondary education are nearly half of those for boys with disabilities[308]. In the Solomon Islands, secondary school attendance is 30% for females with disabilities and 70% for males with disabilities[309]. In Australia, among people with disabilities[310] aged 15-24, 45% of women compared to 55% of men were in school.[311]

Women with disabilities are more likely to be affected by poverty than men with disabilities[312]. For example, in Austria the 'at risk of poverty rate' is 50 % higher for women with disabilities (23 per cent) than for men with disabilities (16 per cent)[313]. In countries of the European Union, it is estimated that about 20 % of women with disabilities live in households at risk of financial poverty[314].

Persons with disabilities in general face difficulties in entering the open labour market, yet seen from a gender perspective, men with disabilities are almost twice as likely to have jobs as their female counterparts. Available data show that women with disabilities have lower participation rates in the labour market than men with disabilities and women without disabilities. In 51 countries, the employed to working-age population ratio for men with disabilities is 53% compared to 65% for men without disabilities. For women, only 20% of them are employed among those with disabilities versus 30% for those without disabilities (Figure 19). Data from Europe, the Caribbean and Arab regions also indicate lower employment rates of women with disabilities in comparison to men with disabilities and women without disabilities. In countries of the European Union, the employment rate among women with disabilities is 44 % compared 65 % among women without disabilities[315]. In the

Caribbean, on average men with disabilities were almost twice as likely to be employed then women without disabilities[316]. In some countries of the Arab States region, employment rates for men with disabilities are as much as 3 to 4 times higher than for women with disabilities[317].

When women with disabilities work, they often experience unequal hiring and promotion standards, unequal access to training and retraining, unequal access to credit and other productive resources, unequal pay for equal work and occupational segregation.[318] It is also reported that women with disabilities are less likely to be referred to vocational training; have a harder time gaining access to rehabilitation programmes; and are less likely to obtain equality in training[319].

Figure 19. Employed to working-age population ratio[320] for persons with and without disabilities, by sex, in 51 countries, 2002-2003
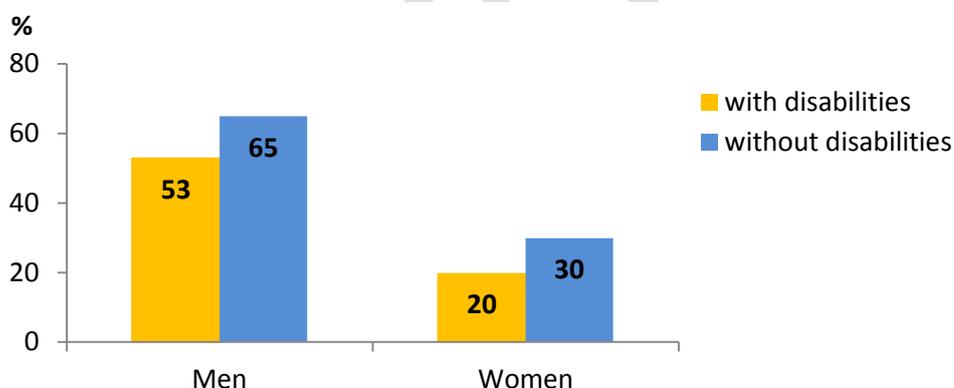
Source: WHO (2011).[186]

Women and girls with disabilities are also at a higher risk of suffering violence. Based on available data from the 28 European Union countries, 34% of women with a health problem or disability had ever experienced physical or sexual violence by an intimate partner, compared to 19% of women without a disability or health problem[321]. Women with disabilities also face specific challenges to access to sexual and reproductive health and

reproductive rights. During visits to general practitioners, women with functional limitations, for example, may be less likely to be asked about contraceptive use[322]. Women with disabilities, in particular those with intellectual disabilities, face restriction to their fertility, including through involuntary sterilization[323], which may also be used as a technique for menstrual management[324].

Measures taken by countries to improve the participation of women and girls with disabilities

Addressing the cross-cutting barriers faced by women and girls with disabilities are essential. Not only is it important to mainstream disability into the gender work but also to ensure that the gender perspective is mainstreamed into the disability policy making, implementation, monitoring and evaluation. A number of national governments have undertaken initiatives to address, from a gender perspective, the issue of disability, such as the adoption of action plans on women with disabilities; undertaking gender analysis in the context of national disability plans; and promoting equal access of women with disabilities to services. Table 14 below summarizes the key legislations, initiatives and programs employed by governments to mainstream a gender perspective in disability policy making.

Table 14. Country-level legislations, policies and action plans that mainstream a gender perspective in disability

	Country	Policy / Legislation / Action Plan
National Action Plans	Spain	In 2006, the government adopted a Plan of Action for Women with Disabilities, which established a strategy and methodology for correcting the inequalities between men and women with disabilities. The most recent iteration of this plan, entitled the Third Plan, while focused more generally on persons with disabilities, it aims at addressing disability along gender-analysis lines[325].

	Uganda	The Ugandan Persons with Disabilities Act pays particular attention to the requirement of the girl child in rural areas and also establishes the duty of the Ugandan government to promote access to health services, which are relevant to women with disabilities[326].
	Croatia	The Joint Inclusion Memorandum of the Republic of Croatia and the National Policy for the Promotion of Gender Equality 2006 – 2010 prescribe the government's obligation to finance projects aimed at improving the status of women with disabilities. It includes the implementation of the project "Same but Different", which promotes the affirmation and more active integration of women with disabilities in the life of the community in areas of special state concern[327].
Education	China	As part of its Programme for the Development of Chinese Women (2001-2010), China has affirmed particular safeguarding of the right to education of girls with disabilities in order to reduce the gap between boys and girls receiving education[328].
	Nepal	Nepal established a Girls' Education Fund targeting Dalit girl students and girls with disabilities; twenty % of the total scholarship is reserved for deserving girl students with disabilities[329].
	Germany	Blind and visually impaired women, trained as Clinical Breast Examiners (CBEs) in a nine-month program supported by the North Rhine Medical Association, are able to detect up to 50 % more and up to 28 % smaller changes in the breast than doctors are able to[330].
Economic Empowerment	Republic of Korea	The Employment Promotion and Vocational Rehabilitation of Disabled Persons Act provides for

		preferential treatment of women with disabilities, including more government financial assistance to business owners who hire them[331].
	Thailand	Funds for Empowerment of Persons with Disabilities, established under disability legislation, provides women with disabilities with access to loans. Since 2007 this has significantly increased the capacity of women with disabilities; data available for uptake of loans shows that women with disabilities had received an equivalent to 33.7 % of the total 12,765 loan borrowers[332].
	Kenya	The government has launched the Uwezo Fund aimed at enabling women, youth and person with disability access finances to promote businesses and enterprises. The Fund has a quota for public procurement: 30% should go to these groups, including women with disabilities[333]. The government, in partnership with the ILO, is also working with women with disabilities on building entrepreneurship skills[334].
Health and Rehabilitation	Brazil	The II National Plan for Women (PNPM II) proposes developing and distributing Strategic Health Guidelines for women with disabilities. The initiative is under the primary responsibility of the Ministry of Health in partnership with the secretariats responsible for women, human rights, racial equality, as well with universities, scientific organizations, and women's and feminist movements[335].
	Austria	A manual for gynaecological health provision and prevention for women with disabilities, and an information brochure on "Visiting the gynaecologist – questions and answers in simple language" were produced. The brochure is also on an audio CD for women and girls with visual impairments[336].

	Kenya	The National Reproductive Health Policy, 2008, recognizes that women with disabilities are entitled to access to reproductive health services[337].
	South Africa	Women with disabilities are represented on the Commission on Gender Equality, which has a mandate to evaluate government policies, promote public education on gender issues, make recommendations to Government for law reform, investigate complaints and monitor Government compliance with international conventions[338].
Leadership	Dominican Republic	In the context of the 2012 the presidential election, efforts were made to increase awareness of the political rights of Dominicans with disabilities. A woman with disability was hired to manage the project; and a local organization of persons with disabilities tasked an all-female team to lead the project. Posters on voting that were distributed included images of women with disabilities[339].
	Tanzania	With the support of UN Women, gender advocates worked to support the participation of women, youth and persons with disabilities in the electoral process. A total of 102 women with disabilities were included in the 2014 electoral candidate lists at the national and local level as parliamentarians and councillors[340].

Conclusion and the way forward

The available data and trends demonstrate that women with disabilities continue to face barriers in access to education and employment. National policies and programs are often 'gender blind' and 'disability blind', leading to policies which do not accommodate for the needs and do not address the issues of women with disabilities. As result, women and girls with disabilities are often left out.

In addition, data disaggregated by disability, sex and age remains insufficient. Most of the significant global development reports across all sectors seldom include information on disability, and where available, is almost never disaggregated by both sex and disability. This hinders progress in developing targeted policy and program responses in socio-economic and civic and political participation.

In light of these barriers and gaps, a set of action points is needed to promote disability-inclusive development with a gender perspective. These action points should aim at dismantling the barriers that women and girls with disabilities face in realizing their human rights and achieving their full potential and include:

1. **Law and policy reform:** Strengthened implementation of laws, policies, strategies and programme activities[341] for women and girls with disabilities, including recognizing the positive role and contribution of women with disabilities and eliminate discrimination against women and girls with disabilities[342].

2. **Mainstreaming gender perspectives into disability:** Make sure that the disability actions, by the member states and the international organizations, include the concerns of women and girls with disabilities and the disability perspective into the gender mainstreaming strategies.

3. **Treaty monitoring process:** Strengthen reporting guidelines to encourage state parties to include standardized information on women and girls with disabilities in their states parties' reports on the implementation of international conventions. Organizations of women with disabilities should be encouraged to participate in the preparation of the states parties' reports, while preparing their shadow or alternative reports.

4. **Gender and disability responsive data.** Collect and analyse reliable data disaggregated by sex, age and disability and develop systems that measure and compare outcomes for

women and girls with disabilities in key sectors vis-à-vis men with disabilities and also women without disabilities.

5. **Strengthening the voices of women with disabilities:** through champions and role models promoting the abilities of women and girls with disabilities. Engage with organizations representative of women and girls with disabilities and ensure their consultation and participation in all aspects of legislation and policy development and within decision making forums relevant to human rights implementation.

6. **Establishment of bodies and focal points focussed on gender and disability:** Strengthen and increase support for institutional mechanisms for gender equality and the empowerment of women and girls[343] with disabilities at all levels. These should focus on the advancement and empowerment of women and girls with disabilities, and should be provided adequate resources and authority. A network of focal points across other government agencies can also assist in mainstreaming disability policies.

7. **Global alliances among women with disabilities and other partners:** Build up global alliances among women with disabilities and interested stakeholders, for example, UN entities, international, regional and local NGOs, academics and civil society partners including women's organizations. Specifically, organizations of and for women with disabilities at national level could be the first starting point for this initiative.

4.2.2 Children with disabilities

Children may be born with a disability or they may acquire one as a result of illness, injury or poor nutrition. Some children may have a single impairment, whilst others may have multiple impairments. The interaction between these impairments, personal factors and the environment mean that each child's experience of disability is different. A child's engagement in activities or ability to access services is primarily dependent on the inclusiveness and accessibility of these services, rather than the disability per se.

Barriers experienced by children with disabilities vary by context and age and are therefore not always the same as those experienced by adults with disabilities. Barriers include stigma and discrimination due to social norms rooted in fear or misunderstanding. Such social norms include ascribing blame for impairments on the behaviour or past sins of parents; fear of those who look or behave differently; and a lack of knowledge and understanding of the causes of some impairments and a misplaced fear of contagion. These societal attitudes and misconceptions may result in parents and caregivers ascribing a lower value to the rights or even the life of a child with a disability and hiding them away from the opportunities to realise their full potential.

Environmental barriers also exist, such as access to buildings, facilities or transport; a lack of assistive devices; policies which are not inclusive; service providers who are unaware of or ignore the rights and needs of children with disabilities; as well as information and communications which are not presented in accessible formats. Financial barriers impact the whole family. Having a child with a disability may restrict the income-generating capacity of parents which when coupled with the additional resources required for treatment, medications, assistive devices, learning materials, transport or other interventions, push families of children with disabilities further into poverty.

Childhood represents a unique opportunity for early interventions, which help to improve the lives of children with disabilities – their health status and developmental potential as well as their social inclusion in all aspects of life. Children with disabilities have dreams for their future life and the desire to fulfil them – they have the potential to be as socially engaged as all other children and grow up to be as economically and civically active as all other young adults.

This chapter will present international legislation on children with disabilities, give an overview of the status and trends of children with disabilities and present measures taken by countries to improve the situation of children with disabilities. It will end by listing measures which can improve the inclusion and participation of children with disabilities.

UN mandates

The United Nations Convention on the Rights of the Child (CRC) provide the same rights for all children, irrespective of whether or not they have a disability. Article 2 of the CRC stipulates that no child should be discriminated against on the grounds of disability. Article 23 addresses specific obligations by States Parties to the Convention to ensure that children with disabilities '*enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community*'.

More recently, the rights of children with disabilities have been articulated in the Convention on the Rights of Persons with Disabilities (CRPD), which stipulates that all possible measures should be taken to protect the equal rights of children with disabilities to family life, inclusive education, opportunities for play, freedom from violence, access to justice, birth registration and protection from forced sterilization. Article 7 of the CRPD reaffirms the obligation of States Parties to ensure that children with disabilities have the *right to express their views freely on all matters affecting them and enjoy all human rights and fundamental freedoms on an equal basis with other children.*

Together, these two Conventions are mutually reinforcing and provide the foundations for a human rights-based approach for efforts aimed at improving the lives and choices of children with disabilities in development and society.

Status and trends

a.   Birth registration

Children with disabilities are frequently not registered at birth. The absence of such birth registration may mean they lack any legal identity and therefore cannot access health, education or social protection services. For example only 29 % of children with disabilities in Ethiopia and 49 % of children with disabilities in Uganda are registered at birth.[344]

b.   Poverty and children with disabilities

Data shows that children in the poorest 60 % of households are at increased risk of disability compared with children in the wealthiest 40 % of households[345]. Social protection systems which aim at reducing poverty can also inadvertently reinforce exclusion for children with disabilities. Conditional cash transfer schemes, for instance, may require compliance with conditions that children with disabilities simply cannot meet due to the inaccessibility of the services or other barriers[346].

c.   Institutionalisation

Many countries, including increasingly in many low and middle income countries, have extremely high rates of institutionalisation of children with disabilities. These children are often removed from their families at birth or immediately following a medical diagnosis, at times against the expressed wishes of the parents.[347]

In an assessment of alternative care in 21 countries, it was found that in 13 countries, disability was listed as the 'root cause' of a child being placed in alternative care[348]. In 2007, one third of children in alternative care in Eastern Europe were children with disabilities.[349] The number of children in institutions in Serbia declined by 63% between 2000 and 2011,

whilst the number of children with disabilities declined by only 37%.[350] Girls with disabilities in many parts of the world are more likely to be institutionalised[351].

Children with disabilities in institutions tend to face a chronic deficit of physical and emotional attention and affection.[352] Research indicates that children with disabilities in institutions are 1.8 times more likely to be neglected and 2.8 times more likely to be emotionally neglected[353].

d.   *Children with disabilities are more vulnerable to neglect, exploitation and violence*

International research has shown that children with disabilities are almost four times as likely as their peers to suffer from physical violence and three times as likely from sexual violence[354]. Children with mental or intellectual disabilities were found to be almost five times more likely to be victims of sexual abuse than peers without disabilities[355]. Children in institutional settings are also more prone to physical, sexual and emotional abuse and this is exacerbated for children with disabilities[356].

The added stress or shame of looking after a child with a disability may cause family tension, neglect and abuse. Data from 15 countries showed that severe physical punishment was more likely to be meted out by family members on children with disability in seven of those countries[357]. In severe cases this neglect and abuse may even lead to infanticide or so called 'mercy killings' – a crime attracting lower penalties in many countries[358].

Children with disabilities may be specifically targeted for abuse or exploitation. A study of children working in the sex industry in Thailand, for instance, found that some brothels purposively trafficked girls with hearing impairments under the assumption that they could not ask for help or communicate with service providers[359].

Girls with disabilities in many parts of the world are at greater risk of sexual and physical abuse, forced sterilization and forced marriages[360]. Children with disabilities may

be denied recognition as competent witnesses in judicial proceedings or as decision makers by their families[361].

e. *Access to health care and assistive devices*

In high-income countries the mortality and morbidity of children with disabilities have seen a very distinct improvement over the past 20 years with advances in surgical and medical care. In many low and middle income countries only the children from the wealthiest households have access to similar services and the health and well-being of many children with disabilities is compromised by the lack appropriate services or medical support.[362] A similar case can be made for many assistive devices. The World Bank has estimated that only 5 -15 % of children and adults who require assistive devices have access to them. [363] This lack of access to even a simple device can turn an impairment into a disability for many children in low-income countries excluding them from learning opportunities and from reaching their full potential.

f. *Access to education*

Household survey data from 13 low and middle income countries show that children with disabilities aged 6–17 years are significantly less likely to be enrolled in school than their peers without disabilities. Disability impacts a child's probability of enrolment even more than gender or class[364]. Studies in southern Africa show that children with disabilities are only half as likely as their peers without disabilities to have ever attended school and this does not account for higher drop-out rates for children with disabilities[365]. In India, the difference between school attendance for children with and without disabilities is even greater, with close to 40% of children with disabilities not enrolled in schools[366].

When children with disabilities attend school, retention is often an issue. A 2008 survey in the United Republic of Tanzania found that children with disabilities who attended primary school progressed to higher levels of education at only half the rate of children

without disabilities[367].   What is preventing children from attending schools is not their impairments, but the multitude of barriers they face,. Many children with disabilities have the potential to succeed in formal education, but are not given the opportunity because the social, financial and environmental barriers are simply insurmountable in the absence of specific support and an education system that is inclusive.

Measures taken by countries to improve inclusion

Many countries are beginning to show success in fostering greater inclusion of children with disabilities. In relation to inclusive social protection schemes, Jamaica, for instance, has combined its conditional cash transfer programme to poor families with children up to 17 years of age with unconditional cash transfers for families caring for children with disabilities, along with free home-based health care visits.[368] In a number of countries in Eastern Europe, parental leave has also supported families taking care of children with disabilities. In Bulgaria and the Czech Republic, for instance, a parent in formal employment is eligible for paid time off work to look after a child with disability who requires medical care until the child's seventh birthday. In Hungary parents may take parental leave until the child reaches ten years of age.[369]

Responding to the increased vulnerability of children with disabilities to abuse, efforts have been made in a number of countries to support inclusive access to justice. In Zimbabwe, for instance, targeted services have been provided to children with disabilities in regional courts and police have now seek professional services as soon as a child with disability is identified as a survivor, witness or alleged offender. Stand-by teams of disability experts have been established in Harare, Masvingo, Mutare, Gweru and Bulawayo and seconded to each regional court. This has enabled improved communication and interpretation of evidence by court intermediaries in cases of abuse and rights violation that involve children with

disabilities, resulting in effective and consistent prosecution and expeditious adjudication of pending cases by magistrates and public prosecutors.[370]

Conclusion and the way forward

Children with disabilities are often not registered at birth. They are often put in institutions, where they cannot grow in a family environment and are often faced with neglect. They often face barriers in accessing education as well as health services and are often victims of exploitation and abuse.

To improve the situation of children with disabilities, awareness raising has to be undertaken at multiple levels, with families and parent groups, service providers, policy makers and legislators. Public awareness and advocacy campaigns need to be targeted at changing mind-sets and social norms directed at children with disabilities – emphasising an understanding of their rights and capacities as well as the challenges they face. More inclusive media is also critical to this. In addition, stigma and prejudice is most effectively addressed through contact – and children learning and playing together helps break down many social stereotypes and establishes norms of inclusion for life. Inclusive education and sport are essential for this.

One of the first steps to ensuring the legal protection of children with disabilities is to enforce the systematic registration of their births and their right to a legal identity. Protection systems also need to have the capacity to detect and respond to specific needs of children with disabilities in the case of violence, abuse, exploitation or neglect. Reporting mechanisms should be structured such that children, whose impairment prevents them from communicating directly, receive the appropriate support they need to report abuse.

Health services need to be made more accessible, both in terms of the physical environment, but also in terms of information and communication. Training and awareness raising on

disability is critical to this. Health workers and other service providers benefit from gaining a greater understanding of child development and disability, and from being trained to deliver integrated services – wherever possible in conjunction with parents and caregivers.

Good public health interventions should also include an emphasis on detecting potential impairments in children. Such screening and early interventions are crucial for children aged 0 – 3 because this is a period characterised by rapid development, especially of the brain. Developmental screening through health centres and parenting interventions such as home visiting programmes are important means of identifying and referring children for further care and support – including dietary supplements, drugs, assistive devices and good early childhood development programmes.

Strong integrated social protections systems are critical to ensuring children with disabilities are able to grow up in home settings which are conducive to their development and can access appropriate assessments and services. Children and families need to receive the financial and social support they require to encourage children with disabilities to develop to their full potential.

Parent's organizations should also be strengthened to help ensure children with disabilities are valued, cherished and supported in a family environment and in their communities. In addition, parents and caregivers need guidance and support in nurturing their children with disabilities through regular visits at home, community centres or other service centres with professional staff. Adequate resource allocations and social protection measures are required to ensure a range of service and care options are developed that can prevent family separation in the first place, and if such separation is necessary, that can offer care that best meets the individual needs of the child.

Children with disabilities, as well as their families and caregivers, need to be consulted and involved at all stages of policy design, service provision and accountability.

Finally, there is a very urgent need to improve the collection of data on children with disabilities and the barriers they face. Investments in sustainable data collection mechanisms and robust research tools are needed to continue to expand the knowledge base on children with disabilities. In order to identify the barriers they face in accessing education and the extent to which school systems are becoming more inclusive, education Management Information Systems (EMIS) using internationally agreed measurements of activity limitations and collect data on the accessibility of the system are crucial.

4.2.3 Youth with disabilities

Youth[371] with disabilities often face marginalization and severe social, economic, and civic disparities as compared to youth without disabilities due to a variety of factors ranging from stigma to inaccessible environments. Youth with disabilities are affected by their experiences as they transition from childhood into adulthood and these experiences similarly spill over into the remainder of their adult lives. For many young people with disabilities, exclusion, isolation, and abuse, as well as lack of educational and economic opportunities are daily experiences.

Disparities in education, employment, and relationships are more pronounced for youth with disabilities compared to youth without disabilities. Like adults with disabilities, youth with disabilities do not enjoy the same human rights or equal access to goods and services as peers without disabilities. Youth with disabilities may lack opportunities to receive an education due to inaccessible school systems, which will in turn impact their vocational skills and ability to accumulate capital and social assets as adults.[372] Without equal opportunities to obtain and retain employment and economic self-sufficiency, youth with disabilities will have to be highly dependent on other household members or Government welfare which negatively impacts household assets and a country's economy.

Youth with disabilities also face severe challenges in exercising their basic rights and for most, full societal acceptance is often out of reach. Youth with disabilities face political and civic disenfranchisement and may experience barriers in youth-driven or youth-focused political and civic participation activities due to the inaccessibility of physical and virtual environments.

UN mandates

The World Programme of Action for Youth (WPAY) adopted by the United Nations, in 1995, calls upon states to pay particular attention to the education of youth with disabilities. The

United Nations Convention on the Rights of Persons with Disabilities further recognizes the importance of ensuring that all persons with disabilities, irrespective of age, enjoy the same human rights as everyone else and provides a framework for legal, civic, and socioeconomic empowerment.

More recently, the 2013 United Nations General Assembly High-level Meeting on Disability and Development recognized the multiple or aggravated forms of discrimination youth with disabilities can be subject to. The importance of addressing the needs and concerns of youth with disabilities was particularly noted in relation to development policies, including those regarding poverty eradication, social inclusion, full and productive employment and decent work, access to basic social services and decision-making processes.[373]

Status and trends

Estimates suggest that there are between 180 and 220 million youth with disabilities worldwide and nearly 80% of them live in developing countries.[374,375] Although the actual figures are uncertain, it is clear that individuals with disabilities form a significant proportion of the youth population in every society. The number of youth with disabilities is likely to increase due to youthful age-structures in most developing countries and medical advancements which promote higher survival rates and life expectancy after impairment-causing diseases, health conditions, and injuries. Being a youth can also be a contributing factor, as young people have been found to be at a higher risk of acquiring a disability through incidents such as road traffic accidents, injuries from diving and other sport activities, violence and warfare.[376]

a.   *Poverty*

Young people constitute a major proportion of those living in poverty across the world. Almost 209 million live on less than US$ 1 a day, and 515 million live on less than US$ 2 a

day.[377] Youth with disabilities face dual disadvantages, as individuals with disabilities are more likely to live in poverty even in developed countries such as the United States, where 29% of persons with disabilities of working-age in 2013 were living in poverty compared to 14% for working-age civilians without disabilities.[378] It has been estimated that 30% of youth living on the streets have a disability.[379]

b.   Education

There are obvious differentials in educational outcomes for young persons with disabilities vis-à-vis the population without a disability. Figure 20 shows that, in all 17 countries but one, youth with disabilities are less likely to attend school than youth without disabilities. In some countries, the percentage of youth attending school is almost double for youth without disabilities than for those with disabilities. Youth with disabilities often drop out of school due to lack of accessible schools and education materials or because it is judged not to be worth to invest in their education.[380] Some families do not feel that youth with disabilities should receive an education, often believing that young people with disabilities are incapable of learning.[381]

Figure 20. Percentage of people 15 to 24 years of age, with and without disabilities, attending school, in 17 countries, 2000-5
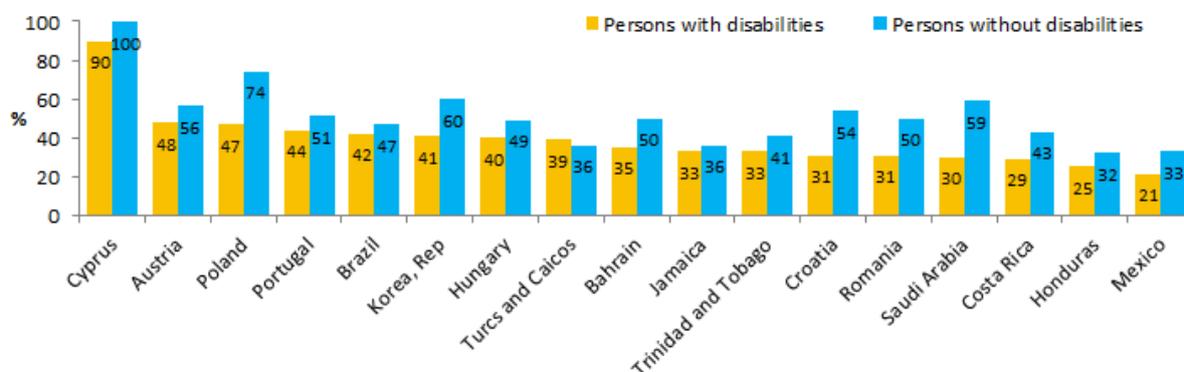
Note: As countries use different methods to collect data on persons with disabilities, these data are not internationally comparable. Despite these differences in methodology, there is a consistent gap across countries on school attendance for youth with and without disabilities.

Source: Data from censuses, surveys and administrative sources for the respective countries[382]

### c.   Independent living and employment

Many young individuals with disabilities face a difficult period of upheaval and uncertainty as they transition from childhood into adulthood, primarily in the area of achieving successful employment and independent living. In developed countries where there are established services to support youth under the age of 18 to advance through school, a sudden lack of individualized support and services, and the need to fight for appropriate accommodations can become a barrier.[383] The lack of an enabling environment supporting youth development in all aspects, including education and health care, is critical for successful transitions into adulthood.[384] Inequities in, and inaccessibility to these systems for youth with disabilities makes their transition even more difficult and barrier-prone than their peers without disabilities.[385]

Youth with disabilities are also less likely to be employed than youth without disabilities.[386] Figure 21 illustrates that youth with disabilities experience relatively poor

employment outcomes relative to their peers without disabilities. These early disparities may contribute to the significant gaps in employment earnings between working-age adults with and without disabilities that has increased over the past two decades.[387] It is also clear from existing data that young adults with disabilities receive lower wages than their peers without disabilities. Although insight to the reasons for wage offer differentials is still somewhat limited, unobserved factors such as discrimination and policy environment have been found to play a significant role in explaining the lower wage offers for youth with disabilities.[388]

Employment creation schemes for youth with disabilities sometimes focus on supporting the development of individual micro-enterprises and self-employment. This approach, although valuable as a means of livelihoods creation, could perpetuate the segregation of youth with disabilities in the labour market if not accompanied by efforts to support the employment of youth with disabilities among employers in the public and private sectors. Good practices for employing youth with disabilities depend on employers becoming 'barrier free'. This means the removal of all barriers faced by youth with disabilities in terms of competing for work and becoming skilled employees, as well as provision of reasonable accommodation for youth with disabilities in the workplace.[389] Based on a review of good practices, transitioning of youth with disabilities into the work force requires specific consideration and planning, including partnerships with organizations specializing in disability services; support for skills trainings; tailored recruitment and job placement services; and the development and implementation of inclusive, equal opportunity policies are essential.[390]

Figure 21. Percentage of population aged 15-24 who is employed, for youth with and without disabilities, in 18 countries, 2000-5[391]
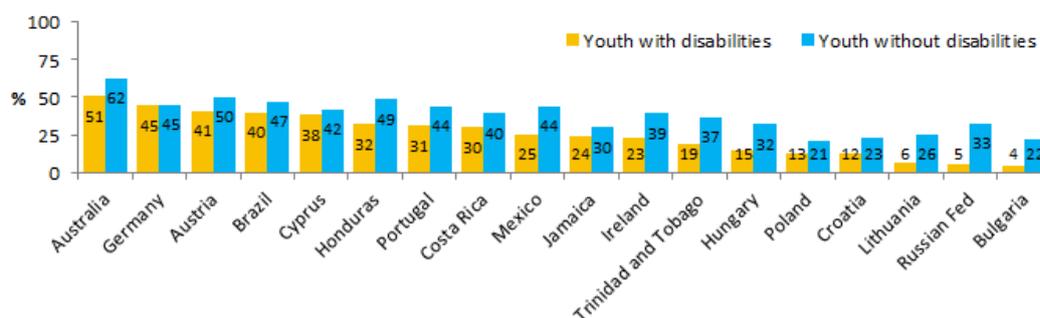
Note: As countries use different methods to collect data on persons with disabilities, these data are not internationally comparable. Despite these differences in methodology, there is a consistent gap across countries on the employment for youth with and without disabilities.
Source: Data from censuses, surveys and administrative sources of the respective countries.[392]

d.   Sexual and reproductive health

In relation to sexual health and wellbeing, youth with disabilities are at a disadvantage as, in most places, society incorrectly believes youth with disabilities are asexual and/or cannot be abused.[393] The lack of social acknowledgment of their sexuality has several negative consequences for youth with disabilities. Access to reproductive health information is often not available to youth with disabilities, or disseminated through such inappropriate means as inaccessible clinics, inaccessible print or electronic media, or by providers who cannot communicate with youth with disabilities.[394]

Few education programmes cater to the sexual and reproductive needs of youth with disabilities. For example, in several countries youth with disabilities often do not receive advice on HIV/AIDS, as the clinics are physically inaccessible, material is not available for those with visual impairments, and providers are unable to communicate in sign language. Well-meaning parents may not acknowledge their children as sexual beings and discourage them from expressing any form of sexuality.[395] Many youth with disabilities may absorb and accept these negative beliefs as facts and refrain from sexuality and intimacy altogether.[396]

Other youth with disabilities may have relationships, but, without receiving appropriate education, may undertake high risk activities.

e.   Families caring for youth with disabilities

The family is the central unit in the lives of most youth. For some families, having a child with a disability may bring them closer together, but for others it can pose significant challenges. In many places, there is considerable societal stigma imposed on families with young members with disabilities. Societal discrimination and negative attitudes arising from misconceptions, stereotypes, and myths, such as disability being a punishment for past sins or signs of a curse, are still predominant in a significant number of countries. Members of communities holding such negative attitudes may disassociate themselves from individuals of that family and greatly diminish the young individuals' chances for community participation and social inclusion. It is not uncommon for families in these societies to respond by hiding young persons with disabilities at home and limiting their interaction with the community.[397] Some youth with disabilities may be in a vulnerable position within their family, as persons with disabilities are more likely to be subjected to physical or sexual abuse than the rest of society.[398] Many youth with disabilities are institutionalised during their adolescence as their families find it too difficult to manage with limited resources or are too old to care for a grown individual.[399]

Families, parents, and caregivers of youth with disabilities are also hindered by lack of information and knowledge on resources and services to support youth with disabilities. A shortage of resources and facilities such as Government assistance, inclusive education facilities, awareness about the rights of youth with disabilities, and public and private accessible facilities for social participation further isolate families who may not know the most effective ways to ensure equal participation in society. In some cases, there are limited

avenues for continued medical support and rehabilitation beyond the immediate acquisition of a disability.

f.   Government support

Cultural context is another key factor in the interplay between family and Government support for persons with disabilities. In cultures where disability is looked upon solely as an individual or family concern or is stigmatized, Governments may not fund adequate support programmes or initiate programs for educational and economic participation. In other cases, where persons with disabilities are looked upon with pity and presumed to be unable to be as productive as persons without disabilities, Governments may only offer financial support such as cash benefits and welfare programs. While financial support may be essential for some families, awareness and knowledge about effective practices for empowerment and services to support equal participation are crucial.

g.   Political participation of youth with disabilities

Youth have been increasingly influential in recent years in crucial political movements and are a key constituency for political advocacy and civic change, especially with the increased usage of social media and other internet driven mechanisms for civic participation.[400] However, youth with disabilities may be unable to participate in social change and political movements, make informed choices about voting and political decisions, or be active citizens due to accessibility barriers in physical and virtual domains of participation including access to information and meeting venues.[401] Youth with disabilities may be disenfranchised if they are unable to vote either due to accessibility barriers at the polling stations and booths or due to laws and policies that prohibit them for having the right to vote because of their disability.[402]

With the evolution of information and communication technology (ICT), it has become easier for young people with disabilities to exercise their civil and political rights, and they have

increased opportunities to interact with persons without disabilities to exchange opinions and have conversations and debates. Social media and ICT-enabled information exchange can help raise the awareness of youth with disabilities of their rights and duties. Similarly advocates and political candidates are increasingly using technology to reach out to voters, and the use of accessible ICT will promote their outreach to youth with disabilities.

Conclusion and the way forward

There is a significant shortage of empirical research on prevalence of disabilities among the youth and their living conditions. Existing evidence shows that youth with disabilities have less access to education and employment than their peers without disabilities. Youth with disabilities also tend to face greater barriers to participation in political and civic life due to the inaccessibility of information or platforms and tend to be excluded in programmes of reproductive and sexual health education. Families, the primary care-givers of many youth with disabilities, often have no support services to assist in the daily challenges.

The experiences that people face in their youth shape the rest of their lives. Providing opportunities for full and equal social, civic, economic, and political participation is beneficial not only to youth with disabilities, but also their societies and countries as the youth can contribute fully to the country's development and economic growth. This will also help inclusion when these youth reach adulthood.

Measures that can support better inclusion of youth with disabilities include:

- Developing inclusive education infrastructure and systems for all youth, with and without disabilities, where youth with disabilities can benefit from equal access to education and skills training side by side all youth.

- Providing regular training to teachers on educating youth with special educational needs.

146

- Creating support services for youth with disabilities to access employment, including through skills training; access to finance programs; skills-matching and internship and apprenticeship programs.

- Implementing inclusive policies and creating awareness campaigns for the private sector to address preconceived prejudices against persons with disabilities. Promoting equal opportunities and implementing reasonable accommodation in workplaces. Developing incentives for the hiring of youth with disabilities through quota systems, tax incentives and other means.

- Providing support for families caring for young persons with disabilities, through a range of public services, such as health and education care support, assistance with transportation and through the provision of information and outreach.

- Actively engaging with organizations of persons with disabilities representing youth with disabilities to develop support services that are responsive to local conditions and barriers.

- Ensuring health care services provide general and reproductive health care information and guidance to youth with disabilities and their families.

- Promoting the active engagement of youth with disabilities in political and civic affairs through systematic dissemination of information and materials in accessible formats.

4.2.4 Older persons with disabilities

Older persons with disabilities contain two groups with distinct needs and challenges: persons who acquired a disability before reaching old age and those who acquire disabilities as they age. Those who had acquired a disability previously in their lives or who had been born with a disability often face major challenges as they age: they may acquire additional disabilities; they may lose caregiver and financial support as their parents and other family members die; they are less likely to have economic assets to sustainably support themselves as they more often experienced higher poverty and lower access to education and employment during their lives.

On the other hand, persons who acquire disabilities as they age are more likely to have the assets and children to support them. They may however experience more difficulties in seeking and using assistive devices and technology, including ICT, as they do not have previous experience in using these.

Despite these differences in financial stability and support, both groups aspire to age healthily. They both need access to health care, employment and social coverage, to adequate nutrition and housing, and to be able to fully participate politically, socially and economically in society.

The two groups are seldom studied separately. Using existing evidence, this section will analyse the group of older persons with disabilities as one group. However, existing differences should be kept in mind. After describing existing UN mandates focusing on disability and ageing, this section will illustrate the situation of elderly with disability in employment, health care and use of assistive devices.

UN mandates

The Madrid International Plan of Action on Ageing and the Political Declaration,[403] adopted in 2002, acts as a flagship for the advancement of older persons in international development. The Declaration calls for "*older persons to be treated fairly and with dignity, regardless of disability*"[404]. The Declaration references adaptive work environments for older persons with disabilities[405], employment opportunities and flexible arrangements for persons with disabilities who want to work[406], implementing programmes "*to sustain the independence of (…) older persons with disabilities*"[407], as well as action in vocational training[408], eradication of poverty[409], promotion of disability insurance and accessible health services and provisions[410], including universal access to health-care services[411]. The Declaration underscores the need for national policy and programming to focus on issues concerning older persons with disabilities, and to develop appropriate policies, physical and mental rehabilitation services, age-friendly standards and housing options for older persons with disabilities[412]. This includes barrier free and inclusive spaces[413].

Status and trends

Since the prevalence of disability increases with age, older persons are disproportionately represented among those with disabilities. For instance, although the elderly constitute only 7% of the total population in Sri Lanka, they constitute 23% of the population with disabilities. Similarly, in Australia, those percentages are 11% and 35%, respectively (Figure 22). As the number of people reaching an older age is expected to triple in less than a century, from 900 million in 2015 to 3.2 billion in 2100, the number of older persons with disabilities is expected to significantly increase as well (Figure 23).

a.   Economic Situation

The economic situation of many people living and ageing with disabilities is on average much lower than the general population[414]. There is evidence that persons with disabilities

face higher rates of poverty than their non-disabled counterparts, and studies suggest that older individuals are more prone to poverty than the younger generations.[415] These trends leave older people living with disabilities at a greater risk of residing in poverty and reduced access to many assistive technologies and basic health care, all of which necessary for successful ageing with disability.

Figure 22. Percentage of older people in total population and in the population with disabilities, in Australia and Sri Lanka, 2001-3
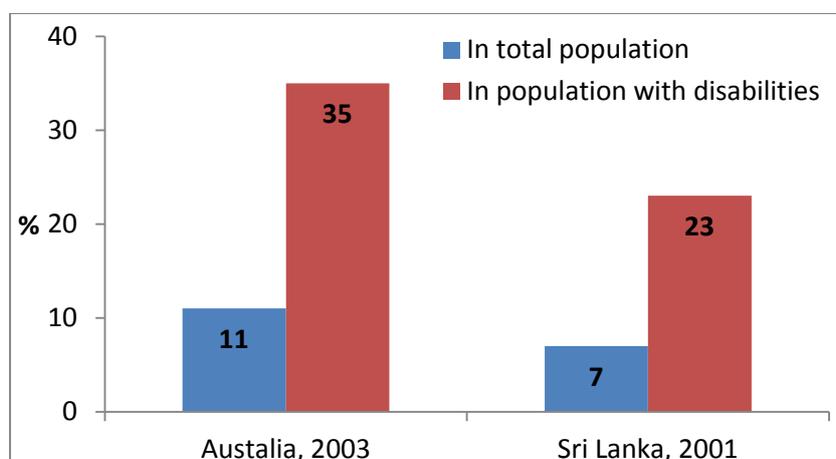
Source: WHO (2011),[186] p.35.

Figure 23. Population 60 years old and over, 1950-2015[416]
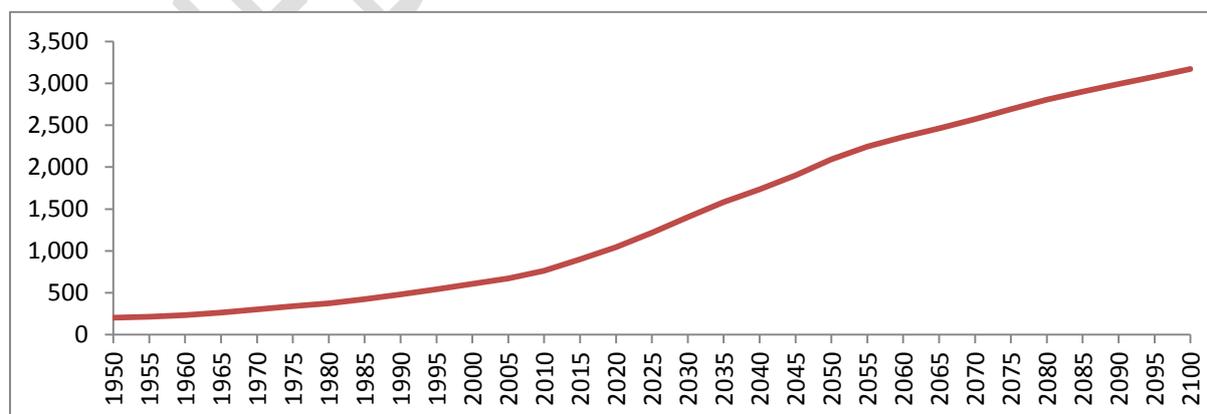
Source: World Population Prospects: The 2015 Revision.

b.   Employment

Like in earlier stages of life, differences between the participation in the workforce for older persons with and without disabilities are significant. Persons over the age of 60 with a disability are less than half as likely to participate in employment (10.4%), as compared to non-disabled counterparts (26.8%)[417]. Although in some cases, as people age and acquire a disability they may opt for stopping working, the persistent disadvantage in access to employment across all age groups (see section 3.1.2 on Employment) suggests that many elderly with disabilities who would like to work are not able to do so due to barriers associated to their disabilities.

c.   Access to healthcare

Unaffordable health care is a barrier for older persons with disabilities, with 39% of elderly[418] persons with disabilities reporting to be unable to afford a health care visit,[419] although this is less of a barrier than for the younger generations (59% for those aged 18-49). Compared to younger persons with disabilities, however, the older persons with disabilities more often do not know where to go for health care (17%).[419] The older persons with disabilities tend to report less difficulties in access to health care financing than younger persons with disabilities, and they are less often victims of catastrophic health expenditures. However, even for the elderly, catastrophic health expenditures are too common as 26% of the elderly suffer them in low-income and low-middle income countries.[420]

Figure 5 illustrates the barriers older persons with disabilities experience when requiring access to medical services. Compared to non-disabled older persons, older persons with disabilities are found to be four times as likely to be treated poorly during the receipt of medical services (14% versus 4%) and three times as likely to be completely denied services (26% versus 3%).[419]

Figure 24. Barriers to seeking necessary medical services, disaggregated by disability, for individuals 60 years and over, in 51 countries, 2002-4
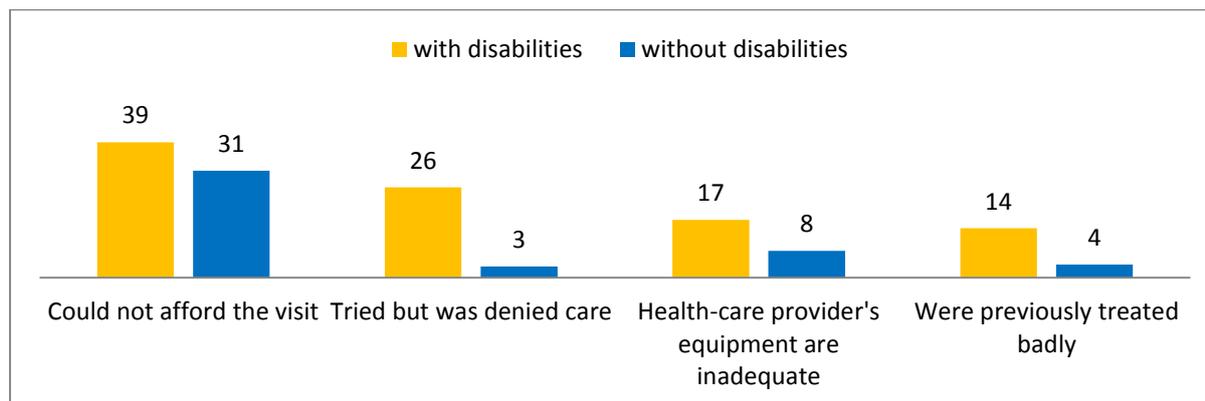
Source: WHO (2011),[186] p.64.

d.   Technological and Assistive Aids

The advancements and opportunities from different technologies contribute to healthy and successful aging for those with disabilities, and assistive devices create opportunities for individuals to meet their independence needs.[421] Among older persons who are disabled, those who use only equipment and no personal care report less difficulty with mobility than those who use personal assistance (either alone or in combination with equipment) but the use of equipment alone is most effective for those with the least severe limitations.[422,423]

Although computer-based and information technologies can contribute to inclusion of all disabled including older persons, it is known that the current cohort of older persons is less familiarized with these technologies.[424] People who acquire disabilities later in life have more difficulties in using assistive devices as they did not had an opportunity to learn to use them earlier in their lives.[425,426]

Conclusion and the way forward

As disability increases with age, older persons are over-represented among the disabled. With the global population of older persons increasingly growing, and projected to reach two billion by 2050[427], older persons will become even more over-represented. In spite of the

different challenges experienced by those who acquired disabilities previously in their lives and those who acquire a disability as they age, all older persons with disability aspire to participate fully in their societies through access to health care, employment, social protection, adequate nutrition and housing, among others. Yet, the evidence illustrates that older persons with disabilities are more likely to be poor and less likely to be employed and to access health care than their non-disabled peers. Although technology and assistive devices can contribute to improving participation of the elderly with disabilities, the digital divide between younger and older generations still prevents the current elderly cohorts from fully benefiting from ICT.

Inclusion in society and independence for older persons with disabilities will translate into improved standards of living and quality of life. Several measures can contribute to healthy ageing of persons with disabilities:

- Provide healthcare services for older persons with disabilities. This may require training as well as and raising awareness on ageing and disability among medical practitioners.

- Establish support systems for older persons with disabilities who lose caretaking and financial support from their families.

- Establish structured support networks for (i) persons who acquire a disability due to ageing; (ii) persons with disabilities who acquire additional disabilities in addition to existing disabilities, as they age. [428] For example, peer-implemented groups have been established for helping those with existing physical disabilities to deal with depression[429] and those with reduced disability due to Alzheimer's disease[430].

- Ensure equal access to vocational and employment activities for older persons with disabilities.

- Provide suitable recreational and social activities for older persons with disabilities.

- Develop more effective policies to make assistive technologies more widely accessible and affordable for older persons with disabilities.

- Establish training support dedicated for older persons with disabilities to learn to use and benefit from ICT technologies.

4.2.5 Indigenous persons with disabilities

Indigenous persons with disabilities often experience multiple forms of discrimination and face barriers to participation and the full enjoyment of their rights, based on both their indigenous identity and disability status[431]. While there is a need to better integrate indigenous persons with disabilities in society, this integration must respect the cultural background of indigenous persons. Often, legislation and policies designed for persons with disabilities aim at ensuring the full inclusion of those persons in mainstream society, but indigenous peoples tend to be wary of any form of mainstreaming that may lead to assimilation and threaten their languages, ways of life and identities. Access to services, education, transportation and employment of indigenous persons with disabilities must be improved in a culturally appropriate manner.

This chapter provides an overview of the status of indigenous persons with disabilities by looking into the different UN mandates that guarantee the rights of indigenous persons with disabilities and by presenting the current status of indigenous persons with disabilities. The chapter also identifies measures that different countries worldwide have already implemented in order to strengthen the inclusion of indigenous persons with disabilities. Finally, the chapter provides recommendations and measures to improve the situation of indigenous persons with disabilities

UN mandates

The rights of indigenous persons with disabilities are protected by the United Nations Declaration on the Rights of Indigenous Peoples and the Convention on the Rights of Persons with Disabilities. The United Nations Declaration on the Rights of Indigenous Peoples specifically mentions persons with disabilities in Article 21 claiming that all states parties should take effective, and when needed special, measures in ensuring the improvement of indigenous people's economic and social conditions, emphasising persons with disabilities.

Moreover, Article 22 states that in implementing the Declaration special attention should be paid on persons with disabilities.[432] In the Convention on the Rights of Persons with Disabilities, indigenous persons are mentioned in the preamble in the context of the multiple forms of discrimination that persons with disabilities are subjected to.[433]

The outcome document of the 2013 High-Level Meeting on Disability and Development, organized by the UN General Assembly, calls for all development policies and their decision-making processes to take into account the needs of and benefit all persons with disabilities including those of indigenous peoples[434]. The outcome document of the High Level Meeting on Indigenous Peoples, also known as the World Conference on Indigenous Peoples, also makes a broad reference to indigenous persons with disabilities by committing to promote and protect the rights of indigenous persons with disabilities and improving their social and economic conditions. Moreover the outcome document calls for national legislative, policy and institutional structures which are inclusive of indigenous persons with disabilities.[435]

Status and trends

There are about 360 million indigenous people in the world and they make up to 4.5% of the world's population. It has been estimated that 15% of the world's population lives with a disability. Applying this percentage to the estimated amount of indigenous persons, the number of indigenous persons with disabilities would be approximately 54 million worldwide[436]. However, existing data suggest this number may be higher.

Available statistics show that indigenous persons are often more likely to experience disability than the general population. For example, in 1991, 24% of Canada's indigenous population between 25 and 34 years of age reported a disability (versus 8% for the total population), the rate going even up to 36% concerning the people aged between 34 and 54 (versus 14% for the total population).[437] In the United States, 27% of all American Indians

and/or Alaska Natives aged 16 to 64 reported a disability in 2009 (versus 16% for non-Hispanic Whites).[438] In Australia, about half of indigenous adults reported a disability in 2008[439], while the national figure has been estimated at 19% in 2009.[440] In New Zealand, in 2006, after adjusting for the age structures of the two populations, the age-standardized disability rate for Maori was 19%, compared with 13% for non-Maori.[441] In Latin America, available statistics for seven countries (Brazil, Colombia, Costa Rica, Ecuador, Mexico, Panama and Uruguay) show that there is a higher rate of disability among indigenous persons than the rest of the population. In Brazil and Colombia, however, the rate is lower among indigenous children. For persons aged 19 and older, there are more indigenous persons with disabilities than non-indigenous for all seven countries, with sizeable gaps in Costa Rica and Uruguay[442].

Many indigenous persons with disabilities are excluded from participating in and benefiting from culturally and otherwise appropriate development. Indigenous families face several obstacles relating to access to education. Studies show that indigenous students have the highest drop-out rates from public schools, the lowest academic achievement levels, the lowest rates of school attendance as well as low levels of participatory post-secondary education.[443,444,445] In addition to educational issues, many indigenous families live in poverty and lack equal access to appropriate health services; work and employment;[446] social protection, sanitation; assistive devices including mobility aids and health and rehabilitation services; as well as to food and clothing, among others[447]. For example, in New Zealand, more Maori persons with disabilities are living in poverty or have no educational achievements, as compared with non-Maori persons with disabilities[448].

Indigenous persons with disabilities face a broad range of challenges in relation to access to the justice system, including physical inaccessibility to police stations, domestic or traditional courts as well as inaccessibly of proceedings, which may not be conducted in

relevant languages or appropriate assistive devices or technology may not be available to make them accessible. [449] Access to information and appropriate services, including forensic services, appropriately trained law enforcement and medical services in instances of criminal cases, to support access to justice are often lacking[450]. While data are scarce, those available suggest that indigenous persons with disabilities also experience disproportionately high rates of incarceration[451].

Lack of support and services for families with indigenous children with disabilities has led to the displacement of families from their communities and often to the separation of children from their families and communities. In many societies, indigenous peoples suffer intergenerational trauma caused by, among other things, forced assimilation and placing indigenous children with disabilities into institutions[452]. Placing children into institutions hinders the child's integration into the society, while they also loose contact to their families and especially their own indigenous culture.

Available evidence shows that girls and women with disabilities are at higher risk of violence than girls and women without disabilities.[453] Moreover, indigenous women are often disproportionately victims of sexual violence.[454] In terms of realization of their rights, as well as access to redress and to remedies for human rights abuses, indigenous women with disabilities often face a complex set of barriers relating to gender, indigenous identity and disability.

A high proportion of indigenous persons with disabilities dies or suffers injuries during disasters because they are rarely consulted about their needs and Governments lack adequate measures to address them[455]. The risk of exposure of indigenous persons with disabilities to disasters and emergencies may be elevated because indigenous peoples often live in areas of particular risk relating to climate change, the environment, militarization and armed conflict and because of the impact of extractive industries.

Measures taken by countries to improve the situation of indigenous persons with disabilities

Member States have been establishing programmes or projects promoting participation of indigenous persons with disabilities. These programs cover issues such as school inclusion, self-employment, access to health services, transportation and employment as well as developing accessible tourism (Table 15).

Table 15. Projects or measures taken by different organizations or countries

	Project/Measure	What it entails
Canada[456]	Assisted Living Program (ALP)	The purpose of the programme is to provide social support services to eligible people living on reserves across Canada, including: in home care, foster care, institutional care and the disability initiative
	Income Assistance Program (IAP)	The programme provides financial support for basic and special needs such as special diets, service dogs, special transportation, child care, accommodation, transportation and more
	Special Education Program	The programme ensures that First nations students with moderate, severe, or profound behavioural and/or physical

		challenges have access to the services and support required, providing access to special education programs and services that are culturally sensitive and meet the relevant provincial or territorial standards.
	Aboriginal Human Resources Development Strategy	The Strategy is a Federal program that funds 79 Aboriginal organizations to provide employment support and human resources programs across Canada. It has earmarked $3 million out of the total budget of 1.6 billion (2%) for aboriginal people with disabilities who have never worked before.
	National Youth Solvent Abuse Program	The programme provides access to culturally appropriate, community-based prevention, intervention, treatment, and aftercare programs to First Nations youth who are addicted to or are at risk of becoming addicted to solvents.
Ecuador[457]	Project 2015 – 2017 for supporting indigenous women and youth to incorporate themselves in	The project promotes self-employment of indigenous women and youth with disabilities in accessible tourism and improving the capacities of the public and

	the accessibility tourist sector in regions of Orellana, Cotopaxi and Esmeralda	private sector in relation to accessible tourism. Project's activities include: establishment of a capacity programme on self-employment on accessible tourism for indigenous women and youth with disabilities, creation of a fund to provide micro credits to selected beneficiaries, a training programme on accessible tourism to public servants in the Ministry of Tourism and local governments in the three regions; the design of an interactive website on accessible tourism and the launching of a campaign on accessible tourism.
Mexico	A programme for children with disabilities in rural and indigenous communities[458]	The programme addresses issues of school inclusion and community attitudes, ensuring an inclusive approach to children with disabilities at the state and municipal levels. Multidisciplinary teams made up of a doctor, a physical or occupational therapist, an education specialist and two community promoters were deployed in the community and financed by the state agency for family development (DIF). The community promoters were men and

women recognized in the local community, with a command of local indigenous languages. The approach addressed equity issues in several dimensions, given that children with disabilities, living in rural communities and of indigenous origin, are doubly or triply excluded from services and community life.

The National Programme for the Development and Inclusion of persons with Disabilities[459]	Strategy 1.6 promotes social inclusion of all persons with disabilities, including rural areas and indigenous peoples. Line of action 1.6.9 aims at carrying out an outreach project in indigenous languages of the rights of persons with disabilities; and action 1.6.10 aims at easing the access to indigenous peoples to the programmes for persons with disabilities. Strategy 3.4 promotes the labour inclusion of persons with disabilities in rural areas and for indigenous peoples and strategy 4.1 promotes inclusive education policies to favour access and permanence of persons with disabilities including

		indigenous peoples.
USA[460]	Vocational rehabilitation services projects for American Indians with Disabilities	A project to assist tribal governments to develop or to increase their capacity to provide a program of vocational rehabilitation services, in a culturally relevant manner, to American Indians with disabilities residing on or near Federal or state reservations. The program's goal is to enable individuals, consistent with their individual strengths, resources, priorities, concerns, abilities, capabilities, and informed choice, to prepare for and engage in gainful employment. Program services are provided under an individualized plan for employment and may include native healing services. In order to qualify for this benefit program, the person must be Native American/American Indian with a disability and must be enrolled in a Federally recognized American Indian tribe or Alaskan Native village.

Conclusion and the way forward

Indigenous persons with disabilities are an especially vulnerable group and easily left in the margins and excluded from the rest of the society. Even though the rights of indigenous

persons with disabilities are guaranteed in United Nations Declaration on the Rights of Indigenous Peoples and the Convention on the Rights of Persons with Disabilities, there is a lot to be done to improve the living conditions and access to services among indigenous persons with disabilities.

Existing studies suggest that the prevalence of disability is higher among indigenous than non-indigenous communities. Indigenous persons with disabilities are more likely to experience poverty and tend to be at a disadvantage in access to education, to health services, to employment, to social protection, sanitation and to assistive devices.

Several countries have taken action in enhancing the livelihoods of indigenous persons with disabilities by starting projects and programmes that promote participation of indigenous persons with disabilities. In addition to the already existing projects, several other measures can be considered:

- Consult indigenous persons with disabilities in any decision making process with an impact on them, to enable them to be heard and to ensure that they are empowered to claim their rights.

- Guarantee accessible education for indigenous children with disabilities, while respecting cultural rights. Promote employment, including self-employment, among indigenous persons with disabilities.

- Design legislation and policies designed for indigenous persons with disabilities which are respectful of indigenous cultures and ensure that indigenous persons with disabilities are supported to fully take part in the life of their communities.

- Guarantee the birth registration of indigenous children with disabilities and take measures to prevent infanticide of indigenous children with disabilities.

- Produce and disseminate disaggregated data on indigenous persons with disabilities which can inform development goals as well as on the actual well-being and inclusion

of indigenous peoples. The situation of indigenous persons with disabilities must be taken into account in efforts to develop new statistical tools that will reflect the situation of indigenous peoples in a culturally sensitive way.

4.2.6 Refugees

By the end of 2014, more than 59 million people had been forcibly displaced from their home and/or country around the world.[461] In spite of common assumptions that persons with disabilities cannot or do not travel, it is now well established that a sizeable proportion of any population of refugees are persons living with disabilities, including invisible disabilities such as mental health conditions, visual or hearing impairments.

There is great diversity in the experience of refugees with disabilities. Refugees acquire disabilities at different points in time: while in their country of origin, in fleeing, after arriving in a host country. The causes – and outcomes - are equally varied. The lived experiences of refugees with disabilities illustrate plainly the role that environment and opportunity play in disabling people - either by creating impairments or by failing to accommodate the needs of persons with disabilities.

Status and trends

Recent research confirms that refugee populations do indeed include persons with every type of disability – and frequently in greater numbers than in societies unaffected by war or catastrophe. In some cases, disability can contribute to the decision to flee, be it for treatment, or to avoid disability-specific persecution. Other refugees will acquire impairments while fleeing or when displaced.[462]

However, under-identification of disabilities is common among refugees because the identification process is often based on self-identification or the perception of the officer registering the refugee. In some settings, individuals are reluctant to self-identify to avoid stigma. Officers tend to only record visible disabilities. Therefore, sensory and mental disabilities are less likely to be identified than physical disabilities.[463] For example, disability prevalence rates among refugees have been recorded at 0.21% in Malaysia and 0.64% in Indonesia in 2012; and 1.71% in a settlement in Uganda in 2013. These values are much

lower than the estimated global disability prevalence.[464] In Pakistan, in 2011, a distinct approach using questions similar to the Washington Group Disability Questions[465,466] led to a disability prevalence amongst Afghan refugees of 15% of the adult population, on par with global estimates.[467]

Older people are statistically much more likely to experience disability.[468] This is equally true for refugee populations. A majority of older Syrian refugees (60 years and above) in Jordan and Lebanon have both a chronic illness and impairments. In 2014, 60% of a surveyed group reported problems undertaking daily living activities, with 65% experiencing psychological distress.[469] In 2013, disability prevalence amongst older Afghan refugees in Pakistan was found to be higher than global estimates (47% versus 43%).[470] Research suggests that refugees with disabilities may be more vulnerable to physical, sexual and emotional abuse.[471] Refugee children with disabilities tend to have more difficulties in accessing schools. In Jordan, in spite of stated policies that refugee children should have access to education, very few refugee children were found to be attending school – much less those with disabilities.[472]

Measures taken to improve the situation of refugees with disabilities

UNHCR has developed guidance documents for implementing the CRPD in the field.[473] This lead to marked changes in attitude to disability as an issue in the management of refugee populations. Countries hosting large numbers of refugees and displaced persons are now providing refugees with access to health, rehabilitation as well as (mainstream and specialised) education facilities, assisting their integration and participation. In Uganda, local disabled people's organizations (DPOs) have broadened their activities and facilities to include refugee populations.

Steps to implement the CRPD have been or are being taken in many countries. Examples include Uganda's move to provide refugee and host community staff with

sensitization training, or awareness raising opportunities. In the settlements of Nakivale and Oruchinga in the country's south, attempts have been made to house refugees with disabilities close to the central management hubs or 'Base Camp'. Housing such refugees near the administration's headquarters operates, at least in theory, to provide increased protection to vulnerable persons both in terms of their personal security and access to health, nutrition and other support services.

In Pakistan, the Government and UNHCR adopted a Washington Group 'functionality' approach to identifying disabilities when conducting a verification exercise involving nearly one million Afghan refugees in 2011. This approach involves asking sequentially about a person's abilities and access to assistive devices or services to meet the needs of persons with disabilities.

Organizations and authorities in many countries are working on improving the physical accessibility of buildings, and providing other forms of assistance, like sign language interpreters. Provision of psychosocial services, including the training of refugee counsellors has been a valuable development in Malaysia. In Uganda, the contributions of the national Association for the Deaf are remarkable, for example in the work done in running schools for deaf children.

Perhaps most important have been those activities aimed at empowering and including refugees with disabilities, such as the efforts in Uganda. This has sometimes involved providing skills development and resources to encourage income generation. In other cases, refugees with disabilities have been given assistance to self-organize, and the resulting groups have been consulted in research and program design.

Conclusion and the way forward

Refugee populations include persons with every type of disability and frequently in greater numbers than in societies unaffected by war or catastrophe. Even where efforts are made to

identify refugees with disabilities, less visible impairments – such as vision and hearing impairments as well as mental disabilities – are often missed. Refugees with disabilities also have a harder time accessing education and are often victims of exploitation or abuse.

More can be done to support the empowerment of refugees with disabilities. The following measures can assist in promoting their inclusion:

- To improve mechanisms for identifying refugees with disabilities, emphasising the systematic inclusion of functionality-based questions. Special attention should be paid to persons with less visible disabilities: those with intellectual disabilities, mental disorders, as well as cognitive, hearing and vision impairments.

- To provide access for refugees and asylum seekers with disabilities to Government disability support programmes.

- To expand and support disability-inclusive health services, especially in areas hosting large refugee populations.

- To improve access to mainstream and specialised education for refugees with disabilities. Flexibility should be demonstrated in enforcing age restrictions for persons who have had restricted or disrupted access to education.

- To promote skills training, employment and income generation programmes that include and empower refugees with disabilities.

- To involve DPOs in the design and implementation of programmes to assist and empower refugees with disabilities. The organization and development of associations of refugees with disabilities should also be promoted and supported. DPOs should consider the inclusion of associations of refugees with disabilities in their activities and umbrella bodies. DPOs can provide valuable models and information sources and mentoring for these associations.

- To establish programmes aimed at building awareness and sensitization. Inclusion of refugees with disabilities should be a priority across all programmes and activities.

4.2.7 Persons with mental and intellectual disabilities

Among persons with disabilities, persons with mental and intellectual disabilities[474] are one of the most marginalized and excluded, often facing misconceptions, stigma, discrimination and severe human rights violations.[475] Many persons with mental and intellectual disabilities are denied civil and political rights such as the right to marry and found a family, personal liberty and the right to vote, as well as economic, social and cultural rights, with restrictions on the rights to education and work, reproductive rights and the right to the highest attainable standard of physical and mental health. This leads to numerous challenges such as poverty, physical or sexual violence, limited participation and accessibility in society, poor health outcomes and premature death.[476] The increased ageing society could be correlated with an increased number of people with dementia and other cognitive conditions associated with ageing, adding to societal and economic costs.

This chapter will provide an overview of international mandates on mental wellbeing and disability, provide an overview of the status and trends of the situation of persons with mental and intellectual disabilities, provide examples of positive measures to promote mental well-being and health and identify measures for better inclusion and participation of persons with mental and intellectual disabilities.

UN mandates

Mental well-being and disability have been included as priorities in the key tools of the United Nations system from its early days. In the Preamble to the Constitution of the World Health Organization (1946),[477] health is defined as "a state of complete physical, *mental* and social well-being" (see Box 15 for a definition of mental health). The right to health referred to in the International Covenant on Economic, Social and Cultural Rights (1966) is "the right of everyone to the enjoyment of the highest attainable standard of physical and *mental* health".[478] Among key human rights conventions, the Convention against Torture and Other

Cruel, Inhuman or Degrading Treatment or Punishment (1984),[479] the Convention on the Rights of the Child (1989)[480] and its optional protocols[481] include concepts related to mental and psychological well-being and disability. The Convention on the Rights of Persons with Disabilities (2008)[482] also references mental and intellectual impairments. In 2013, the World Health Assembly adopted the *Comprehensive Mental Health Action Plan 2013–2020.*[483,484]

Concerning persons with mental and intellectual disabilities, the Declarations on the Rights of Mentally Retarded Persons (1971)[485] and the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)[486] adopted by the General Assembly played important roles in promoting awareness regarding these neglected issues but they employed a "limited" rights model, i.e. certain rights could be suspended under these tools, which is not consistent with the Convention. The General Assembly also declared 21 March as World Down Syndrome Day (A/RES/66/149), 2 April as World Autism Awareness Day (A/RES/62/139), 26 June as International Day Against Drug Abuse and Illicit Trafficking (A/RES/42/112) and 3 December as the International Day of Persons with Disabilities (A/RES/47/3).

The Sendai Framework for Disaster Risk Reduction 2015-2030, includes, among its priority actions: "to enhance recovery schemes to provide psychosocial support and mental health services for all people in need such as in disaster preparedness and recovery, rehabilitation and reconstruction".[487]

Box 15. Defining mental health

Mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".[488]

Status and trends

Persons with severe mental illness on average die earlier than those without, partly owing to physical health problems that are often left unattended and increased rates of suicide in this population.[489] The Organization for Economic Co-operation and Development (OECD) reports that people with severe mental ill-health die 20 years earlier than others.[490] Suicide leads to over 800,000 deaths each year worldwide.[491] Among young girls, suicide is the leading cause of death.[492] In addition, mental well-being and disability often affect, and are affected by, other diseases such as cancer, cardiovascular disease, AIDS and physical and sensory disabilities.[493]

In 2004, mental, neurological and substance use disorders accounted for 13% of the total global burden of disease,[494] with depression alone accounting for 4.3% of the global burden of disease. In countries from the OECD, one in two people experience a mental health condition in their lifetime.[495] As the impact of poor mental well-being and health can lead to morbidity and mortality, poverty, unemployment, disengagement from education, and delays in recovery after crisis, the economic loss due to mental disabilities is far-reaching, with direct and indirect costs of mental illness exceeding, at times, 4% of GDP.[496] Despite this economic burden, only 36% of people living in low-income countries are covered by mental health legislation.[497]

Civil society movements for mental health in low-income and middle-income countries tend not to be well developed, with organizations of persons with mental and intellectual disabilities present in only 49% of low-income countries, compared to 83% of high-income countries.[498]

a.   Availability and access to mental health services

Access to appropriate care is problematic for many people with mental health conditions. Between 76% and 85% of people with severe mental disorders receive no treatment for their mental health conditions in low- and middle-income countries; the corresponding range for high-income countries is lower, at between 35% and 50%.[499] In most countries, care is still predominantly provided in institutions, but community-based mental health services have been shown to be effective, less costly and better at lessening social exclusion.[500,501] In low-income and middle-income countries there is less than one outpatient contact or visit (0.7) per day spent in inpatient care.[502]

The number of both specialized mental health service providers and primary care staff dealing with mental well-being and disabilities is insufficient. Globally, the median number of mental health workers is 9 per 100,000 while there is extreme variation from below 1 to 50.[503] Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200,000 or more people.[504] Additionally, the number of health professionals with appropriate training to assist persons with mental and intellectual disabilities is scarce. A median of just over 2% of physicians and 1.8% of nurses and midwives received at least 2-day training in mental health in the previous two years.[505,506] Research indicates that in 42 low-income and middle-income countries, resources for mental health services are overwhelmingly concentrated in urban setting.[507] Rural populations typically have less access to services.[508]

b.   Education

Persons with mental and intellectual disabilities disproportionately face barriers in accessing education[509], creating a wider gap between children with and without mental and intellectual disabilities. In many countries, instead of attending schools, some children and adolescents with mental and intellectual disabilities are institutionalised in facilities that do not offer

education[510] or are simply excluded from everywhere. Children with mental and intellectual disabilities who do attend schools face stigma and discrimination by their peers, and sometimes by their teachers, leading to poor academic performance or drop-out, as well as worsened mental health and well-being and reduced quality of life.[511] Lack of training and awareness among teachers around provisions for inclusive and accessible education for persons with mental and intellectual disabilities creates inaccessible education facilities and tools.[512] In many countries, education policies are discriminatory against children with mental and intellectual disabilities.[513]

c.   Employment

Mental or intellectual disabilities are associated with high rates of unemployment; in some low and middle income countries, 90% of persons with severe mental illnesses are unemployed.[514] Persons with mental and intellectual disabilities can work if universal design and reasonable accommodations are available, yet a lack of knowledge on mental and intellectual disabilities, misconceptions and stigma have led to challenging situations regarding jobs for persons with mental and intellectual disabilities. In addition, persons with mental and intellectual disabilities tend to be excluded from other income-generating programs such as vocational and recreational activities,[515] manufacturing a vicious cycle of exclusion and poverty.

d.   Disasters and humanitarian crises

In situations of disasters or humanitarian crises, persons with mental and intellectual disabilities tend to be left behind, and face severe barriers.[516] Persons with mental and intellectual disabilities often experience worsened symptoms due to the stress of emergencies, in addition to the deprivation from support providers such as health care or social support service providers. Emergency health and social support services tend to lack services related to mental well-being and disability, and persons with mental and intellectual disabilities tend

to face difficulties in accessing immediate and emergency medical interventions and medications, social support, information, or even minimum services to fulfill basic needs.[517] Overall, during and after disasters and crisis situations, people experience mental and emotional distress, affecting quality of life, resilience and ability to prepare, recover and reconstruct.[518] These conditions can have long-term consequences, medically, psychologically, socially, and economically, and can affect recovery and reconstruction as a whole if not addressed.

Measures taken by countries to improve mental health and wellbeing

A number of countries have undertaken initiatives to promote mental health and wellbeing. Overall, 68% countries have a stand-alone policy or plan for mental health and 51% have a stand-alone mental health law, though these are not always fully in line with human rights instruments and implementation is weak in many countries; 41% countries have at least two functioning mental health promotion and prevention programmes.[519] Among 400 reported programmes, over half were related to improvement of mental health literacy[520] or combating stigma.

Conclusion and the way forward

The evidence suggests that overall development efforts in +health care, education and social systems, the labour force market as well as support services in disaster and humanitarian crisis situations have not yet adequately responded to the needs of persons with mental and intellectual disabilities. Although some countries are making positive moves by creating community services and support for people with mental and intellectual disabilities and therefore allowing them to live in their communities, these approaches need to be scaled up. In general, policies, legislation and action plans promoting inclusion and accessibility for this vulnerable group need to be strengthened, particularly in the following areas:

- Education, which is important to prevent and provide support related to mental illness, as well as increasing awareness on the situation of persons with mental and intellectual disabilities among the younger generations. Integrating children with mental and intellectual disabilities into mainstream education should be promoted.

- Employment, with particular attention on strengthening education and training for employers, human resources staff and supervisors on the rights and inclusion of persons with mental and intellectual disabilities.

- Mental health services, which can be improved through (i) development of comprehensive community-based mental health and social care services and strengthening community-based service delivery for mental health based on recovery-oriented approach; (ii) developing and updating policies and laws relating to mental health within all relevant sectors in line with the Convention on the Rights of Persons with Disabilities with strengthening coordination among key stakeholders at international, national and community levels; (iii) greater integration of mental health services into general hospitals and primary health care while ensuring evidence-based services; (iv) increasing skilled human resources for mental well-being and disability such as community health workers and specialized health professionals; (iii) strengthening outpatient mental health support through community services; (iv) strengthening outpatient mental health care through follow-up care and mobile teams; (v) discouraging hospitalization, especially in large mental hospitals; (vi) utilizing electronic and mobile health technologies and outreach; (vii) promoting deinstitutionalisation and promoting multisectoral coordination of holistic care, including alternatives to coercive practices. It is also important to develop support systems for families and support providers of persons with mental and intellectual disabilities.

- Accessibility and inclusion through ICT and either state-of-the art technologies. More efforts and support to innovation in this area are needed.

- Preparedness and resilience for disasters and humanitarian crisis, by including the perspectives of persons with mental and intellectual disabilities in all stages of planning and response.

- Promotion of public awareness, which is imperative in tackling the misconceptions and stigma attached to mental and intellectual disabilities.

In all of these steps, it is important to include and empower persons with mental and intellectual disabilities in consultations, decision making, implementation, monitoring and evaluation as well as follow-up. In particular, there is an urgent need to include the voices of organizations of persons with mental and intellectual disabilities in low-income countries.

4.3   Examples of Emerging Issues in Disability and Development

4.3.1 Disability-inclusive disaster risk reduction and humanitarian response

The world is increasingly facing critical disaster and humanitarian situations on a massive scale with more people affected by conflicts or natural or man-made disasters, more frequently and for a longer period, with more complexity than ever. The number of people affected by humanitarian crises has almost doubled over the past decade[521].

Disaster and humanitarian crises are closely inter-related with disability. Individuals with disabilities are disproportionately affected in disaster, emergency, and conflict situations due to inaccessible evacuation, response (including shelters, camps, and food distribution), and recovery efforts. In addition, disaster or humanitarian crises contribute to an increase in new physical, mental, intellectual or sensory disabilities. Furthermore, persons with disabilities are a key constituency to realize reconstruction as members of communities. Increased attention is now given to the resilience of people and communities with an understanding that promoting inclusion of and accessibility to persons with disabilities is crucial.

UN mandates

The Convention on the Rights of Persons with Disabilities, which was adopted by the United Nations General Assembly in 2006, states that all State Parties shall take "all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters" (Para. 11). More recently, the United Nations High-level Meeting on Disability and Development (HLMDD) was held in New York in 2013 and made specific recommendations to include disability-inclusive disaster risk reduction and humanitarian response in the post-2015 frameworks. At the HLMDD, Member States affirmed their commitments to inclusion of persons with disabilities in the post-2015 development

frameworks, including in disaster risk reduction. The Outcome Document of the HLMDD specifically urges Member States to take actions "to continue to strengthen the inclusion of and focus on the needs of persons with disabilities in humanitarian programming and response, and include accessibility and rehabilitation as essential components in all aspects and stages of humanitarian response, inter alia, by strengthening preparedness and disaster risk reduction."[522]

Moreover, the outcome documents of Regional and Global Platforms on disaster risk reduction, such as the Incheon Strategy "To Make the Right Real[523]" and the Sendai statement[524] to promote disability inclusive disaster risk reduction, have all recognized persons with disabilities as key stakeholders who must participate in efforts to enhance resilience and reducing disaster and humanitarian risks. In addition, a call for prioritization of disability in development and humanitarian response was crystalized in a series of General Assembly and ECOSOC resolutions.

In March 2015, the Third United Nations World Conference on Disaster Risk Reduction was held in Sendai, Japan. In the conference, new focus was given to the concept "inclusion saves life" and a variety of activities related to disability were organized. As a result, disability was included as a key priority in the Sendai Declaration and the Sendai Framework for Disaster Risk Reduction 2015-2030, which recognized the increasing impact of disasters and their complexity in the world.

The outcome document, Sendai Framework for Disaster Risk Reduction 2015-2030, integrated disability in various sections of the document. In the section which looked into lessons learned, gaps identified and future challenges, it is stated that "Governments should engage with relevant stakeholders, including women, children and youth, persons with disabilities, poor people, migrants, indigenous peoples, volunteers, the community of

practitioners and older persons in the design and implementation of policies, plans and standards" (Para. 4). Disability is also positioned in its Guiding Principles (Para. 19 (d)): "A gender, age, disability and cultural perspective should be integrated in all policies and practices, and women and youth leadership should be promoted" and (g) "Disaster risk reduction requires a multi-hazard approach and inclusive risk-informed decision-making based on the open exchange and dissemination of disaggregated data, including by sex, age and disability as well as on easily accessible, up-to-date, comprehensible, science-based, non-sensitive risk information, complemented by traditional knowledge".

Among four Priorities for Action, Priority 4 on enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation and reconstruction refers to "Empowering women and persons with disabilities to publicly lead and promote gender equitable and universally accessible response, recovery, rehabilitation and reconstruction approaches is key" (Para. 32). The role of stakeholders is outlined in Para 36 (iii), which states "Persons with disabilities and their organizations are critical in the assessment of disaster risk and in designing and implementing plans tailored to specific requirements, taking into consideration, inter alia, the principles of universal design."

Experience of persons with disabilities before, during and after disasters and conflicts

Compared to the general population, persons with disabilities, face higher risks and are disproportionately affected by conflicts and disasters. The mortality rate of persons with disabilities is two to four times higher than that of the persons without disabilities in many

disaster situations.[525]   In particular, persons with invisible disabilities such as persons with mental or intellectual disabilities tend to be more adversely affected.

In 2013, the United Nations Office for Disaster Risk Reduction (UNISDR) has conducted a first-ever United Nations Survey on Living with Disabilities and Disasters which looked into factors related to how persons with disabilities cope with disasters (see section on Measuring disability and data collection).[526] The respondents had a variety of disabilities, with 39% reporting a degree of difficulty in hearing, 53% in seeing, 68% in walking or climbing steps, 45% in communicating, 52% in remembering and concentrating, and 52% in self-care such as washing or dressing.[527] The top six hazards or disaster risks faced were floods (57%), extreme weather (43%), drought (40%), tornados (38%), earthquakes (33%) and cyclones (31%).

The survey showed that 72% of persons with disabilities surveyed had no personal preparedness plan for disasters; 31% of them always have someone to help them evacuate but 13% did not had anyone to assist them. Only 21% answered that they could evacuate immediately without difficulty in the event of a sudden disaster; while 73% would face certain difficulty and 6% would not be able to evacuate at all. If given sufficient time, the percentage of those who could evacuate with no difficulty rises from 21 % to 38%. However, 58% feel they would still have difficulty while 4% would not be able to evacuate at all.

In addition, only 17% of respondents were aware of a disaster management plan in their community and as few as 14% said they had been consulted on such plans. Half of respondents expressed a wish to participate in community disaster management; 21% were not sure, and 24% said they do not want to do so.

Data that describes the situation of persons with disabilities in disasters and conflict situations is extremely limited. In addition, systematic analyses and reviews of country

preparedness, resources and experiences related to disability-inclusive disaster risk reduction and humanitarian response is scarce.

Conclusion and the way forward

The scarce data on persons with disabilities in disasters suggests that the majority of persons with disabilities have no personal preparedness plan for disasters; few of them would be able to evacuate immediately without difficulty in the event of a sudden disaster and even fewer are aware of a disaster management plan in their community.

The best way to ensure accessibility of persons with disabilities is to include them in all planning and programming phases. When governments consider disaster or humanitarian policies or legislations, or when a community is developing an evacuation plan, it is strategic to include persons with disabilities as a key actor from the planning phase.

This is also true for the reconstruction phase to build back better after crises devastate infrastructures and community systems. This will enable plans to implement inclusive and universal access not only to persons with disabilities but also for older persons, children, pregnant women, those who got injuries or severe psychological stress, migrants and others, which "leaves no one behind".

Conflicts devastate infrastructures and community systems. Thus, consideration should be given to inclusion of persons with disabilities in peace building, and reconciliation processes, too. Those who are disabled in conflicts both physically and mentally should be able to bring new perspectives in the peace processes as direct stakeholders. Further, it is necessary to include measures on social services or support system for persons who are physically or mentally disabled through conflicts in peace negotiations.

It is also necessary to strengthen capacity of persons with disabilities in the area of disaster risk reduction and humanitarian response. It will contribute not only to self-

protection and survival of persons with disabilities, but also will promote persons with disabilities as a key contributor in those crises situations. Persons with disabilities are expected to contribute to planning and implementing disaster risk reduction and humanitarian action with bringing in new perspectives, and helping others after crises.

In addition, it is necessary to provide training on disability for all the aid stakeholders at both policy and practice levels. Aid workers should understand perspectives, needs and strengths of persons with disabilities, which will prove useful in working for and with persons with disabilities in crises situations.

Further, it is critical to ensure emergency information, commodities, infrastructures and services are inclusive and available in accessible formats. Universal design should be employed in all aspects of disaster risk reduction and humanitarian response. In relation to this, it should be noted that some people might require specialized services in humanitarian situations in addition to these mainstreaming efforts. It is necessary to map needs of specialized services and commodities, and prepare together with persons with disabilities before the crises come.

Finally, another urgent need is to consolidate a data collection system on persons with disabilities at all levels related to conflicts and disasters. In particular, data collection should assess overall numbers and different needs of persons with disabilities in certain communities when a disaster risk reduction plan is developed. In addition, disability registers of persons with disabilities who might require support in crises situation should be developed so that local municipality can immediately respond to the needs of certain persons with disabilities in need. Furthermore, rapid assessment after crises should include a disability perspective, and develop a systematic way to evaluate magnitude and type of needs among persons with disabilities after conflicts or disasters. To assess the number of injuries and deaths among persons with disabilities is not sufficient. Using reliable data in all phases – before, during

and after crises – while paying attention to key but neglected aspects such as how to utilize new technologies such as cell phones and social media is crucial.

4.3.2 Persons with disabilities in human settlements and urban development

Cities and planners are increasingly under immense pressure to ensure that urban development is inclusive and responds to the needs of all groups, including persons with disabilities. But poor planning and unregulated urban development are still norm in many places and can have negative consequences for persons with disabilities. Persons with disabilities face technical and environmental barriers such as steps at the entrances of buildings, the absence of lifts in multi-floor buildings and a lack of information in accessible formats.

The main goal of this chapter is to present the UN legislation on disability inclusion in urban development, review the progress made in recent years in this area and highlight good practices. The chapter will also offer a set of measures to ensure that city initiatives, in any part of the globe, respond to the needs of persons with disabilities.

UN mandates

The Convention on the Rights of Persons with Disabilities calls for State Parties to *"ensure to persons with disabilities access, on an equal basis with others, to the physical environment(…) and to other facilities and services open or provided to the public, both in urban and in rural areas"*[528]. In addition, the international community, in the Outcome Document of the 2013 UN High Level Meeting on Disability and Development, reaffirmed its commitment to advancing a disability-inclusive development agenda, emphasizing among other issues, the importance of accessibility and inclusion for persons with disabilities in urban development contexts.[529] The 2030 Agenda for Sustainable Development includes two targets related to accessibility in urban areas under SDG 11 on 'Make cities and human settlements inclusive, safe, resilient and sustainable'. These targets, targets 11.2 and 11.7 call

for, respectively, accessible transport with attention to the needs of persons with disabilities and accessible green and public spaces for persons with disabilities.[84]

Status and trends

Based on estimates of urban populations and disability prevalence, it can be estimated that more than half of all people with disabilities now live in towns and cities and, by 2030, this number may grow to between 750,000 and 1 billion.[530] However, country data suggests that disability prevalence in urban versus rural settings varies. Some countries observe higher prevalence in urban areas, whereas others have lower prevalence in urban areas (Figure 25).

There is a lack of data on the barriers that persons with disabilities face in urban settings. However, some studies exist. For instance, while persons with disabilities living in South African cities were less likely to experience barriers rooted in negative social attitudes towards persons with disabilities, they were much more likely to experience barriers resultant of inaccessible products and technology that they used on a daily basis.[531] Accessibility of the built environment is still not seen as a priority by local and municipal governments in many parts of the world.[532,533,534]

Figure 25. Percentage of persons with disabilities living in urban and rural areas, in 15 countries, 2000-5
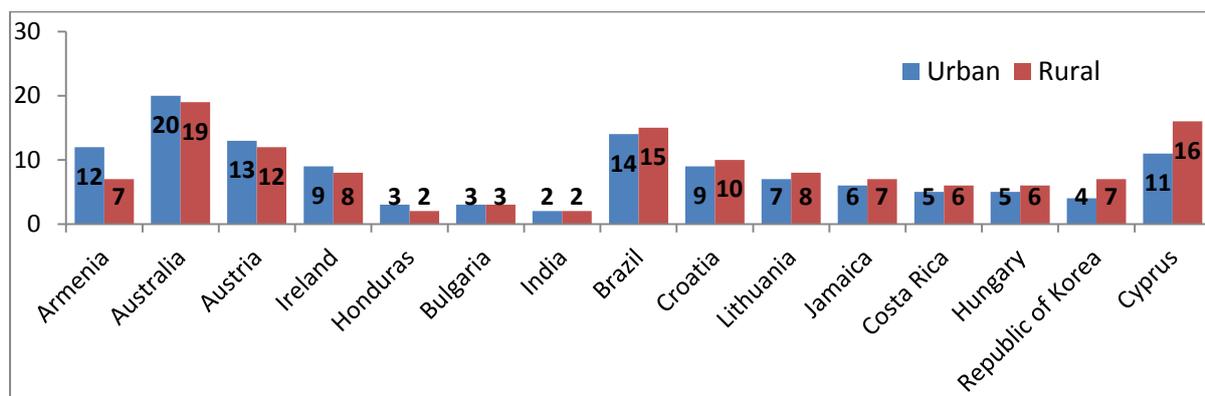
 Note: As countries use different methods to collect data on persons with disabilities, these data are not internationally comparable. Despite these differences in methodology, there is a consistent gap across countries on school attendance for youth with and without disabilities.

Source: Censuses, surveys and administrative sources from countries.[535]

Measures taken by countries to enhance the situation of persons with disabilities in cities

Municipal policy innovations have allowed persons with disabilities to enjoy a greater degree of autonomy and individual choice; they have also contributed to improve participation of persons with disabilities in society. However, disability-inclusion policies vary greatly across countries and even between cities in the same country. Sometimes these innovations occur in States undergoing administrative decentralization, where greater responsibility in implementing policies are given to local governments who are, in turn, empowered to test innovative ideas and formulate policies in close collaboration with local groups.[536] Some of these innovative policies have improved accessibility of physical environments; others have contributed to more access to jobs for persons with disabilities living in urban areas. For example, in Yerevan (Armenia), the city architect formed a partnership with disability rights groups, working together to identify, prioritize, and monitor the construction of hundreds of sloped curb cuts in the historic city centre. This initiative was successful, with replications to

address bus-stops and the provision of other municipal services.[537] In China, municipal governments have incentivized and supported businesses to include persons with disabilities through policies that provide tax breaks to businesses that employ significant numbers of persons with disabilities. Over the course of ten years, this policy quadrupled the number of persons with disabilities employed. However, since employment and benefits associated with labor for persons with disabilities are overseen by municipalities, the application and success of these policies was uneven across Chinese cities. For example, in one of China's fastest growing cities, 90% of persons with disabilities eligible for jobs were employed, but in an equally sized city that had been much less successful in supporting competitive enterprises, fewer than 50% of those eligible have been integrated into the workplace.[538]

Conclusion and the way forward

Policies and programmes on inclusive urban development have been implemented in some countries and have led to successful outcomes by improving accessibility and fostering participation of persons with disabilities. However, at the global level there is a lack of data to properly assess the barriers that urban residents with disabilities experience and how inclusive the cities where they live in are.

In the near future, additional energy needs to be put towards (i) producing data and monitoring the situation of persons with disabilities in urban settings and the barriers they experience; (ii) improving accessibility of services for persons with disabilities; (iv) making legal reforms necessary to make urban settings more disablity inclusive; (iv) assessing negative social attitudes as well as mobilizing civil society to address complex factors and persistent challenges. Like other urban issues, tackling accessibility will require assessing and responding to shortcomings in infrastructure management, municipal codes, land use,

transportation planning, housing and community development, mobility and social services. The following recommendations can help realize this goal:

- **Plan for multimodal and accessible transportation:** A multimodal transportation system allows people to use a variety of transportation modes, including walking, biking, other mobility devices like wheelchairs, as well as accessible transit.

- **Provide an accessible complete street network: A**n accessible complete street network is one that accommodates for needs of those with all types of disabilities, including by providing sloped curb cuts for those using wheelchairs and appropriate traffic signals for those with visual disabilities (e.g. beeping sounds at traffic lights).

- **Provide accessible public facilities and spaces:** Public facilities should be able to accommodate persons of all ages and abilities.

- **Engage persons with disabilities and their organizations at all stages of the planning and decision-making processes:** Engaging stakeholders, including persons with disabilities and their organizations, throughout the planning and decision-making processes —from creating a community vision to defining goals, principles, objectives, and action steps, as well as in implementation and evaluation—is important to ensure that any urban development reflects their priority and needs. Information about the planning should be available in accessible formats and languages to ensure that all persons with disabilities can access the information.

- **Develop technical standards, regulations and inspection regimes for accessibility in urban settlements, especially for buildings, streets and transportation:** Standards are key to coordinate and encourage urban initiatives on accessibility and inspection regimes are crucial to ensure their implementation. The standards should follow ISO guidelines if possible and be developed in consultation with persons with disabilities and their organizations.

Coordinating efforts to improve and scale up disability inclusive urban development can spur innovations in other areas of urban policy, such as poverty alleviation, environmental sustainability, access to quality education, and increasing participation, and in doing so help eliminate the root causes of persistent inequality, marginality, and dependence for persons with disabilities.

Chapter 5. The way forward: disability-inclusive 2030 Agenda for Sustainable Development

The international normative framework on disability and development in line with the Convention on the Rights of Persons with Disabilities as well as the international commitments to inclusive development have given a strong impetus to mainstream disability in all aspects of society and development in the last decade. Particularly, since the adoption of the Convention, there has been a renewed vigour to address the rights and concerns of persons with disabilities in development as a cross-cutting issue in the global agenda.

Over the past decade, the General Assembly[539] has reiterated its commitment to include the disability perspective in the global development agenda, calling for urgent action, in particular, to advance an evidence-based approach to disability and to promote accessibility as a means and goal of inclusive development for all, including persons with disabilities. In this context, inclusive and accessible environments, including through information and communications technology, advance not only full and effective participation of persons with disabilities but all members of society.

Despite these UN mandates, persons with disabilities are still excluded from development. They are more likely to be poor, less likely to be educated and employed, less likely to have health care to meet their needs, and more at risk of being abused or suffering violence. Particular groups are at risk, especially those that are victims of double discrimination, like women, children, youth and older persons with disabilities, as well as indigenous and refugees with disabilities and those with mental and intellectual disabilities. The world is becoming increasingly urbanized, but the needs of persons with disabilities in urban settlements are not always addressed. Similarly, there is also scope to better address the needs of persons with disabilities in planning for, during and after disasters and humanitarian

situations. These gaps have been difficult to address, in part, because of the insufficient data to guide policy making on disability inclusive development.

A number of countries have taken promising measures to address these issues. What is needed now is to scale the best practices up.

Foreseeing the importance of disability inclusive development, the UN General Assembly convened a High-Level Meeting on Disability and Development with the overarching theme "The way forward: a disability inclusive development agenda towards 2015 and beyond", which encouraged the international community to seize every opportunity to include disability as a cross-cutting issue in the global development agenda. The 2030 Agenda for Sustainable Development process followed up on this request and underscored the importance of disability inclusion. As a result, the final Agenda includes several references to disability and several targets aiming at improved participation and decreased barriers for persons with disabilities. Now that the 2030 Agenda for Sustainable Development is in place, there is a need for action to ensure implementation of its goals for persons with disabilities as well as the provisions of CRPD.

5.1   Sustainable Development Goals and disability

At the UN Sustainable Development Summit 2015, Member States adopted the 2030 Agenda for Sustainable Development including a set of seventeen Sustainable Development Goals (SDGs) to be achieved by 2030. There are eleven references to disability or persons with disabilities in the Agenda, of which three in the introductory text of the Declaration, one in the 'Follow-up and Review' section and the remaining seven in the targets related to the goals on education[540], employment and decent work[541], inequality[542], cities and human settlements[543] and implementation and global partnership for sustainable development[544] (Box 16).

Besides these explicit references, there are six other targets referring to 'the vulnerable' or "persons in vulnerable situations, which focus on social protection;[545] access to economic resources;[546] disaster resilience, exposure[547] and impact;[548] hunger;[549] water and sanitation.[550] In addition, two other targets address discrimination, which is a key cause of unequal access to opportunities and services for persons with disabilities.[551] Several targets are universal targets, including the target on ending poverty,[552] and thus must also be achieved for persons with disabilities. Among the universal targets, seven cover areas where persons with disabilities have been particularly at a disadvantage: poverty,[553] child mortality,[554] health coverage and financial risk protection,[555] violence against women,[556] sexual and reproductive health[557] as well as birth registration.[558] Therefore, achieving those universal targets will require achieving them for all persons with disabilities too.

Disability has been included as a cross-cutting issue in the 2030 Agenda for Sustainable Development. However, where disability has been latently included, efforts need to be stepped up to ensure that these targets too will be achieved for persons with disabilities. The High-Level Panel of Eminent Persons on the Post-2015 Development Agenda suggested marking goals and targets as achieved only when this is the case for all income and social groups. This approach would ensure that all social groups, including persons with disabilities, and included in the implementation, follow-up and review of the SDGs.

Box 16. Explicit references to disability in the 2030 Agenda for Sustainable Development

Declaration, The new agenda

19. We reaffirm the importance of the Universal Declaration of Human Rights, as well as other international instruments relating to human rights and international law. We emphasize the responsibilities of all States, in conformity with the Charter of the United Nations, to respect, protect and promote human rights and fundamental freedoms for all, without

distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, **disability** or other status.

23. People who are vulnerable must be empowered. Those whose needs are reflected in the Agenda include all children, youth, **persons with disabilities** (of whom more than 80% live in poverty), people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants. (…)

25. We commit to providing inclusive and equitable quality education at all levels – early childhood, primary, secondary, tertiary, technical and vocational training. All people, irrespective of sex, age, race, ethnicity, and **persons with disabilities**, migrants, indigenous peoples, children and youth, especially those in vulnerable situations, should have access to life-long learning opportunities that help them acquire the knowledge and skills needed to exploit opportunities and to participate fully in society. (…)

SDG targets

4.5   by 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including **persons with disabilities**, indigenous peoples, and children in vulnerable situations

4.a   build and upgrade education facilities that are child, **disability** and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all

8.5   by 2030 achieve full and productive employment and decent work for all women and men, including for young people and **persons with disabilities**, and equal pay for work of equal value

10.2   by 2030 empower and promote the social, economic and political inclusion of all irrespective of age, sex, **disability**, race, ethnicity, origin, religion or economic or other status

11.2   by 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special

attention to the needs of those in vulnerable situations, women, children, **persons with disabilities** and older persons

11.7   by 2030, provide universal access to safe, inclusive and accessible, green and public spaces, particularly for women and children, older persons and **persons with disabilities**

17.8   by 2020, enhance capacity building support to developing countries, including for LDCs and SIDS, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, **disability**, geographic location and other characteristics relevant in national contexts

Follow-up and Review

74. Follow-up and review processes at all levels will be guided by the following principles: (…)

g. They will be rigorous and based on evidence, informed by country-led evaluations and data which is high-quality, accessible, timely, reliable and disaggregated by income, sex, age, race, ethnicity, migration status, **disability** and geographic location and other characteristics relevant in national contexts.

5.2   Monitoring and evaluation

Since the start of the process of developing a successor framework to the MDGs, the need for more information disaggregated by disability has been highlighted. This call has been made by civil society organizations,[559] by the Secretary-General's Independent Expert Advisory Group on a Data Revolution for Sustainable Development in the data revolution report 'A world that counts'[560], by international human rights mechanisms[561] , in the Synthesis Report of the UN Secretary-General released in 2015[562], and by the Member States themselves.[563] In particular, the 2030 Agenda for Sustainable Development aims for enhancing capacity building support to developing countries to increase significantly the availability of high-

quality, timely and reliable data disaggregated by disability, by 2020, i.e. within five years of the adoption of the Agenda.[564] In addition, monitoring, reviewing and following-up on progress towards SDG targets which explicitly focusing on persons with disabilities, will require disability specific indicators, focusing on accessible and participation of persons with disabilities. In particular, three SDG targets focus on accessibility of education,[565] transport,[566] public and green spaces;[567] another three targets focus on participation of persons with disabilities in education,[568] employment[569] as well as in social, economic and political spheres.[570] The completion of the SDG global indicator process, to be concluded in March 2016, poses an opportunity to develop appropriate indicators for these targets. Additionally, countries may expand any global disability indicators with national indicators for their policy needs regarding persons with disabilities.

At the national level, disability indicators can be used to assess the success of efforts for inclusive development. With this aim, countries may focus on establishing indicators to be collected regularly to assess in an inclusive manner the situation of persons with disabilities and the barriers they face, and to design disability specific indicators to capture progress in implementing various policies and programs aimed at inclusion and to evaluate in an inclusive manner their final impact. Most of these indicators will fall into one of these categories:

- Indicators to monitor the wellbeing of people with disabilities as compared to people without disabilities, e.g. unemployment rate for persons with disabilities, school attendance for children with disabilities.

- Indicators on accessibility and barriers faced by persons with disabilities, e.g. percentage of public buildings accessible for persons with disabilities; number of sign language interpreters available; percentage of persons with disabilities indicating discriminating prejudices as a reason for not getting a job.[571]

197

It is essential that the SDG indicators, as most as possible, be disaggregated by disability, so that countries can monitor whether their development activities are reaching people with disabilities. Apart from disaggregating data by disability, *double-disaggregations* will be needed to achieve the SDGs for those who are at a double disadvantage, like women with disabilities. Data should be disaggregated:

- simultaneously by disability and sex (to monitor girls and women with disabilities);

- simultaneously by disability and age (to monitor children and older persons with disabilities);

- simultaneously by disability and income groups (to monitor the poor with disabilities);

- by type of disability (to monitor, among others, persons with mental and intellectual disabilities).

Data on refugees should also be disaggregated by disability. In addition, data should be collected on the extra costs incurred by persons with disabilities due to their disability. Without this information, it is difficult to assess the extent of poverty among persons with disabilities. Poverty figures for persons with disabilities should be adjusted for the estimated costs of living with a disability.

At the national level, several approaches to data and information collection can be used to obtain a picture of the participation and barriers faced by persons with disabilities and to provide data to assess progress towards the SDGs for persons with disabilities:

- Adding short set of questions to existing censuses and national surveys, like Demographic Health Survey, Labour Force Surveys, Household Income and Expenditure Surveys, or any other national surveys that will serve as the basis for the SDG indicators. The Washington Group short set of questions have been

developed with that aim. These questions will identify people who are at risk of being excluded because of functional difficulties. If gaps exist in the SDG indicators for people with and without these functional difficulties, then this is a sign that barriers are preventing people with disabilities from benefiting from economic development on an equal basis with their non-disabled peers. This approach is low cost as it requires only a modest addition of six questions to existing censuses or surveys.

- Carrying out detailed national disability surveys, ideally every five years, to get a full picture of the situations of persons with disabilities. Examples for such surveys include the WHO Module Disability Survey. These surveys are essential to obtain quantitative data on the nature and extent of disability, the development outcomes for people with disabilities, and the barriers they face.

- Conducting qualitative studies to understand the dynamics underlying how existing barriers affect the lives of people with disabilities, and to provide insights into how best to intervene to remove these barriers.

- Incorporating disability information into Education Management Information Systems (EMIS).[572]   EMIS's are based on school censuses administered on an annual basis by ministries of education. These systems should not only identify children with disabilities, but also collect information on the accessibility of structures and materials and the training of teachers on educating children with special needs.

- Monitoring children with disabilities by using disability questions appropriate to them. UNICEF and the Washington Group on Disability Statistics are currently developing disability questions for children.

Rigorous evaluations of the impact of policies and programs on persons with disabilities are lacking. These require not only high-quality data on disability and the environment, but also baseline data and well-constructed comparison or control groups. Such studies are scarce[573] and more efforts should be placed into monitoring and evaluating national policies impacting on persons with disabilities. In particular, with the implementation of new policies and programs, care should be taken to establish baseline data and set up proper comparison or control groups so that outcomes can be evaluated properly. These evaluations should be conducted in a participatory manner including persons with disabilities who are ultimately the beneficiaries of the programmes.

Finally, in the current era of digitisation, persons with disabilities should benefit from the data revolution and the opportunities that such a revolution may provide in making them more visible. New technologies should be explored to identify ways to monitor the situation of persons with disabilities at a lower cost. These data should be freely available and accessible.

5.3   Financing for disability-inclusive development

The Third International Conference on Financing for Development (FfD3) was held in July 2015 and gathered high-level political representatives, including Heads of State and Government, and Ministers of Finance, Foreign Affairs and Development Cooperation, as well as all relevant institutional stakeholders, non-governmental organizations and business sector entities. The Conference resulted in an inter-governmentally negotiated and agreed outcome, the Addis Ababa Action Agenda, [574] which constitutes an important contribution to a disability inclusive 2030 Agenda for Sustainable Development. In particular, in the Agenda, Members States commit to:

- Providing social protection to persons with disabilities

- Encouraging the full participation of persons with disabilities in the labour market

- Delivering quality education to all by reaching children with disabilities

- Upgrading education facilities that are disability sensitive

- Facilitating accessible technology for persons with disabilities

- Increasing and using data disaggregated by disability

Official Development Assistance (ODA) is important for raising public resources in countries with limited capacity, and accordingly, the Agenda urges developed countries "to step up efforts to increase their ODA and to make additional concrete efforts towards the ODA targets" to developing countries.[575] ODA, if properly directed, can drive inclusive development and better facilitate access for persons with disabilities to education, employment, social protection and ICT. Moreover, reversing the declining share of ODA to least developing countries, as pledged in the Addis Ababa Action Agenda, would also help these countries to move towards disability inclusive development.

The Addis Ababa Action Agenda also encourages Member States and the business sector to work in partnership with regional and national organizations. If disability organizations are included, the needs of persons with disabilities can be better addressed in financing for development. In addition, the following aspects can assist financing for disability-inclusive development: [576]

i. Turn accessibility into a key criterion in the mobilization and execution of domestic and international resources. This will ensure access to services and infrastructures that are available to all from the start.

ii. Progressively increase domestic and international resources for disability support services like assistive devices, community-based services, social protection schemes, support for employment and self-employment.

iii.   Use a disability-inclusive approach in the design, implementation, financing and monitoring of budget and fiscal policies.

iv.   Disaggregate data by disability in order to achieve transparency and accountability and make sure that financing for sustainable development reaches the most marginalized populations.

5.4   Disability-inclusive international development cooperation

Since the adoption of the UN Convention in 2006, there has been an increase in global commitment to address and respond to the needs and concerns of persons with disabilities in development. This is reflected in the steady increase in global funding to disability-specific international development projects since 2007 (Figure 26). Despite this rise, financing for disability in development still remains low compared to other vulnerable groups.

Figure 26. Concessional financing for projects targeting disability, 2000-2013
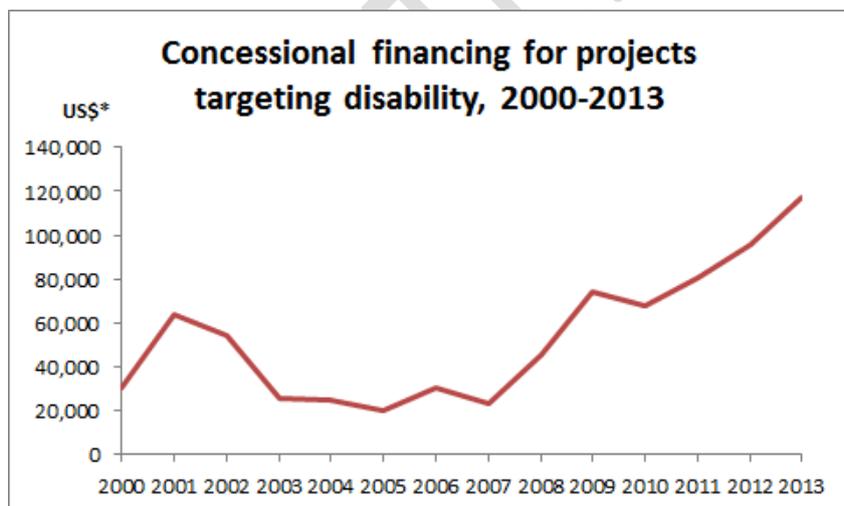
*2013 constant US dollars.
Source: OECD. [577]

As the international community prepares for the adoption of the 2030 Agenda for Sustainable Development, there have been increasing efforts and recognition of the importance of taking more concerted action to incorporate disability in international development cooperation activities. The international community has repeatedly called for development cooperation strategies to adopt a twin-track approach, involving a combination of disability-specific initiatives as well as inclusive programming, through the mainstreaming of disability in all processes of development.[578]

However, although many bilateral development agencies have considerable experience in implementing programs that have been specifically designed for persons with disabilities, mainstreaming of disability within overall frameworks for development cooperation remains a challenge.[579] Often disability issues are approached in silos, without interaction or synergies with sectoral projects and programs. Effective mainstreaming relies on clear technical guidelines for mainstreaming as well as collaborative partnerships between disability experts and sectoral experts as well as a system-wide mandate requiring results to be disaggregated by disability to ensure disability issues are not siloed or treated as an 'add on'.[580]

Moreover, programs addressing disability issues have sometimes grouped persons with disabilities with other marginalised groups for the purpose of measuring the overall impact of a development project.[581] Following this approach, there is a risk that the impact of projects on persons with disabilities remains 'invisible' among the more 'visible' social groups.

Shortcomings in the availability of consistent and reliable data have posed on going challenges in the area of disability and development. In the absence of consistently generated data in communities, longer-term impacts from programmes and projects are often difficult to measure. In this respect, it has been recognised by donor agencies that the capacity building

needs of countries and statistical offices needs to be filled. In recent years, there has been a major push by large donors such as DFID and DFAT to strengthen capacity and technical support to recipient governments in the area of disability data and statistics.[582] This is of critical importance in the context of the 2030 agenda for sustainable development to ensure persons with disabilities are being reached under relevant goals and targets.

Similarly, it is impossible to effectively monitor the impact of development programs without the active participation of persons with disabilities. Participatory monitoring should be a goal in and of itself in all development projects. This principle has been incorporated into a number of international aid, with donors, such as Australia, Italy and Norway, funding capacity-building of organizations of persons with disabilities in aid-recipient countries, however further capacity building and technical assistance to organizations of persons with disabilities needs to take place to fully equip these groups to contribute to all stages of development processes.[583]

International cooperation needs also to focus on addressing inequalities in technology transfers specifically experienced by persons with disabilities. Making commitments for disability-inclusive technology transfer is essential to reducing inequalities in aid recipient countries.

Endnotes

[1] As stated in the United Nations World Programme of Action concerning Disabled Persons (1982) and the United Nations Decade of Persons with Disabilities (1982-1993).

[2] General Assembly/RES/63/150, A/RES/64/131, A/RES/65/185, A/RES/66/124, A/RES/67/140, A/RES/68/3 and A/RES/69/142.

[3] United Nations, *Charter of the United Nations*, 24 October 1945, 1 UNTS XVI.

[4] United Nations, *Universal Declaration of Human Rights.* Available at: http://www.un.org/en/documents/udhr/index.shtml#atop.

[5] Available here: http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

[6] http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

[7] United Nations. UN Enable. *Chapter III: The early years. available at* http://www.un.org/esa/socdev/enable/dis50y20.htm.

[8] Declaration on Social Progress and Development, G.A. res. 2542 (XXIV), 24 U.N. GAOR Supp. (No. 30) at 49, U.N. Doc. A/7630 (1969), *aavailable at* http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/NR0/256/76/IMG/NR025676.pdf?OpenElement.

[9] Declaration on the Rights of Mentally Retarded Persons, G.A. Res. 2856 (XXVI), at 93, U.N. GAOR, Supp. No. 29, U.N. Doc. A/8429 (Dec. 20, 1971) [hereinafter 1971 Declaration], art. 1; prmbl. 5.

[10] Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/RightsOfDisabledPersons.aspx

[11] United Nations. UN Enable. *The International Year of Disabled Persons 1981.* http://www.un.org/disabilities/default.asp?id=126#star.

[12] Available here: http://www.un.org/documents/ga/res/37/a37r052.htm

[13] United Nations Enable. *Chapter VII: United Nations Decade of Disabled Persons.* United Nations and Disabled Persons – The First Fifty Years. http://www.un.org/esa/socdev/enable/dis50y60.htm.

[14] Expert Group Meeting in Stockholm, Sweden (1987) to review the implementation of the world programme of action concerning disabled persons.

[15] The mandate of the Special Rapporteur of the Commission for Social Development came to an end in December 2014.

[16] Section 6, paragraph 63. http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx

[17] Section 6.29 (c) http://www.un.org/popin/icpd/conference/offeng/poa.html

[18] *Copenhagen Declaration on Social Development.* World Summit for Social Development U.N. Doc. A/CONF.166/9. Copenhagen Denmark (Mar. 14, 1995) annex I, no. 5, *available at* http://www.un-documents.net/cope-dec.htm.

[19] Paragraph 32: http://www.un.org/womenwatch/daw/beijing/platform/declar.htm

[20] *Vienna Declaration and Programme of Action* (adopted by the World Conference on Human Rights), (June 25, 1992), *available at* http://www.ohchr.org/en/professionalinterest/pages/vienna.aspx.

[21] *Id.* at para. 63.

[22] *Copenhagen Declaration on Social Development.* World Summit for Social Development U.N. Doc. A/CONF.166/9. Copenhagen Denmark (Mar. 14, 1995) annex I, no. 5, *available at* http://www.un-documents.net/cope-dec.htm.

[23] Including an analysis by Quinn & Degener, 2002. Available here: http://www.ohchr.org/Documents/Publications/HRDisabilityen.pdf

[24] United Nations. Enable. *History of United Nations and Persons with Disabilities- The first millennium decade.* http://www.un.org/disabilities/default.asp?id=134.

[25] *History of United Nations and Persons with Disabilities- The first millennium decade. supra* n. 99.

[26] WHO and World Bank (2011). World Report on Disability. Available at: http://www.who.int/disabilities/world_report/2011/en/

[27] http://www.un.org/disabilities/default.asp?id=1590

[28] A/RES/68/3, on the 23rd September 2013.

[29] A/RES/68/3

[30] WHO (2001). International Classification of Functioning, Disability and Health. Available at: http://www.who.int/classifications/icf/en/

[31] Madans, JH, BM Altman, EKR Rasch, M Mbogoni, M Synneborn, J Banda, A Me E DePalma, (2004) Washington Group Position Paper: Proposed Purpose of an Internationally Comparable General Disability Measure, available at http://www.cdc.gov/nchs/data/washington_group/WG_purpose_paper.pdf

[32] The Salamanca Statement and Framework for Action on Special Needs Education, p. 19

http://unesdoc.unesco.org/images/0009/000984/098427eo.pdf

[33] UN (2008). Principles and Recommendations for Population and Housing Censuses - Revision 2. Available at: http://unstats.un.org/unsd/demographic/sources/census/docs/P&R_%20Rev2.pdf

[34] United Nations Disability Statistics Database (DISTAT). Available at: http://unstats.un.org/unsd/demographic/sconcerns/disability/disab2.asp

[35] D. Mont (2007). Measuring Disability Prevalence, Social Protection Discussion Paper No. 0706, The World Bank.

[36] R. Velázquez Lerma (2015). La discapacidad en cifras: experiencia del INEGI en la integración de datos sobre discapacidad. Congreso de Salud 2015. Presentation given at 'Discapacidad y Prevención: Una visión de derechos e inclusión social - Sistema para el Desarrollo Integral de la Familia del Distrito Federal', México D.F., 19 October 2015.

[37] The 166 countries/territories correspond to those that, as of November 2015, had a census questionnaire available at http://unstats.un.org/unsd/demographic/sources/census/censusquest.htm#M .

[38] Seven countries/territories included "disabled" as a reply option for the census question on economic activity, but did not include any other question to identify persons with disabilities. These countries/territories were not considered here to have collected data on disability. The seven countries/territories and census years are Cyprus 2011, Isle of Man 2006, Lithuania 2011, Niue 2006, Saint Helena 2008, Singapore 2010 and Switzerland 2010.

[39] Based on information obtained from the United Nations Statistics Division Census Questionnaire Database and Senegal's census report (http://www.ansd.sn/ressources/rapports/Rapport-definitif-RGPHAE2013.pdf)

[40] Labour Force Surveys (LFS) in several countries used the Washington group questions, including Cambodia LFS 2012, Myanmar LFS 2015, Tanzania LFS 2015 and Zambia LFS 2012.

[41] For instance, Uganda Demographic and Health Surveys included the Washington Group questions in 2006 (http://dhsprogram.com/pubs/pdf/FR194/FR194.pdf) and 2011 (https://dhsprogram.com/pubs/pdf/FR264/FR264.pdf).

[42] For example, Living Standards Measurement Surveys (LSMS) have included the Washington Group disability questions in Ethiopia 2011/12 and 2013/4, Malawi 2010/11, Nigeria 2012/11 and 2012/13, Tanzania 2010/11, Uganda 2009/2010,2010/11 and 2011/12. See World Bank LSMS Data Table at: http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTLSMS/0,,contentMDK:21485765~menuPK:4417929~pagePK:64168445~piPK:64168309~theSitePK:3358997~isCURL:Y,00.html

[43] ILO (2015). Statistics on the labour force characteristics of people with disabilities: a compendium of national methodologies. Available at: http://www.ilo.org/surveydata/files/disabilities_final.pdf

[44] http://www.who.int/healthinfo/survey/en/

[45] The data from these surveys is available online at: http://www.ilo.org/employment/areas/youth-employment/work-for-youth/WCMS_191853/lang--en/index.htm

[46] Mathers, CD, AD Lopez, CJL Murray, (2006) The burden of disease and mortality by condition: data, methods and results for 2001, In Lopez, AD et al., eds. Global burden of disease and risk factors, first edition, Washington, Oxford University Press and World Bank.

[47] Sabariego, C. et al. (2015). Measuring disability: comparing the impact of two approaches for data collection and analyses on disability rates. Int J Environ Res Public Health. (To be published)

[48] This estimate is for people aged 18 years old or over. The estimate is based on data from 59 countries.

[49] This estimate is for people aged 15 years old or over.

[50] This estimate includes moderate and severe disabilities.

[51] Loeb, M (2015) International census/survey data and the short set of disability questions developed by the Washington Group on Disability Statistics, forthcoming in BM Altman (ed), International Measurement of Disability: Purpose, Method and Application – The work of the Washington Group on Disability Statistics, Springer 2015.

[52] Newacheck, PW and N Halfon, 'Prevalence and impact of disabling chronic conditions in childhood,' American Journal of Public Health, Vol. 88, (1998)

[53] Blackburn, CN, J Spencer and JM Read, (2010) 'Prevalence of childhood disability and the characteristics and circumstances of disabled children in the UK: secondary analysis of the Family Resources Survey,' BMC Pediatrics

[54] WHO (2012). Developmental difficulties in early childhood: prevention, early identification, assessment and

intervention in low- and middle-income countries: a review. Available at: http://apps.who.int/iris/bitstream/10665/97942/1/9789241503549_eng.pdf

[55] This estimate includes moderate and severe disabilities.

[56] Australian Bureau of Statistics (2004). Disability, Ageing and Carers, Australia: Summary of Findings, 2003. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12003?OpenDocument

[57] Statistics New Zealand (2002). Disability counts 2001. Available at: http://www.stats.govt.nz/browse_for_stats/health/disabilities/disability-counts.aspx

[58] WHO and World Bank (2011)[26] pp. 35

[59] Gerst-Emerson, K., Wong, R., Michaels-Obregon, A., and Palloni, A. (2015). Cross-National Differences in Disability Among Elders: Transitions in Disability in Mexico and the United States. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*.

[60] Stone, S. D. (2014). Age-Related Disability. *The Ages of Life: Living and Aging in Conflict?* edited by Ulla Kriebernegg, Roberta Maierhofer .

[61] Mitra, S., and Sambamoorthi, U. (2013). Disability prevalence among adults: estimates for 54 countries and progress toward a global estimate. Disability & Rehabilitation, 36(11), 940-947.

[62] Tareque, MI, S Begum, Y Saito, (2014) Inequality in Disability in Bangladesh, PLOS/One.

[63] World Bank (2009), People with Disabilities in India: From Commitments to Outcomes. Washington, D.C.: World Bank.

[64] Based on data in the appendices of Mitra and Sambamoorthi (2014).

[65] Entries in the table represent the average of countries examined in each region. This is an average of country prevalence rates, not a weighted average based on the relative population sizes in the various countries. So for example, if one takes the prevalence rates for mobility limitations in each of the African countries included in this study and averages them together, the result is 13%. This includes people with both severe and moderate limitations. The 54 countries include 20 developed countries and 34 developing countries.

[66] Groce, N, M Kett, R Lang, J Trani (2011). "Disability and poverty: the need for a more nuanced understanding of implications for development policy and practice," Third World Quarterly, 32(8)

[67] Yeo R, Moore K. 2003. Including disabled people in poverty reduction work: nothing about us, without us. World Development 31(3): 571–590.

[68] World Health Organization (2014). World Health Statistics 2014. Available at: http://www.who.int/gho/publications/world_health_statistics/2014/en/

[69] Mont, D, and N Cuong, (2011) Disability and Poverty in Vietnam, World Bank Economic Review, Vol. 25, No. 2

[70] Adioetomo, SM, D Mont and Irwanto (2013), People with Disabilities: Empirical Facts and Implications for Social Protection Policies, Demographic Institute of the University of Indonesia, available at http://www.tnp2k.go.id/en/download/persons-with-disabilities-in-indonesia-empirical-facts-and-implications-for-social-protection-policies/

[71] Trani, J. and M Loeb. (2010). Poverty and disability: A vicious circle? Evidence from Afghanistan and Zambia, Journal of International Development 24(S1):S19-S52

[72] Mont, D and CV Nguyen, (2013) Spatial Variation in the Disability-Poverty Correlation: Evidence from Vietnam, Leonard Cheshire Disability and Inclusive Development Centre Working Paper 20, University College, available at https://www.ucl.ac.uk/lcccr/centrepublications/workingpapers/WP20_Spatial_Variation.pdf

[73] She, P, and GA Livermore, (2008) Long-term poverty and disability among working-age adults." Journal of Disability Policy Studies

[74] Tibble, Mike (2005). Review of existing research on the extra costs of disability. Leeds, UK: Corporate Document Services

[75] Zaidi, A, and T Burchardt. (2005) Comparing incomes when needs differ: equivalization for the extra costs of disability in the UK. Review of Income and Wealth 51.1

[76] Rosales-Rueda, MF. (2014). Family investment responses to childhood health conditions: Intrafamily allocation of resources. Journal of Health Economics 37

[77] F. J. Braña Pino and J. I. Antón Pérez (2011). Pobreza, discapacidad y dependencia en España. *Papeles de Economía Española - Aspectos económicos y sociales de la dependencia*, nr 129.

[78] Cullinan, J, B Gannon, and S Lyons. "Estimating the extra cost of living for people with disabilities." Health Economics 20.5 (2011): 582-599.

[79] Cullinan, J, B Gannon, and E O'Shea. The welfare implications of disability for older people in Ireland. *The European Journal of Health Economics* 14.2 (2013): 171-183

[80] Loyalka, P, L Liu, G Chen, X Zheng, The cost of disability in China. Demography 51.1 (2014): 97-118.

[81] Morciano, M, R Hancock, and S Pudney. Disability costs and equivalence scales in the older population. No. 2012-09. ISER Working Paper Series, 2012.

[82] Saunders, P, "The costs of disability and the incidence of poverty." (2007) The Australian Journal of Social Issues, Volume 42 Issue 4

[83] Leonard Cheshire Disability and Inclusive Development Centre (2013)

[84] A/RES/70/1 - Transforming our world: the 2030 Agenda for Sustainable Development. Available at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

[85] Convention on the Rights of Persons with Disabilities, article 9.

[86] http://www.un.org/disabilities/documents/accessibility_and_development.pdf

[87] Selwyn Goldsmith in 1963 (Designing for the Disabled) https://books.google.com/books/about/Designing_for_the_Disabled.html?id=39My5jduOUIC

[88] UniversalDesign.com is an online platform dedicated to advancing the field of Universal Design by playing a central role in providing free access to information and by supporting education and research in the field.

[89] Ronald Mace (http://www.humancentereddesign.org/universal-design/history-universal-design)

[90] These principles have been formulated and are promoted by the Institute for Human Centered Design, which is dedicated to enhancing the experience of people of all ages and abilities through excellence in design.

[91] Available here: http://www.un.org/documents/ga/res/37/a37r052.htm

[92] Available here: http://www.un.org/esa/socdev/enable/dissre00.htm

[93] Full text here: http://www.un.org/disabilities/convention/conventionfull.shtml

[94] See General Assembly resolutions, 63/150, 64/145 and 65/186.

[95] Full CRPD here: http://www.un.org/disabilities/convention/conventionfull.shtml

[96] A/RES/68/3.

[97] A/RES/68/3, II, 4(h).

[98] A/RES/70/1 - Transforming our world: the 2030 Agenda for Sustainable Development. Available at: https://sustainabledevelopment.un.org/post2015/transformingourworld

[99] http://www.bbc.com/future/story/20130731-helping-the-deaf-to-see-sound

[100] Rydeen (1999). http://asumag.com/accessibility/universal-design

[101] Taken from a paper by Rydeen (1999). http://asumag.com/accessibility/universal-design

[102] WHO and World Bank (2011). World Report on Disability, p. 187.

[103] http://www.cambodiainvestment.gov.kh/content/uploads/2011/09/Law-on-the-Protection-and-the-Promotion-of-the-Rights-of-Persons-with-Disabilities_090812.pdf

[104] Available here: http://www.dinf.ne.jp/doc/english/intl/z15/z15009gl/z1500901.html

[105] ISO 21542:2011 standards.

[106] http://finduslaw.com/americans-disabilities-act-1990-ada-42-us-code-chapter-126

[107] http://www.austlii.edu.au/au/legis/cth/consol_act/dda1992264/

[108] http://laws-lois.justice.gc.ca/PDF/H-6.pdf

[109] http://laws-lois.justice.gc.ca/eng/acts/E-5.401/FullText.html

[110] http://laws-lois.justice.gc.ca/eng/acts/L-2/FullText.html

[111] https://lovdata.no/dokument/NL/lov/2013-06-21-61

[112] LOI no 2005-102 du 11 février 2005 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées . Available at: http://www.legifrance.gouv.fr/jopdf/common/jo_pdf.jsp?numJO=0&dateJO=20050212&numTexte=1&pageDebut=02353&pageFin=02388

[113] http://www.legislation.gov.uk/ukpga/2010/15

[114] http://www.justice.gov.za/legislation/acts/2000-004.pdf

[115] http://www.island.lk/2009/11/08/news17.html

[116] Accessible public buildings Indicators on political participation of persons with disabilities (2014). Available at: http://fra.europa.eu/en/publications-and-resources/data-and-maps/comparative-data/political-participation/accessible-buildings

[117] http://triggered.clockss.org/ServeContent?url=http://archfami.ama-assn.org%2Fcgi%2Fcontent%2Ffull%2F8%2F1%2F44

[118] ftp://ftp.cen.eu/boss/reference_documents/guides/cen_clc/cen_clc_6.pdf

[119] Available at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0078:EN:HTML.

[120] Accessibility in built environment . Available at ftp://ftp.cen.eu/cen/Sectors/Accessibility/Draft_Joint_Report_2011-08-03_version_PC.pdf.

[121] Report of the Interministerial Observatory on accessibility and universal design, for the Prime Minister, 2012. Available at: www.territoires.gouv.fr/IMG/pdf/Rapport_Obiacu_2012.pdf

[122] Swedish Agency for Disability Policy Co-ordination (*Handisam*), Accessibility in the political life of local governments (*Tillgängligheten i det politiska livet i kommuner och landsting*), 2007, p. 10-11, available at: www.handisam.se/Publikationer-och-press/Rapporter/Handikappolitisk-utveckling/Tillgangligheten-i-det-politiska-livet-i-kommuner-och-landsting/

[123] Department of Economics & Social Affairs report on Accessibility & Development. http://www.un.org/disabilities/documents/accessibility_and_development.pdf

[124] Ratzka. Report of the CIB Expert Seminar on Building Non-Handicapping Environments (Budapest, 1991). http://www.independentliving.org/cib/cibbudapest28.html

[125] Bradley, N., and W. Poppen. 2003. Assistive technology, computers and Internet may decrease sense of isolation for homebound elderly and disabled persons. Technology and Disability 15:19–25

[126] The ISO/IEC 40500:2012 standards are also known as the Web Content Accessibility Guidelines 2.0, developed by World Wide Web Consortium. Available at: http://www.iso.org/iso/iso_catalogue/catalogue_tc/catalogue_detail.htm?csnumber=58625

[127] http://www.w3.org/WAI/ER/tools/

[128] http://www.powermapper.com/blog/government-accessibility-standards/

[129] http://ec.europa.eu/ipg/standards/accessibility/index_en.htm

[130] Available at http:// www.w3.org/TR/WCAG20.

[131] Features of a program must function in a way that it is possible for all users to access the content.

[132] http://unpan3.un.org/egovkb/Portals/egovkb/Documents/un/2012-Survey/unpan048065.pdf

[133] Form elements are different types of input elements, checkboxes, radio buttons, submit buttons, and more (http://www.w3schools.com/html/html_forms.asp).

[134] 2014 UN E-Government Survey. Available at: http://unpan3.un.org/egovkb/Portals/egovkb/Documents/un/2014-Survey/E-Gov_Complete_Survey-2014.pdf

[135] 2012 UN E-Government Survey. Available at: http://unpan3.un.org/egovkb/Portals/egovkb/Documents/un/2012-Survey/unpan048065.pdf

[136] http://g3ict.org/resource_center/publications_and_reports/p/productCategory_books/subCat_1/id_191

[137] http://g3ict.org/resource_center/publications_and_reports/p/productCategory_books/subCat_1/id_191 , page 19

[138] http://g3ict.org/resource_center/publications_and_reports/p/productCategory_books/subCat_1/id_191, pages 51-61.

[139] Like a raise dot on the number 5. These type of markers help orient fingers in the keypad.

[140] Human operated service using a sign language interpreter to enable communication between a persons with a hearing disability and anyone else.

[141] Transfers both right and left audio to both ears – useful for those with hearing disabilities affecting one ear.

[142] Like pre-programmed text messages which can be reused with the touch of fewer buttons than typing the whole text.

[143] Sesame Touch-free Smartphone, see http://sesame-enable.com/

[144] International Telecommunication Union and G3ict (2012). Making Mobile Phones and Services Accessible for Persons with Disabilities. Available at: http://g3ict.org/resource_center/publications_and_reports/p/productCategory_books/subCat_1/id_191

[145] Report of the ICT Consultation in support of the High-Level Meeting on Disability and Development of the 68th session of the United Nations General Assembly in 2013, titled "The ICT Opportunity for a Disability-Inclusive Development Framework" https://www.itu.int/en/action/accessibility/Documents/The%20ICT%20Opportunity%20for%20a%20Disability_Inclusive%20Development%20Framework.pdf

[146] World Report on Disability and Development (2011). World Health Organization, pg. 173.

[147] Goggin, G., and C. Newell. 2007. The business of digital disability. The Information Society 23:159–68.

[148] Numerous studies have suggested that persons with disabilities are more likely to be poor than the rest of the population (see section on Participation).

[149] Vicente Cuervo, M.R. & López Menéndez, A.J. (2010). "A Multidimensional Analysis of the Disability Digital Divide: Some Evidence for Internet Use". In The Information Society, 26 (1), 48-64. Abingdon: Taylor & Francis.

[150] Vicente Cuervo, M.R. & López Menéndez, A.J. (2010). "A Multidimensional Analysis of the Disability Digital Divide: Some Evidence for Internet Use". In The Information Society, 26 (1), 48-64. Abingdon: Taylor & Francis.

[151] For example, a 2010 paper by Vicente and Lopez reported that screenreader programs for people who are blind, visually impaired, or learning disabled can cost more than $1,000; even upgrades for them can cost hundreds of dollars.

[152] Vicente Cuervo, M.R. & López Menéndez, A.J. (2010). "A Multidimensional Analysis of the Disability Digital Divide: Some Evidence for Internet Use". In The Information Society, 26 (1), 48-64. Abingdon: Taylor & Francis.

[153] The Core International Human Rights Treaties (2014). United Nations Human Rights Office of the High Commissioner. Available at: http://www.ohchr.org/Documents/Publications/CoreInternationalHumanRightsTreaties_en.pdf

[154] Promoting the Rights of Children with Disabilities (2007). UNICEF Innocenti Research Centre. Available at: http://www.un.org/esa/socdev/unyin/documents/children_disability_rights.pdf

[155] Standard Rules on the Equalization of Opportunities for Persons with Disabilities. http://www.un.org/esa/socdev/enable/dissre04.htm

[156] Conference took place in in Jomtien, Thailand in 1990 and convened by the United Nations Educational, Scientific and Cultural Organization (UNESCO).

[157] Co-convened by UNESCO and the Ministry of Education and Science of Spain.

[158] The Salamanca Statement and Framework for Action on Special Needs Education. (1994), paragraph 7. UNESCO. Available at : https://www.european-agency.org/sites/default/files/salamanca-statement-and-framework.pdf

[159] The Salamanca Statement and Framework for Action on Special Needs Education. (1994), paragraph 7. UNESCO. Available at : https://www.european-agency.org/sites/default/files/salamanca-statement-and-framework.pdf

[160] Available at: http://www.unesco.at/bildung/basisdokumente/dakar_aktionsplan.pdf

[161] See: the Outcome Document of the High-Level Meeting on Disability and Development, the Rio+20 Outcome Document, the Report of the High-Level Panel on the Post 2015 Development Agenda.

[162] Extract from UNESCO's Policy Guidelines on Inclusion in Education, 2009

http://unesdoc.unesco.org/images/0017/001778/177849e.pdf

[163] The Salamanca Statement and Framework for Action on Special Needs Education, pp. 11

http://unesdoc.unesco.org/images/0009/000984/098427eo.pdf

[164] Assessment in Inclusive Settings: Key Issues for Policy and Practice, European Agency for Development in Special Needs Education, 2007, pp.47

[165] UNESCO (2014), Fixing the Broken Promise of Education for All: Findings from the Global Initiative on Out-of-School Children, UNESCO, UIS & UNICEF, Paris.

[166] 2011 World Report on Disability, World Health Organization and the World Bank, pp.205

[167] Disability and Poverty in Developing Countries: A Snapshot from the World Health Survey, Mitra S., Posarac A. and Vick Br., 2011, pp.45

[168] Filmer D., Disability, Poverty, and Schooling in Developing Countries: Results from 14 Household Surveys, in the World Bank Economic Review, Vol. 22, No. 1, pp. 150–159

[169] Ibid, pp. 207

[170] Ibid

[171] Disability and Poverty in Developing Countries: A Snapshot from the World Health Survey, Mitra S., Posarac A. and Vick Br., 2011, pp.45

[172] WHO/World Bank, World Report on Disability, page 215.

[173] See for example: Outside the Circle: a Research Initiative by Plan International into the Rights of children with Disabilities to Education and Protection in West Africa, Plan West Africa 2013 and Making Schools Inclusive, How change can happen: Save the Children's Experience, 2008

[174] http://www.disabilityscoop.com/2015/06/17/feds-millions-training-sped/20390/

[175] http://www.huffingtonpost.com/2015/06/05/california-special-education-training_n_7519784.html

[176] Polat F., Inclusion in Education: A step towards social justice in the International Journal of Educational Development 31, 2011, pp. 50-58

[177] Mosia Paseka Andrew, Threats to inclusive education in Lesotho: An overview of policy and implementation challenges, Africa Education Review, 11:3, 2014, pp. 302

[178] Rioux M and Pinto P., A time for the universal right to education : back to basics, British Journal of Sociology of Education, pp.628-629

[179] Ahmmed M., Sharma U. and Deppeler J., Variables affecting teachers intentions to include students with disabilities in regular primary schools in Bangladesh, Disability and Society 2014, Vol.29 no.2 , pp. 317-331

[180] Unianu E., Teachers attitudes towards inclusive education, in Social and Behavioural Sciences 33, 2012, pp.900-904

[181] Ahmmed M., Sharma U. and Deppeler J., Variables affecting teachers intentions to include students with disabilities in regular primary schools in Bangladesh, Disability and Society 2014, Vol.29 no.2 , pp. 317-331

[182] Unianu E., Teachers attitudes towards inclusive education, in Social and Behavioural Sciences 33, 2012, pp.900-904

[183] Ahmmed M., Sharma U. and Deppeler J., Variables affecting teachers intentions to include students with disabilities in regular primary schools in Bangladesh, Disability and Society 2014, Vol.29 no.2 , pp. 317-331

[184] WHO (2011). World Report on Disability. Page 212.

[185] Sources: Portugal: 2001 Population and housing census; Jamaica: 2002 Population and housing census; Hungary: 2000 Census; Honduras: Survey (Encuesta Permanente de Hogares de Própositos Múltiples, Septiembre 2002); Austria: Labour Force Survey ad-hoc module on employment of didabled people, 2002; Brazil: 2000 Census; Korea, Rep: National Survey on the Disabled People, 2005 ; Trinidad and Tobago: 2000 Census; Costa Rica: 2000 Population census; Turcs and Caicos: 2001 Census; Saudi Arabia: 2004 Population and housing census; Bahrain: 2001 Population, Housing, Buildings & Establishments Census; Croatia: 2001 Population and housing census; Mexico: 2000 Population and housing census; Romania: Registration for disability and annual exhaustive surveys carried out by NIS in educational establishments, 2004.

[186] WHO and World Bank (2011). World Report on Disability. Available at: http://www.who.int/disabilities/world_report/2011/en/

[187] Morgon Banks L. and Polack S., The Economic Costs of Exclusion and Gains of Inclusion of People with Disabilities : Evidence from Low and Middle Income Countries, International Centre for Evidence in Disability, London School of Hygiene & Tropical Medicine

[188] K. Lamichhane (2015). Disability, Education and Employment in Developing Countries: From Charity to Investment. Cambridge University Press.

[189] UNICEF (2013). The State of the World's Children: Children with Disabilities, UNICEF, New York

[190] UNICEF Children with Disabilities in Malaysia: Mapping the policies, programmes, interventions and stakeholders, 2014 and Contributions to the OHCHR study on the Right to Education of Persons with Disabilities, Malaysia

[191] http://www.unicef.org/namibia/na._Namibia_-_MoE_Sector_Policy_on_Inclusive_Education_(2013).pdf

[192] UNICEF Children with Disabilities in Malaysia: Mapping the policies, programmes, interventions and stakeholders, 2014 and Contributions to the OHCHR study on the Right to Education of Persons with Disabilities, Malaysia

[193] Sharma U., Shaukat S. and Furlonger Br., Attitudes and self-efficacy of pre-service teachers towards inclusion in Pakistan in Journal if Research in Special Education Needs, June 2014, pp. 1-7. See p.6.

[194] Bines H. and Lei Ph., Disability and education: the longest road to inclusion in the International Journal of Educational Development 31, 2011, pp.423

[195] WHO (2011). World Report on Disability. Page 210.

[196] https://education.gov.au/more-support-students-disabilities

[197] R. Sermier Dessemontet & G . Bless, The impact of including children with intellectual disability in

general education classrooms on the academic achievement of their low- average and high-achieving peers, Journal of Intellectual & Developmental Disability, March 2013; 38(1): 23–30

[198] Cushing, L. S., & Kennedy, C. H. (1997). Academic effects of providing peer support in general education classrooms on students without disabilities, Journal of

Applied Behavior Analysis, 30(1), 139-151.

[199] Afroditi Kalambouka , Peter Farrell , Alan Dyson & Ian Kaplan (2007) The impact of placing pupils with special educational needs in mainstream schools on the achievement

of their peers, Educational Research, 49:4, 365-382

[200] Nienke M. Ruijs , Ineke Van der Veen & Thea T.D. Peetsma (2010) Inclusive education and students without special educational needs, Educational Research, 52:4, 351-390

[201] Nakken, H. and Pijl, S. J. 2002. Getting along with classmates in regular schools: A review of the effects of integration on the development of social relationships. International Journal of Inclusive Education, 6(1): 47–61.

[202] Salend, S. J. and Garrick Duhaney, L. M. 1999. The impact of inclusion on students with and without disabilities and their educators. Remedial and Special Education, 20: 114–126.

[203] Staub, D. and Peck, C. A. 1994. What are the outcomes for non-disabled students. Educational Leadership, 54(4): 36–40.

[204] Access to ICTs in education is hindered by: physical barriers when inclusive ICTs and learning environments, content and materials are not accessible; cognitive barriers for some learners with intellectual disabilities or specific learning problems; content barriers that may occur when the operating language of a device or software is not the same as a learner's mother tongue; didactical barriers where learning is inflexible and teachers lack the skills to facilitate inclusive education; and financial barriers relating to the cost of devices, hardware and software, Model Policy for Inclusive ICTs in Education for Persons with Disabilities, UNESCO, European Agency for Special Needs and Inclusive Education and G3ict, 2014, pp.10

[205] Salomon JA, Mathers CD, Chatterji S, Sadana R, Ustün TB, Murray CJL. In: Health systems performace assessment: debates, methods and empiricism. Murray CJL, Evans DB, editor. Geneva: WHO; 2003. Quantifying Individual Levels of Health: definitions, concepts, and measurement issues; p. 301–318.

[206] WHO. 2001. The International Classification of Functioning, Disability and Health. Geneva: World Health Organization.

[207] Simon JG, Boer de JB, Joung IMA, Bosma H, Mackenbach JP. 2005. How is your health in general**?** A qualitative study on self-assessed health. *European Journal of Public Health*, 15(2):200-208.

[208] This is exemplified in Quality of Life instruments and the OECD Better Life Index (OECD).

[209] Kahneman, D., Diener, E., & Schwarz, N. (Eds.).(1999). Well-being: The foundations of hedonic psychology. New York: Russell Sage Foundation.

[210] Diener, E & Biswas-Diener, R. 2008. *Happiness*. Oxford: Blackwell

[211] For example, the Day Reconstruction Method to collect data describing the experiences a person has on a given day and the Global Life Satisfaction question.

[212] Alan B. Krueger and David A. Schkade (2008). The Reliability of Subjective Well-Being Measures. J Public Econ. 2008 Aug; 92(8-9): 1833–1845. doi: 10.1016/j.jpubeco.2007.12.015

[213] Kahneman, D, Krueger, AB, Schkade, DA, Schwarz, N and Stone, AA. 2004. A survey method for characterizing daily life experience: the Day Reconstruction Method. Science. 306: 1776–80

[214] Layard, D. 2005. Happiness: Lessons from a New Science. London: Penguin Books

[215] Stiglitz, JE, Sen, A and Fitoussi, JP. 2009. Report by the Commission on the Measurement of Economic Performance and Social Progress. OECD

[216] WHO (2014). Disability - Draft WHO global disability action plan 2014–2021: Better health for all people with disability - Report by the Secretariat. Sixty-Seventh World Health Assembly, A67/16. Available at: http://www.who.int/disabilities/actionplan/en/

[217] Prince M et al. 2007. No health without mental health. *Lancet.* 370:859-877.

[218] Khlat M et al. 2010. Lorhandicap Group Social disparities in musculoskeletal disorders and associated mental malaise: findings from a population-based survey in France. *Scandinavian Journal of Public Health.*38:495-501.

[219] Ohayon MM, Schatzberg AF. 2009. Chronic pain and major depressive disorder in the general population. *Journal of Psychiatric Research.* 44:454-461.

[220] Prince M et al. 2007. No health without mental health. *Lancet.* 370:859-877.

[221] Australian Institute of Health and Welfare (AIHW). 2000. *Disability and ageing: Australian population patterns and implications*. Canberra: Australian Institute of Health and Welfare.

[222] Australian Institute of Health and Welfare (AIHW). 2010. *Australia's health 2010*. Canberra: AIHW.

[223] Rimmer JH, Rowland JL. 2008. Health promotion for people with disabilities: implications for empowering the person and promoting disability-friendly environments. *Journal of Lifestyle Medicine.* 2:409-420.

[224] Woodcock K and Pole JD. 2007. Health profile of deaf Canadians: analysis of the Canada Community Health Survey. *Canadian Family Physician Médecin de Famille Canadien*, 53:2140-2141.

[225] WHO. 2002. *World report on violence and health*. Geneva: World Health Organization.

[226] Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. Lancet. 2007;370(9590):851–858.

[227] Disability Rights Commission, UK (DRC), 2006. *Equality treatment: closing the gap: a formal investigation into the physical health inequalities experiences by people with learning disabilities and/or mental health problems*. London: DRC.

[228] A. Nocon (2006). Background evidence for the DRC's formal investigation into health inequalities experienced by people with learning disabilities or mental health problems. Disability Rights Commission, UK. Available at: http://disability-studies.leeds.ac.uk/files/library/nocon-Evidence-paper-2006.pdf

[229] WHO and World Bank (2011). World Report on Disability. Available at: http://www.who.int/disabilities/world_report/2011/en/

[230] Marmot, M. Review of Social Determinants and the Health Divicde in the WHO European Region. Final Report. 2014. Print.

[231] Albrecht, GL & Devlieger, PJ. 1999. The disability paradox: High quality of lie against all odds. Social Science and Medicine. 48, 977-988.

[232] Kahneman, D. 2000. Evaluation by moments: past and future. In Choices, values and frames. D. Kahneman and A. Tversky (eds.) New York: Cambridge University Press and the Russell Sage Foundation. pp. 293-308.

[233] Kahneman, D & Krueger, AB. 2006. Developments in the measurement of subjective well-being. Journal of Economic Perspectives. 20(1): 3–24.

[234] Diener, E. (Ed.). (2009). The science of well-being: The collected works of Ed Diener (Vol. 37). Springer Science & Business Media.

[235] Koivumaa-Honkanen, H., Honkanen, R., Viinamaeki, H., Heikkilae, K., Kaprio, J., & Koskenvuo, M. (2014). Life satisfaction and suicide: a 20-year follow-up study. American Journal of Psychiatry.

[236] Tyc, V. L. (1992). Psychosocial adaptation of children and adolescents with limb deficiencies: A review. Clinical Psychology Review, 2, 275-91.

[237] Fellinghauer B, Reinhardt JD, Stucki G, Bickenbach J, 2012. Explaining the disability paradox: a cross-sectional analysis of the Swiss general population. BMC Public Health 12: 655.

[238] This has been called 'proportionate universalism': where everyone is included in health interventions and public health strategies, but the nature, scale and intensity of the intervention is geared to the nature, scale and intensity of the particular need so that the outcome of the intervention is equivalent (Marmot et al. 2013).

[239] ILO Convention No. 159 (1983) Convention concerning Vocational Rehabilitation and Employment (Disabled Persons). Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C159

[240] ILO Recommendation No. 168 (1983): Recommendation concerning

Vocational Rehabilitation and Employment (Disabled Persons). Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?R168

[241] ILO Convention No. 159 (1983): Convention concerning Vocational Rehabilitation and Employment (Disabled Persons). Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C159

[242] ILO Recommendation No. 168 (1983): Recommendation concerning

Vocational Rehabilitation and Employment (Disabled Persons). Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?R168

[243] ILO Convention No. 142 (1975): Convention concerning Vocational Guidance and Vocational Training in the Development of Human Resources. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C142

[244] ILO Convention No. 155 (1981): Convention concerning Occupational Safety and Health and the Working Environment. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C155

[245] ILO Convention No. 181 (1997): Convention concerning Private Employment Agencies. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C181

[246] Transforming Our World – Finalized Text for Adoption (1 August). Available at: https://sustainabledevelopment.un.org/post2015

[247] http://www.un.org/disabilities/convention/conventionfull.shtml

[248] ILO Recommendation No. 195 (2004): Recommendation concerning Human Resources Development: Education, Training and Lifelong Learning. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?R195

[249] ILO Convention No. 181 (1997): Convention concerning Private Employment Agencies. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C181

[250] ILO Convention No. 159 (1983): Convention concerning Vocational Rehabilitation and Employment (Disabled Persons). Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C159

[251] ILO Recommendation No. 168 (1983): Recommendation concerning

Vocational Rehabilitation and Employment (Disabled Persons). Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?R168

[252] ILO Convention No. 155 (1981): Convention concerning Occupational Safety and Health and the Working Environment. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C155

[253] ILO Convention No. 142 (1975): Convention concerning Vocational Guidance and Vocational Training in the Development of Human Resources. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C142

[254] ILO Convention No. 111 (1958): Convention concerning Discrimination in Respect of Employment and Occupation. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C111

[255] The employed to working-age population ratio gives the proportion of the country's working-age population (usually ages 15 to 64, but differs among countries) that is employed. Out of that proportion are people who are not looking for work, like students or house-spouses, as well as people who are looking for work but are unemployed.

[256] Japan, Peru, Poland, South-Africa and Spain.

[257] Disability, education and employment in developing countries - from charity to investment, K. Lamichhane (2015).

[258] Disability, education and employment in developing countries - from charity to investment, K. Lamichhane (2015), page 180.

[259] The self-employment rate is the percentage of the employed who are self employed.

[260] S. Mizonoya and S. Mitra (2013). Is there a disability gap in employment rates in developing countries?, Fordham University Department of Economics Discussion paper No. 2012-03. Available at: http://legacy.fordham.edu/images/academics/graduate_schools/gsas/economics/dp2012_03_Mizonoya_Mitra.pdf

[261] http://www.tandfonline.com/doi/abs/10.1080/13504850802047011

[262] http://onlinelibrary.wiley.com/doi/10.1111/j.1564-913X.2012.00134.x/abstract

[263] http://oep.oxfordjournals.org/content/58/3/407.abstract

[264] http://www.sciencedirect.com/science/article/pii/S0167629600000436

[265] http://www.jstor.org/stable/146053?seq=1#page_scan_tab_contents

[266] Botswana, Gambia, Guyana, Honduras, Kiribati, Mauritius, New Zealand, Nigeria, Republic of Korea, Saint Vincent and the Grenadines, Sri Lanka and Swaziland.

[267] ILO. 2014. Minimum wage systems. International Labour Conference, Report III (Part 1B). 103rd session. Available online at http://labordoc.ilo.org/record/461266?ln=en

[268] Committee on the Rights of Persons with Disabilities. Concluding observations on the initial report of New Zealand (CRPD/C/NZL/CO/1); Committee on the Rights of Persons with Disabilities. Concluding observations on the initial report of the Republic of Korea (CRPD/C/KOR/CO/1)

[269] Committee on the Rights of Persons with Disabilities. Initial report submitted by Ecuador (CRPD/C/ECU/1)

[270] http://www.oecd.org/els/sickness-disability-and-work-breaking-the-barriers-9789264088856-en.htm

[271] Buckup, S. 2009. The price of exclusion: The economic consequences of excluding people with

disabilities from the world of work. ILO Employment Sector Working Paper No. 43

[272] ILO. 2014. Achieving Equal Employment Opportunities for People with Disabilities through Legislation. Guidelines (2nd edition). Geneva. Available at : http://labordoc.ilo.org/record/461989?ln=en

[273] This list of countries is only illustrative. There may be other countries that have taken these measures.

[274] 1% of positions in the public sector are reserved for persons with disabilities.

[275] The law stipulates that companies employ persons with disabilities for at least 1% of their posts.

[276] An increasing number of national business and disability networks are linked with the ILO Global Business and Disability Network.

[277] Award launched by the Costa Rican Ministry of Labour and Social Security, the National Council for Rehabilitation and Special Education, UNDP and the ILO.

[278] ILO Convention (No. 102) 1952: Convention concerning Minimum Standards of Social Security, Part IX – Invalidity Benefit. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C102

[279] ILO Convention (No. 128) 1967: Convention concerning Invalidity, Old-Age and Survivors' Benefits. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C128

[280] ILO Recommendation (No. 131) 1967: Recommendation concerning Invalidity, Old-Age and Survivors' Benefits. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?R131

[281] ILO Convention (No. 130) 1969: Convention concerning Medical Care and Sickness Benefits. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?C130

[282] ILO Recommendation (No. 202) 2012: Recommendation concerning National Floors of Social Protection. Available at: www.ilo.org/ilolex/cgi-lex/convde.pl?R202

[283] ILO. 2014. World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice, p. 4

[284] ILO. 2014. World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice, p. 56

[285] ILO. 2014. World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice

[286] Australia, Denmark, Hungary, Luxembourg and the Netherlands.

[287] WHO/World Bank, World Report on Disability (2011), p60.

[288] WHO/World Bank, World Report on Disability (2011), p248.

[289] ILO. 2014. World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice, p. 56

[290] Draft General Comment on Article 6: Women with disabilities, prepared by the Committee on the Rights of Persons with Disabilities, (CRPD/C/14/R.1), 22 May 2015, paragraph 2.

[291] Ibid, paragraph 3.

[292] UN Women (2015). Progress of the World's Women 2015-2016. Transforming Economies, Realizing Rights, page 171. Available at http://progress.unwomen.org/en/2015/pdf/UNW_progressreport.pdf. Cites: Parker, G. and H. Clarke. 2002. "Making the Ends Meet: Do Carers and Disabled People Have a Common Agenda?" Policy & Politics 30, no. 3: 347–59

[293] Carmichael F, and Charles, S. (2003). The opportunity costs of informal care: does gender matter? *Journal of Health Economics*, 22, 781-803. doi:10.1016/S0167-6296(03)00044-4 PMID:12946459

[294] UN Women (2015). Progress of the World's Women 2015-2016. Transforming Economies, Realizing Rights.. Available at http://progress.unwomen.org/en/2015/pdf/UNW_progressreport.pdf

[295] Committee on the Rights of Persons with Disabilities, General Comment on Article 6: Women with Disabilities, CRPD/C/14/R.1, (May 2015), paragraph 1.

[296] Convention on the Elimination of all Forms of Discrimination against Women (1979). Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women (1995).

[297] Beijing declaration and platform for action: adopted by the Fourth World Conference on Women: action for equality, development and peace, Beijing, China, 4-15 September 1995 (1995). Beijing: United Nations, paragraphs 46 and 225.

[298] World Health Organization and The World Bank(2011). World Report on Disability,, page. 28. Available at http://www.who.int/disabilities/world_report/2011/report.pdf

[299] United Nations (2010). Report of the Secretary-General on Keeping the promise: realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond, A/65/173, paragraph 26.

[300] United Nations (2010). The World's Women 2010: Trends and Statistics. United Nations Department of Economics and Social Affairs, p. 20. Available at http://unstats.un.org/unsd/demographic/products/Worldswomen/WW_full%20report_color.pdf

[301] United Nations (2010). The World's Women 2010: Trends and Statistics. United Nations Department of Economics and Social Affairs, p. 11. Available at http://unstats.un.org/unsd/demographic/products/Worldswomen/WW_full%20report_color.pdf

[302] United Nations (2015). Report of the Secretary-General on the Review and appraisal of the implementation of the Beijing Declaration and Platform for Action and the outcomes of the twenty-third special session of the General Assembly (E/CN.6/2015/3), 15 December 2014, paragraph 53.

[303] United Nations (2015). Report of the Secretary-General on the Review and appraisal of the implementation of the Beijing Declaration and Platform for Action and the outcomes of the twenty-third special session of the General Assembly (E/CN.6/2015/3), 15 December 2014, paragraph 57.

[304] World Health Organization and The World Bank(2011). World Report on Disability, Chapter 7, p. 206

[305] Coe S. (2013). Outside the Circle: a Research Initiative by Plan International into the Rights of children with

Disabilities to Education and Protection in West Africa. Dakar: Plan West Africa.

[306] The 51 countries include high, middle and low income countries. The high-income and high-middle-income countries included (20) are: Bosnia and Herzegovina, Brazil, Croatia, Czech Republic, Dominican Republic, Estonia, Hungary, Kazakhstan, Latvia, Malaysia, Mauritius, Mexico, Namibia, the Russian Federation, Slovakia, Spain, South Africa, Turkey, United Arab Emirates, Uruguay. The low-income and low-middle-

income countries included (31) are: Bangladesh, Burkina Faso, Chad, China, Comoros, Congo, Côte d'Ivoire, Ecuador, Ethiopia, Georgia, Ghana, India, Kenya, Lao People's Democratic Republic, Malawi, Mali, Mauritania, Morocco, Myanmar, Nepal, Pakistan, Philippines, Paraguay, Senegal, Sri Lanka, Swaziland, Tunisia, Ukraine, Viet Nam, Zambia, Zimbabwe.

[307] Committee on the Rights of Persons with Disabilities, Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States parties under article 35 of the Convention, New Zealand, CRPD/C/NZL/1, (31 March 2011), p28. para 161 (b)

[308] Committee on the Rights of Persons with Disabilities, Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States parties under article 35 of the Convention, New Zealand, CRPD/C/NZL/1, (31 March 2011)], p28. para 161 (b)

[309] Committee on the Elimination of Discrimination against Women, Consideration of reports submitted by States parties under article 18 of the Convention, Initial to third periodic reports due in 2011 Solomon Islands, CEDAW/C/SLB/1-3, (1 November 2013), paragraph 283.

[310] Persons with disabilities here refers to persons with profound or severe core-activity limitations.

[311] Disability, Vocation and Education Training, Australian Bureau of Statistics. (2009). Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Products/4438.0~2009~Main+Features~People+aged+15%E2%80%9324+years?OpenDocument

[312] Groce et al (2011). Poverty and Disability: A critical review of the literature in low and middle-income countries. Available at https://www.ucl.ac.uk/lc-ccr/centrepublications/workingpapers/WP16_Poverty_and_Disability_review.pdf

[313] Committee on the Rights of Persons with Disabilities, Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States parties under article 35 of the Convention, Austria, 2010, CRPD/C/AUT/1, pg. 46, para 316

[314] Consideration of reports submitted by States parties under article 35 of the Convention , Initial report of States parties due in 2012 , European Union, 2014, CRPD/C/EU/1 pg. 55, para 186

[315] Grammenos (2013). European comparative data on Europe 2020 & People with Disabilities p.. 27

[316] ECLAC ((2011), Availability, Collection and use of disability data in the Caribbean sub region. United Nations Economic Commission for Latin America and the Caribbean. Available at http://archivo.cepal.org/pdfs/2011/S2011011.pdf

[317] ESCWA and the League of Arab States (2014). Disability in the Arab Region. United Nations Economic and Social Commission for Western Asia, pg. 19. Available at http://www.escwa.un.org/divisions/div_editor/Download.asp?table_name=divisions_other&field_name=ID&FileID=1658

[318] O'Reilly, A. (2003). Employment Barriers for Women with Disabilities in The Right to Decent Work of Persons with Disabilities IFP/Skills Working, Paper No. 14. International Labour Organization, pg.32.

[319] O'Reilly A. (2007). The right to decent work of persons with disabilities, International Labour Organization, p.49

[320] The employed to working-age population ratio gives the proportion of the country's working-age population (usually ages 15 to 64, but differs among countries) that is employed. Out of that proportion are people who are not looking for work, like students or house-spouses, as well as people who are looking for work but are unemployed.

[321] European Union Agency for Fundamental Rights (2014). Violence against women: an EU-wide survey. Main results. P. 186. Publications Office of the European Union, Luxemburg. Available at http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-main-results-apr14_en.pdf.

[322] World Health Organization and The World Bank (2011). World Report on Disability, page 61. Available at http://www.who.int/disabilities/world_report/2011/report.pdf. The text refers to a national study in the United States. Cites: Chevarley FM et al. Health, preventive health care, and health care access among women with disabilities in the 1994– 1995 National Health Interview Survey, Supplement on Disability. Women's Health Issues: official publication of the Jacobs Institute of Women's Health, 2006,16:297-312. doi:10.1016/j.whi.2006.10.002 PMID:17188213

[323] World Health Organization and The World Bank (2011). World Report on Disability, page 78. Available at http://www.who.int/disabilities/world_report/2011/report.pdf. Cites: Dyer O. Gynaecologist is struck off for sterilising women without their consent. British Medical Journal, 2002,325:1260-doi:10.1136/bmj.325.7375.1260; Grover SR. Menstrual and contraceptive management in women with an intellectual disability. The Medical Journal of Australia, 2002,176:108-110. PMID:11936305; Servais L. Sexual

health care in persons with intellectual disabilities. Mental Retardation and Developmental Disabilities Research Reviews, 2006,12:48-56. doi:10.1002/mrdd.20093 PMID:16435330; Stansfield AJ, Holland AJ, Clare ICH. The sterilisation of people with intellectual disabilities in England and Wales during the period 1988 to 1999. Journal of Intellectual Disability Research: JIDR, 2007,51:569-579. doi:10.1111/j.1365-2788.2006.00920.x PMID:17598870.

[324] World Health Organization and The World Bank (2011). World Report on Disability, p. 78. Available at http://www.who.int/disabilities/world_report/2011/report.pdf

[325] Committee on the Rights of Persons with Disabilities, Initial reports submitted by State parties in accordance with article 35 of the Convention, Spain, CRPD/C/ESP/1 (5 October 2010), para 17, pg. 5

[326] Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention Initial reports of States parties due in 2010, Uganda, CRPD/C/UGA/1 (10 March 2015), para 226, pg.48

[327] Committee on the Elimination of Discrimination against Women, Consideration of reports submitted by States parties under article 18 of the Convention: Fourth and fifth periodic reports of States parties due in 2009: Croatia CEDAW/C/HRV/4-5 (13 December 2013), paragraph 8.

[328] Committee on the Rights of Persons with Disabilities, Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States Parties under article 35 of the Convention, China 2010. CRPD/C/CHN/1 pg. 12, para 28

[329] Committee on the Rights of Persons with Disabilities, Initial Report of the government of Nepal on measures take to give effect to the convention on the rights of persons with disabilities, CRPD/C/NPL/1, July 2014, page 17 paragraph 63

[330] See Zero project, http://zeroproject.org/practice/discovering-hands-germany/ - the project was selected as an innovative practice on employment for women with disabilities

[331] Committee on the Rights of Persons with Disabilities, Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States parties under article 35 of the Convention, Republic of Korea, CRPD/C/KOR/1, 2011, pg. 8 para 3 and pg. 16 para 35.

[332] Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention Initial reports of States parties due in 2010 Thailand, CRPD/C/THA/1, 2012 page. 6, paragraph 21 (a)

[333] See Uwezo Fund: http://www.uwezo.go.ke/

[334] Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, Initial reports of State parties due in 2010, Kenya, CRPD/C/KEN/1, page. 42, paragraph 223

[335] Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, Initial reports of States parties due in 2010 Brazil, CRPD/C/BRA/1 (14 July 2014), paragraph 97

[336] Committee on the Rights of Persons with Disabilities, Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States parties under article 35 of the Convention, Austria, 2010, CRPD/C/AUT/1, pg. 41, para 271.

[337] Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, Initial reports of State parties due in 2010 Kenya, 2012 CRPD/C/KEN/1, page. 38 paragraph 198

[338] Committee on the Rights of Persons with Disabilities, Initial Country Report to the United Nations on the Implementation of the Convention on the Rights of Persons with Disabilities, South Africa. CRPD/C/ZAF/1 (2013) para 369, pg. 73

[339] International Foundation for Electoral Systems and National Democratic Institute (2014). Equal Access How to Include Persons with Disabilities in Elections and Political Processes, p. 69. Available at: https://www.ndi.org/files/Equal-Access_How-to-include-PWD-in-elections-political-processes.pdf

[340] Committee on the Rights of Persons with Disabilities, Initial Country Report to the United Nations on the Implementation of the Convention on the Rights of Persons with Disabilities, South Africa. CRPD/C/ZAF/1 (2013) para 369, pg. 73

[341] Political declaration on the occasion of the twentieth anniversary of the Fourth World Conference on Women, contained in the Report of the fifty-ninth session of the Commission on the Status of Women, Economic and Social Council Official Records Supplement No. 7, E/2015/27-E/CN.6/2015/10 (2015) resolution 59/1 page 20, paragraph 6.

[342] Political declaration on the occasion of the twentieth anniversary of the Fourth World Conference on Women, contained in the Report of the fifty-ninth session of the Commission on the Status of Women, Economic and Social Council Official Records Supplement No. 7, E/2015/27-E/CN.6/2015/10 (2015) resolution 59/1, page 20, paragraph 6.

[343] Political declaration on the occasion of the twentieth anniversary of the Fourth World Conference on Women, contained in the Report of the fifty-ninth session of the Commission on the Status of Women, Economic and Social Council Official Records Supplement No. 7, E/2015/27-E/CN.6/2015/10 (2015) resolution 59/1, page 20, paragraph 6.

[344] ACPF (2011). The Lives of Children with Disabilities in Africa: A glimpse into a hidden world, African Child Policy Forum, Addis Ababa, Ethiopia

[345] UNICEF & University of Wisconsin (2008), Monitoring Child Disability in Developing Countries: Results from MICS. New York

[346] UNICEF (2013). Children and Young People with Disabilities: Fact Sheet, UNICEF, New York, May 2013

[347] UNOHCHR (2014), CRPD concluding observations related to children, UNOHCHR, Geneva

[348] SOS Children's Villages International & University of Bedfordshire, (2014), From a Whisper to a Shout: A call to end violence against children in alternative care, Innsbruck.

[349] Ibid.

[350] UNICEF (2013). The State of the World's Children: Children with Disabilities, New York.

[351] SOS Children's Villages International & University of Bedfordshire, (2014), From a Whisper to a Shout: A call to end violence against children in alternative care, Innsbruck, Austria

[352] The Committee on the Rights of the Child has noted this issue on several occasions across Latin America, Africa and Asia

353 SOS Children's Villages International & University of Bedfordshire, (2014), From a Whisper to a Shout: A call to end violence against children in alternative care, Innsbruck, Austria

[354] UNICEF (2013), The State of the World's Children: Children with Disabilities quoting a study on 17 high-income countries by a research team from the Liverpool John Moores University & WHO.

[355] *ibid*

[356] SOS Children's Villages International & University of Bedfordshire, (2014), From a Whisper to a Shout: A call to end violence against children in alternative care, Innsbruck, Austria

[357] Monitoring Child Disability in Developing Countries: Results from MICS (2008). UNICEF & University of Wisconsin, New York

[358] Children and Young People with Disabilities: Fact Sheet (2013), UNICEF, New York, May 2013

[359] *ibid*

[360] UNICEF (2014), Hidden in Plain Sight: a statistical analysis of violence against children, UNICEF, New York

[361] UNICEF (2013). The State of the World's Children: Children with Disabilities, UNICEF, New York

[362] WHO (2010) Community Based Rehabilitation (CBR) Guidelines. Geneva: World Health Organisation. http://www.who.int/disabilities/cbr/guidelines/en/index.html and Werner D. (2009) Disabled Village Children. Berkeley, CA.: The HesperianFoundation. http://hesperian.org/books-and-resources/ quoted in UNICEF (2013) Children and Young People with Disabilities: Fact Sheet, UNICEF, New York, May 2013

[363] WHO (2012). (2Assistive devices/technologies: what WHO is doing: World Health Organization; 2012 [19 June 2012]. Available from: http://www.who.int/disabilities/technology/activities/en/#.

[364] Filmer, (2011), 'Disability, Poverty, and Schooling in Developing Countries: Results from 14 household surveys', World Bank Economic Review, vol. 22, no. 1, 2008, pp. 141–163, as cited in World Health Organization and the World Bank, World Report on Disability, 2011

[365] Loeb, M. & A. Eide (2004). Living conditions among people with activity limitations in Malawi, a national representative study. Oslo: SINTEF Health Research, 2004.

[366] World Bank (2007), Disability in India: From Commitments to Outcomes. Working Paper, 2007, Washington DC

[367] Government of Tanzania (2009), 2008 Tanzania Disability Survey, United Republic of Tanzania National Bureau of Statistics, Dar es Salam, Tanzania, quoted in UNICEF (2013), The State of the World's Children: Children with Disabilities, UNICEF, New York

[368] UNICEF (2012), Integrated Social Protection Systems: Enhancing Equity for Children, UNICEF, New York

[369] UNICEF (2012), Integrated Social Protection Systems: Enhancing Equity for Children, UNICEF, New York

[370] UNICEF Zimbabwe, Country Office Annual Report 2014

[371] The United Nations defines youth as those persons between the ages of 15 and 24 years. See General Assembly Resolution A/36/215.

[372] Mitra, S., Posarac, A., & Vick, B. (2013). *Disability and poverty in developing countries: a multidimensional study. World Development*, 41, 1-18.

[373] A/RES/68/3, 4(b).

[374] Groce, N.E. (2003). HIV/AIDS and people with disability. The Lancet, 361(9367), 1401-1402.

[375] Roggero, P., Tarricone, R., Nicoli, M., & Mangiaterra, V. (2005). Employment & Youth with Disabilities: Sharing Knowledge and Practices. Washington, D.C.: World Bank.

[376]Aito, S., D'Andrea, M.D., Werhagen, W. (2005) Spinal cord injuries due to diving accidents. Spinal Cord, *43*(2), 109-116; Cripps, R.A. (2006) Spinal Cord Injury, Australia 2003-04. Canberra: Australian Institute of Health and Welfare.

[377] UN Department of Economic and Social Affairs. (2007). *United Nations World Youth Report 2005.*

[378] University of New Hampshire, Institute on Disability (2014). 2014 Disability Statistics Annual Report: A Publication of the Disability Statistics and Demographics Rehabilitation Research & Training Center. http://www.disabilitycompendium.org/docs/default-source/2014-compendium/annual-report.pdf

[379] United Nations Children's Fund. (1999). *Global Survey of Adolescents with Disability: An Overview of Young People Living with Disabilities: Their Needs and Rights*. New York: UNICEF.

[380] Hollar, D. (2005). Risk behaviors for varying categories of Disability in NELS:88. *The Journal of School Health, 75*(9),350-359; World Health Organization and World Bank, *World Report on Disability* 29 (2011), available at http://www.who.int/disabilities/world_report/2011/report/en/

[381] Groce, N.E. (2004) Adolescents and youth with disability: Issues and Challenges. *Asia Pacific Disability Rehabilitation Journal, 15*(2), 13- 32.

[382] Cyprus: Labour Force Survey 2002; Austria: Labour Force Survey ad-hoc module on employment of disabled people, 2002; Poland: Labour Force Survey 2005; Portugal: 2001 Population and housing census; Brazil: 2000 Census; Korea, Rep: National Survey on the Disabled People, 2005 ; Hungary: 2000 Census; Turcs and Caicos: 2001 Census; Bahrain: 2001 Population, Housing, Buildings & Establishments Census; Jamaica: 2002 Population and housing census; Trinidad and Tobago: 2000 Census; Croatia: 2001 Population and housing census; Romania: Registration for disability and annual exhaustive surveys carried out in educational establishments, NIS, 2004; Saudi Arabia: 2004 Population and housing census; Costa Rica: 2000 Population census; Honduras: Encuesta Permanente de Hogares de Própositos Múltiples, Septiembre 2002; Mexico: 2000 Population and housing census.

[383] National Council on Disability. (2000, November 1). *Transition and Post-School Outcomes for Youth with Disabilities: Closing the Gaps to Post-Secondary Education and Employment.* Retrieved June 8, 2009, from http://www.ncd.gov/newsroom/publications/2000/transition_11-01-00.htm#1

[384] UN Department of Economic and Social Affairs. (2007). *United Nations World Youth Report 2005.* Retrieved May 13, 2013, from http://social.un.org/index/WorldYouthReport/2005.aspx

[385] UN Department of Economic and Social Affairs. (2007). *United Nations World Youth Report 2005.* Retrieved May 13, 2013, from http://social.un.org/index/WorldYouthReport/2005.aspx

[386] Note, methods of identification of disability is not uniform among the countries presented in the data.

[387] Mann, D.R. & Wittenburg, D.C. (2015) *Starting Behind: Wage and Employment Differentials Between Young Adults with and without Disabilities*. *Jounral of Disability Policy Studies*, 26(2), 89-99.

[388] Mann, D.R. & Wittenburg, D.C. (2015) *Starting Behind: Wage and Employment Differentials Between Young Adults with and without Disabilities*. *Jounral of Disability Policy Studies*, 26(2), 89-99.

[389] ILO, Inclusion of youth with disabilities: The business case, (2014).

[390] ILO, Inclusion of youth with disabilities: The business case, (2014).

[391] Australia: 2003 Survey of Disability, Ageing and Carers; Germany: Labour Force Survey ad-hoc module on employment of disabled people, 2002; Austria: 2000 Census; Brazil: 2001 Population and Housing Census; Cyprus: 2000 Population census; Honduras: 2001 Population and housing census; Portugal: Labour Force Survey 2002; Costa Rica: 2003 Survey (Microcensus); Mexico: Encuesta Permanente de Hogares de Própositos Múltiples, September 2002; Jamaica: ; Ireland: 2002 Populations census; Trinidad and Tobago: 2002 Population and housing census; Hungary: 2001 Population and housing census; Poland: 2000 Population and housing census; Croatia: Labour Force Survey 2005; Lithuania: 2001 Population and housing census; Russian Fed: Administrative Sources, 2005; Bulgaria: 2000 Census

[392] Australia: 2003 Survey of Disability, Ageing and Carers; Germany: Labour Force Survey ad-hoc module on employment of disabled people, 2002; Austria: 2000 Census; Brazil: 2001 Population and Housing Census; Cyprus: 2000 Population census; Honduras: 2001 Population and housing census; Portugal: Labour Force Survey 2002; Costa Rica: 2003 Survey (Microcensus); Mexico: Encuesta Permanente de Hogares de Própositos Múltiples, September 2002; Jamaica: ; Ireland: 2002 Populations census; Trinidad and Tobago: 2002 Population and housing census; Hungary: 2001 Population and housing census; Poland: 2000 Population and housing census; Croatia: Labour Force Survey 2005; Lithuania: 2001 Population and housing census; Russian Fed: Administrative Sources, 2005; Bulgaria: 2000 Census

[393] Milligan, M.S., & Neufeldt, A.H. (2001). The myth of asexuality: A survey of social and empirical evidence. *Sexuality and Disability, 19*(2), 91-109; Groce, N.E. (2004) Adolescents and youth with disability: Issues and Challenges. *Asia Pacific Disability Rehabilitation Journal, 15*(2), 13- 32.

[394] Milligan, M.S., & Neufeldt, A.H. (2001). The myth of asexuality: A survey of social and empirical evidence. *Sexuality and Disability, 19*(2), 91-109; Groce, N.E. (2004) Adolescents and youth with disability: Issues and Challenges. *Asia Pacific Disability Rehabilitation Journal, 15*(2), 13- 32.

[395] Di Giulio, G. (2003) Sexuality and persons living with physical or developmental disabilities: A review of key issues. *The Canadian Journal of Human Sexuality, 12*(1), 53-68.

[396] Milligan, M.S., & Neufeldt, A.H. (2001). The myth of asexuality: A survey of social and empirical evidence. *Sexuality and Disability, 19*(2), 91-109.

[397] Inclusion International. (2006). *Hear our voices: A global report - People with an intellectual disability & their families speak out on poverty and exclusion.* Retrieved June 9, 2009, from http://www.ii.tomekklas.com/site_uploads/File/Hear%20Our%20Voices%20w%20Covers.pdf

[398] Groce, N.E. (2003). HIV/AIDS and people with disability. *The Lancet, 361*(9367), 1401-1402.

[399] Groce, N.E. (2004) Adolescents and youth with disability: Issues and Challenges. *Asia Pacific Disability Rehabilitation Journal, 15*(2), 13- 32.

[400] Al-Momani, M. (2011). The Arab "Youth Quake": Implications on democratization and stability. *Middle East Law and Governance, 3*(1-2), 159-170; Fisher, D. (2012). Youth political participation: bridging activism and electoral politics. *Annual Review of Sociology, 38*, 119-137.

[401] Lord, J.E.,. & Stein, M.A. (2008). The Domestic Incorporation of Human Rights Law and the United Nations Convention on the Rights of Persons with Disabilities. Faculty Publications. Paper 665. Retrieved May 13, 2013 from http://scholarship.law.wm.edu/facpubs/665; Parker Harris, S. (2011). *Civic Engagement and Disability: using advocacy and technology to advance the political participation of people with disabilities*. UIC Institute for Policy and Civic Engagement. Retrieved May 13, 2013, from http://www.uic.edu/cuppa/ipce/interior/CivicEngagement&DisabilityFullReport.pdf

[402] Lord, J., Guernsey, K., Balfe, J., Karr, V., & deFranco, A. (2012). *Human rights. YES! Action and advocacy on the rights of persons with disabilities* [2nd Ed.]. Minneapolis, MN: University of Minnesota Human Rights

Center; Schur, L., & Adya, M. (2012). Sidelined or mainstreamed? Political participation and attitudes of people with disabilities in the United States. *Social Science Quarterly (published online 18 July 2012).*

[403] Madrid International Plan of Action on Ageing and the Political Declaration . Available for download at http://undesadspd.org/Ageing/MadridPlanofActionanditsImplementation.aspx

[404] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 21 (g)

[405] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 24

[406] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 28 (c)

[407] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 33 (a)

[408] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 40 (b)

[409] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 46

[410] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 52

[411] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 69

[412] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 90

[413] Madrid International Plan of Action on Ageing and the Political Declaration. Paragraph 99

[414] Current Status of the Social Situation, Wellbeing and Participation in Development and Rights of Older Persons Worldwide (2011). United Nations Department of Economics and Social Affairs. Available at: http://www.un.org/esa/socdev/ageing/documents/publications/current-status-older-persons.pdf

[415] Walker, A., Gordon, D., Levitas, R., Phillimore, P., Phillipson, C., Salomon, M. E., & Yeates, N. (2010). *The Peter Townsend Reader.* The Policy Press, UK.

[416] Values from 2020 onwards and projections.

[417] World Disability Report, World Health Organization and The World Bank, 2011, page 238. Available at http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf?ua=1

[418] Population aged 60 years or over.

[419] WHO and the World Bank (2011). World Report on Disability, p. 64

[420] Based on data from the World Health Surveys in 31 low-income and low-middle income countries.

[421] Agree, E. (2013). The potential for technology to enhance independence for those aging with a disability. *Disability and Health Journal, 7,* S33-39.

[422] http://www.sciencedirect.com/science/article/pii/S0277953698003694

[423] Based on data from the 1994 Survey of Asset and Health Dynamics of the Oldest Old in the US.

[424] http://www.sciencedirect.com/science/article/pii/S1936657413001581

[425] http://www.ncbi.nlm.nih.gov/pubmed/19160906

[426] Based on data from 2005 in the US.

[427] World Population Prospects (2015). United Nations. Available at: http://esa.un.org/unpd/wpp/publications/files/key_findings_wpp_2015.pdf

[428] Factor, A., Heller, T., & Janicki, M. (2012). Bridging the Aging and Developmental Disabilities Service Networks: Challenges and Best Practices. Available at: http://www.acf.hhs.gov/sites/default/files/aidd/bridgingreport_3_15_2012.pdf

[429] Hassouneh, D., Nguyen, T., Chen, Z., & NcNeff, E. (2013). Healing pathways: a program for women with physical disabilities and depression. Rehabilitation Research and Practice, doi:10.1155/2013/649875.

[430] U.D. Department of Health and Human Services: Reducing Disability in Alzheimer's Disease. An Evidence-Based Intervention. Available at: http://www.aoa.gov/AoA_Programs/HPW/Alz_Grants/reducing.aspx

[431] United Nations. Inter-Agency Support Group on Indigenous Peoples' Issues. Thematic paper towards the preparation of the 2014 World Conference on Indigenous Peoples. Rights of indigenous peoples/persons with disabilities. Paragraph 2.

[432] United Nations Declaration on the Rights of Indigenous People. 2007.

[433] Convention on the Rights of Persons with Disabilities.

[434] United Nations. Outcome document of the high-level meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond A/68/L.1. 17 September 2013. Para II. 4. (b).

[435] United Nations. Outcome document of the high-level plenary meeting of the General Assembly known as the World Conference on Indigenous Peoples. A/RES/69/2. 25 September 2014. Paras 9, 10 and 18.

[436] Study on the situation of indigenous persons with disabilities, with a particular focus on challenges faced with regards to the full enjoyment of human rights and inclusion in development. United Nations Permanent Forum on Indigenous Issues. E/C.19/2013/6, p. 3.

[437] E. Ng (1996). Disability among Canada's Aboriginal Peoples in 1991. Statistics Canada Health Reports, Summer 1996, Vol 8, No 1, pages 25-32. Available at: http://www.statcan.gc.ca/pub/82-003-x/1996001/article/2823-eng.pdf

[438] L. Cohen at al (2012). Native American Developmental Disabilities Needs Assessment, Association of University Centers on Disabilities. Available at: http://www.aucd.org/docs/publications/native_am_needs_assmt_sm.pdf

[439] Australian Indigenous. Disability. Available at: http://www.healthinfonet.ecu.edu.au/health-facts/overviews/disability

[440] Australian survey of disability, ageing and carers.

[441] http://www.stats.govt.nz/browse_for_stats/health/disabilities/disability-and-maori.aspx

[442] Study on the situation of indigenous persons with disabilities, with a particular focus on challenges faced with regards to the full enjoyment of human rights and inclusion in development. United Nations Permanent Forum on Indigenous Issues. E/C.19/2013/6. New York, 5 February 2013. Para. 4.

[443] Deyhle, D. & Swisher, K. (1997). Research in American Indian and Alaska Native education: From assimilation to self-determination. In Apple, M. W. (Ed.) Review of research in education (pp. 113-194). Washington DC: American Educational Research Association

[444] National Council on Disability, (2003). People with disabilities on tribal lands. Government Documents Service: Online Publications (Y3.D 63/3:2 P 39). Available at: www.asu.edu/lib/hayden/govdocs/onlinepubs/ncd.html

[445] United States Commission on Civil Rights, (2003). A quiet crisis: Federal funding and unmet needs in Indian Country. Available at from www.usccr.gov/pubs/na0704.pdf

[446] http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/publication/wcms_396412.pdf

[447] United Nations Permanent Forum on Indigenous Issues. E/C.19/2013/6. pages 9-13

[448] Office for Disability Issues and Statistics New Zealand, *Disability and Maori in New Zealand in*

2006: Results from the New Zealand Disability Survey (Wellington, Statistics New Zealand, 2010).

[449] Pollak A. Carol. Access to Justice for Indigenous Persons with Disabilities: Key Issues and Opportunities. In "Indigenous Peoples access to justice, including truth and reconciliation processes. Institute for the Study of Human Rights. Columbia University. New York, USA. 2014. Page. 308.

[450] United Nations. Access to justice in the promotion and protection of the rights

of indigenous peoples. Expert Mechanism on the Rights of Indigenous Peoples. A/HRC/EMRIP/2013/2.

[451] United Nations. Access to justice in the promotion and protection of the rights of indigenous peoples. A/HRC/24/50.

[452] United Nations Permanent Forum on Indigenous Issues. E/C.19/2013/6. pages 13-14.

[453] Office of the High Commissioner for Human Rights. *Thematic study on the issue of violence against women and girls and disability.* A/HRC/20/5 of 30 March 2012. page 5.

[454] UNICEF, UNFPA, UN WOMEN, ILO and the SRSG on Violence against Children. *Breaking the silence on violence against indigenous girls, adolescents and young women.* May 2013. page. 5-6.

[455] For further information, see UNISDR, UN global survey explains why so many people living with disabilities die in disasters. Available at: http://www.unisdr.org/archive/35032.

[456] Hirji-Khalfan Raihanna. 2009. Federal Support for Aboriginal People with Disabilities. Available at: cdd.journals.yorku.ca/index.php/cdd/article/download/23386/21577.

[457] PROYECTO: Inclusión socio laboral de mujeres y jóvenes con discapacidad en el sector del turismo accesible en Ecuador. 2015. Available at: http://www.cocemfe.es/cooperacion/index.php?option=com_content&view=article&id=62&Itemid=71

[458] The Americas and Caribbean Region Office. 2011. Case Study on Narrowing the Gaps for Equity. Cross-cutting social innovations for the fulfilment of indigenous children's and adolescents' rights. Developed in collaboration with UNIFEC. Available at: http://www.unicef.org/equity/files/ICONEquity_Case_Study_Mexico_FINAL.pdf. Viewed August 28 2015.

[459] National Programme for the Development and Inclusion of Persons with Disabilities 2014-2018. Official Journal of the Federation. 30 April 2014.

[460] US Department of Education. Vocational Rehabilitation Services Projects for American Indians with DisabilitiesVocational Rehabilitation Services Projects for American Indians with Disabilities Available at: http://www.benefits.gov/benefits/benefit-details/915.

[461] UNHCR (2015). UNHCR Global Trends: Forced Displacement in 2014. Available at: http://unhcr.org/556725e69.html

[462] Smith-Khan, L. et al (2015). To 'promote, protect and ensure': overcoming obstacles to identifying disability in forced migration. *Journal of Refugee Studies,* vol 28, p. 38-68. doi: 10.1093/jrs/feu020

[463] HelpAge International & Handicap International (2014). Hidden victims of the Syrian crisis: disabled, injured and older refugees. London: HelpAge International, Lyon: Handicap International, p. 19.

[464] See section 3.3 'Prevalence of disability'.

[465] Washington Group on Disability Statistics (2011) 'Washington Group: Extended Question Set on Functioning (WG ES-F), Version 9', November 2011. Available at: http://www.cdc.gov/nchs/data/washington_group/WG_Extended_Question_Set_on_Functioning.pdf

[466] See section 3.2 'Measuring disability'.

[467] Ibid.

[468] See section 3.3 'Prevalence of disability'.

[469] HelpAge International & Handicap International (2014). Hidden victims of the Syrian crisis: disabled, injured and older refugees. London: HelpAge International, Lyon: Handicap International, p. 6.

[470] These figures are quoted from a report co-developed by the University of Sydney and UNHCR Islamabad, taken from data from the *Population Profiling, Verification and Response Survey of Afghans 2011.* See http://blogs.usyd.edu.au/refugees-disabilities/ for links to this and other key publications. The global estimate (of lower income countries) is taken from WHO 2011, p. 27.

[471] Refugee Law Project (2014) From the Frying Pan into the Fire: Psychosocial Challenges Faced by Vulnerable Refugee Women and Girls in Kampala. Kampala: Refugee Law Project (April 2014).

[472] Reported by researchers from the University of Sydney. See report on Syrian refugees with disabilities at http://blogs.usyd.edu.au/refugees-disabilities/

[473] UNHCR (2011) Need to Know Guidance: Working with Persons with Disabilities in Forced Displacement. Geneva: UNHCR, Available at: http://www.unhcr.org/4ec3c81c9.pdf

[474] In this chapter, "mental and intellectual disabilities" is used to refer to persons with mental impairments and persons with intellectual impairments based on the terminology in the Convention on the Rights of Persons with Disabilities. WHO uses the term "psychosocial disabilities" in the Comprehensive Mental Health Action Plan 2013-2020 (WHA66.8) which refers to "people who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion. People living with

psychosocial disabilities include ex-users, current users of the mental health care services, as well as persons that identify themselves as survivors of these services or with the psychosocial disability itself".

[475] Mental Health Atlas (2014). World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1

[476] Mental Health Atlas (2014). World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1

[477] Available at: http://www.who.int/governance/eb/who_constitution_en.pdf

[478] International Covenant on Economic, Social and Cultural Rights (1966). Article 12. Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

[479] Article 1. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx

[480] Articles 17 and 25. Available at http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

[481] Optional Protocol to the CRC on the Involvement of Children in Armed Conflict (2000) Preamble, Article 6. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPACCRC.aspx. The Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography (2000). Preamble, Article 8, 9, 10. Available at http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPSCCRC.aspx

[482] Articles 1.

[483] Available at: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

[484] In addition, mental well-being and disability is included in strategic plans of the United Nations funds and programmes: UNFPA Strategic Plan 2008-2013; UNRWA Medium Term Strategy, 2010-2015; UNAIDS Strategy 2011-2015; UNODC Strategy 2012-2015; UNHCR Public Health Strategy 2014-2018; UNICEF Strategic Plan 2014-2017.

[485] UN General Assembly resolution 2856 (XXVI). Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/RightsOfMentallyRetardedPersons.aspx

[486] A/RES/46/119, Available at: http://www.un.org/documents/ga/res/46/a46r119.htm

[487] Sendai Framework for Disaster Risk Reduction: 2015-2030, Paragraph 33 (o). Available at: http://www.preventionweb.net/files/43291_sendaiframeworkfordrren.pdf

[488] World Health Organisation (2014). Available at: http://www.who.int/features/factfiles/mental_health/en/

[489] World Health Organization Factsheet. Available at: http://www.who.int/mental_health/management/info_sheet.pdf

[490] Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care (2014). OECD. Available at http://www.oecd-ilibrary.org/social-issues-migration-health/making-mental-health-count_9789264208445-en

[491] World Health Organization. Suicide Data. Available at: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

[492] Health for the World's Adolescents: A Second Chance in the Second Decade. World Health Organization. Accessed on 28/08/2015 from http://apps.who.int/adolescent/second-decade/

[493] Andrews, G., Slade, T., & Issakidis, C. (2002). Deconstructing current comorbidity: data from the Australian National Survey of Mental Health and Well-Being. *British Journal of Psychiatry, 181*, 306-314.

[494] Mental Health Action Plan 2013-2020. World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

[495] OECD Policy Framework (2015). OECD High-Level Political Forum on Mental Health and Work. Available at: http://www.oecd.org/mental-health-and-work-forum/documents/OECD-POLICY-FRAMEWORK.pdf

[496] Focus on Health (2014). OECD. Available at: http://www.oecd.org/els/health-systems/Focus-on-Health-Making-Mental-Health-Count.pdf

[497] Mental Health Action Plan 2013-2020. World Health Organization. Paragraph 15. Available at: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

[498] Global burden of mental disorders and the need fora comprehensive, coordinated response from

health and social sectors at the country level (2011). World Health Organization: Report by the Secretariat. Paragraph 12. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_9-en.pdf

[499] Global burden of mental disorders and the need for a comprehensive, coordinated response from

health and social sectors at the country level (2011). World Health Organization. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_9-en.pdf

[500] World Health Organization (2006). Dollars, DALYs and Decisions - Economic Aspects of the Mental Health System. Geneva. Available at: http://www.who.int/mental_health/publications/financing/dollars_dalys_and_decisions/en/

[501] Iemmi, V, Gibson, L, Blanchet, K, Kumar, KS, Rath, S, Hartley, S, Murthy, GVS, Patel, V, Weber, J and Kuper H, 2015. Community-based rehabilitation for people with disabilities in low- and middle-income countries: a systematic review, 3ie Grantee Final Review. London: International Initiative for Impact Evaluation (3ie). Available at: http://www.3ieimpact.org/evidence/systematic-reviews/details/209/

[502] Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross national analysis. Geneva, World Health Organization, 2009

[503] Mental Health Atlas 2014 (2015). World Health Organization. Available at http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/

[504] WHO Quality Rights: Service Standards and Quality in Mental Health Care. The World Health Organization. Accessed on 28/08/2015 from http://www.who.int/mental_health/policy/quality_rights/infosheet_hrs_day.pdf

[505] Mental Health Atlas 2014 (2015). World Health Organization. Available at http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en

[506] Based on data from 67 countries.

[507] Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross national analysis. Geneva, World Health Organization, 2009.

[508] Saxena S et al. (2007). Resources for mental health: scarcity, inequity, and inefficiency. Lancet, 370, 878-889.

[509] The State of the World's Children (2013). UNICEF. Available at: http://www.unicef.org/pacificislands/UNI138269.pdf

[510] ECOSOC Meeting "Addressing noncommunicable diseases and mental health: major challenges to sustainable development in the 21st century" (2009). Discussion Paper. Available at: http://www.who.int/nmh/publications/discussion_paper_en.pdf

[511]Chronic Illness and School Performance: A Literature Review Focusing on Asthma and Mental Health Conditions (2010). Children's Health Fund. Available at:http://www.childrenshealthfund.org/sites/default/files/chronic-illness-and-school-performance.pdf

[512] The State of the World's Children (2013). UNICEF. Available at: http://www.unicef.org/pacificislands/UNI138269.pdf

[513] Children and Young People with Disabilities: Fact Sheet (2013). UNICEF. Available at: http://www.unicef.org/disabilities/files/Factsheet_A5__Web_NEW.pdf

[514] Harnois G, Gabriel P. (2000). Mental health and work: impact issues and good practices. World Health Organization and International Labour Organisation. Available at: http://whqlibdoc.who.int/hq/2000/WHO_MSD_MPS_00.2.pdf

[515] Sport and Persons with Disabilities: Fostering Inclusion and Well-Being (2008). In Harnessing the Power of Sport for Development and Peace: Recommendations to Government. United Nations Sport for Development and Peace International Working Group. Accessed on 18/08/2015 from http://www.un.org/wcm/content/site/sport/home/unplayers/memberstates/sdpiwg_keydocs

[516] Expert Group Meeting on Mental Well-being, Disability and Disaster Risk Reduction (2014). http://www.jointokyo.org/en/news/story/EGM_MWB_DDR_report/

[517] Disaster Risk Management for Health: Mental Health and Psychosocial Support (2011). World Health Organization. Available at: http://www.who.int/hac/events/drm_fact_sheet_mental_health.pdf

[518] Crisis Intervention. Encyclopedia of Mental Disorders. Accessed on 28/08/2015 from http://www.minddisorders.com/Br-Del/Crisis-intervention.html.

[519] Mental Health Atlas 2014 (2015). World Health Organization. Available at http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/

[520] Mental health literacy is defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention.

[521] OCHA. Global Humanitarian Overview - Status Report. 2015

[522] RES/A/68/3

[523] Available from: http://www.unescap.org/resources/incheon-strategy-per centE2per cent80per cent9Cmake-right-realper centE2per cent80per cent9D-persons-disabilities-asia-and-pacific

[524] "Sendai Statement to Promote Disability-inclusive Disaster Risk Reduction for Resilient, Inclusive and equitable Societies in Asia and the Pacific" (24 April 2014). Available at http://www.riglobal.org/sendai-statement-to-promote-disability-inclusive-disaster-risk-reduction-for-resilient-inclusive-and-equitable-societies-in-asia-and-the-pacific/

[525] Rehabilitation International (RI), the Nippon Foundation and UNESCAP, "Sendai Statement to Promote Disability-inclusive Disaster Risk Reduction for Resilient, Inclusive and equitable Societies in Asia and the Pacific" (24 April 2014). Available at http://www.riglobal.org/sendai-statement-to-promote-disability-inclusive-disaster-risk-reduction-for-resilient-inclusive-and-equitable-societies-in-asia-and-the-pacific/

[526] UNISDR. Living with Disability and Disasters: UNISDR 2013 Survey on Living with Disabilities and Disasters - Key Findings. 2014

[527] Survey results are available online: (http://www.unisdr.org/2014/iddr/documents/2013DisabilitySurveryReport_030714.pdf), and it provides a solid foundation for further improvement in promoting disability-inclusive disaster risk reduction since one of the challenges that persons with disabilities faces is lack of reliable and disaggregated data.

[528] Article 9 on Accessibility

[529] General Assembly Resolution 68/3.

[530] Utilizing 5 billion urban dwellers, it is estimated that 15-20% of these would be persons living with some form of disability. Data sources derived from WHO World Disability Report (2011) and "Urbanization | UNFPA - United Nations Population Fund." Accessed May 3, 2015. http://www.unfpa.org/urbanization.

[531] Maart, S., A. H. Eide, J. Jelsma, M. E. Loeb, and M. Ka Toni. "Environmental Barriers Experienced by Urban and Rural Disabled People in South Africa." *Disability & Society* 22, no. 4 (2007): 357–69.

[532] Maart, S., A. H. Eide, J. Jelsma, M. E. Loeb, and M. Ka Toni. "Environmental Barriers Experienced by Urban and Rural Disabled People in South Africa." *Disability & Society* 22, no. 4 (2007): 357–69.

[533] "AYWDN: Med Ssengoba, Uganda - YouTube." Accessed May 7, 2015. https://www.youtube.com/watch?v=if0rmVwyyJ0&list=PL407C8373BB7BE5C3&index=12.

[534] "AYWDN: Rose Kwamboka, Kenya - YouTube." Accessed May 7, 2015. https://www.youtube.com/watch?v=BZm8emJaLDU&list=PL407C8373BB7BE5C3&index=5.

[535] Armenia: Register of persons with disabilities, 2005; Australia: 2003 Survey of Disability, Ageing and Carers; Austria: 2002 Labour Force Survey; Ireland: 2002 Population Census; Honduras: Encuesta Permanente de Hogares de Propósitos Múltiples, September 2002; Bulgaria: 2001 Population and Housing Census; India: 2001 Census; Brazil: 2000 Census; Croatia: 2001 Population and Housing Census; Lithuania: 2001 Census; Jamaica: 2001 Census; Costa Rica: 2000 Census; Hungary: 2001 Census; Republic of Korea: National Survey on the Disabled Persons, 2005; Cyprus: 2002 Labour Force Survey.

[536] Although support for decentralization has grown so has the proliferation of short-term policies. As such urban interventions promoting inclusion fall short with technical or financial support to effectively implement comprehensive transformations on the local level.

[537] Pineda, Victor Santiago. "Enabling Justice: Spatializing Disability in the Built Environment." *Critical Planning Journal* 15, no. Summer 2008: 111–23. and Pineda, Victor Santiago. "The Capability Model of Disability: Assessing the Success of the UAE Federal Law No. 29 of 2006." University of California Los Angeles, 2010.

[538] Ibid.

[539] A/RES/63/150, A/RES/64/131, A/RES/65/185, A/RES/66/124, A/RES/67/140, A/RES/68/3 and A/RES/69/142

[540] Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all

[541] Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

[542] Goal 10: Reduce inequality within and among countries

[543] Goal 11: Make cities and human settlements inclusive, safe, resilient and sustainable

[544] Goal 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development

[545] Target 1.3

[546] Target 1.4

[547] Target 1.5

[548] Target 11.5

[549] Target 2.1

[550] Target 6.2

[551] Targets 10.3 and 16.b

[552] Target 1.1

[553] Target 1.1

[554] Target 3.2

[555] Target 3.8

[556] Target 5.2

[557] Target 5.6

[558] Target 16.9

[559] The first recommendation adopted by the 65th Annual UN DPI/NGO Conference, representatives of nongovernmental organizations (NGOs) from around the world, assembled at the United Nations, Headquarters in New York, from 27 to 29 August 2014, stated that "No (sustainable development) goal or target should be considered met until it is met for all groups that are affected, particularly the lowest quintiles of the national income distribution, ensuring that we leave no one behind".

[560] 'No one should be invisible. To the extent possible and with due safeguards for individual privacy and data quality, data should be disaggregated across many dimensions, such as geography, wealth, disability, sex and age. Disaggregated data should be collected on other dimensions based on their relevance to the program, policy or other matter under consideration, for example, ethnicity, migrant status, marital status, HIV status, sexual orientation and gender identity, with due protections for privacy and human rights. Disaggregated data can provide a better comparative picture of what works, and help inform and promote evidence based policy making at every level.'

[561] Treaty bodies and Special Rapporteurs of the Human Rights Council of the United Nations issued several statements on the post-2015 development agenda, see http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15505&LangID=E and http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13341&

[562] SG Synthesis Report: Road to Dignity by 2030 : 'the agenda itself mirrors the broader international human rights framework, including elements of economic, social, cultural, civil, and political rights, as well as the right

to development. Specific targets are set for disadvantaged groups. Indicators will need to be broadly disaggregated across all goals and targets.'

[563] In the 2030 Agenda for Sustainable Development, target 18 in SDG 17 calls for data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.

[564] Target 17.18

[565] Target 4.a

[566] Target 11.2

[567] Target 11.7

[568] Target 4.5

[569] Target 8.5

[570] Target 10.2

[571] Data for this indicator were collected in the ILO School-to-Work Transition Surveys.

[572] http://www.inclusive-education.org/sites/default/files/uploads/booklets/IE_Webinar_Booklet_6.pdf

[573] Examples of rigorous evaluation of disability policies include: http://www.sciencedirect.com/science/article/pii/S0305750X1000121X and http://bjp.rcpsych.org/content/bjprcpsych/199/6/459.full.pdf

[574] http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

[575] Paragraph 51

[576] These aspects are based on recommendations provided by http://www.light-for-the-world.org/newsdetail/title/on-the-road-to-addis/

[577] Data provided by OECD in June 2015.

[578] A/69/187

[579] EuropeAid, Guidance Note for EU Staff, Disability-Inclusive Development Cooperation, 2012.

[580] Report from the Expert Group Meeting 'Operationalisation of the post-2015 Development Agenda for Persons with Disabilities', held in Beirut, Lebanon from May 11-13. The report is available at: http://www.un.org/disabilities/default.asp?navid=15&pid=1631

[581] A/69/187.

[582] Brief description of London Meeting in 2014 held by DFID and DFAT program with UN Secretariat and WG.

[583] A/69/187