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Disability and Development Report 2024

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

Advance Unedited Version


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Department of Economic and Social Affairs

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

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Department of Economic and Social Affairs

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

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

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

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

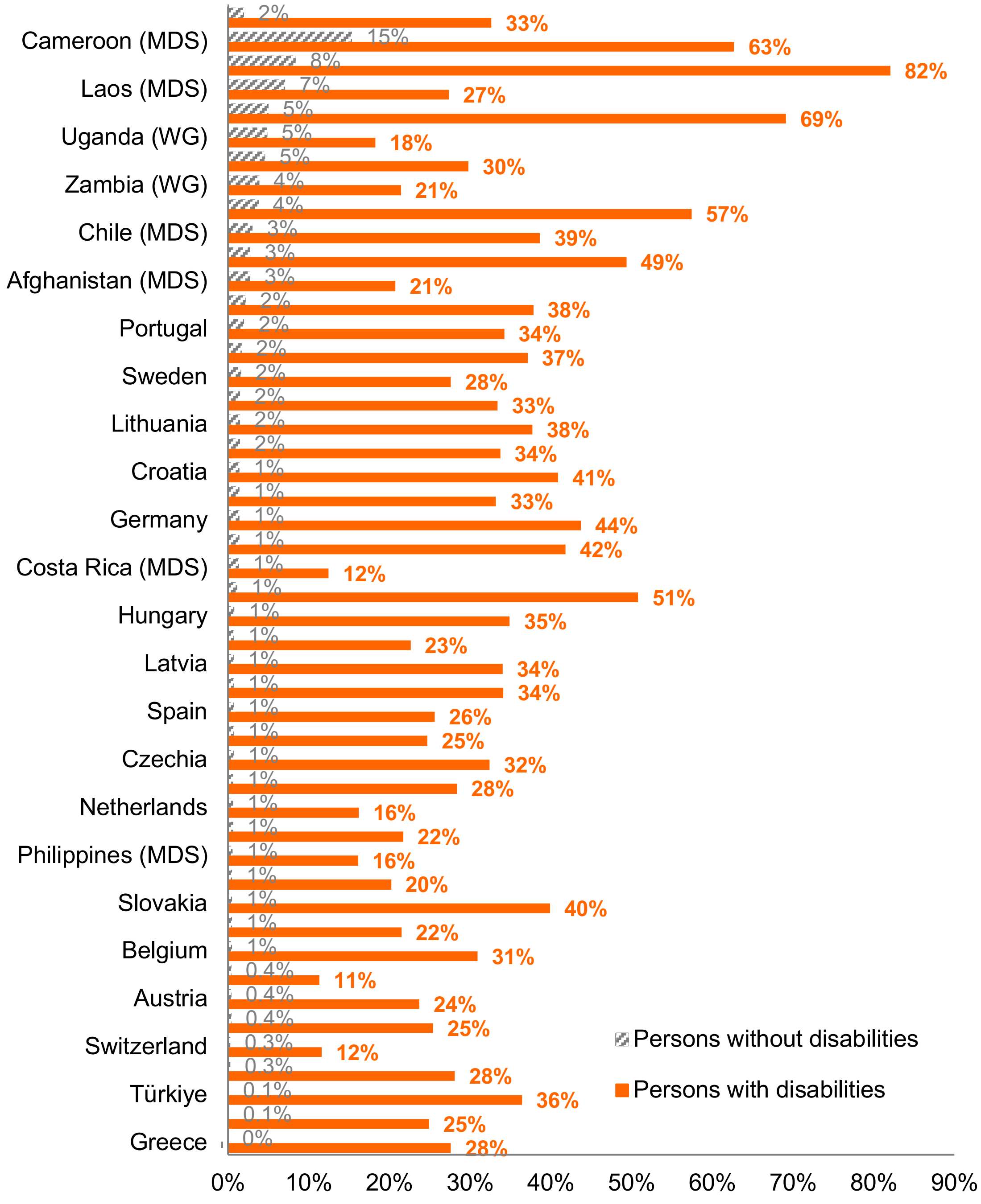
During the COVID-19 pandemic, a momentum for disability inclusion in the health sector was created as countries recognized and committed to act towards health equity for persons with disabilities. A landmark World Health Assembly resolution (WHA74.8) on “The highest attainable standard of health for persons with disabilities” was adopted by countries in 2021. This resolution reiterated the need for a commitment to ensure that persons with disabilities exercise their full right to health. The Resolution aims to advance the agenda of disability inclusion in the health sector in countries, focusing on three key areas - access to effective health services within the context of UHC; access to cross-sectorial public health interventions to improve health and well-being of persons with disabilities; and protection during health emergencies.

Current situation and progress so far

Persons with disabilities still experience health inequities in terms of higher premature mortality and morbidity rates.[51] In 2017, the crude annual death rate for persons with intellectual disabilities was double compared to the general population in the UK, with children with disabilities being eight times more likely to die before the age of 17,[52] and older adults with disabilities dying significantly more often within 30 days of hospitalization compared to those without disabilities.[53] There are also health inequities in morbidity faced by persons with disabilities. Persons with disabilities have higher incidence of communicable and non-communicable diseases such as tuberculosis, diabetes, stroke, cardiovascular problems and asthma.[54] The differences in prevalence of comorbid health conditions between those with and without disabilities continue into older age[55] and apply also to women's health issues (see chapter on targets 3.7 and 5.6). For example, there is evidence that significantly more women with physical (33 per cent), sensory (30 per cent), intellectual (49 per cent) and multiple (42 per cent) impairments have a postpartum emergency visit compared to those without these impairments (24 per cent).[56] Persons with disabilities are also significantly more likely to report having been diagnosed with a sexually transmitted infection or mental health condition, compared to individuals without disabilities.[57,58,59] Persons with intellectual disabilities have a range of secondary chronic conditions in higher rates than those without disabilities, including thyroid dysfunction;[60] viral or infective diseases, neurological disorders, blood diseases, eye diseases, respiratory system diseases, digestive system diseases, skin diseases and diseases of the genitourinary system.[61,62,63,64] Similarly, adults with intellectual disabilities have higher rates of diabetes, asthma, arthritis, cardiac disease, and hypertension, than those without intellectual disabilities.[65,66] These differences are visible from a very early age. For example, children with developmental disabilities are three times more likely to have diabetes than other children.[67]

These health inequities are observed in national data on individual's health, in which persons with disabilities systematically report poorer health than others. In 47 countries or areas, health is self-perceived as bad or very bad by an average of 33 per cent of persons with disabilities compared to 2 per cent of persons without disabilities (Figure 29). Persons with disabilities are more likely to experience poor health than persons without disabilities in all 47 countries. Data from European countries suggests there has been some progress since 2015. Among 33 countries, on average, 33 per cent of persons with disabilities self-reported bad or very bad health in 2021 down from 37 per cent in 2015 (Figure 30). But the progress has been mixed, with a higher percentage of persons with disabilities reporting bad or very bad health in 2021 than in 2015 in 9 countries.

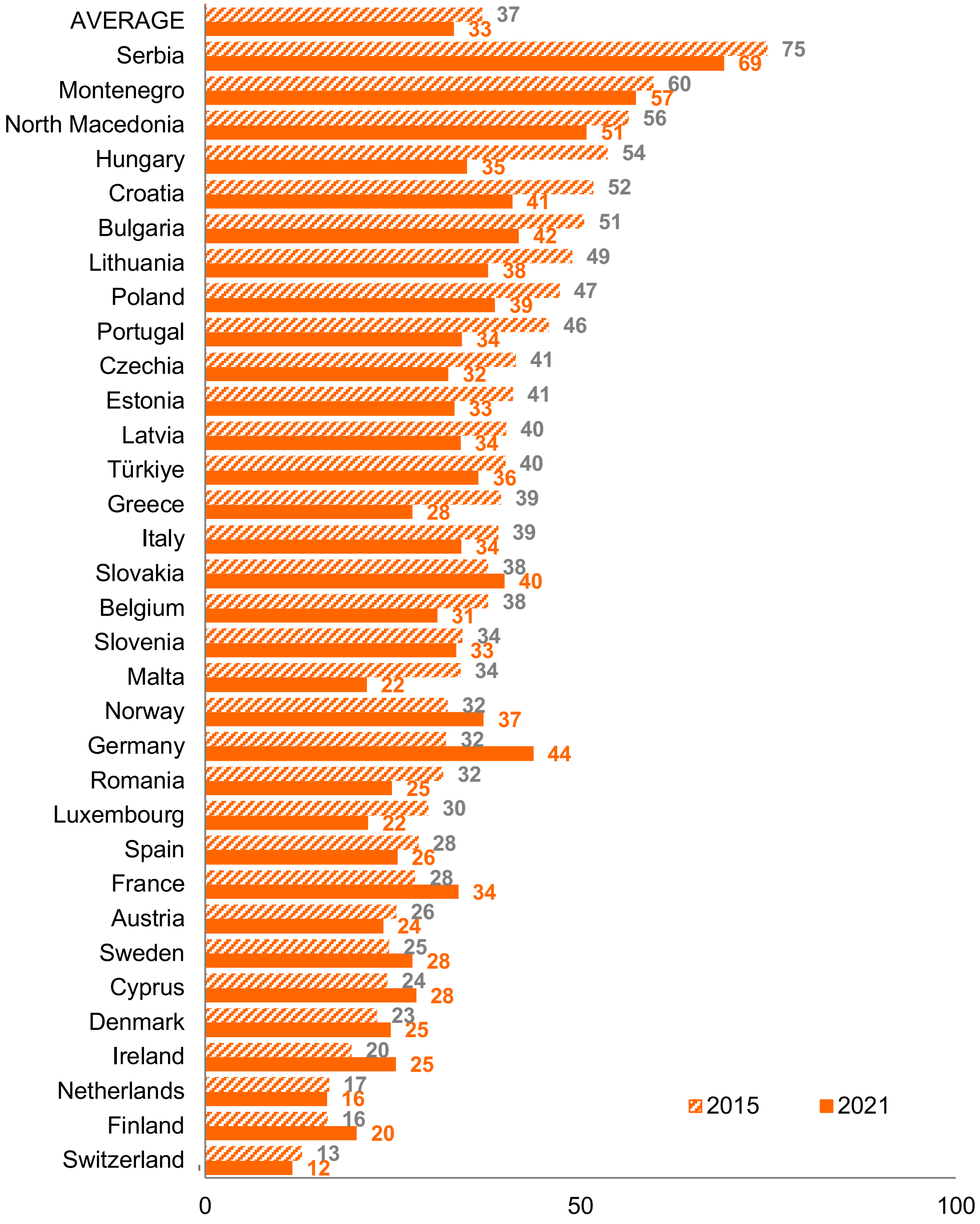
Figure 29. Percentage of persons with self-perceived health as bad or very bad, by disability status, in 47 countries or areas, in 2021 or latest year available.



Note: (MDS) identifies data produced using the Model Disability Survey. (WG) identifies data produced using the Washington Group Short Set of Questions. Data from Cameroon was collected in selected regions of the country and is not nationally representative.

Source: Eurostat,[7] *UNDESA (on the basis of data from SINTEF*[9]*) and WHO.*

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



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

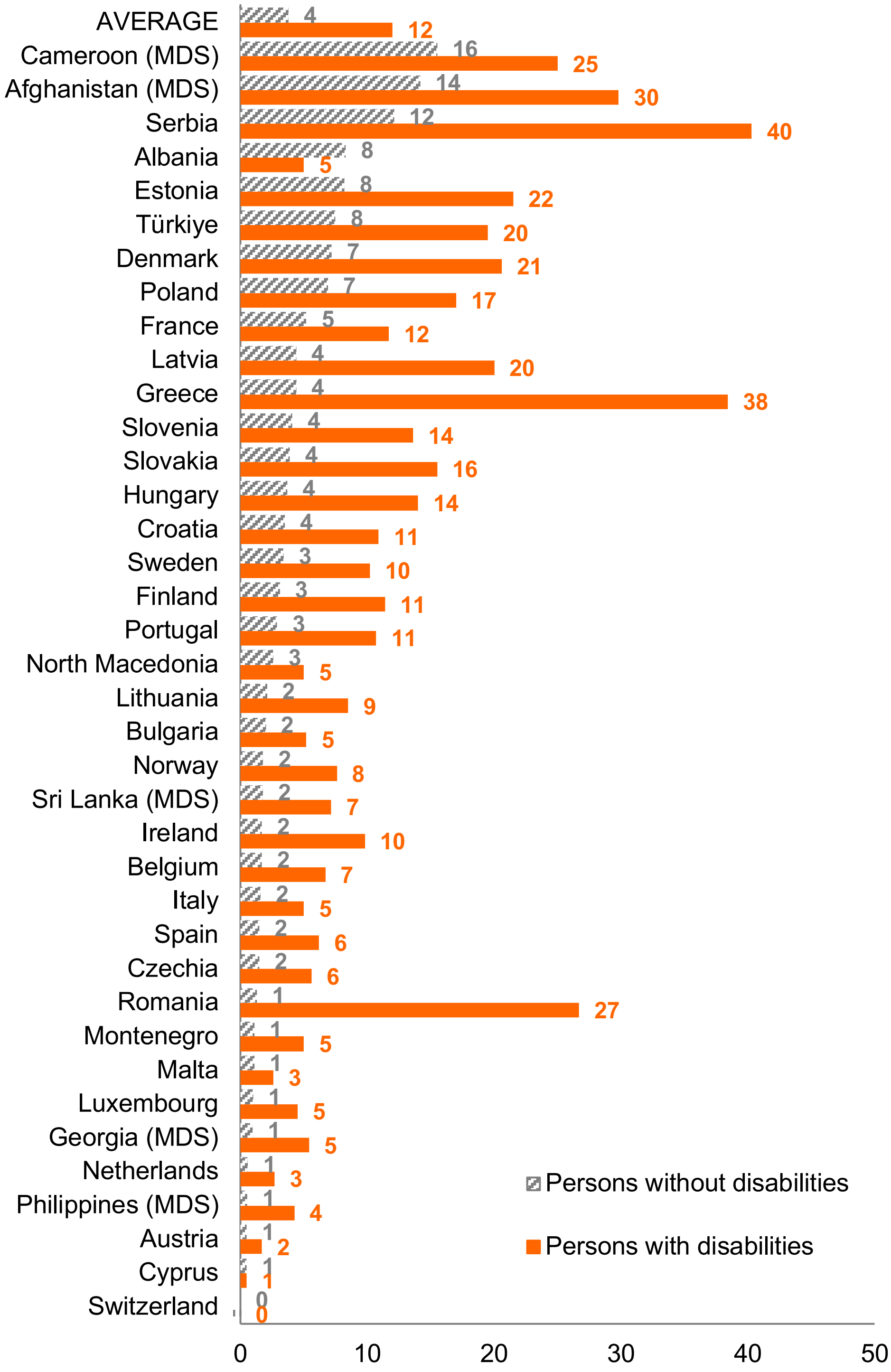
Source: Eurostat. [7]

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

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

In European countries, the costs of the services, the geographical location, which can be difficult to reach, or the long waiting lists, which disproportionately affect persons with disabilities, are major factors to the lower access to health services by persons with disabilities (Figure 32). Among 33 countries, in 2021, 5 per cent of persons with disabilities could not get medical health care when they needed it because of these barriers. Even though a positive trend is observed between 2015 and 2021 and progress has been made in many countries in removing these barriers for persons with disabilities, the differences in unmet needs to medical examination between individuals with disability and the general population are still significant. For example, in Poland, the percentage of persons with disabilities who needed but could not get medical examination because of cost, distance or waiting lists, decreased from 16 per cent to 5 per cent from 2015 to 2021, but it is still larger compared to persons without disabilities (2 per cent). Similarly, in Latvia, there was a decrease of 7 percentage points for persons with disabilities in a period of 6 years, yet the difference with persons without disabilities is 9-fold.

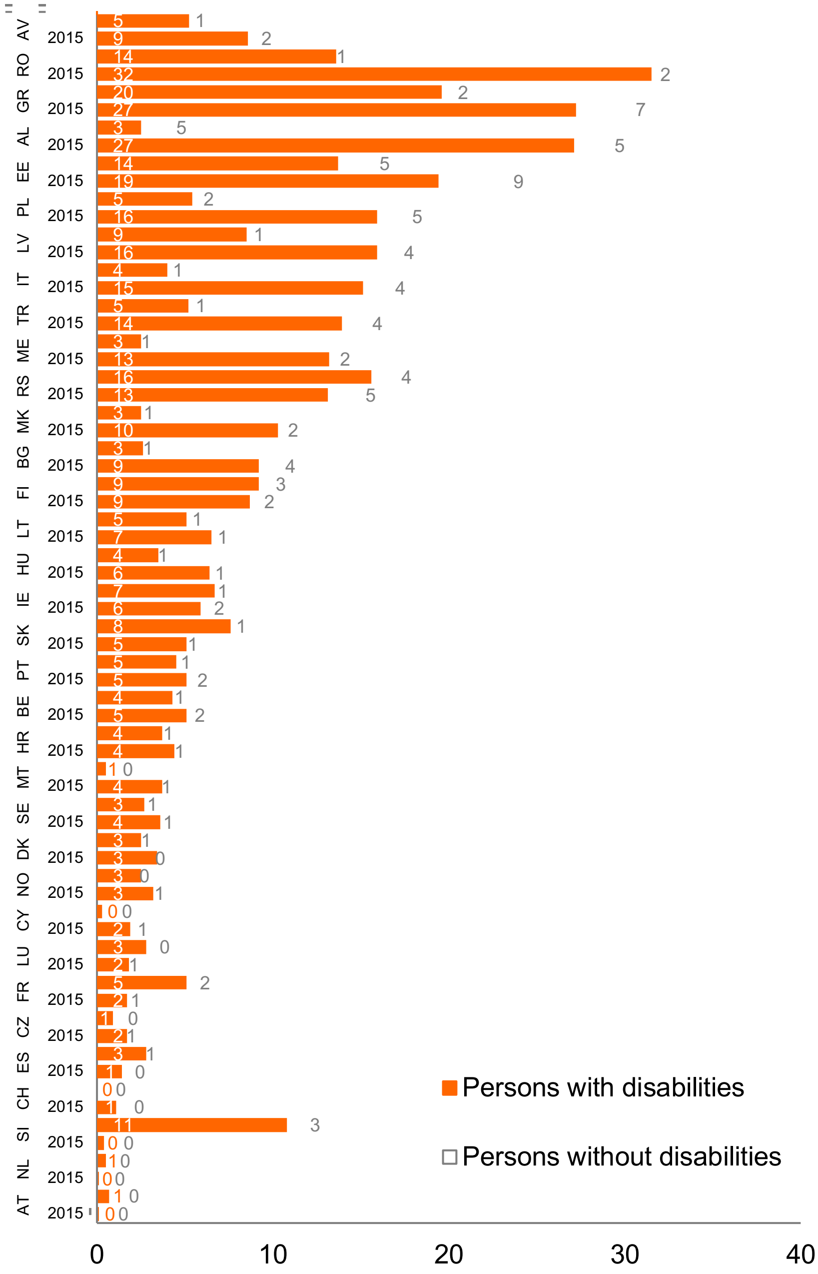
Figure 31. Percentage of persons who needed but could not get health care, by disability status, in 38 countries or areas, in 2021 or latest year available.



Note: Data from Cameroon were collected in selected regions and are not nationally representative.

Source: Eurostat[7] *and WHO.*

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

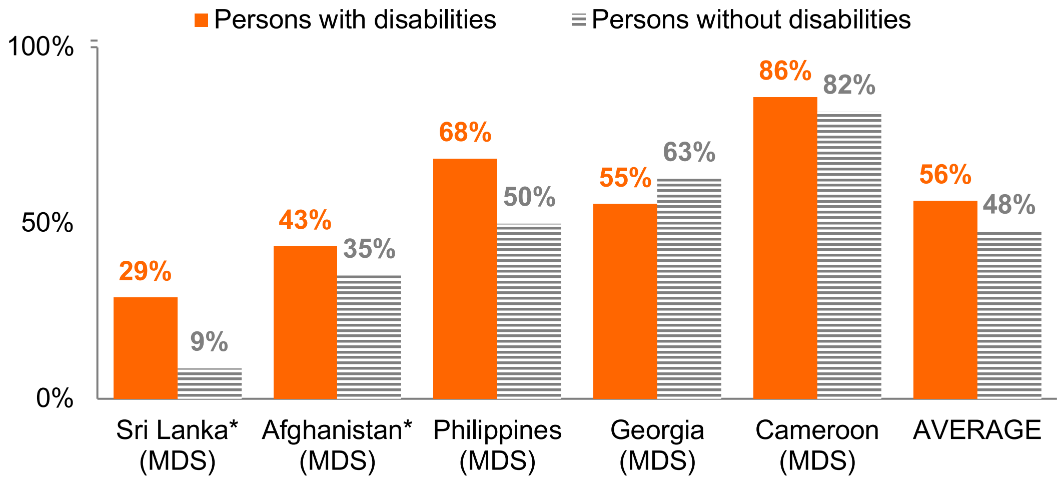


Note: AV, AVERAGE; AL, Albania; AT, Austria; BE, Belgium; BG, Bulgaria; CH, Switzerland; CY, Cyprus; CZ, Czechia; DK, Denmark; EE, Estonia; ES, Spain; FI, Finland; FR, France; GR, Greece; HR, Croatia; HU, Hungary; IE, Ireland; IT, Italy; LT, Lithuania; LU, Luxembourg; LV, Latvia; ME, Montenegro; MK,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

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

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

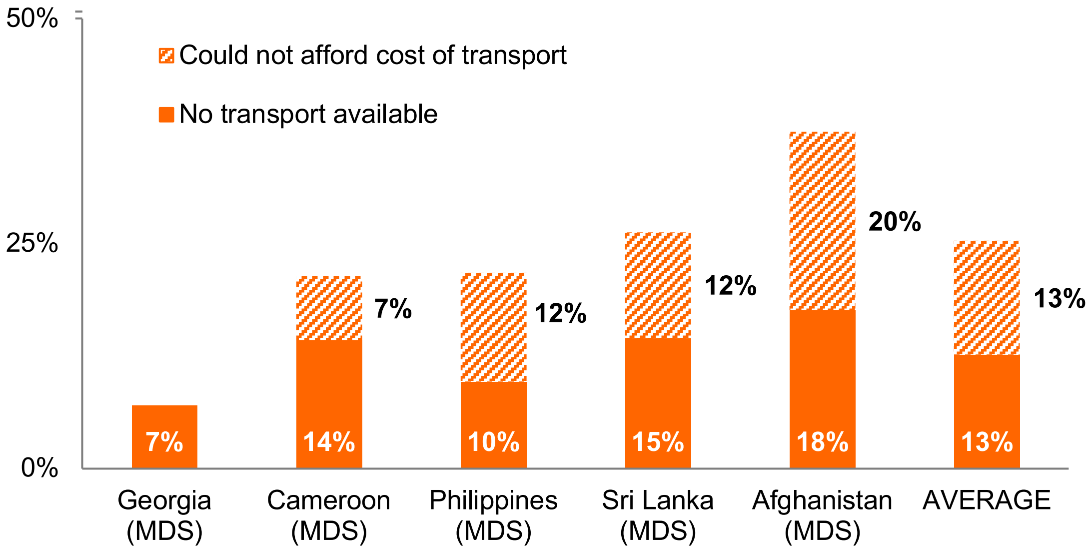
Figure 33. Percentage of persons with disabilities who did not get health care when needed because they could not afford its cost, in 5 countries, in 2021 or latest year available.



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

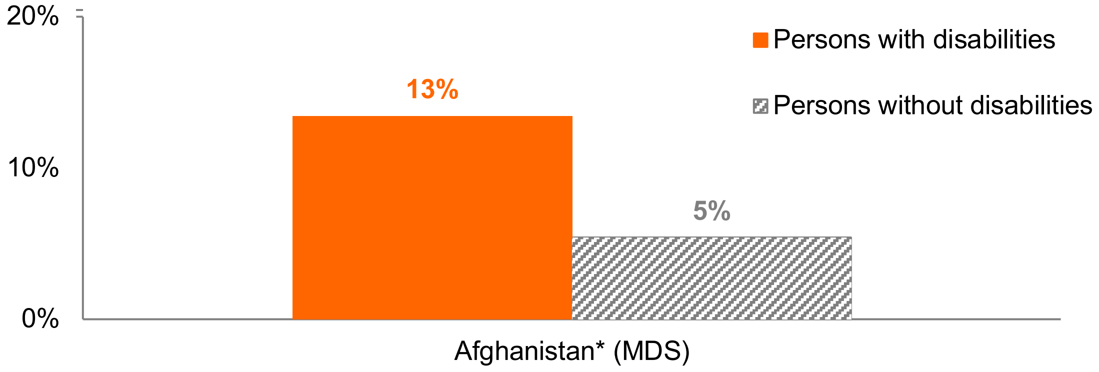
Cost is also a major barrier to health care for persons with disabilities in other developed countries. In the United States, persons with cognitive impairments and persons with physical impairments have up to 5 times more medical expenditures compared to those without disabilities.[86] In the United States, a greater percentage of older adults with disabilities compared to older adults without disabilities delay seeing a doctor due to cost (6 per cent versus 3 per cent)[87]. In the United Kingdom, persons with disabilities living in the community are 5 times more likely to have unmet needs for mental healthcare due to cost, including the cost of prescribed medicines, with women with disabilities 7 times more likely than men with disabilities to have unmet needs due to cost of care or medication.[88]

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



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

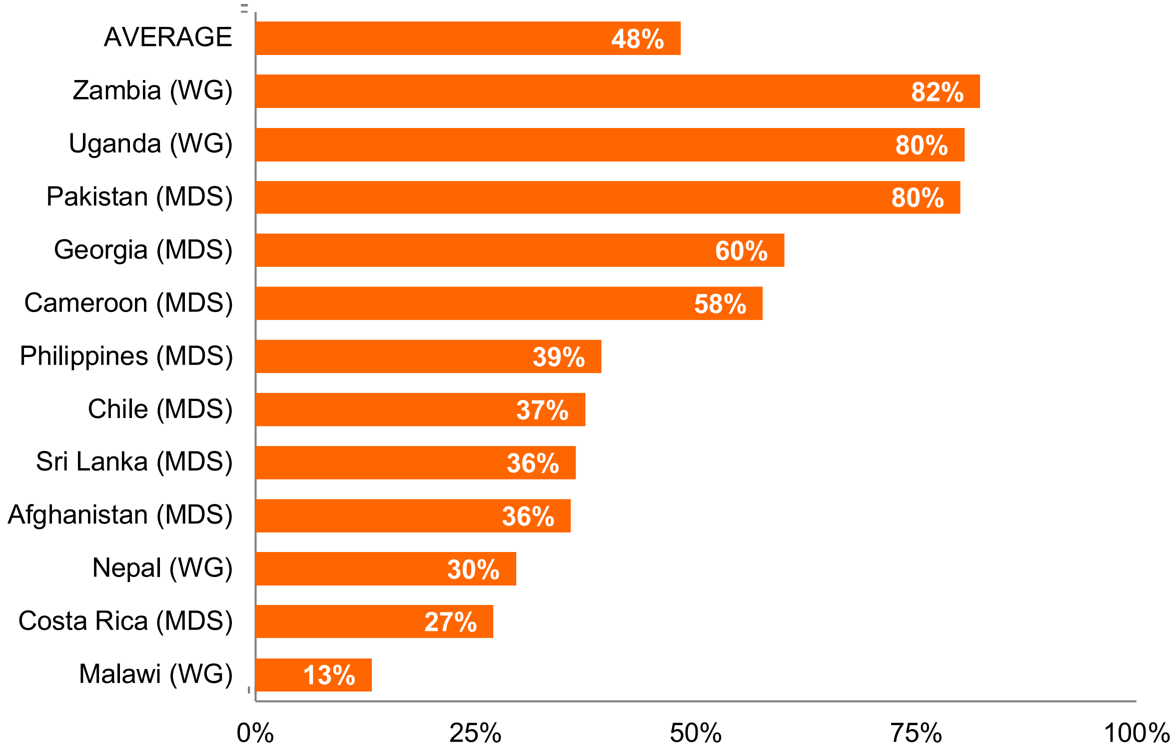
Figure 35. Percentage of persons who were badly treated during inpatient or outpatient health care, by disability status, in Afghanistan, in 2019.



Source: WHO.

In developing countries, the inability to pay for health care or the inability to get transport to the health-care facility tends to be a major barrier for persons with disabilities. Among 5 countries, an average of 56 per cent of persons with disabilities could not afford the cost of needed health care, compared to 48 per cent of persons without disabilities (Figure 33). In Cameroon, 86 per cent of persons with disabilities who needed but could not get health care indicated unaffordability as the barrier. In the Philippines, 68 per cent indicated they could not afford the health-care service; 55 per cent in Georgia, 43 per cent in Afghanistan and 29 per cent in Sri Lanka. Lack of transport hinders access to health services to a much larger extent for persons with disabilities than for persons without disabilities. Among 5 countries or areas, on average, 13 per cent of persons with disabilities could not get health care when needed because they had no transport, and another 13 per cent because the transport was not affordable (Figure 34). In Afghanistan, 20 per cent could not afford the cost of transport to the health facilities and 18 per cent had no transport available to get to the facilities.

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



Note: (WG) identifies data produced using the Washington Group Short Set of Questions; (MDS) identifies data produced using the Model Disability Survey. Data from Cameroon and Pakistan were collected in selected regions and are not nationally representative.

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

Attitudinal barriers also compromise access to health care for persons with disabilities when health professionals have negative of stigmatizing attitudes towards these patients and do not treat them with respect. For example, in Afghanistan, in 2019, 12 per cent of persons with disabilities versus 5 per cent of persons without disabilities indicated that they were badly treated during inpatient or outpatient health care (Figure 35).

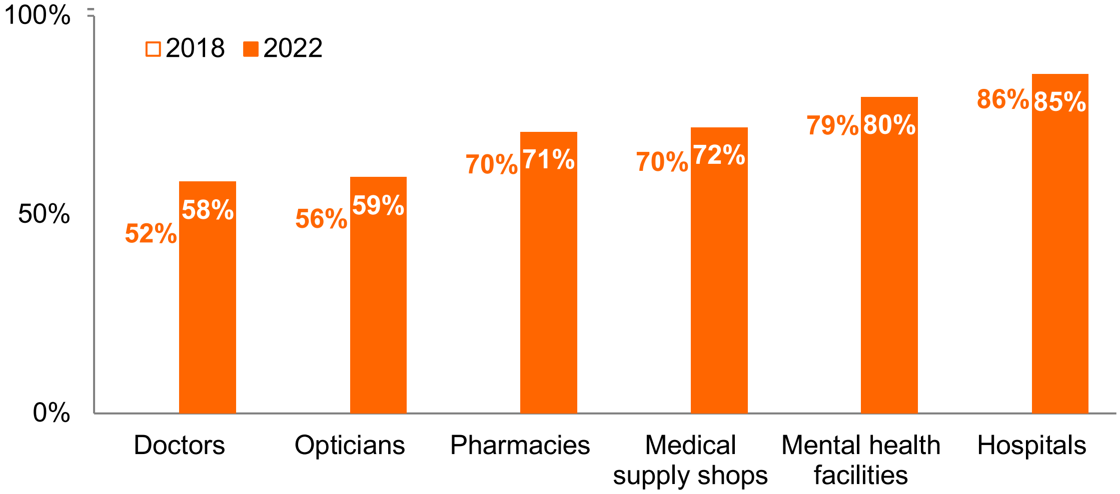
Persons with disabilities have lower coverage rates of receiving population wide interventions compared to persons without disabilities, including for various interventions such as cancer screening, HIV testing and treatment, family planning or prevention of noncommunicable diseases (Table 1). In terms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

Another major factor that hinders access to health services for persons with disabilities is the lack of physical accessibility of health facilities. On average, more than 48 per cent of persons with disabilities experience difficulties accessing health facilities due to physical barriers (In developing countries, the inability to pay for health care or the inability to get transport to the health-care facility tends to be a major barrier for persons with disabilities. Among 5 countries, an average of 56 per cent of persons with disabilities could not afford the cost of needed health care, compared to 48 per cent of persons without disabilities (Figure 33). In Cameroon, 86 per cent of persons with disabilities who needed but could not get health care indicated unaffordability as the barrier. In the Philippines, 68 per cent indicated they could not afford the health-care service; 55 per cent in Georgia, 43 per cent in Afghanistan and 29 per cent in Sri Lanka. Lack of transport hinders access to health services to a much larger extent for persons with disabilities than for persons without disabilities. Among 5 countries or areas, on average, 13 per cent of persons with disabilities could not get health care when needed because they had no transport, and another 13 per cent because the transport was not affordable (Figure 34). In Afghanistan, 20 per cent could not afford the cost of transport to the health facilities and 18 per cent had no transport available to get to the facilities.

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

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

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

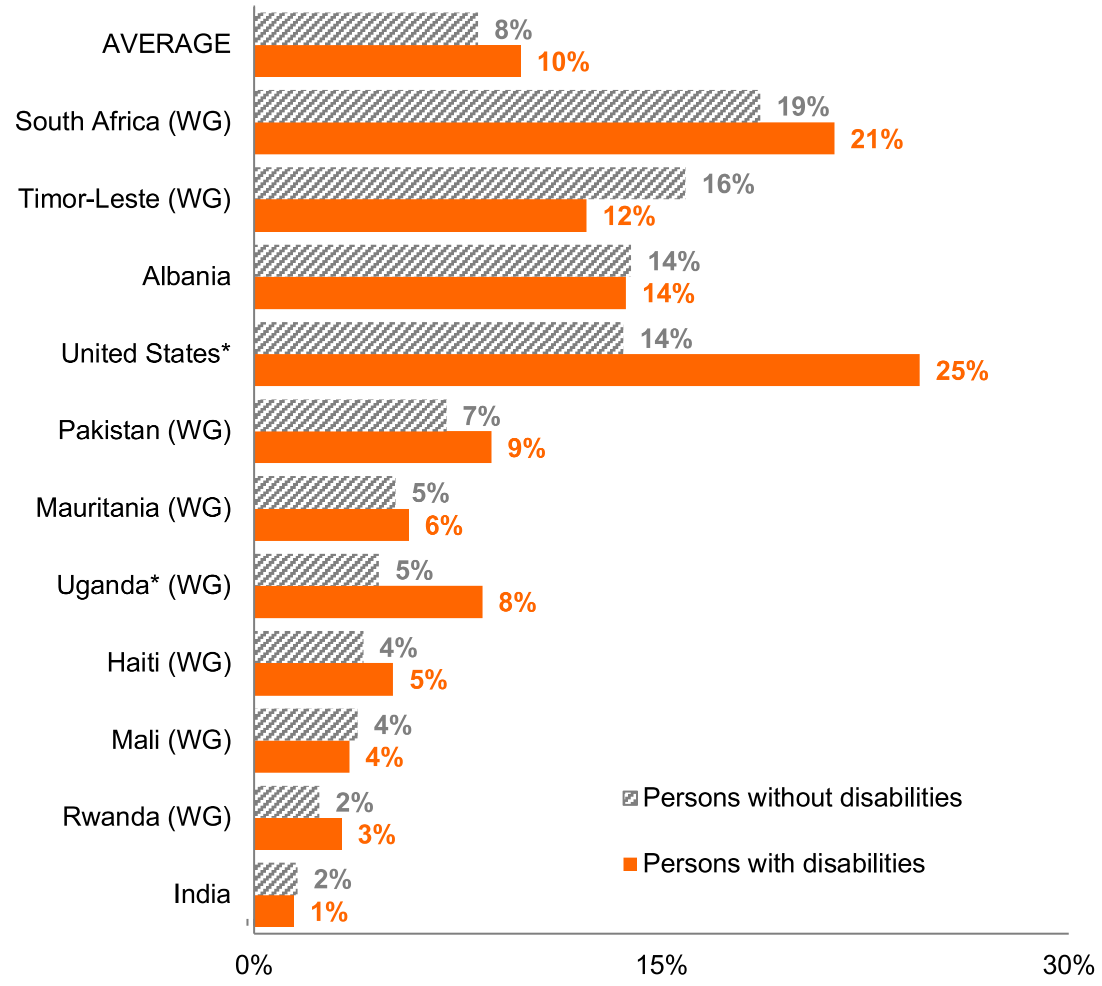


Source: UNDESA (on the basis of data from Sozialhelden[10]).

Depending on the country, smoking may be more or less prevalent among persons with disabilities (Figure 38). In the United States, a higher percentage of persons with disabilities than persons without disabilities smokes, with 25 per cent of adults with disabilities currently smoking compared to 13 per cent of adults without disabilities. Higher prevalence of smokers among persons with disabilities compared to others is also observed in Haiti, Mauritania, Pakistan, Rwanda, South Africa and Uganda.

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

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



Note: Data from the United States refers to current smokers aged 18 years and older; all other data refers to daily and occasional smokers aged 15 to 49. (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between persons with and without disabilities is statistically significant at the level of 5 per cent.

Source: Okoro et al (2020)[104] and UNDESA (on the basis of data from DHS[6]).

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

Regarding national legislation, there has been some progress in the last decades in terms of implementing the right to health for persons with disabilities in national constitutions. Prior to 1990, only 6 per cent of adopted constitutions guaranteed some form of this right. This percentage increased to 33 per cent of constitutions adopted in the 1990s, 52 per cent adopted in the 2000s and 63 per cent of constitutions adopted in 2010.[105] However, overall guarantees of the right to health for persons with disabilities are still very low. As of 2022, only about one third of countries in the world had disability inclusion incorporated in their national health strategies.[106]

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

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

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

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

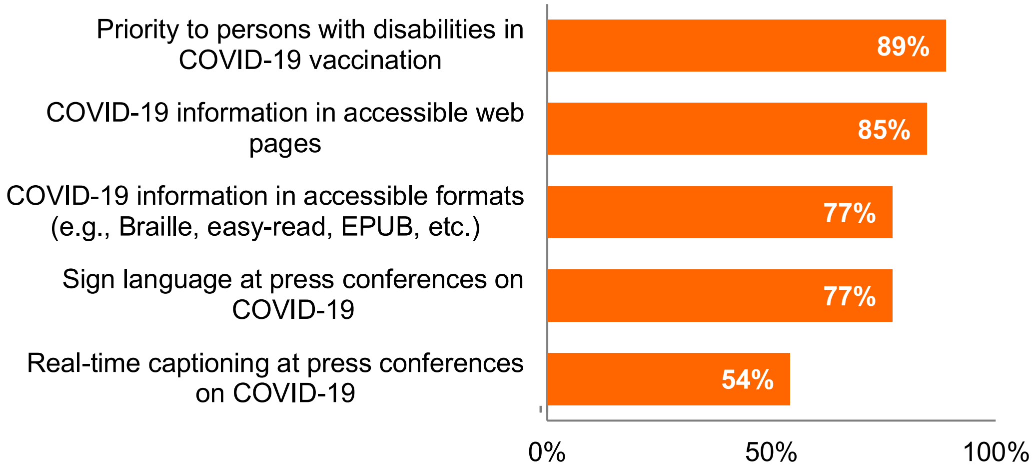
Impact of the COVID-19 pandemic

The COVID-19 pandemic disproportionately affected the health of persons with disabilities and persons with disabilities were more likely to die from COVID-19 than others. For example, in the Republic of Korea and the United Kingdom, more than half of the COVID-19 related deaths have occurred among persons with disabilities, and it can be assumed that this number was much higher in countries with lower resource settings where evidence is more limited.[116,117] In the Republic of Korea, in the early phase of the pandemic, the chance of dying once infected with COVID-19 was 16 per cent for persons with severe or moderate disabilities, 11 per cent for persons with mild disabilities and 2 per cent for persons without disabilities.[118] In England, persons with disabilities were up to 3 times more likely to die from the virus,[119] with those with intellectual disabilities being 7-8 times more likely to die than those without an intellectual disability.[120] This higher death rate impacted especially young persons with intellectual disabilities, aged 18 to 34, who were 30 times more likely to die from COVID-19 than others in the same age group.[121]

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

Unconscious bias[123,124,125,126,127] and preconceptions of medical staff[123] have been linked to discriminatory triage practices in the COVID-19 response. In a review of triage policies for intensive-care units in 14 European countries, in 2020, in more than half of the countries triage protocols recommended the consideration of functional status or frailty assessments,[128] terms which can be confused with “disability”. In the United Kingdom, persons with intellectual disabilities infected with COVID-19 were 50 per cent less likely to be admitted to intensive care, despite having more severe symptoms on admission and similar rates of complications as their counterparts without disabilities.[129] Moreover, persons with disabilities encountered barriers in accessing personal protective equipment and COVID-19 testing during the pandemic. In 2020, a higher proportion of parents/caregivers with disabilities, compared to those without, reported needing and not having essential items to protect them from the COVID-19 virus such as sanitiser (66 per cent vs 54 per cent) and masks (64 per cent vs 50 per cent).[16] And more parents/caregivers with disabilities than those without reported needing and not having access to COVID-19 testing (41 per cent vs 28 per cent).[16] One of the barriers to access was cost, as many persons with disabilities could not afford essential items and services needed to stay healthy during the COVID-19 crisis.[16,130] Another obstacle was accessibility: COVID-19 testing as well as many COVID-19 outpatient and inpatient services, including online health services, were not accessible to many persons with disabilities.[128] In particular, the standard at home COVID-19 tests have barriers for blind users as they rely on visual information not accessible for persons with visual impairments. The technology to produce accessible tests, which rely on non-visual information such as temperature, smell or sound, already existed at the start of the pandemic but they were not produced till about 2 years after the start of the pandemic.[131] Moreover, during the COVID-19 pandemic, wearing face masks became necessary within health care. But face masks hinder speech comprehension for persons with hearing impairments who rely on lip-reading. Although transparent face masks already existed in 2020, research into their efficacy in blocking the transmission of COVID-19 was not pursued in a timely manner to inform on their usage during the pandemic.[132]

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



Note: Data COVID-19 vaccination is based on 27 countries/territories; data on real-time captioning is based on 24 countries/territories; all other data is based on 26 countries/territories.

Source: ESCAP.[14]

Measures to control the COVID-19 outbreak – like community lockdowns, physical distancing requirements and prioritization of selected health services – without considering the needs of persons with disabilities may have caused a lack of sufficient physical activity as well as a reduction of essential health services, social care and support services for persons with disabilities, leading ultimately to higher risks of new or worsening health conditions. About 70 per cent of persons with autism in Europe were left without everyday support due to interruptions in health and social care.[128] Regarding critical health services, worldwide, in 2020, more parents/caregivers with disabilities than those without reported needing and not having access to medicine (40 per cent vs 32 per cent) and to in-person healthcare (34 per cent vs 22 per cent).[16] This lack of access to health services and support may have deteriorated the health of persons with disabilities during the pandemic and made them more vulnerable to death when infected by COVID-19. Disrupted access to critical services such as regular health consultations, medication, psychosocial support, rehabilitation including assistive devices provision, as well as personal assistant and home support services also led to increased pressure on families of persons with disabilities and on informal care mechanisms.[133,134,135,136,137,138,139]

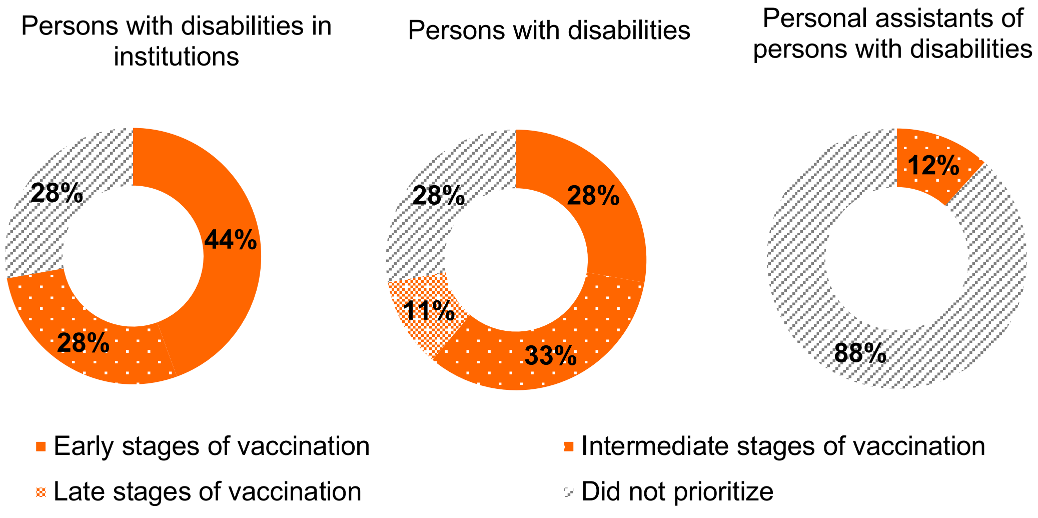
The mental health and psychosocial wellbeing of persons with disabilities has also been impacted by the COVID-19 crisis. In 2020, a total of 82 per cent of parents/caregivers with disabilities reported reduced psychosocial wellbeing since the start of the COVID-19 outbreak.[16] Among persons with disabilities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

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

Persons with disabilities have expressed the need to be prioritized in national COVID-19 vaccination plans and the need to also prioritize their support networks, including personal assistants, family caregivers and persons working in disability-related services.[141] However, despite higher mortality rates, persons with disabilities and their support networks were not always prioritized in national vaccination campaigns. In Asia and the Pacific, persons with disabilities were prioritized in 89 per cent of countries/territories (Figure 39). In Latin America and the Caribbean, persons with disabilities living in institutions were prioritized at the early stage of COVID-19 vaccination in 44 per cent of countries and at the intermediate stage in 28 per cent of countries (Figure 40). Persons with disabilities not living in institutions were less likely to be prioritized in early stages, with only 28 per cent of countries prioritizing them in early stages, 33 per cent in intermediate stages and 11 per cent in late stages of COVID-19 vaccination. And 28 per cent of countries did not prioritize persons with disabilities in their COVID-19 vaccination plans at any stage. Personal assistants were seldom prioritized, with only 12 per cent of countries in Latin America and the Caribbean prioritizing them, and at the intermediate stage of vaccination. Moreover, many COVID-19 vaccination online registration sites were not designed with accessible features for persons with disabilities (see chapter on SDG target 9.c).

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

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



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

Summary of findings and the way forward

Persons with disabilities continue experiencing higher mortality and morbidity; and the contributing factors to these inequities have not changed over the past decade. Persons with disabilities are 15 times more likely to perceive their health as bad or very bad than persons without disabilities and evidence since 2015 suggests progress has been too slow. For example, in European countries, to achieve levels of health similar to persons without disabilities by 2030, the percentage of persons with disabilities self-reporting bad or very bad health would have to decrease 5 times faster than current trends.

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

Many persons with disabilities still do not receive health services according to their needs. Persons with disabilities are 7 times more likely than others to not have access to health care when they need it. In various developing countries, more than half of persons with disabilities do not get health care when needed because they cannot afford the cost. And about a quarter because they do not have or cannot afford transport to health care facilities. In some developed countries, more than 10 per cent of persons with disabilities does not get health care when needed because they cannot afford the cost, the health care is too far to travel or the waiting list is too long.

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

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

Many health facilities remain inaccessible for persons with disabilities. In various developing countries, more than 30 per cent of persons with disabilities indicate that health-care facilities are hindering or not accessible to them. In some countries, this percentage reaches 80 per cent. Crowdsourced data indicates that worldwide, in 2022, 42 per cent doctors' offices, 29 per cent of pharmacies and 15 per cent of hospitals were not accessible for wheelchair users. In the past five years, progress in increasing the accessibility of health related premises has been slow or stagnant. Doctors' offices would need to become accessible for persons using wheelchairs at a rate 3 times faster and pharmacies 7 times faster than current rates of progress to achieve full accessibility by 2030. Progress for hospitals' accessibility has stagnated and needs to be revamped to achieve full accessibility by 2030.

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

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

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

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

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

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

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

4. Ensure that health emergencies management include and protect persons with disabilities. If countries invest in having an inclusive and well-functioning health system, they will be better prepared and able to respond to health emergencies like COVID-19. In practice, this can be done through strengthening essential health service coverage and public health interventions, contributing to the prevention of outbreaks, mitigating risks and building community resilience to such hazards. In addition, responses to health emergencies responses should take into account accessibility for persons with disabilities and impact on the overall lives of persons with disabilities. More research is needed into the efficacy of transparent face masks to prevent transmission of disease as the use opaque face masks cause barriers for persons who are deaf or with hearing impairments in health services, in education and in employment. More efforts are needed to put in practice existing technology and produce in scale tests for medical conditions accessible for blind users and users with visual impairments, including accessible COVID-19 tests. Persons with disabilities, their family members, support services and health care providers should play a central role in health emergency planning, response and implementation, working together to identify the needs of individuals with disabilities.

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

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

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

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

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

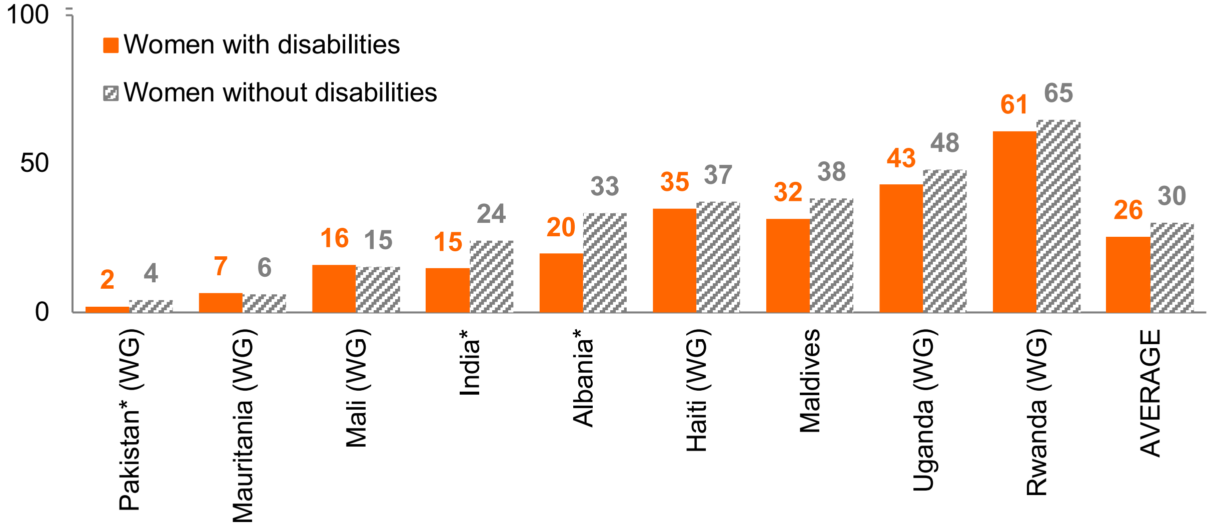
Sexual and reproductive health and reproductive rights are defined by three concepts: the right to make decisions on reproduction and sexuality free from discrimination, coercion and violence; the right to the highest standard of sexual and reproductive health; and the right to access a range of sexual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

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

Current situation and progress so far

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

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



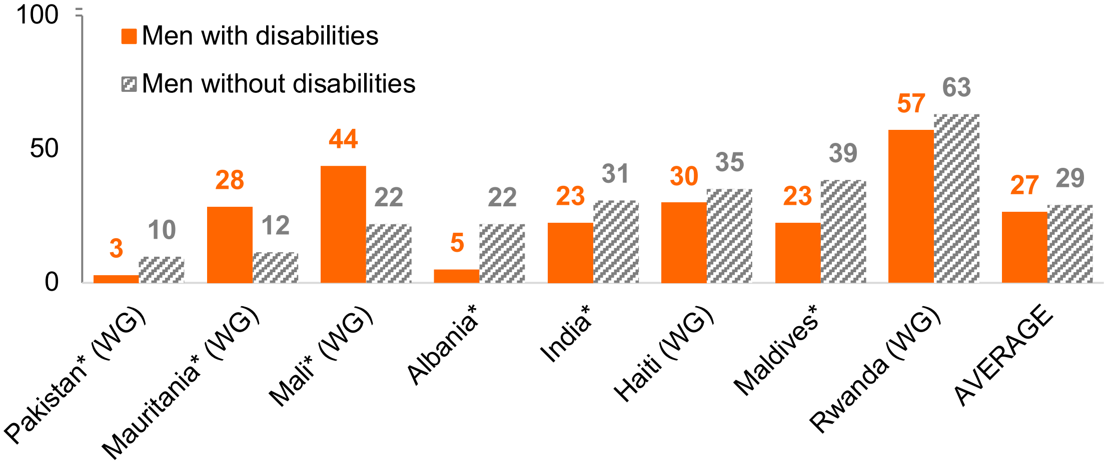
Note: (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.

Source: UNDESA and UNFPA (on the basis of microdata from DHS[6]).

A persistent barrier for persons with disabilities is their lack of access to information about their reproductive rights as well as about sexual and reproductive health and related services. Due to this lack of access, persons with disabilities, especially individuals with intellectual disabilities, end up with low levels of sexuality education and sexual and reproductive health knowledge,[166] including low levels of knowledge on the prevention and transmission of sexually transmitted diseases. Among 9 countries, 26 per cent of women with disabilities versus 30 per cent of women without disabilities have comprehensive HIV knowledge (Figure 41). The percentage of women with disabilities with this knowledge varies from 2 per cent in Pakistan to 61 per cent in Uganda, with the largest gaps between women with and without disabilities observed in Albania and India. Among 8 countries, 27 per cent of men with disabilities versus 29 per cent of men without disabilities have comprehensive HIV knowledge (Figure 42). The percentage of men with disabilities with this knowledge varies from 3 per cent in Pakistan to 57 per cent in Rwanda.

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

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



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

Several factors act as barriers for persons with disabilities to access information on sexual and reproductive health. Stigma and stereotypes significantly limit access to sexual and reproductive health by persons with disabilities and the realization of their reproductive rights, from both community and healthcare providers.[173] The sexuality of persons with disabilities is generally considered a taboo subject.[174] Relatives, teachers and healthcare providers are often anxious, untrained and unconfident about discussing sexuality with them.[175] There is a prevalent assumption that persons with disabilities are either non-sexual or hypersexual.[176] Those stigmas and prejudices are particularly strong about persons with intellectual and psychosocial disabilities.[177] Stigma and stereotypes about sexuality can also lead to the exclusion of girls and young women with disabilities, as well as boys and young men, from existing sexuality education programmes by their parents, guardians and teachers.[178] There is a general lack of guidance for families and teachers on how to talk about sexuality and equality with children and youth with disabilities.[179]

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

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

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

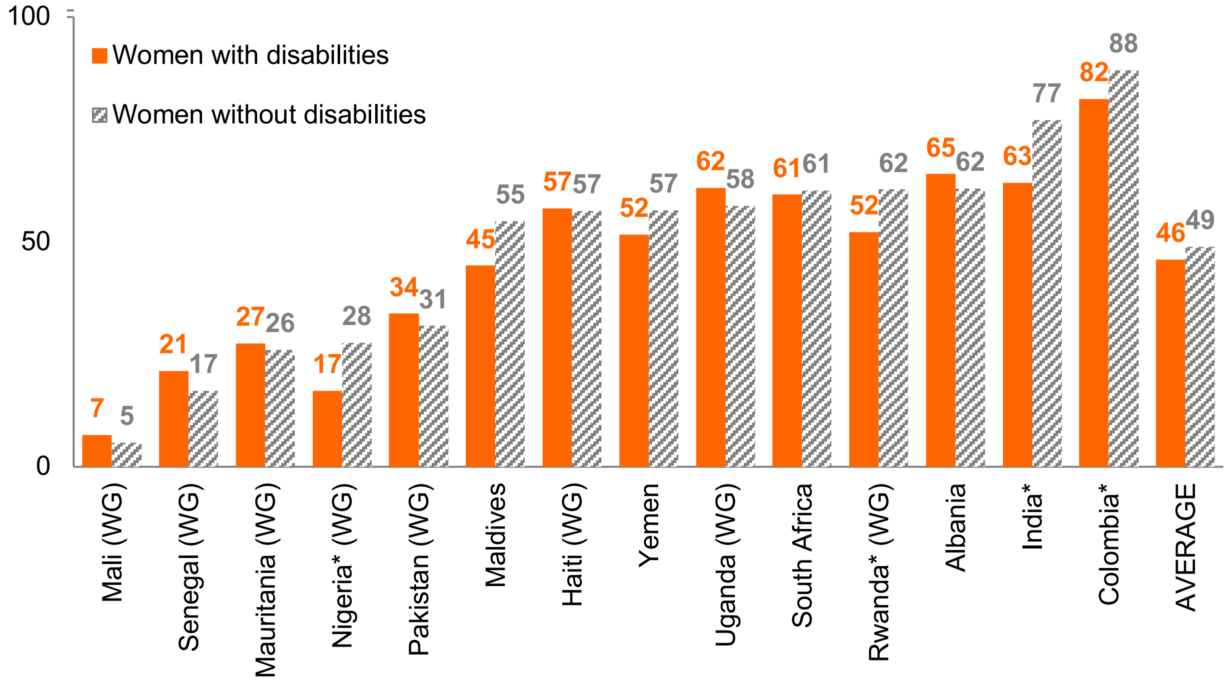
Legal capacity is the capacity to be both a holder of rights and an actor under the law. Legal capacity entitles a person to the full protection of their rights by the legal system, with the power to engage in transactions and create, modify or end legal relationships; supported decision-making may be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

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

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

Moreover, sexuality education is not always delivered in accessible formats, sign languages and other alternative accessible modes of communication, and very often, it does not address disability-specific needs.[186] Furthermore, in many parts of the world, girls and boys with disabilities are often excluded from the education system (see chapter on Goal 2) or drop out from school too early to receive access to sexuality education. For girls and boys with disabilities who attend special education, sexual education programmes are also often unavailable in these education settings.

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



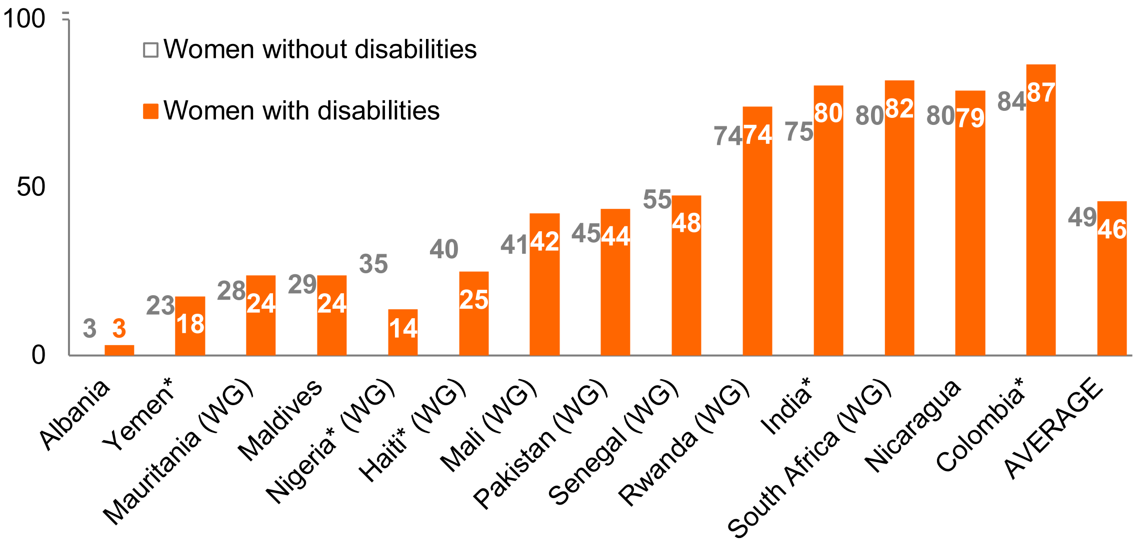
Note: A woman is considered to have autonomy in reproductive health decision making and to be empowered to exercise their reproductive rights if they (i) decide on health care for themselves, either alone or jointly with their husbands or partners, (ii) decide on use or non-use of contraception, either alone or jointly with their husbands or partners and (iii) can say no to sex with their husband/partner if they do not want to. Data on (iii) was not collected in Colombia, Egypt, India, Senegal and Yemen. (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.

Source: ESCWA, UNDESA and UNFPA (all based on data from DHS[6]).

In addition to these barriers, for persons with disabilities, the right to make decisions about their body, health and sexuality is often not realized. Bodily autonomy encompasses an individual's power and agency to make choices about one's body, health, life and future, and having the information, services and means to do so free from discrimination, coercion and violence. It includes fundamental decisions such as whether to have sex, use contraception or seek health care. Key concepts related to autonomous decision-making regarding sexual and reproductive health and reproductive rights include equal recognition before the law, legal capacity, informed consent and supported decision-making (see Box 2). In many societies, the decision-making power of persons with disabilities is subordinated to that of their families, guardians or the State. Social norms, sometimes enshrined in law, deem them incapable of making their own choices.

Women who have bodily autonomy – i.e. they make decisions about their health care and their use of contraception, and they can say no to their husbands or partners if they do not want to have sexual intercourse -- are empowered to realize their reproductive rights. Among 14 countries, the proportion of women with disabilities able to make these autonomous decisions ranges from 7 per cent in Mali to 82 per cent in Colombia (Figure 43). In 4 of these countries, women with disabilities have significantly less bodily autonomy than women without disabilities, with India and Nigeria showing the largest gaps between them. In the other countries, women with disabilities have similar bodily autonomy than women without disabilities.

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



Note: (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.

Source: UNDESA (on the basis of data from DHS[6]).

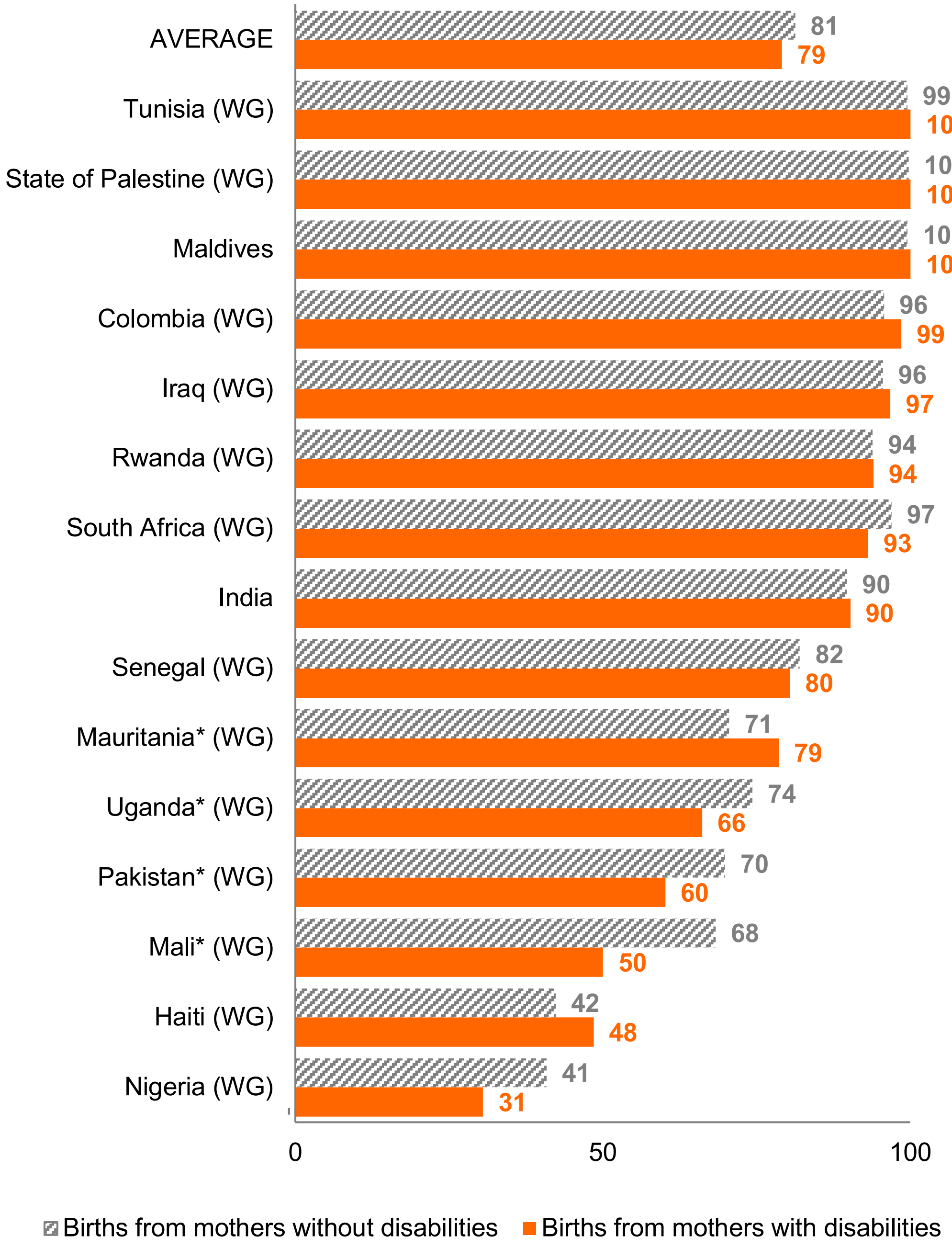
Despite having the same sexual and reproductive needs and rights, and being as sexually active as their peers,[187,188] persons with disabilities face many barriers to accessing sexual and reproductive health care and services. In addition, the widespread false belief within the general population that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

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

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

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

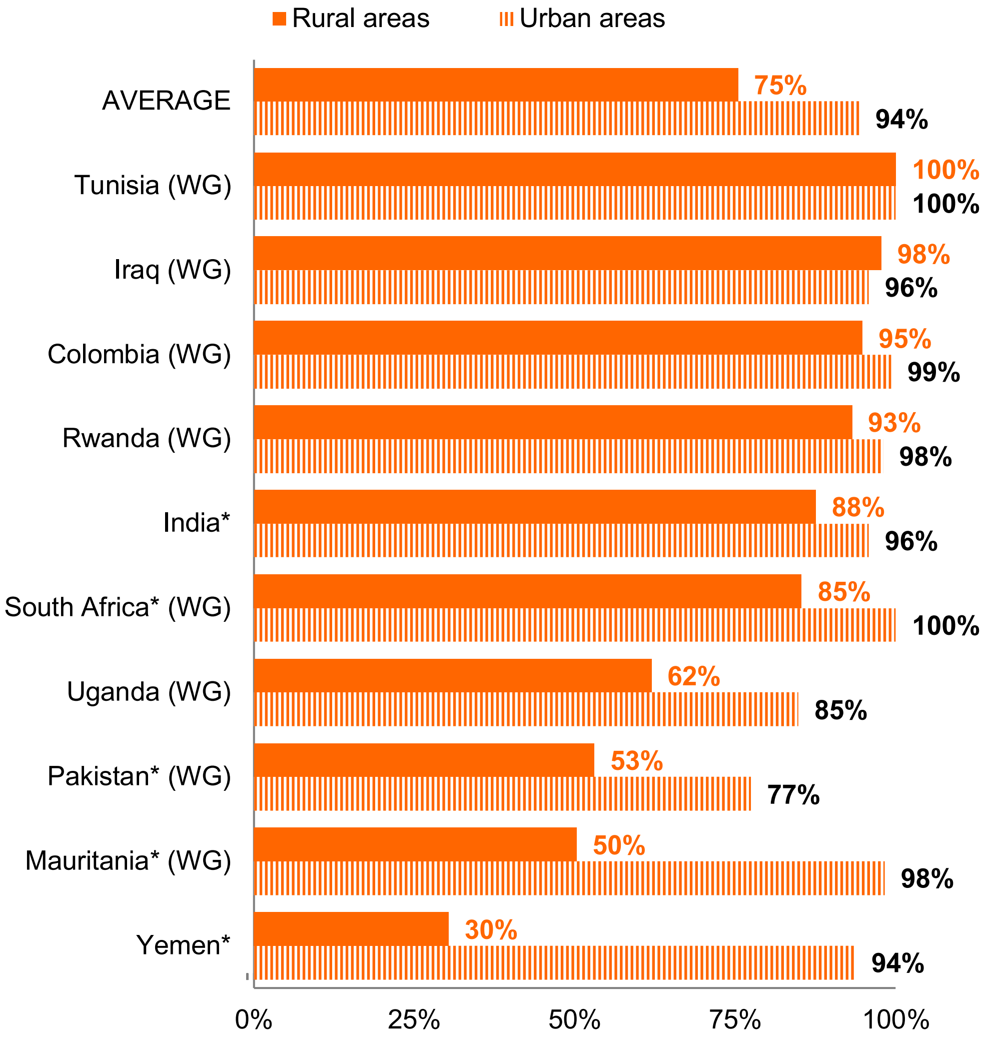
Figure 45. Percentage of births attended by skilled health personnel, by disability status of the mother, in 15 countries or areas, in 2021 or latest year available.



Note: (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between the births of women with and without disabilities are statistically significant at 5 per cent level.

Source: ESCWA (on the basis of data from MICS), UNDESA and UNFPA (on the basis of data from DHS[6]).

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

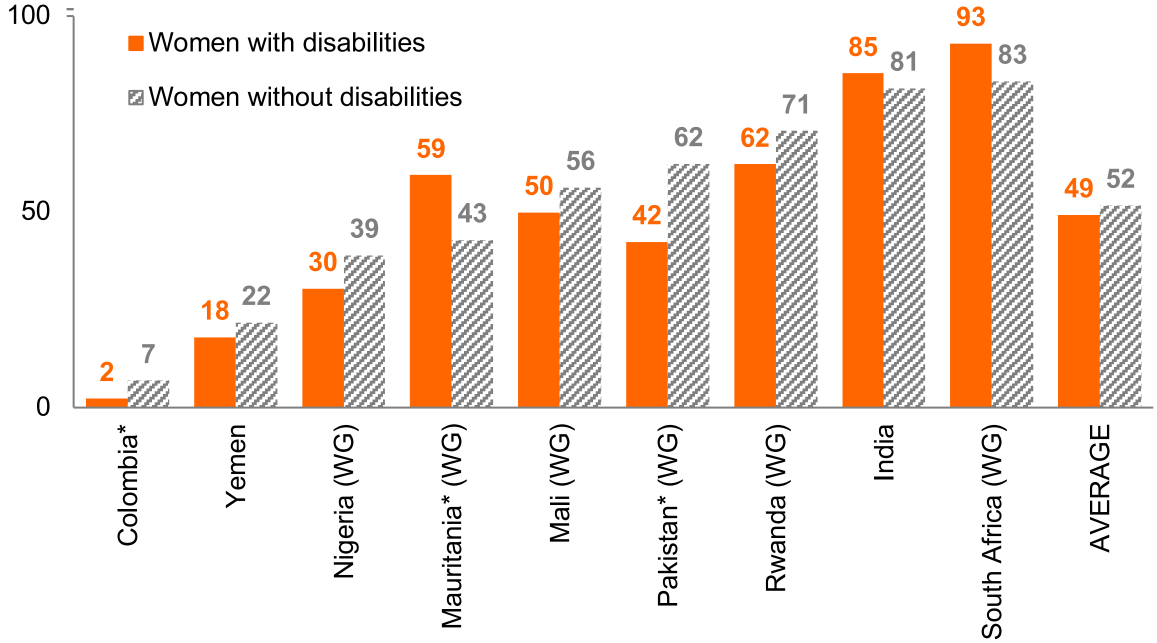


Note: (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between the births of women with disabilities in rural and urban areas are statistically significant at 5 per cent level.

Source: ESCWA (on the basis of data from MICS) and UNDESA (on the basis of data from DHS[6]).

Mothers with disabilities do not always receive a timely postnatal check after birth, i.e., a check 2 days after giving birth (Figure 47). In nine countries, the percentage of women with disabilities who received a timely post-natal care visit for their last birth ranges from 2 per cent in Colombia to 93 per cent in South Africa. In Colombia and Pakistan, a significantly larger percentage of women with disabilities than women without disabilities received a timely post-natal care but in Mauritania, a significantly lower percentage of women with disabilities received such a visit. The lack of access to health care can be particularly impactful on women with disabilities because they are at greater risk than women without disabilities for perinatal complications. For example, in Canada, significantly more women with physical (33 per cent), sensory (30 per cent), intellectual (49 per cent) and multiple (42 per cent) impairments have a postpartum emergency visit compared to those without these impairments (24 per cent).[191]

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



Note: This indicator reflects the percentage of women with a live birth during the 2 years preceding the survey who received a postnatal check in the first 2 days after giving birth. The measure includes women who received a check from a doctor, midwife, nurse, community health worker or traditional birth attendant. Data from Colombia does not reflect the type of health provider performing the postnatal check. (WG) identifies data produced using the Washington Group Short Set of Questions. An asterisk (*) indicates that the difference between women with and without disabilities is statistically significant at the 5 per cent level.

Source: UNDESA and UNFPA (on the basis of data from DHS[6]).

Poorer access to sexual and reproductive health care among women with disabilities increases their risk of contracting additional disabilities related to sexual and reproductive health, including obstetric fistula and uterine prolapse. Obstetric fistula, a hole in the birth canal caused by prolonged labour without medical intervention, leaves a woman with chronic incontinence and, in most cases, a stillborn baby. If left untreated, fistula can also lead to ulcerations, kidney disease and nerve damage. Fistula occurs when obstetric care is unavailable which is why women with disabilities living in remote rural areas are most at risk. Surgery can normally repair the injury, but this procedure can be unaffordable for women with disabilities with the condition. Uterine prolapse occurs when the uterus sags or slips from its normal position into the vagina. Uterine prolapse can result from prolonged labour, too early or too closely spaced pregnancies, improper delivery techniques and resuming work too soon after childbirth. This condition can also lead to additional disabilities unless there is a surgical intervention, a procedure which is not always available, particularly in remote areas, and is often unaffordable for women with disabilities.

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

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

Compounding these barriers, persons with disabilities are frequently excluded in other domains of life, such as education, employment and socialization (see chapters on Goals 4, 8 and 10). This means that persons with disabilities often lack the education, income and social support systems that would allow them to make informed decisions about their sexual and reproductive health options. Many persons with disabilities continue to live in institutions (see chapter on Goal 10), where they are often not allowed to decide on their sexual and reproductive health care or access such services.

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

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

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

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

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

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

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

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

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

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

Impact of the COVID-19 pandemic

The COVID-19 pandemic has exacerbated existing barriers and created new challenges to the achievement of sexual and reproductive health and the realization of reproductive rights for persons with disabilities. There has been a lack of disability perspectives and inclusion in planning and developing the responses to the pandemic. The COVID-19 pandemic resulted in service disruptions that affected access to abortion, contraceptives and testing for HIV and sexually transmitted infections.[217] For persons with disabilities, these service disruptions and epidemic control measures such as school closures[218,219] and lockdowns, exacerbated existing barriers to access information and services.[220,221,222] Remote learning and school closures (see chapter on Goal 4) lead to lack of access to sexuality education thought in schools. Strained health care resources during the pandemic resulted in policies and practices that failed to take disability into account, such as exclusion from remote learning platforms for comprehensive sexuality education.[223,224] online remote-based information and services were not always made accessible to persons with disabilities.

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

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

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

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

Source: UNFPA (2021).[225]

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

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

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

Source: UNFPA (2021).[225]

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

Summary of findings and the way forward

Sexual and reproductive health is as important to persons with disabilities as for all members of society. Persons with disabilities are as sexually active as persons without disabilities and have similar sexual and reproductive health needs. Yet, persons with disabilities are regularly excluded from the provision of sexual and reproductive health services due to environmental and attitudinal barriers, such as lack of physical accessibility in health-care facilities and public transport, low level of awareness and misperceptions about the sexual and reproductive health needs of persons with disabilities. In various countries, more than 50% of women with disabilities do not have comprehensive knowledge of HIV/AIDS, do not have their need for family planning satisfied with modern methods, do not have the births of their babies attended by skilled health personnel, do not receive a timely postnatal check, do not have autonomy in making decisions about their reproductive health – with others making decisions for them – and are not empowered to exercise their reproductive rights. Similarly, in various countries, more than 50% of men with disabilities do not have comprehensive knowledge of HIV/AIDS.

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

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

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

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

2. Develop national laws and policies that guarantee access to sexual and reproductive health and reproductive rights for persons with disabilities. Eliminate discriminatory laws that prevent persons with disabilities from exercising their reproductive rights and prevent discriminatory actions, including unconsented sterilization. Reproductive and obstetric violence should be defined, integrated and prohibited in local, national and regional gender and sexual and reproductive health strategies, policies and action plans. Ensure the participation of persons with disabilities in developing these laws and policies, as part of national programme planning and decision-making processes.

3. Remove barriers to access sexual and reproductive health services, including by making the services safe and affordable and the care facilities, communication and information accessible. Health-care facilities must be physically accessible and the information on sexual and reproductive health must be provided in accessible formats. Persons with disabilities must feel safe at the hands of healthcare providers and mechanisms to monitor, report and eliminate gender-based violence in healthcare settings must be in place. There is an urgency to promote access to maternal health, family planning and contraception and safe abortion for persons with disabilities and to address barriers to the ability to seek, reach, afford and use services to achieve sexual and reproductive health and reproductive rights. Programmes working to eliminate female genital mutilation must consider and include girls with disabilities in all outreach efforts.

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

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

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

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