YOUNG PERSONS WITH DISABILITIES:

GLOBAL STUDY ON ENDING GENDER-BASED VIOLENCE, AND REALISING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

aecid
Spanish Agency for International Development Cooperation

WE DECIDE

UNFPA

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INTRODUCTION

Around the world, more than 1 billion women and men and boys and girls are living with some form of disability.[1] Although most people will experience disability at some point in their lives, understanding the meaning of disability and its impact on the ability of each individual to be active participants in social, economic, socio-cultural, and political life remains a challenge. Physical, social, and legal barriers continue to limit access to education, health care including sexual and reproductive health (SRH), employment, leisure activities, and family life for millions of persons with disabilities worldwide.[2] These barriers can be most acute for young persons with disabilities.

Globally, an estimated 180 to 200 million persons with disabilities are between the ages of 10 and 24.[3] Young persons with disabilities[4] are like young people everywhere: They have dreams and ambitions, interests and desires, and hopes for their futures. But young persons with disabilities face persistent social disadvantages worldwide stemming from discrimination, stigma and prejudice, and the routine failure to incorporate disability into building policy, and programme designs. Physical, socio-economic, socio-cultural, and legal barriers continue to limit access to education, health care including SRH, employment, leisure activities, and family life for millions of persons with disabilities worldwide, and violence against young persons with disabilities is widespread.[5]

Persons with disabilities, including young persons with disabilities, are at greater risk of living in poverty than are their peers without disabilities.[6] They are much more vulnerable to violence, including gender-based violence (GBV), and are less likely to attend school. They receive too little information about puberty, sexuality, and healthy relationships, introducing new vulnerabilities to sexual exploitation and denying them the rights to live satisfying sexual lives, choose to be married, and have children.

A safe passage from childhood into adult life is the right of every person, including those with disabilities. But more than just having a right to safety, young people everywhere have the right to participate in their communities, to speak out and be listened to, to share in technological advancements and design them, to be creative, and to take the lead on matters that concern them. Full inclusion of young persons with disabilities means recognising that they too have the right to actively participate in society as equal members with the same rights and privileges as every other young person has.

Young persons with disabilities have been repeatedly recognised as rights holders in international agreements. The Programme of Action adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo includes three objectives and associated recommended actions directly related to persons with disabilities. These objectives include: a) To ensure the realisation of the rights of all persons with disabilities and their participation in all aspects of social, economic, and cultural life; b) To create, improve, and develop necessary conditions that will ensure equal opportunities for persons with disabilities and the valuing of their capabilities in the process of economic and social development; and c) To ensure the dignity and promote the self-reliance of persons with disabilities.

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

recognises the rights of persons with disabilities of all ages to the full enjoyment of all human rights, including the right to equal participation in society and the right to live a life with dignity.

Likewise, the 2030 Agenda for Sustainable Development calls on states to promote inclusive development that recognises the right of persons with disabilities to equal access to education and employment, among other things. It sets targets for state action to eliminate violence against all girls and women, including those with disabilities, and to ensure access to SRH services and education for all.

In the 2030 Agenda for Sustainable Development, the global community has committed to leave no one behind. To make this commitment a reality for young persons with disabilities, governments must invest in young people and ensure that young persons with disabilities have the opportunities, knowledge, and skills they need to live healthy, fulfilled, and productive lives.

Governments must also be proactive in identifying and removing the barriers that prevent young persons with disabilities from achieving their full potential. This report is an effort to assist governments in meeting this goal.

In 2016, recognising that young persons with disabilities are essential partners in efforts to create peaceful, more egalitarian societies worldwide, UNFPA, with financial support from the Spanish Agency for International Development Cooperation (AECID), and a host of partners launched the WE DECIDE programme to support women and young persons with disabilities to have their voices heard. As stated during the programme's launch, 'WE DECIDE is about amplifying the contributions of young people to peace, social justice and human rights, and in breaking barriers and stereotypes.'[7]

Young people are not only patients, clients, and beneficiaries of health services and programmes. Young people are providers, leaders, and advocates that can and will lead us to a healthier future. They are poised to design policies and programmes to meet their needs and those of their peers.[8]

To increase the visibility of young persons with disabilities to policymakers and advocates, UNFPA commissioned this study as part of the WE DECIDE programme. The study provides the following:

1. An up-to-date analysis on the situation of young persons with disabilities concerning discrimination and sexual violence, including the impact on their sexual and reproductive health and rights (SRHR);

2. A detailed assessment of legal, policy, and programming developments and specific good practices in service delivery along with best-standard prevention and protection measures; and

3. Detailed policy and programming recommendations to assist UNFPA in building a comprehensive programme in this field.

The study seeks to contribute to the strengthening of state laws and policies that foster social inclusion and gender equality for the benefit of young persons with disabilities, especially young women and girls with disabilities; to eliminate discrimination against them, particularly with regard to access to and enjoyment of SRHR and GBV prevention and

response services; and to recognise and promote their right to be active members of society with the acknowledged capacity to make decisions on issues affecting them. The study also seeks to identify areas in which data are missing or insufficient and in which additional research would be valuable.

> Empowering young people with disabilities with sexual and reproductive health and rights knowledge and information is one of the keys to change.
>
> –Aniyamuzaala James Rwampigi, former president of the African Youth with Disabilities Network

The intended audience includes relevant government entities, United Nations (UN) agencies, human rights advocates, and civil society organisations (CSOs) including disabled persons' organisations (DPOs), women's organisations, and youth organisations. Included in this audience are individuals working to ensure that young persons with disabilities, especially young women and girls with disabilities, can enjoy and access SRHR and GBV prevention and response services. The United Nations Population Fund (UNFPA) is the lead UN agency for delivering a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled. As part of this mandate, UNFPA's work on disability has focused on ensuring that women, adolescents, and youth are free of discrimination and violence and are empowered to make decisions regarding their SRH and life options. This study is intended to promote the human rights and social inclusion of young persons with disabilities, with an emphasis on access to services to prevent and respond to sexual violence and gender-based violence (GBV) along with access to and enjoyment of SRHR-related services, information, and education.

TAKING DISABILITY INTO ACCOUNT

Disability is a complex and dynamic concept. Among other challenges, its meaning in the lives of people with impairments is not uniform.[9] Individuals with mobility impairments may experience disability in ways that differ substantially from how those with intellectual disabilities do. Those born with impairments may similarly have a very different experience of disability than do those who acquire an impairment later in life. Chapter 1 offers a fuller discussion of the ways in which disability has been theorised over time and with what consequences. But for now, it is important to note that many of the discriminatory barriers young persons with disabilities face are a result of negative or paternalistic attitudes and assumptions about what it means to be a person with a disability. Too often, the barriers young persons with disabilities face to full inclusion are simply the result of a failure of planners, policymakers, lawmakers, activists, and others to take disability in all its diversity into account.

Disability is part of the normal life course – something that will affect almost everyone at some point in his or her life.[10]

> Disability is … a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.
>
> –World Health Organisation[11]

Disability is a part of the diversity of the human experience. Taking it into account requires more than merely making existing structures and

programmes accessible. Full inclusion demands that states, donors, and civil society actors of all kinds draft laws and policies and design programmes in a way that recognises how diverse the human experience is, especially among young people. Rather than planning for an able-d norm, which can be made accessible to those who fall outside that norm, full inclusion insists on truly *equal* participation that anticipates the possibility and probability of difference.

> When it comes to people, there is no such thing as "normal." The interactions we design with technology depend heavily on what we can see, hear, say, and touch. Assuming all those senses and abilities are fully enabled all the time creates the potential to ignore much of the range of humanity.
>
> –Microsoft[12]

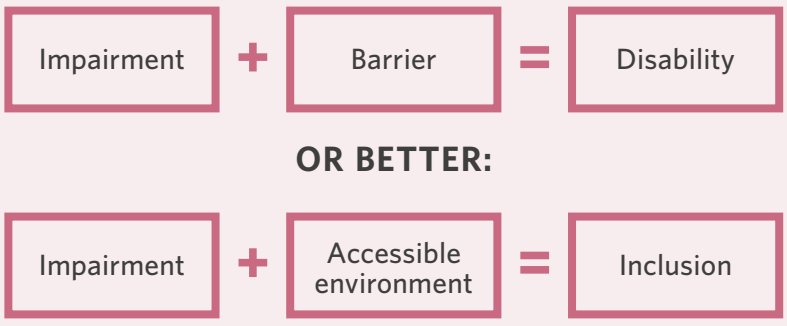
This study documents where barriers to full inclusion of young persons with disabilities persist, especially with respect to the fulfilment of SRHR and GBV prevention and response, and it provides concrete examples of promising steps that states are taking to address and remove these barriers. Though each state has its own unique strengths and challenges, the interventions highlighted in this study are drawn from diverse contexts around the world and illustrate the potential for all to take meaningful action toward the inclusion and fulfilment of the rights of young persons with disabilities.

OVERVIEW OF METHODOLOGY

The research for this report included an extensive literature review, consultations with national and international experts and advocates

DISABILITY VS. INCLUSION

Put simply, disability can be defined as the relationship between a person's impairment and their environment. When inclusive and comprehensively accessible environments are provided, an impairment on its own would not lead to disability. CBM has developed two equations to simplify this complex relationship:



Note: A text alternative for this infographic is available as an annex here.
Source: CBM International (2017). *Accountability Inclusive Development Toolkit.*

through semi-structured interviews and the distribution of questionnaire surveys, field visits in four countries, and technical advisory review and input at two in-person meetings at UNFPA headquarters in New York and through written submissions.

Rights-based research: co-production and engaging young persons with disabilities[13]

One of the core tenets of the disability rights movement is 'nothing about us, without us'. The research process for this report sought to honour that principle by including persons with disabilities, especially young persons with disabilities, as much as possible. Persons with disabilities were principal members of the group of experts who commented on the research design, offered input on its development, and provided technical guidance on its findings and recommendations. In addition, throughout the research process, the research team consulted with members of DPOs as stakeholders and key informants and received guidance on how issues were framed.

Further, during each of the four field visits, researchers conducted focus groups with young persons with disabilities and also contacted organisations run by young people to invite participation in the study by their members, including any members with disabilities. These organisations included YouAct, based in Europe; FRIDA – The Young Feminist Fund; and participants in Women Deliver's Young Leaders Programme, among others. A small group of university students, including students with disabilities, also supported the research team during the course of the study.

Although input from young persons with disabilities is incorporated as much as possible throughout the report, it does not represent the full range of experience of young persons with disabilities globally, who as the study documents are often denied access to the education, skills, associations, and technology that were necessary to enable them to participate. Nor can it be considered representative of all impairment types, as nearly all of those participating were associated with organisations representing discrete impairment types. The voices of young persons with intellectual disabilities in particular are the most likely to be missing in these pages, reflecting their marginalisation in communities around the world.

Recognising the diversity of young persons with disabilities

Young persons with disabilities are not a uniform group and include a much broader population than is currently reflected either in existing research or in policy language. Young persons with disabilities, like their peers without disabilities, hold diverse gender, racial, ethnic, and class identities, among many others, but data that recognise intersectional identities, especially gender identities, among young persons with disabilities are scarce. Instead, as discussed in Chapters 1 and 4, research that considers GBV against young persons with disabilities tends to focus on the experiences of those who identify as women and girls, with a small but growing body of research on sexual violence against men and boys with disabilities. Research on the experiences of transsexual women or men, or other members of the LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex) community, is largely absent. There are similar gaps in research and analysis of other marginalised groups and intersecting identities that include young persons with disabilities.

Similarly, existing policy language regarding gender equality and the prevention of and

response to GBV typically reflects a binary approach to gender, condemning violence against women and girls (VAWG) without recognising the potential for violence against men and boys along with transgender women and men and others within the gender spectrum.

Although this report largely reflects the terminology used in much public discourse and existing research, the authors recognise the need for greater inclusion of *all* young persons with disabilities in the recommendations included in Chapter 7, beginning with language we use to recognise the young persons with disabilities policies and programmes are designed to benefit.

Readers will also note that although this report highlights the intersectional nature of discrimination, particularly discrimination against young persons with disabilities, the report is unable provide a comprehensive look at all of the forms of discrimination to which young persons with disabilities may be subjected. Young persons with disabilities are as diverse as the global population and may be subjected to discrimination on the basis of race, ethnicity, class, indigeneity, and a host of other bases in addition to discrimination on the basis of age, sex, and disability that is discussed in this report.

Promising initiatives would benefit from monitoring and evaluation

This report adopts a case study approach designed to highlight promising steps states are taking to advance the rights of young persons with disabilities. Case study research by its nature is specific to cases embedded in particular environmental contexts, making generalisability more difficult than it is with broad-based research. The importance of case studies, however, is to preserve the complexity of cases often lost in larger samples and to play a generative role in identifying themes, principles, and patterns that can be used in developing new research in fields in which there is little existing knowledge. In short, it begins the process of filling gaps in existing knowledge.

The case studies contained in this report highlight initiatives that are considered promising to the extent they conform to recognised guidelines for good practices or are considered to be positive steps by activists or shown to be such by published evaluations. Many of the initiatives described are the products of partnerships with civil society and reflect coordination of services with multiple stakeholders, itself a good practice. The examples provided are not exhaustive, nor can they be assumed to work in all locations and for all individuals. Researchers have not independently monitored any of the interventions described, nor have they independently assessed their sustainability or satisfactory implementation.

Each initiative discussed here is acknowledged as a single step in a broader, interdependent process to ensure that young persons with disabilities can access and enjoy their rights. It is important to note that although each of these steps may be necessary, no one of them is sufficient on its own. Laws that are not implemented may have little effect, and policies to which resources are not committed or for which no one is held accountable are unlikely to achieve their goals. For governments to ensure that young persons with disabilities can enjoy their rights and freedoms on the same basis as their peers without disabilities do, governments must adopt a comprehensive approach that informs and engages stakeholders across multiple sectors, including young persons with disabilities themselves. Steps toward that engagement are discussed below.

More research is needed to increase the visibility of young persons with disabilities

[T]here are currently no reliable and representative global estimates of the number and proportion of children with disabilities. The dearth of sound and comparable statistics has contributed to the misconception that disability is not an important global health and human rights concern.[14]

The challenges young persons with disabilities face are exacerbated by the absence of information about their lived experiences, especially information that takes into account the diversity of young people with disabilities and intersecting forms of discrimination. Too often, research that addresses persons with disabilities fails to account for the unique experiences of children and young adults with disabilities. Similarly, research focusing on prevention of or response to GBV or access to and enjoyment of SRHR neglects to include persons with disabilities.

This study seeks to fill the gap in research and offers suggestions for the path forward.

ORGANISATION OF THE STUDY

This study is the culmination of primary and secondary research to understand the barriers with which young persons with disabilities must contend to achieve their SRHR and their right to live free from violence, in particular GBV. It identifies and describes promising steps that states have taken to guarantee those rights. In this sense, it contributes to a growing body of literature on state obligations and actions to invest in and include young persons with disabilities in laws, policies, and programming so that they may realise their full potential as equal members of society.

Chapter 1 sets out the situational context in which young persons with disabilities seek to exercise their rights. It discusses the compounding nature of discrimination to which young persons with disabilities are too often subjected because of their disabilities, their youth, and their gender. Chapter 1 then highlights the ways in which young persons with disabilities are vulnerable to violence, especially GBV, and the barriers they face when seeking services and obtaining support to respond to such violence. Chapter 1 concludes with a discussion of the challenges of accessing and exercising SRHR, made more difficult because of inaccessibility, absence of autonomy, and limited empowerment, among other things.

Chapter 2 continues the discussion of situational context and emphasises how time and space can have profound effects on the ability of young persons with disabilities to access their rights to health and safety. In humanitarian crises and low-resource environments, young persons with disabilities are often the last to receive meaningful attention. Institutionalisation of young persons with disabilities remains far too common and places young people within spaces in which the denial of their rights is routine and rates of violence profound. Chapter 2 also includes comparative analysis of the four states in which field research was conducted, themselves representative contexts in which policymakers must set priorities and take action to promote inclusion of young persons with disabilities.

Chapter 3 lays out the international and regional normative frameworks establishing states' obligations to prevent and respond to violence against young persons with disabilities and to ensure their access to and enjoyment of SRHR.

Chapter 4 outlines effective strategies to prevent and respond to GBV and includes case studies of promising programmes at the international, regional, and state level.

Chapter 5 similarly describes good practices in fostering the realisation of SRHR for young persons with disabilities.

Chapter 6 discusses the importance of inclusion, partnership, and engagement of CSOs in all phases of policy and programme development.

Chapter 7 introduces detailed recommendations for action to ensure that young persons with disabilities can achieve the full enjoyment of their rights.

Throughout each chapter, efforts are made to identify and highlight progress being made at the regional and national level and to provide checklists for action as a guide for stakeholders and policymakers. Each chapter also includes text boxes drawing on information gained during the four field visits, highlighting promising steps being taken in Ecuador, Morocco, Mozambique, and Spain.

The study identified multiple areas in which CSOs, national policymakers, regional monitoring bodies, and international organisations are making progress in reducing and eliminating discrimination against young persons with disabilities. This report seeks to further that important work and to contribute to the global movement to leave no one behind.

// CHAPTER 1

UNDERSTANDING THE ISSUE

I. INTRODUCTION

A fundamental prerequisite for young persons with disabilities to fully participate in all aspects of social, economic, and political life is the freedom to exercise agency—the freedom to make decisions for themselves about all aspects of their lives. Young persons with disabilities are too often denied agency by stigma and prejudice that assumes they are less capable than they are, by laws and norms that legalise discrimination against young persons with disabilities, and by physical barriers and inattention to the rights of young persons with disabilities to access public spaces and information. When young persons with disabilities are denied agency, they are less able to access services they need, such as health care, including sexual and reproductive health (SRH) services, education, information technologies, and employment, which has important consequences for development.

> We have been lied to about disability . . . We have been sold the lie that disability is a bad thing and to live with disability makes you exceptional. It's not a bad thing. And it doesn't make you exceptional.
>
> Disability does not make you exceptional. But questioning what you think you know about it does.
>
> –Stella Young, TEDxSydney, April 2014

Recognising that not all young persons with disabilities are the same, the following sections explore the ways in which the social experiences of youth, disability, and gender intersect and create barriers for young persons with disabilities in exercising agency and fulfilling their human rights in two important areas: the freedom to live free from violence, especially GBV, and the freedom to decide about their own sexual and reproductive lives. Age and gender are just two among many intersecting factors that can affect how discrimination manifests against young persons with disabilities. Race, ethnicity, religion, class, indigeneity, and a host of other social categories and contexts can give rise to discrimination or affect how it is experienced. In addition, gender identities can also lead to discriminatory treatment. The research team acknowledges that there are many ways in which diverse identities can complicate and give rise to discrimination; however, a full discussion of this topic is beyond the scope of this study. More research is needed to ensure all forms of discrimination against young persons with disabilities are made visible and eliminated.

CHAPTER OVERVIEW

This chapter begins with an overview of evolving concepts of disability and the degree to which these have reinforced or contested negative attitudes toward persons with disabilities that too often lead to discriminatory treatment. It analyses how youth, gender, and the social experience of disability intersect and can limit the ability of young persons with disabilities to fully enjoy their human rights. Further, this chapter explores findings in recent research on the vulnerabilities to violence of young persons with disabilities, barriers they must confront to respond to such violence, and discrimination in accessing and enjoying their sexual and reproductive health and rights (SRHR). Each section highlights how and when age and gender intersect with disability to make rights more and less available to young persons with disabilities.

KEY POINTS

- The freedom to exercise agency—the **freedom to make decisions for themselves** about all aspects of their lives—is essential to the right of young persons with disabilities to fully participate in social, economic, and political life. **Young persons with disabilities are too often denied agency by stigma and prejudice, discriminatory laws, and physical barriers** and inattention to the rights of young persons with disabilities to access public spaces and information.
- Young persons with disabilities are vulnerable to discrimination based on their age, their gender, and their disability, among other factors. **Multiple forms of discrimination intersect and compound existing disadvantages**, increasing the vulnerability of young persons with disabilities to being denied human rights.
- **Disability is a complex, dynamic, and evolving concept**. Barriers to full inclusion of young persons with disabilities are social, environmental, and physical, and not all barriers are experienced by all young persons with disabilities in the same way.
- **Recognising how different systems of oppression intersect to shape experiences of discrimination is essential** to a comprehensive understanding of the diverse and complex range of effects it can have in practice.
- Young persons with disabilities, especially young women and girls with disabilities, are **more vulnerable to violence** than are their peers without disabilities. They face different forms of violence, including **physical, sexual, psychological, and emotional abuse; bullying, coercion, institutionalisation, trafficking, and forced sterilisation; and beliefs and practices not conducive to human rights such as child marriage and female genital mutilation.**
- Young persons with disabilities, especially young women and girls with disabilities, are often **denied access to justice and response services for survivors** of sexual violence and GBV.
- Young persons with disabilities face **persistent inequalities** in accessing SRH services, which are compounded by discrimination based on age, gender, and disability.
- The difficulties faced by young persons with disabilities in accessing their rights are **compounded by poverty, risks associated with conflict settings and humanitarian crises, and institutionalisation**.
- The **collection of data that is disaggregated by disability, sex, and age is critical** to understand the situation of young persons with disabilities and to inform policies that will ensure these young persons' social inclusion and human rights.

II. THE INTERSECTIONS OF YOUTH, DISABILITY, AND GENDER

There are more young people between the ages of 10 and 24 alive today than at any other time in history.[15] How well these young people transition to adulthood will be an important determinant of the kind of future all can enjoy and a powerful reflection of how seriously the global community takes its commitment in the 2030 Agenda for Sustainable Development to 'leave no one behind'. It is widely accepted that investing in young people makes economic sense and is essential for sustainable development. But as youth advocates point out, fully engaging and capitalising on the skills and creativity of young people requires recognition of the human rights of young people—all young people—to full participation in their communities and global society.[16]

Young persons with disabilities share the same rights and aspirations as their peers without disabilities do and have the same power to shape a sustainable future for all. There are an estimated 270 million young persons with disabilities around the world, the majority of whom live in developing countries. For their power and potential to be fully tapped, young persons with disabilities need to be made visible and allowed to exercise agency.

All young people face obstacles on the path to adulthood, and those obstacles vary during different life stages. In some parts of the world, when a girl reaches the age of 10, she is considered ready for marriage.[17] An estimated 47,700 girls 17 or younger are married every day in developing countries.[18] By the time girls reach the age of 19 years old, 1 in 3 will have married, and many will have given birth, neither of which may have been by choice.[19]

Adolescents are also likely to face challenges accessing health services and making positive choices about their health. More than half of adolescents between the ages of 10 and 19 live in countries with high levels of malnutrition and high rates of human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS), injury, and violence. Where adolescents are sexually active but lack information about the risks of sexually transmitted infections (STIs) or the use of contraception or are unable to negotiate contraceptive use, they are at particular risk. One out of every seven new HIV infections occurs during adolescence.[20]

For young persons with disabilities, these challenges can be even more significant. There is growing evidence that young persons with disabilities throughout the world are disproportionately isolated within their own communities, are far less likely than their peers to achieve the same educational and employment outcomes, and are often unable to begin families or establish healthy sexual partnerships. These outcomes, which span developed and developing countries alike, mean that many young persons with disabilities are unable to successfully transition into adulthood, defined for present purposes as taking on 'adult roles' within their communities. Although those adult roles may be defined differently within specific cultures, the notion of being able to fully participate in a society's social, economic, and political development is broadly shared around the world.

WHAT EMPOWERMENT SOUNDS LIKE

In 2011, the African Youth with Disabilities Network was founded to unite African youth with disabilities groups to give young persons with disabilities a voice across the continent. In 2012, Robert Ssewagudde, the leader of a Ugandan disability rights advocacy group, joined the network and attended The Raising our Voices for Inclusion conference supported by the Open Society Foundations and World Enabled. During the conference, Robert described his feeling of empowerment:

In my community, if someone is deaf, you are abused. You are [called] Kasiru. In our language, that means stupid. So that hurt me very much and kept me worried for a long time. People are looking at me like I was nothing. I had entered a new world with no experience. But I never give up. I gained confidence. My mother felt pity because I was deaf. She felt so bad while I was staying at home and people were referring to me as stupid. So, she tried to get somewhere to place me, and I was placed in a deaf school in Ntinda [in the Kampala suburbs] . . . Although I went to a special school, I really wanted to know what was going on with hearing students. When I finished the [special] school, I passed very well . . . and I was integrated into a [regular] secondary school . . . I continued up to six years of education, and now I plan to join the university and to learn non-governmental management skills. So, I feel as a deaf person I'm proud, I've achieved a lot, I've worked hard. I lost my hearing, but never gave up. We [Young persons with disabilities] are dreaming a lot about inclusion, about quality education. We are dreaming about human rights; we are dreaming about many things. But we know that we shall achieve that. People may say it is impossible, but I say it is possible and that the future is very bright.

Robert's story exemplifies that young persons with disabilities are not only able to achieve things in their personal life but also that they are active agents of social change. Since going to university, Robert has continued to work as an advocate not only in Uganda but also across Africa, encouraging other young persons with disabilities to not just dream about their rights but also to claim them.

Though the human rights of all young people need to be protected to ensure a successful transition to adulthood, the unique intersection of age and disability requires states to take appropriate measures to ensure human rights are protected specifically for young persons with disabilities. States must take positive measures not only to prevent young persons with disabilities from 'falling through the cracks', but also to address the way multiple forms of discrimination interact to render these young persons both invisible and as targets for the active denial of their human rights.

DISABILITY AND DISCRIMINATION

The seminal World Report on Disability (2011) describes disability as 'complex, dynamic, multidimensional, and contested'.[21] It is an 'evolving concept' that in many ways is a product of social and environmental factors.[22] The Convention on the Rights of Persons with Disabilities (CRPD) recognises persons with disabilities as 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'. That same interaction—between health conditions and contextual factors—animates the approach to disability in the World Report on Disability.[23]

Rather than disability being an attribute of any individual person, both the CRPD and the World Report on Disability emphasise that disability is a product of *both* impairment and personal and environmental factors that prevent or limit activities and promote social exclusion.

Different conceptions of disability have tended to locate disability in the individual and reinforced preconceived notions of normalcy (able-bodied-ness) that define what is different, i.e. dis-able-bodied-ness, as abnormal.[24] Three of the five main models or conceptualisations of disability, the moral, charity, and medical models, all approach disability as something to be fixed, a symbol of divine retribution or personal tragedy that needs to be cared for or cured, not accommodated. In each case, agency

DISABILITY MODELS

Moral model: Views disability as a sign of moral failing or the result of a divine or supernatural act.

Charitable model: Views persons with disabilities as having minimum capacity, requiring care and protection.

Medical model: Focuses on 'curing' disability or providing medical interventions to treat the diagnosis rather than the individual.

Social model: Considers the barriers to exclusion for persons with disabilities and works to remove them to enable inclusion and participation.

Rights-based model: Centres on disability rights as human rights and promotes and protects equal social, economic, and physical accessibility and inclusion.

Despite the good intentions of medical and charitable models, both have proven to further marginalise young persons with disabilities by limiting their social and economic inclusion and independence. The CRPD promotes the use of social and rights-based models.

is effectively denied to persons with disabilities, placing decision-making authority in the hands of medical and social welfare professionals while reinforcing the idea of disability as difference, something less than.

> The more ways in which you differ from the normal, the more exposed you will be, and the bigger the risk of feeling stigmatised is.
>
> –Psychologist in a children's rights organisation, Denmark[25]

The idea that disability equates to abnormality or inability/incapacity underpins negative attitudes and stigma, both of which lead to discrimination against persons with disabilities and promote their exclusion from full participation in society. Negative attitudes of others toward persons with disabilities affect the potential for and the quality of integration in their communities, the types and quality of the services they receive, and their ability to live full and complete lives on the same basis as their peers do.[26] In one study of attitudes toward persons with intellectual disabilities, the researchers defined such attitudes as the degree of social distance which people prefer to keep between themselves and persons with disabilities, suggesting that the less well members of the public understood persons with disabilities, the less likely they were to want to work with, live near or be associated with persons with disabilities.[27] Although there is evidence that negative attitudes toward persons with disabilities are changing, members of the public still report feeling uneasy, uncomfortable, and unsure how to act when with persons with disabilities.[28]

Though all persons with disabilities face social barriers, the nature of those barriers may differ depending on disability group. Children who are deaf, blind or autistic, have psychosocial and intellectual disabilities, or have multiple impairments are most vulnerable to all forms of violence.[29] Studies have found that children with intellectual disabilities are five times more likely to be subjected to abuse than other children, and are far more vulnerable to bullying.[30]

Young persons with intellectual disabilities are at increased risk of being denied the legal right to make decisions for themselves. The denial of legal capacity to young persons with disabilities not only violates their human rights but can exacerbate their vulnerability to GBV. Further, it can make it more difficult for them to report violence and abuse against them—and be believed by relevant authorities[31]– and reduces or eliminates their ability to testify against their abusers. When the denial of legal capacity is used to permit sterilisation of women and girls with disabilities without their consent, not only are their reproductive rights violated but they are also made easier targets for sexual abusers, as pregnancy is no longer a risk.

Belonging to other disability groups can similarly create unique barriers. A study on the experiences of deaf people accessing SRH services in Ghana, for example, highlighted the barriers faced when seeking such services: communication barriers including illiteracy among deaf people and poor interpretive skills among sign language interpreters, ignorance about deafness and attitudes toward deaf people, the absence of privacy and confidentiality in the centres, limited time for consultation, and a lack of trust combined to discourage persons with disabilities from seeking needed SRH services and denied them access to high-quality and accurate information about their SRH.[32]

YOUNG PERSONS AND DISABILITY

Negative attitudes, a lack of understanding about disability, and stigma can have profound consequences for all persons with disabilities but especially for young persons with disabilities. These attitudes represent one of the greatest impediments young persons with disabilities face in achieving inclusion. Children with disabilities are among the most marginalised and excluded groups of children.[33] According to one report in Canada, 53 per cent of children with a disability reported having no or one close friend, and significant percentages said they were shunned or avoided at school.[34] Children with disabilities are also at risk of bullying, which can have long-term consequences for their social development and mental health.[35] In many cases, stigma against children with disabilities extends to family members and caregivers, leading many families of children with disabilities to keep them at home to avoid prejudice and protect them from potential abuse.[36]

KEY FACTS INDICATE THAT:[37]

- Relatively little data exist on children with disabilities, and what evidence does exist is based on a smaller set of studies than is available for most other groups of children.
- Children who are living in the context of poverty are more likely to become disabled through poor health care, malnutrition, lack of access to clean water and basic sanitation, and dangerous living and working conditions. Once disabled, they are more likely to be denied basic resources that would mitigate or prevent deepening poverty. Poverty and disability reinforce each other, contributing to increased vulnerability and exclusion.
- A significant proportion of children with disabilities are denied access to basic services including education and health care.
- Although all children have an equal right to live in a family environment, many children with disabilities continue to spend much or all of their lives in institutions, nursing homes, group homes, or other residential institutions.
- Children with disabilities are disproportionately vulnerable to violence, exploitation, and abuse.
- Cultural, legal, and institutional barriers render girls and young women with disabilities the victims of two-fold discrimination: as a consequence of both their gender and their disability.
- Children with disabilities are often overlooked in humanitarian action and become even more marginalised, as fewer resources are available in the midst of an emergency.
- The greatest barriers to inclusion of children with disabilities are stigma, prejudice, lack of knowledge, and lack of training and capacity building.

BARRIERS TO INCLUSION OF YOUNG PERSONS WITH DISABILITIES

Negative attitudes – Attitudes motivate how we choose to respond to others. They represent a predisposition or acquired disposition 'to act in a stereotypical and predictable way in the presence of other persons who are part of a certain group'.[38] They involve judgement and favourable/unfavourable reactions to aspects of disability.[39] Negative attitudes towards persons with disabilities are at the basis of laws, policies, and practices that discriminate against persons with disabilities. For positive social change to be sustainable, negative attitudes need to be addressed.

Stigma – Stigma is the extreme social disapproval of persons who have one of more characteristics that significantly deviate from a society's cultural norms. Disability stigma describes the way people react and ultimately reject persons with disabilities because their physical, mental health (psychosocial), intellectual, or sensory impairment puts them outside of social norms. Erving Goffman, author of two crucial texts in Disability Studies, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1959) and *Stigma: Notes on Management of Spoiled Identity* (1962), defined stigma as, 'The phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute. Stigma is a process by which the reaction of others spoils normal identity.'[40] Goffman is a major contributor toward understanding disability as a social construction.

Accessibility – Accessibility is a precondition for persons with disabilities to live independently, participate fully and equally in society, and enjoy their human rights on an equal basis with others. The right to accessibility includes access to the physical environment, transportation, information and communication, and services.[41] The lack of accessibility is due to buildings being built, products being designed, and services being provided with the expectation that they should only be made available to people who fit within a small range of physical, mental health (psychosocial), intellectual, or sensory norms. The CRPD recommends the principles of universal design for achieving accessibility. 'Universal design' means the design of products, environments, programmes, and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design.[42]

Invisibility – Invisible is the way many persons with disabilities describe themselves. People 'talk about me as if I'm not there'[43] and either make decisions on their behalf or simply ignore them. Treating persons with disabilities as if they are invisible is not only the result of prejudicial attitudes but also of a lack of laws, policies, and practices that promote awareness. For example, policies that deny persons with disabilities legal capacity and instead assign legal guardians render persons with disabilities invisible in their own decision-making processes.

Lack of data – The failure to collect data that include persons with disabilities or ensuring data are disaggregated on the basis of disabilities contributes to the invisibility of persons with disabilities. Article 31 of the CRPD mandates that states collect 'appropriate information' about the status and situation of persons with disabilities so as to inform policy.

Developing successful peer relationships is a critical component of child development.[44] Not only does the stigmatisation and exclusion of children with disabilities inhibit those relationships, but also it can lead to the internalisation of negative attitudes about their own value, increasing their vulnerability to violence, as will be discussed further below.[45] It also risks making children with disabilities invisible to educators, health-care providers, policymakers and others, compounding the potential for continuing exclusion as they age into adulthood.

GENDER AND DISABILITY

Gendered discrimination against girls and young women with disabilities begins at a very early age. Girls with disabilities are less likely to receive care and food in the home and are more likely to be left out of family interactions and activities.[46] They are less likely to receive health care or assistive devices than are boys with disabilities and are also less likely to receive an education or vocational training which would enable them to find employment.[47] Female infants born with disabilities are more likely to die through 'mercy killings' than male infants with disabilities are,[48] and may never be legally registered, which cuts them off from publicly provided health care, education, and social services and makes them more vulnerable to violence and abuse.[49] Girls with disabilities are less likely than their male peers with disabilities to attend school, making these girls less eligible to hold formal employment and to be literate. As women, they are more likely to live in poverty and to be subjected to GBV.[50]

Girls and young women with disabilities tend to internalise what they perceive as society's rejection.[51] They are more likely than their male peers are to think of themselves as disabled and hold a negative self-image. This in turn can make them more vulnerable to harmful social interactions. Young women with disabilities have admitted that they may be more willing to accept a partner who is abusive or mistreats them, if only to have a partner.[52] Some have reported that the need to be loved was more important for them than was practicing safe sex.[53]

Research also suggests that gender has a powerful effect on the social experience of men with disabilities. One research study reviewed the limited research on masculinity and disability and concluded that disability works to destabilise men's ideas about themselves. 'Men with disabilities tend to identify with hegemonic ideals of masculinity such as physical strength, independence, and bravado, which places them in conflict with their marginalised status.'[54] How men respond to this conflict tends to be complicated and individualised.[55]

Persons with disabilities who identify as LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex) are also vulnerable to particular forms of gendered discrimination that lead to the denial of rights.[56] They commonly experience discrimination on the basis of their sexual orientation or gender identity and disability at school, at work, and in supported living environments, and are at high risk for bullying and poor school outcomes.[57] Sexual diversity is often a missing factor in SRHR programmes, as is disability inclusion in programmes and services for sexual minorities.[58] These topics are often forbidden in many school-based special education programmes, limiting the ability of young persons with disabilities to develop positive and diverse identities or explore healthy relationships.[59]

For policymakers, researchers, and advocates, recognising how different systems of oppression intersect to shape experiences of discrimination is essential to a comprehensive understanding of the diverse and complex range of impacts discrimination can have in practice.[60]

III. VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

Violence against children and young adults is among the most serious global problems. Data on violence against children are difficult to access, largely because such violence often goes unreported and because data collection is often uneven and of differing reliability across countries and dependent on varied definitions of violence and of children.[61] However, studies from around the world have shown that young persons with disabilities, especially girls with disabilities, are far more vulnerable to violence than are their peers without disabilities.

- Children with disabilities are almost four times more likely to become victims of violence than are children without disabilities. More than one in four have been subjected to some form of violence, and one in five is a victim of physical violence.[62]

- Girls and boys with disabilities are nearly three times more likely to be subjected to sexual violence, with girls at the greatest risk.[63] In one study by the African Child Policy Forum of violence against children with disabilities, nearly every young person (between ages 18 and 24) who was interviewed had been sexually abused at least once and most more than once in their lifetimes.[64]

- Children who are deaf, blind, or autistic, have psychosocial and intellectual disabilities, or have multiple impairments are most vulnerable to all forms of violence.[65] Studies have found that children with intellectual disabilities are five times more likely to be subjected to abuse than other children are and are far more vulnerable to bullying.[66]

- Girls and young women with disabilities are more likely to experience violence than either their male peers with disabilities or girls and young women without disabilities are.[67] In one study in Australia, as many as 62 per cent of women with disabilities under the age of 50 had experienced violence since the age of 15, and women with disabilities had experienced sexual violence at three times the rate of those without disabilities.[68]

- Belonging to a racial, religious or sexual minority or living in poverty increases the risk of sexual violence for girls and young women with disabilities.[69]

Research has shown that children with disabilities are exposed to a broad range of violence perpetrated by parents, peers, educators, service providers, and others, including dating partners.[70] Violence can take many forms, including bullying in school, physical discipline at the hands of caregivers, the forced sterilisation of girls, or violence in the guise of treatment, such as electric shock 'aversion therapy' to control behaviour. In some cases, children are deliberately harmed so as to inflict disabilities to make them more sympathetic as beggars in the street.[71]

Children with disabilities can be more vulnerable to violence at school. A study of school children with disabilities in Uganda found that schools were the main places where they experienced

violence, often at the hands of school staff and their male and female peers without disabilities.[72] Yet other studies have found that girls and young women with disabilities are at greater risk of sexual violence when out of school.[73] Neighbours and family members who know they are alone can use the opportunity to sexually abuse them, with little risk of being caught.[74]

Despite existing evidence of high rates of violence against young persons with disabilities, much of the research that has been done to date has not included all of the forms of violence to which children with disabilities are vulnerable, suggesting that children with disabilities may be exposed to violence at significantly higher-than-reported rates.[75]

Research has also been largely focused on high-income countries, leaving low- and middle-income countries relatively unexamined. Given that the latter group generally has higher population rates of disability and fewer available support services for those living with disabilities or violence, the gap in research may leave many millions of children with disabilities unaccounted for.[76]

BREAKING THE SILENCE: A REPORT ON VIOLENCE AGAINST CHILDREN WITH DISABILITIES IN AFRICA[77]

A 2010 report undertaken by the African Child Policy Forum draws attention to the experience of violence by children with disabilities in five countries in Africa. Researchers conducted nearly 1,000 structured interviews with young persons with disabilities between the ages of 18 and 24 years in Cameroon, Ethiopia, Senegal, Uganda, and Zambia.

- Every young person participating in the study had been physically abused at least once, and most had been subjected to physical violence from three to ten times or more.
- The perpetrators were primarily other children in the same schools or neighbourhood, followed by non-immediate family members.
- More than half of those who had been subjected to physical violence said that they had suffered broken bones or teeth or bleeding and bruising. Two per cent had become permanently disabled because of the abuse.
- In four of the five countries studied, every participant had been sexually abused at least once and most close to three times.
- Overall, more than one in three had been forced to have sexual intercourse, and in Cameroon 30 per cent had been forced into prostitution.
- Both young women and young men reported having been subjected to sexual violence at least once, and at nearly the same rates, but girls were far more likely to have been sexually abused repeatedly, ten times or more.

WHY IS VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES SO PREVALENT?

Hughes et al. (2012)[78] attributed the increased risk faced by persons with disabilities to violence to exclusion from education and employment, dependence on personal assistance, reduced physical and emotional defences, communication barriers, stigma, and discrimination. Many of these factors not only heighten the risk of violence but also contribute to the violence being repeated, lasting a longer period, and going unreported.[79]

Violence against children and young persons with disabilities has been attributed to many of the same factors and to the added strain placed on parents of caring for a child with a disability, the absence of community support for parents of children with disabilities and the prejudice to which they may be subjected, and the frequency

POTENTIAL CAUSES OF VIOLENCE AGAINST CHILDREN WITH DISABILITIES

Note: The causes of violence against children with disabilities were identified by respondents from the source study which included professionals, key stakeholders from disabled persons' organisations, parent organisations and other nongovernmental organisations, and policymakers in 13 European Union Member States: Austria, Bulgaria, Croatia, the Czech Republic, Denmark, Italy, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Sweden, and the United Kingdom. A text alternative for this infographic is available as an annex here.

Source: European Union Agency for Fundamental Rights (2015). *Violence against children with disabilities: legislation, policies, and programmes in the EU*.

with which children with disabilities are placed in institutions – all of which can increase the risk of violence, in the latter case, dramatically.[80]

Violence against children with disabilities is also widely tolerated, in part as a way of controlling or disciplining behaviour. A 2017 study by the United Nations Children's Fund (UNICEF) found that worldwide, around 1.1. billion caregivers, or slightly more than 1 in 4, admit to believing that physical violence is necessary to punish or control unwanted behaviour.[81]

Violence against any child can harm the child's physical, psychological, and social well-being and, in some cases, can lead to premature death.[82] Violence can also cause a disability or exacerbate an existing disabling condition.[83]

GENDER AND THE EXPERIENCE OF VIOLENCE FOR YOUNG WOMEN AND GIRLS WITH DISABILITIES

Although persons with disabilities all over the world must contend with obstacles to achieving their rights, girls and young women with disabilities are significantly worse off, particularly with respect to violence.

In a study on the SRHR of girls and young women with disabilities, Special Rapporteur on the Rights of Persons with Disabilities collected robust evidence on the prevalence of violence against girls and young women with disabilities, in which consistent patterns are visible.[84] Studies from around the world have found that women and girls with disabilities are at greater risk of sexual violence and exploitation than are either women without disabilities or men with disabilities.[85] Women with disabilities in the United States, for example, are 40 per cent more likely to experience abuse than are women without disabilities,[86] and studies in Nepal, Bangladesh, and Australia, among others, found that violence against women and girls (VAWG) with disabilities was widespread.[87]

Violence against women and girls with disabilities occurs at home but also in institutions, schools, health centres, and other public and private spaces and has a wider range of perpetrators.[88] In a study in Cambodia, researchers found that women with disabilities reported much higher rates for all types of violence than their peers without disabilities did and that the perpetrators were varied and included a number of different family members.[89]

Moreover, for young women and girls with disabilities, domestic and sexual violence are experienced both as gendered oppression and disabling violence.[90] This means that attitudes toward both gender and disability shape both how young women and girls with disabilities experience sexual violence and how (and whether) it is or is not addressed in their communities.[91] One study exposed the complex nature of abuse and its profound and pervasive impact on women with disabilities through a series of interviews.[92]

Survivors of abuse recalled how their experiences of disability and their own ideas about their value exacerbated their abusers' power:

> That is what I remember . . . the verbal abuse. Power of that mustn't be underestimated. If you're disabled, it's such a struggle to maintain a positive body image anyway . . . probably I thought that was all I was worth physically. I was impaired; I wasn't worth treating well.[93]

HOW DOES VIOLENCE AGAINST CHILDREN WITH DISABILITIES MANIFEST?

The Convention on the Rights of the Child (CRC) defines violence against children to include 'all forms of physical or mental violence', without exception.[94] The Committee on the Rights of the Child has specified that this includes particular forms of violence directed at children with disabilities:[95]

- **Neglect or negligent treatment**. Neglect includes the failure to meet children's physical or psychological needs, protect children from danger, or obtain medical, birth registration, or other services when those responsible for children's care have the means, knowledge, and access to services to do so.
- **Mental violence**. Mental violence refers to psychological maltreatment, mental abuse, verbal abuse, and emotional abuse or neglect.
- **Physical violence**. For all children, physical violence includes both fatal and non-fatal violence, but children with disabilities may also be at risk of particular forms of physical violence, such as forced sterilisation, violence in the guise of 'treatment', such as aversion treatment to control behaviour, and violence at the hands of caregivers and staff within institutional and residential settings.[96]
- **Sexual abuse and exploitation**. Sexual abuse and exploitation includes the inducement or coercion of a child to engage in any unlawful or psychologically harmful sexual activity, the use of children in commercial sexual exploitation, child prostitution, trafficking, and the sale of children into forced marriage, among others.
- **Torture and inhuman or degrading treatment or punishment**. This includes the punishment of children for unwanted behaviours at the hands of staff of residential and other institutions or force used by the same actors to coerce children to engage in activities against their will.
- **Beliefs and practices not conducive to human rights.** These include, among others, female genital mutilation; forced, early, and child marriage; accusations of witchcraft; and amputations, binding, scarring, burning, and branding, among other practices.
- **Violence through information and communication technologies**. As all children, but especially children with disabilities, are in increased contact with others through information and communication technology (ICT), they may be exposed to cyber bullying, mockery, or harassment or may be exposed to harmful, violent, biased, or prejudiced information intended to mock or cause psychological harm.
- **Institutional and systemic violations of child rights**. The failure of those responsible for the protection of children from violence to adopt or adequately and effectively implement relevant laws, or to provide sufficient resources to identify and respond to violence against children with disabilities, constitutes violations of the rights of children with disabilities and has the potential to cause substantial harm.

SEXUAL VIOLENCE AGAINST MEN AND BOYS WITH DISABILITIES

It is well documented that persons with disabilities are at a higher risk of GBV, including sexual violence, than are persons without disabilities. Among persons with disabilities, women and girls are the most at risk of GBV, including sexual violence; however, men and boys also experience sexual violence at alarming rates.

A 2011 population-based study in the United States concluded that men with disabilities are more than four times more likely to report both lifetime and past-year victimisation than are men without disabilities (13.9 per cent compared to 3.7 per cent, respectively).[97] Results from a more recent (2014) study of intimate partner violence in the relationships of men with disabilities in the United States similarly revealed that men with disabilities were more likely to report lifetime intimate partner violence than were men without disabilities. The study also found that men with disabilities were more likely to report past-year intimate partner violence than both men and women without disabilities were.[98]

Further research into GBV including sexual violence against men and boys with disabilities is vital to creating systems and mechanisms that can prevent and respond to instances of violence.

Yes, I was exhausted, absolutely exhausted, shattered. And being deaf is hard work you know . . . and he'd be furious and slap me and kick me awake. And he used to say, 'Don't you fall asleep on me; I want a wife, a real wife, not an old woman'. . . and I hated it; I hated it.[99]

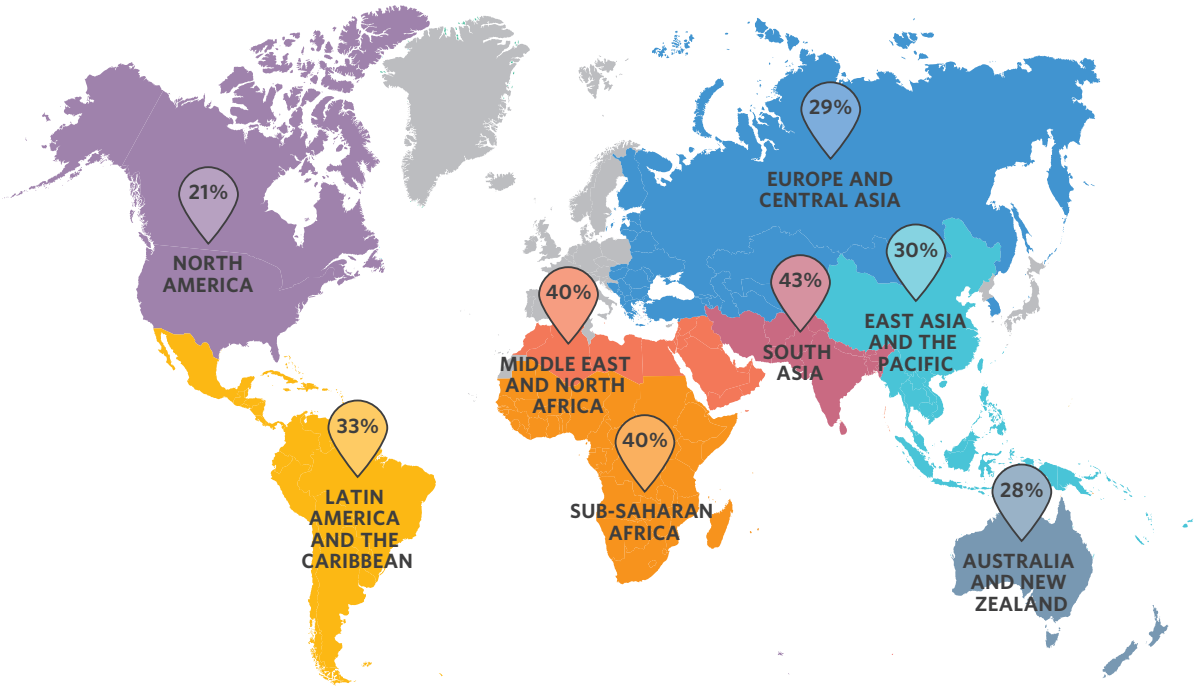
He'd insult me with all those names, you 'spassy' and so on, who'd want to marry you, just look at you . . . Shouting insults, 'you cripple', all that sort of thing. Once, when he was furious, he threw me on the floor with my dinner and said that's where you eat your dinner; that's where you belong. Of course, I couldn't get up again.[100]

Intimate partners, caregivers, and even service providers are all more likely to perpetrate violence against women with disabilities than against men with disabilities and the general population of persons without disabilities. But the perception that caregivers are 'caring heroes' can enable abuse to go undetected:[101]

People pity him because he is taking care of you . . . People are reluctant to criticise this saint or to think he could be doing these terrible things. And possibly as well . . . people don't really 'see' a disabled woman as a wife, partner, mother. So I think for some people it's hard to think, well this might be a woman who's being sexually or physically abused by her partner, is experiencing domestic violence, because disabled women don't have sex, do they?[102]

The overlapping disadvantages that accompany both disability discrimination and gender

REGIONAL RATES OF INTIMATE PARTNER VIOLENCE AROUND THE WORLD



Note: Data for the areas shaded in grey were not available. Map utilises World Bank Group regions. A text alternative for this infographic is available as an annex here.

Source: Preliminary analysis of the World Health Organisation global prevalence database (2013) as presented in *Voice and Agency: Empowering Women and Girls for Shared Prosperity* (2014) by Klugman et al.

discrimination thus amplify the experience of violence by young women and girls with disabilities, increase their vulnerability to it, and make it more difficult for them to be believed when they report it.

Discriminatory attitudes toward women and girls with disabilities can also make it more difficult for them to recognise gendered violence when it happens to them. Exclusion of girls and young women from sexuality education because of the perception that they are asexual or nonsexual has been recognised to increase their vulnerability to sexual abuse, as they are less able to distinguish between behaviour that is appropriate and not.[103] The inability to recognise GBV when it is happening exposes young women with disabilities to significant additional health consequences, increasing their risk of contracting HIV/AIDS or other STIs, and making them vulnerable to unplanned pregnancies.

BELIEFS AND PRACTICES NOT CONDUCIVE TO HUMAN RIGHTS AND SPECIAL FORMS OF VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

Young women and girls with disabilities are as vulnerable to beliefs and practices not conducive to human rights such as early or child marriage or female genital mutilation as their peers without disabilities are and far more vulnerable to being trafficked into sexual or other forms of forced labour.

SOCIO-CULTURAL NORMS, INCLUDING MYTHS AND STIGMA, CONTRIBUTE TO VULNERABILITY OF YOUNG PERSONS WITH DISABILITIES

Attitudes and beliefs about disability differ within communities and families but in many cases are affected by socio-cultural norms, including myths that lead to increased vulnerability to violence against young persons with disabilities. A 2011 study by the African Child Policy Forum in Cameroon, Ethiopia, Senegal, Uganda, and Zambia revealed persistent beliefs that childhood disability was caused by the mother's sin or promiscuity, an ancestral curse, or demonic possession.[104] In some instances, the stigma associated with these beliefs causes families to hide their children with disabilities and for such children to be excluded from school and contact with their communities.

One of the most significant myths for young persons with disabilities is the belief that people who have an STI can cure the infection by having sexual intercourse with a virgin.[105] Young persons with disabilities are at particular risk of rape by infected individuals because they are often incorrectly believed to be asexual – and thus virgins. They may also represent easier targets because of physical mobility or other vulnerabilities. In interviews conducted for the 2004 *Global Survey on HIV/AIDS and Disability*, disability advocates and service providers reported virgin rapes of people with disabilities in 14 of 21 countries reviewed.[106]

Twenty-one per cent of women between the ages of 20 and 24 worldwide were married before the age of 18, including 5 per cent who were married by age 15.[107] Pregnancy-related complications are among the leading causes of death globally for girls between the ages of 15 and 19,[108] and girls who give birth before the age of 15 are five times more likely to die in childbirth than are women aged 20–24,[109] making early marriage a significant risk factor for disability or death for young girls. Data on the prevalence of early or child marriage of children with disabilities are scarce, but a 2017 study on child marriage in Nepal found that children with disabilities are proposed for marriage around the same age as their peers without disabilities are and for similar reasons. Disability, however, added an additional layer of vulnerability.[110]

> [T]he compromised condition under which the marriage takes place for children with disabilities intensifies the consequences and impact of marriage. It does not only affect the overall well-being and quality of life of the child, but also compromises their capacity to cope with and overcome the impact. It thus has a spiralling effect throughout their childhood and beyond also impacting their children.[111]

Although girls are far more likely to be affected by child marriage, boys may also be married before the age of 18. According to UNFPA, and based on data from 83 low- and middle- income countries,

DEFINING VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES[112]

Women and girls with disabilities are exposed to the same forms of violence experienced by their peers without disabilities. However, the intersection of disability makes women and girls with disabilities vulnerable to additional forms of violence, both physical and psychological.

In its *Thematic study on the issue of violence against women and girls and disability*, the United Nations (UN) Office of the High Commissioner for Human Rights recognised that VAWG with disabilities can include:

- The withholding of medication and assistive devices (such as wheelchairs, braces, and white canes);
- The removal of a ramp or mobility devices;
- The refusal by a caregiver to assist with daily living (such as bathing, dressing, and eating);
- Denial of food or water, or threat of engaging in any of those acts;
- Verbal abuse and ridicule relating to the disability;
- Removing or controlling communication aids;
- Causing fear by intimidation;
- Harming or threatening to harm, take or kill pets or support animals, or destroy objects;
- Psychological manipulation;
- Controlling behaviours involving restricting access to family, friends, or phone calls; and
- Forced sterilisation and medical treatment, including the administration of drugs and electroshocks.

only 1 in 25 boys (3.8 per cent) marry before the age of 18 and marriage before age 15 is extremely low at 0.3 per cent. Of these countries, only 10 exhibit a child marriage prevalence for boys over 10 per cent.[113] It is not clear how many boys or young men with disabilities are among those married early, but research suggests one catalyst for forced or early marriage is a desire to ensure care for a person with special needs, suggesting that both boys and girls with disabilities would be at greater risk.[114]

Disability also increases young people's risk of being trafficked for sexual or other forced labour. The 2016 Trafficking in Persons Report published by the United States Department of State highlighted the vulnerability of children and young adults to human trafficking. Children with disabilities may be targeted by traffickers who force them to beg and believe these children's disabilities make the children more sympathetic to passersby. In some cases, children, especially girls, are abused so as to become disabled and make them better prospects for begging. [115]

NUMBER AND SHARE OF GIRLS AGES 10-17 NOT PROTECTED AGAINST CHILD MARRIAGE, 112 COUNTRIES

INCOME GROUPS	LOW	LOWER MIDDLE	UPPER MIDDLE	HIGH
LEGAL AGE				
2015	2.0%	10.0%	5.7%	1.1%
2017	2.0%	10.0%	5.7%	1.1%
PARENTAL CONSENT				
2015	12.2%	21.1%	22.5%	18.0%
2017	8.1%	22.5%	15.9%	17.7%
JUDICIAL CONSENT				
2017	16.8%	35.1%	33.7%	26.3%
EITHER CONSENT				
2017	20.3%	38.1%	36.3%	35.5%

Note: Three definitions of the age for marriage in each country are used: (1) the legal age for marriage without consent from parents or judicial bodies; (2) the minimum age with parental consent; and (3) the minimum age with the authorisation of judicial bodies. The sample includes 22 low-income countries, 35 lower middle income countries, 3 upper middle income countries, and 22 higher income countries. The analysis is carried out in these 112 countries using data on laws for the minimum age for marriage collected by the Women, Business and the Law programme at the World Bank. A text alternative for this infographic is available as an annex here.

Source: Wodon, Q., Tavares, P., Fiala, O., Le Nestour, A., and Wise, L. (2017). *Ending Child Marriage: Legal Age for Marriage, Illegal Child Marriages, and the Need for Interventions.*

A 2012 submission by Disability Rights International to the Inter-American Commission of Human Rights called for an investigation of allegations of trafficking of women with disabilities who had been institutionalised.[116] The petition alleged that women with intellectual disabilities were being forced to have sex with other patients and were being trafficked into a prison next door by prison guards. In response to the petition, the Commission ordered the government of Guatemala to take immediate measures to prevent sexual violence and exploitation of women and girls within the institution.[117]

The risk is attributed to the lack of social inclusion of young persons with disabilities, few of whom may attend school and many of whom may be subject to stigmatisation. 'All too often, young persons with disabilities are regarded as undesirable and may even be subjected to trafficking by their own families.'[118] Lack of accommodations within legal systems may also make it difficult for young persons with disabilities who are trafficked to report abuse or testify against traffickers, empowering traffickers to target such young persons with impunity.

GENDER-BASED VIOLENCE AS A CAUSE OF DISABILITY

On May 29, 1983, while Maria da Penha Fernandes was asleep in her home, her husband shot her in the head. This was the culmination of years of violent abuse that had caused repeated injuries. After the shooting, Maria was left paralysed from the waist down and suffering from severe psychological and physical trauma. She was forced to undergo numerous surgeries, yet two weeks after she returned from the hospital, her husband tried to electrocute her while she was bathing.[119]

Maria da Penha's case before the Inter-American Court of Human Rights resulted in a landmark decision that for the first time held a state responsible for failing to take action to protect a woman from domestic violence. But it also represents a notable example of the risk of disability that GBV presents to all women.

Research in the United States has shown that intimate partner violence is one of the most common causes of injury to women.[120] Between 40 and 60 per cent of women who are abused in any given year suffer injuries.[121] Battered women were more likely to have been injured in the head, face, and neck than other women were, and many were subjected to forced sex, leading to long-lasting and disabling gynaecological problems.[122] Research has consistently shown an increased risk of disability among women survivors of intimate partner violence, which can include chronic physical and psychological symptoms.[123]

Increasingly, researchers have connected the risk of traumatic brain injuries with exposure to intimate partner violence. Half of domestic violence victims are strangled at some point in the course of their relationship, in many cases repeatedly and over years.[124] Strangulation increases the risk of death from stroke, blood clot, or aspiration, and blows to the head are connected with the risk of traumatic brain injury), which can lead to substantial disability.[125] The term traumatic brain injury refers to a disruption in brain function and can lead to depression and anxiety, as well as cognitive decline, among other harms. It is often misdiagnosed in women suffering from domestic violence, leaving many women with newly acquired disabilities or at heightened risk of disability with inadequate health care.[126]

RESPONSES TO VIOLENCE: ACCESS TO JUSTICE FOR YOUNG PERSONS WITH DISABILITIES

In its 2011 report on the Progress of the World's Women: In Pursuit of Justice, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) traced the significant transformation in women's legal rights that has occurred over the past century.[127]

Yet even as laws have been passed to reduce or eliminate discrimination against women, justice systems have been slow to adjust, and barriers

to women pursuing legal relief have persisted. As the report noted, in some communities, women are unable to access justice systems without the assistance of a male relative, and they lack autonomy to make decisions outside the household.[128] In others, social norms promote resolving grievances within the family or community rather than involving outsiders. Often, law enforcement and judicial officers are unwilling or unable to respond to women's particular needs.

Young women and girls with disabilities faced with accessing judicial systems to make claims of sexual and other abuse confront the same barriers, compounded by discriminatory attitudes toward disability. In the absence of significant institutional and community support, young women and girls are unlikely to achieve justice for violations of their rights.

> If we are serious about achieving gender equality, well into the 21st century, we must devote more energy to dismantling prejudicial presumptions about women and men . . . We must see them for who they are—human beings in all their diversity. This is the demand of equality, which is the foundation of human rights law . . . It is my sincere hope that work on this critical issue will begin in the place that most symbolises justice: the courtroom.
>
> –Judge Navi Pillay, then UN High Commissioner for Human Rights[129]

Institutional support begins with the passage and implementation of disability- and gender-sensitive laws. Most countries around the world now have laws that prohibit many of the acts that constitute violence against women.[130] However, a review of domestic violence legislation in 22 countries found few substantive references to disability or the specific needs or vulnerabilities of persons with disabilities within those laws. Where laws addressing GBV fail to incorporate the particular forms of violence that persons with disabilities may encounter, these laws offer little protection against such violence to those most vulnerable to it.

> The community and especially the law enforcing agents should change their attitude towards we girls and women with intellectual disability; this is through sharing training with . . . stakeholders including us to know us better. It is bad when such a thing happens to you, and when you go to the police, they begin laughing and joking at us that we are big and mature [so should] not . . . present such as a sexual abuse case.
>
> –A self-advocate woman with an intellectual disability, interviewed by Coalition on Violence against Women and Kenya Association for the Intellectually Handicapped[131]

Research has also shown that governments often fail to effectively implement laws on VAWG. A 2017 report from Oxfam Canada found that those within governments who were responsible for implementing laws on VAWG failed to follow the procedures laid out in the laws themselves.[132] There was little consistency in how claims were handled, in the measures of protection made available to women who brought claims, or to enforcement of court orders. Few services were available to women attempting to escape violence – whether they needed shelter, counselling, or legal assistance – and approaches to detention of perpetrators and quality of facilities poorly restricted perpetrators. Women who pursued claims in the justice system were often harassed, victimised again, blamed, or not believed.[133]

Research into the experiences of women and girls with disabilities has found similar problems. Simply reporting sexual abuse is challenging for the many reasons previously highlighted, namely, that women and girls with disabilities are often dependent on their abusers for care in addition to financial support and cannot make claims without risking their own welfare. Women with intellectual disabilities face additional challenges recognising abuse and communicating about it when it happens, and many are not believed when they do.[134]

If a case is going to be prosecuted, the survivor must be interviewed and testify in court, and her testimony must be sufficiently understood and plausible as to justify a conviction against an accused abuser. Where police, judges, and court staff lack knowledge regarding disability and the appropriate tools to communicate with individuals with intellectual disabilities, claims against abusers are unlikely to go far.

A recent study by Human Rights Watch of 17 cases of sexual violence against women with disabilities in India found evidence that women with disabilities do not get the support they need at every stage of the judicial process.[135] In one case, a young woman with an intellectual disability was raped repeatedly by a neighbour but was unaware that she should report the rape and found it difficult to explain what had happened.[136] In another case, an 11-year-old rape victim with an intellectual disability was taken to the police who offered a sign language interpreter, even though the young victim had no knowledge of sign language and was not deaf.[137] According to the deputy police commissioner for women in West Bengal, quoted in the report:

> We have had no training. When we meet a disabled woman, we may not know how to speak to her properly. The police are not cruel. In most cases, police are simply ignorant. It is not that we don't want to believe them, but we also worry if we make a mistake, the wrong person will be punished. The police need education, and we need to be sensitised on how to handle these cases.[138]

In Kenya, the Coalition on Violence against Women and Kenya Association for the Intellectually Handicapped collaborated on a project to enhance access to justice for women and girls with intellectual disabilities who have been sexually abused.[139] The partnership included a baseline survey that assessed barriers women and girls with disabilities face in terms of reporting abuse. More than half of the women and girls surveyed reported having been sexually abused at least once and most of these reported multiple times. But when asked to rate the services they received from health-care workers or law enforcement officials, most rated them poorly. Among the most significant needs they cited were training on how to preserve evidence (in the case of rape or sexual assault), support services, including psycho-social support for survivors, and more active involvement by law enforcement agents and health-care providers with regard to collecting evidence, taking statements, and providing post-rape care.

One of the most significant challenges young women and girls with disabilities face in asserting claims in courts is the assertion of their right to legal capacity, which is the subject of the text box below.

THE RIGHT TO LEGAL CAPACITY

Article 12 of the CRPD recognises the right of all persons with disabilities to 'equality before the law'. This means that persons with disabilities must be recognised as holders of rights and recognised as legal persons entitled to birth certificates, for example, or medical assistance when needed. It also means that persons with disabilities have legal agency to act on their rights, and to have their decisions recognised by legal authorities.[140] In its first General Comment under the CRPD, the Committee on the Rights of Persons with Disabilities recognised the importance of legal capacity to persons with disabilities, who too often had their rights denied:

Legal capacity is indispensable for the exercise of civil, political, economic, social and cultural rights. It acquires a special significance for persons with disabilities when they have to make fundamental decisions regarding their health, education and work. The denial to legal capacity to persons with disabilities has, in many cases, led to their being deprived of many fundamental rights, including the right to vote, the right to marry and found a family, reproductive rights, parental rights, [and] the right to give consent to intimate relationships and medical treatment[.]

The denial of legal capacity to women and girls with disabilities not only violates their human rights but also can exacerbate their vulnerability to GBV. It canmake it more difficult for them to report violence and abuse against them—and to be believed by relevant authorities—and reduces or eliminates their ability to testify against their abusers. When the denial of legal capacity is used to permit sterilisation of women and girls with disabilities without their consent, not only are their reproductive rights violated, but also they are made easier targets for sexual abusers, who no longer risk making their victims pregnant.

IV. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Young persons with disabilities have the same SRH-related needs and rights as their peers without disabilities do.[141] Studies have shown that they are sexually active and have the same concerns about sexuality, relationships, and identity as their peers.[142] Yet too often stigma and misconceptions about disability, along with a lack of accessible SRH services, limited personal autonomy, and a lack of empowerment, prevent young persons with disabilities from leading healthy sexual lives and fully enjoying their rights.[143]

It is the ideology of ability[144] or the discourse of normalcy[145] that provides the horizon of possibilities or limitations' through which access to sexual and reproductive health services is mediated for young persons with disabilities.[146]

MARGINALISATION OF GIRLS AND YOUNG WOMEN WITH DISABILITIES IN MOZAMBIQUE[147]

During the research study's field visit to Mozambique, both SRH service providers and disability rights advocates expressed that girls and young women with disabilities face extraordinary obstacles to accessing and exercising even minimal SRHR. These girls and young women, they argued, are at heightened risk of HIV infection, particularly because many are unable to negotiate for safe sex practices or monogamy with sexual partners. Key informants stated that social norms so devalue women with disabilities that advocates reported that men who chose to have a long-term relationship with women with disabilities would not be respected. One interviewee, a nurse at a family planning clinic in Maputo operated by a national CSO, said: 'There is too much stigma. They [men] do pursue them, but it is only out of curiosity. They want to know what it is like to be with a disabled woman, but they would never want a relationship.' As a result, women are unable to maintain healthy relationships or hold sexual partners accountable, despite their awareness of the risks of engaging in sex with men who have multiple partners.

Many women with disabilities suffer from extreme poverty and will use transactional sex for survival. A female board member of a national cross-disability organisation of persons with disabilities in Maputo explained, 'If she is hungry, she will have sex with a man for a meal. There is no question about condoms. Not if she needs to eat.' The key informant shared that even when women with disabilities are aware of the risks, it is common to engage in risky sexual behaviour as a result of poverty and their survival needs.

When women with disabilities did seek SRH services, they were also likely to experience discrimination. In a focus group with young deaf women who were members of a disabled persons' organisation (DPO) of young deaf persons, one 19-year-old woman explained that when she was pregnant two years before, the nurse would discriminate: 'My mother did not tell me anything about pregnancy, so I was more than five months pregnant before I went to the hospital, but there the nurse refused to explain anything. They did not have any information, no pre-birth consultation. The nurse refused to do anything and even demanded money.'

> The inability of PWDs [persons with disabilities] to access health services is due to a complex web of discrimination made up of negative social attitudes and cultural assumptions as well as environmental barriers including policies, laws, structures and services which results in marginalisation and social exclusion.[148]

- Research reveals that adolescents with disabilities feel socially isolated and lack social confidence and sexual self-esteem.[149] Parents, teachers, and health-care providers report feeling anxious, untrained, and unconfident about discussing sexuality with children and adolescents with disabilities, particularly children and adolescents with intellectual disabilities.[150]

- Young persons with disabilities have been found to have low levels of SRH knowledge, with girls and young women having the lowest levels.[151] Girls and young women with disabilities are not seen as needing information about their SRHR or as capable of making their own decisions about their sexual and reproductive lives.[152]

- Low levels of sexual education, including education about HIV transmission and prevention, can lead to risky sexual behaviours. Studies have shown that adolescents with disabilities report a low level of condom and contraceptive use, engaging in casual and transactional sex, and having multiple partners during their lifetime.[153] Evidence indicates that young persons with disabilities have the same or higher risk of contracting STIs as their peers without disabilities do, but testing for HIV is lower among young persons with disabilities.[154]

- Young persons with disabilities also report low levels of access to family planning and SRH. In one study in India, only 22 per cent of women reported having had regular gynaecology visits.[155]

Young people the world over continue to struggle accessing reproductive rights and having their needs met.[156] For individuals and young persons with disabilities, the challenge is finding ways to combat existing misconceptions and stigma about disability and sex to enable equitable representation in discourse around issues of health and justice that are critical for the safety, health, and well-being of all people.

No other group of marginalised people has ever been as severely restricted, or negatively treated, in respect to their reproductive rights, as women with disabilities.[157]

COMPREHENSIVE SEXUALITY EDUCATION AND YOUNG PERSONS WITH DISABILITIES

The UN Educational, Scientific, and Cultural Organisation's (UNESCO) *International Technical Guidance on Sexuality Education* takes a comprehensive approach to sexuality education that begins from the principle that sexuality is a fundamental aspect of human life with important physical, psychological, social, spiritual, and cultural dimensions.[158] In keeping with the International Conference on Population and Development (ICPD) Programme of Action and the CRC, the Technical Guidance stresses that all young people need sexuality education, including young persons with disabilities. Among other things, effective sexuality education is a vital part of prevention of HIV and STIs and reduces the risks of unintended pregnancies and coercive or abusive sexual activity while increasing the knowledge and skills of young people so they can make informed decisions about their own SRH and well-being and that of their actual or prospective partners.[159]

Research has shown that young persons with disabilities have low levels of sexuality education

STIGMA, SEX AND, DISABILITY[160]

Research shows that absence of SRHR and education is often due to a failure to acknowledge that sexual activity is a normal, healthy aspect of growth and development.

To assure that young persons with disabilities have equal rights and access to appropriate education and information, the following must be recognised:

- Despite fallacies suggesting that young persons with disabilities are in a perpetual childlike state, most young persons with physical, intellectual, and psychosocial disabilities experience puberty and the development of sexual interest and desire at the same rate as that of their peers;
- Regardless of disability, all people need love, affection, and companionship;
- The perception that young persons with disabilities are hypersexual and/or unable to control their urges is often the result of a failure to appropriately explain issues related to sexuality and the absence or denial of SRH education.
- Reproductive health education is particularly important, as those with disabilities have the right to make decisions about their own fertility and ability or interest in carrying or raising a child.
- Access to SRH education is a right and not a luxury.

and little knowledge regarding SRH.[161] Girls with disabilities are likely to have even less knowledge than their male peers have.[162] Differences in levels of knowledge have been attributed to differences in disability type and severity, with young persons with intellectual disabilities having the lowest level.[163]

The limited SRHR knowledge of young persons with disabilities is in part a product of their social exclusion, particularly from schools and other centres where sexuality education is available. Many girls with disabilities, in particular, do not attend school or do not stay in school through grades in which sexuality education is taught.[164]

Parents may also present a barrier to young persons with disabilities gaining appropriate SRHR knowledge. Many parents of young persons with disabilities report being uncomfortable about communicating with their child about sexuality, and many such parents lack confidence that they can do so effectively.[165] If sought out, SRHR service providers often fail to provide information to young persons with disabilities due to stereotypical beliefs that persons with disabilities are asexual, uninterested, or incapable of consenting.

General public health campaigns are also frequently inaccessible. For example, young persons with disabilities do not equally benefit

KNOWLEDGE AND ATTITUDES ABOUT SEXUAL AND REPRODUCTIVE HEALTH AMONG YOUNG PERSONS WITH DISABILITIES IN ETHIOPIA[166]

A 2012 survey of 426 young persons with disabilities in Addis Ababa, Ethiopia, found that few had comprehensive knowledge regarding their SRH. The survey was administered to young persons with disabilities between the ages of 10 and 24 who were enrolled in organisations supporting those with physical disabilities, visual and hearing impairments, leprosy, and intellectual disabilities. The majority of participants were between the ages of 15 and 24, largely because younger persons with disabilities had limited access to DPOs.

Key findings included:

- Most of the respondents had heard about family planning methods but had limited knowledge. Few knew when in the menstrual cycle pregnancy was most likely to occur or how to use various methods of contraception.
- Most had also heard that certain diseases could be transmitted through sexual contact, but few knew much about them, and some did not know that HIV/AIDS was linked to STIs.
- Young persons with intellectual disabilities were the least informed about SRHR.
- Half of the respondents believed that SRH services were unavailable to persons with disabilities. Inaccessibility of service providers was the main barrier (cited by 62.2 per cent), with lack of information (43.7 per cent), providers' disapproval (33.3 per cent), lack of money (26 per cent), fear of going for services (23 per cent), and parents' disapproval (13 per cent) offered as additional reasons.
- Fewer than 1 in 4 thought they were at risk of contracting HIV/AIDS, and 88 per cent had poor knowledge about means of preventing HIV transmission.
- Most (77.9 per cent) had never spoken about SRHR topics with their parents; and
- Only 60 per cent believed that a wife has a right to refuse unprotected sex with her husband.

The study's authors concluded that young persons with disabilities showed limited knowledge of SRHR, poor usage of services, and a high percentage of negative attitudes toward the use of such services.

from HIV/AIDS prevention programmes, as clinics are sometimes physically inaccessible, and informational materials are often unavailable for those who are visually impaired (Braille) or deaf (accompanied by sign language interpretation).

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Even though persons with disabilities are entitled to the same SRHR as their peers without disabilities are, there is evidence of consistent denial and/or violations of these rights in communities across the globe. The barriers persons with disabilities face are complex, ranging from the absence of laws and policies protecting their rights in certain contexts to subtler barriers motivated by beliefs and attitudes regarding persons with disabilities. Barriers are not necessarily linked to impairment but rather reflect the lack of legal and institutional support available to young persons with disabilities.[167]

Half of all young women aged 15 to 19 in the global South who are sexually active and want to avoid pregnancy have an unmet need for modern contraception.[168] Very young adolescents (between 10 and 14) had an estimated 777,000 births in 2016,[169] and more than 15 million adolescent girls between the 15 and 19 are believed to give birth each year.[170] Adolescent birth rates are substantially higher for those in the poorest 20 per cent of the global population, among those living in rural areas, and among those with the lowest levels of education.[171]

Accessing SRH services is particularly challenging for young persons with disabilities. The attitudes of providers, particularly toward young women, is one deterrent, as are stigmas attached to premarital sex.[172] Young persons with disabilities also must contend with stigma and prejudice toward their disability. Women with disabilities who sought reproductive health services in South Africa, for example, reported that health-care providers asked inappropriate questions as to how and why they engaged in sexual activity and were otherwise not prepared to accept persons with disabilities as sexually active human beings.[173]

Health-care facilities are often inaccessible to persons with disabilities, making it difficult for them to obtain reproductive health services.[174] Where young persons with disabilities need to be accompanied to enable them to access services, whether by a caregiver or sign language interpreter or the like, they are much less likely to seek such services out.[175]

The quality of the services that young persons with disabilities receive is also affected by discriminatory attitudes toward disability. Reproductive health providers, who often assume persons with disabilities are not sexually active, systematically do not screen them for disabilities for STIs or provide access to contraceptives.[176] This exclusion has been found to be especially prevalent in many developing countries[177] and to pose even greater risks to young women and girls with disabilities in areas with high incidence of HIV/AIDS.[178]

The quality of care is also influenced by the type of disability and level of communication it allows. Research among deaf women in Cape Town, for example, found that communication was a major determinant of the quality of pregnancy and maternity services these women received.[179] More than half of participants reported that they and health-care staff did not understand each other during appointments, and close to two-thirds reported the same during labour and delivery. The number one need they cited was for access to interpretation services.[180]

FORCED STERILISATION AND COERCED ABORTION

Historically, theories of eugenics promoted the notion that only those deemed 'fit' should be permitted to reproduce; according to the theory, those who were too different or considered inferior would weaken the species if they were permitted to have families. For people with disabilities, especially women, such theories gave licence to a wholesale denial of their rights to live freely and choose whether and when to begin families. Though eugenics has long since fallen into disrepute, women and girls with disabilities still confront lingering perceptions that they are unfit to be mothers.

Forced sterilisation is prohibited by the CRPD, the Convention on the Elimination of all Forms of Violence against Women (CEDAW), and CRC, and represents the violation of the human rights of young women and girls with disabilities.[181] Yet it remains widespread, with women and girls with disabilities disproportionately subjected to forced and involuntary sterilisation for a number of reasons.[182] Sterilisation is often justified by caregivers as a means to reduce the added care burden caused by management of menstruation and as an effort to prevent pregnancy.[183]

Parents and service providers often pursue sterilisation of young persons with intellectual

DENIAL OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR WOMEN WITH INTELLECTUAL DISABILITIES – MEXICO[184]

In 2015, Disability Rights International published a report on the denial of SRHR of women with intellectual disabilities in Mexico. After surveying 51 women with intellectual disabilities, the researchers found that more than half had been told that they should not have a child. One interviewee wrote, 'According to the cultural and socially constructed beliefs I was brought up with, it is non-disabled women's responsibility to reproduce, and I, as a woman with disabilities, could not and should not reproduce.'

Other key findings include:

- More than half of the women said that they knew little about sexuality or reproductive health, and most said they did not visit a gynaecologist regularly or had never been to one.
- Forty-three per cent of the women surveyed said they had been sexually abused at the gynaecologist's office, and some had even been raped by a health-care provider or staff.
- One in two of the women surveyed had been recommended for sterilisation by a family member, and close to half of those answering the survey had been permanently sterilised.
- Three of the women who had been sterilised knew that they had had a surgery but had not known what it was for at the time.
- Of those women who had become pregnant, close to one-third had been pressured to have an abortion.

disabilities instead of addressing the perceived challenges of preventing abuse and providing CSE. One of the more common reasons given for sterilisation of girls and young women with disabilities is that it will protect them from becoming pregnant if they are raped.[185] But in practice, far from protecting young women and girls from sexual violence, sterilisation can increase her vulnerability to sexual abuse, in part because it makes the abuse more difficult to detect.[186]

Contraception without the free and informed consent of girls and young women with disabilities is also widespread, as is forced or coerced abortion, for many of the same reasons noted above. Although young women and girls with disabilities have the same contraceptive needs of their peers without disabilities, they are more likely to receive contraception by injection or intra-uterine device rather than orally, to reduce the burden on caregivers.[187] Such methods tend to be longer-lasting and provide coverage without requiring frequent intervention.

HIV/AIDS AND YOUNG PERSONS WITH DISABILITIES

Adolescents and young people as a whole are at a higher risk of HIV/AIDS exposure than is any other age group. Part of that higher risk is because youth is defined by the transition from childhood to adulthood, including the transition from being non-sexually active to being sexually active. Oftentimes, that transition occurs at a point in time before youth have learned necessary SRH information, freely established stable relationships with their sexual partners, exercised control over their living environments and their personal safety, and gained the freedom to meet with SRH providers freely and in privacy. An estimated one in every seven new HIV infections occur during adolescence,[188] and HIV is the second leading cause of death for adolescents worldwide.[189]

Persons with disabilities have an equal to greater risk of HIV exposure than the general population. Specific groups of young persons with disabilities are at greater risk than others, including women and girls, young persons with intellectual impairments, and young persons with disabilities in institutions or other segregated environments. This is a direct result of disability discrimination, including social attitudes and false beliefs about the sexuality of persons with disabilities and the specific relationship between HIV and persons with disabilities. As a result of disability discrimination, persons with disabilities are overwhelmingly less likely to have access to education, information, or communications; often have less control over their living situation and daily environment; are unable to access basic public and private services; and do not enjoy the freedom to privately consult health-care providers. Just 5 per cent of children with disabilities complete their primary school educations,[190] resulting in their exclusion from school-based sexual education and HIV/AIDS awareness programmes. When children with disabilities are enrolled in school, they are often in special education classes where sexual education is not included in the curriculum.[191] Human immunodeficiency virus-related information is often not available in multiple formats and public outreach, such as door-to-door campaigns, and often not provided in accessible forms of communication. Persons with disabilities are more likely to be institutionalised or placed in segregated facilities, such as special education schools. This is especially true for persons with psychosocial or intellectual disabilities, who are often placed in inpatient residential facilities, which can be sites of high levels of sexual violence.[192] Human

immunodeficiency virus-related services are often in facilities that are inaccessible to persons with disabilities, and personnel are untrained in disability inclusion and accommodation.[193] Lastly, persons with disabilities, especially young persons with disabilities, are often dependent on caregivers, either because of legal guardianship or basic necessity, to access clinics and other facilities and thus cannot privately access services and consultation.

Gender adds an additional dimension of discrimination and vulnerability to youth and disability. Gendered beliefs about the role of women and girls in society means that women and girls are more vulnerable to HIV infection than are men and boys in many contexts.[194] This is because women and girls are less likely to have access to sexual education, have lower economic and social status, and are often denied basic rights, including control over their bodies. For example, women's poverty or economic dependence on men increases women's engagement in risky behaviours, such as sex work and limits women's ability to negotiate safe sex within relationships.[195] In other contexts, young women and girls are not able to choose their long-term sexual partners, including marriage partners. There are still an estimated 39,000 girls who are forced into marriage every day,[196] often without the most basic sexual education and without any ability to control their sexual and reproductive choices within the marriage.

Social attitudes and false beliefs about age, disability, and gender are primary contributors toward the increased risk that young persons with disabilities, especially young women and adolescent girls, face. For example, young persons with disabilities, especially young women and girls, are often believed by others to be nonsexual beings.[197]

This is at the root of many policies and practices that discriminate against persons with disabilities, denying them access to HIV-related information or basic services on the basis that it is unnecessary because they are simply nonsexual. Other more specific beliefs play a harmful role. For example, during a qualitative study on the relationship between HIV and disability in Zambia, an interviewee who had explained that she had been denied testing at a local HIV/AIDS clinic stated that when she asked to be tested, the clinician refused and replied, 'God has already punished you once; He will not punish you again by giving you AIDS.'[198] This is a powerful demonstration of the moral/religious model of disability as divine punishment and a similar belief being applied to HIV infection. Young persons with disabilities, especially women and girls, are also at increased vulnerability because of specific local beliefs regarding HIV, such as the belief in virgin cleansing. Young persons with disabilities are targeted for sexual violence by persons living with HIV who believe that such young persons are virgins and that raping a person with a disability is, as such, a cure for HIV.[199] Children are also often presumed to be virgins because community members believe their young age precludes them from sexual activity.[200] Thus children and adolescents with disabilities, especially young women and girls, are at an even higher risk than are either children without disabilities or older adults with disabilities.

Another dimension of intersectionality is between HIV status and disability and other social identities and characteristics. Many societies stigmatise persons affected by HIV/AIDS. The majority of research on HIV and intersectionality has focused on the multiple dimensions of discrimination faced by racial and ethnic minorities, LGBTQI persons, sex

workers, and other traditionally discriminated against groups.[201] It is rare for HIV/AIDS-related literature to use an intersectional analysis to consider the intersection between HIV-related stigma and disability discrimination, much less the specific intersection between HIV-related stigma and young persons with disabilities. There are a few important exceptions written from a disability studies perspective that highlight the fact that many HIV-related service providers and advocates discriminate against persons with disabilities, creating a double discrimination of persons with disabilities affected by HIV/AIDS.[202] This includes the belief by HIV/AIDS advocates and service providers that persons with disabilities are nonsexual, thus their awareness campaigns and other services rarely utilise multiple formats for information and communication.[203] Persons with disabilities and their representative organisations can also discriminate against persons with disabilities affected by HIV, including by rejecting persons living with HIV from membership in DPOs and refusing to make their rights to HIV services a priority in DPO advocacy. There are, however, positive signs of disability organisations and HIV-related organisations collaborating and creating policies and programmes that address this important intersection, including the way that both HIV and disability stigma intersects with youth and gender.[204]

The human rights model of disability perspective shows that the participation of young persons with disabilities in HIV/AIDS services goes beyond a narrow focus on access and inclusion in health services delivery but requires an approach that recognises the interconnection of all rights. The CRPD provides a template for developing national legal and policy approaches to the inclusion of young persons with disabilities in HIV-related services by highlighting the importance of a comprehensive approach to rights.[205] It is necessary to recognise that all rights are interconnected and must be promoted to ensure that young persons with disabilities, especially young women and adolescent girls, can fully enjoy their right to HIV/AIDS services. For example, the economic right to an adequate standard of living addresses poverty, the social right to education provides the tools to access information, the civil right to access to justice is necessary for gender-based violence protections to be effective, the political right to vote is needed to hold governments accountable for delivering accessible services, and so forth. The realisation of each of these rights directly contributes to addressing young persons with disabilities' increased vulnerability to HIV. They also require positive measures, such as ensuring the right to education through inclusive education or the right to access to justice through the provision of accommodations and the capacity development of police, court, and other justice personnel.

// CHAPTER 2

RECOGNISING THE RIGHTS OF YOUNG PERSONS WITH DISABILITIES IN DIVERSE CONTEXTS

I. INTRODUCTION

In the same way that youth and gender, along with the multitude of other identities young persons with disabilities may hold, can have a profound effect on how young persons with disabilities experience discrimination, discriminatory barriers can be the product of a variety of contexts. More people than ever before have been forcibly displaced from their homes,[206] and many communities are experiencing more devastating natural disasters than they have in the past.[207] Young persons with disabilities who are forcibly displaced are believed to be more likely than are their peers without disabilities to be subjected to violence and abuse. For example, a United Nations (UN) High Commissioner for Refugees' report on Bhutanese refugees in Nepal revealed that almost half—49 per cent—of rape survivors were persons with disabilities.[208]

In addition to these humanitarian crises, other problems persist. For example, the majority of the world's population continues to live in poor or low-income countries,[209] a significant number of people continue to live in isolated rural areas,[210] and people living in many regions continue to face epidemics, such as HIV/AIDS. Lastly, despite many countries adopting deinstitutionalisation policies, tens of thousands of people around the globe continue to live in orphanages, psychiatric hospitals, nursing facilities, prisons, and other residential facilities.

Even where young persons with disabilities are not confronting crises, where they live can be an important factor in whether they are able to access their rights. The research for this global study included field visits to four countries—Ecuador, Morocco, Mozambique, and Spain—which are all parties to the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC) and committed to meeting the Sustainable Development Goals (SDGs). Although each state has pledged to achieve the same standards and recognise the same rights for young persons with disabilities, implementation of these standards differs substantially state to state, with the consequence that the most marginalised children, youth, and adolescents are at risk of being left behind.

The following sections recognise that it is within highly local contexts and in relation to specific circumstances that adolescents and youth with disabilities live out their daily lives. Young persons with disabilities are everywhere. They live in remote rural villages in low-income states, major coastal cities in the path of hurricanes, and institutions that cut them off from the outside world. Young persons with disabilities are also part of communities that are temporary or on the move, such as emergency shelters in the aftermath of a natural disaster or internally displaced populations in search of safety or sustenance during a time of conflict or famine. They are also part of economic migrant and political refugee populations resettled in new communities or living in camps far from their homes. Young women and men and adolescent girls and boys with disabilities experience specific barriers to exercising their human rights within these unique contexts, including sexual and reproductive health and rights (SRHR) and access to gender-based violence (GBV) prevention and response services.

These specific barriers often build off of and exacerbate barriers that young persons with disabilities already experience based on their diverse identities defined by their age, gender, disability and membership in other marginalised and discriminated population groups on the basis of race, ethnicity, religion, sexual orientation, and

gender identity, and so forth. For example, young persons with disabilities who belong to particular ethnicities, castes, minorities, and indigenous groups may face additional barriers in law, policy, and practice due to these other axes of inequality.[211] Policymakers, project implementers, and advocates must keep in mind that young persons with disabilities are diverse, are members of all of population groups, and have a multitude of intersecting identities. Any initiative promoting young persons with disabilities' rights and access to services must be attentive to the compounding forms of discrimination that young persons with disabilities face.

In many cases, young persons with disabilities' identities intersect with the identity of being a refugee, a person living in a rural area, a person living with HIV, or a person who has been institutionalised. As such, they are often subjected to new forms of discrimination, such as being discriminated against within the disability community because they are HIV-positive or being discriminated against within a refugee camp because they are a person with disabilities. Addressing these discriminatory attitudes is necessary in all of these contexts and for all of the identities associated with them.

As noted in Chapter 1, a fundamental prerequisite for young persons with disabilities to fully participate in all aspects of social, economic, and political life is the freedom to exercise agency—the freedom to make decisions for themselves about all aspects of their lives. To ensure that truly no young person is left behind, states need to take the diversity of local environments and circumstances into account to ensure young persons with disabilities can exercise agency, particularly with respect to their health and physical safety. The risk of sexual violence during a time of conflict is substantially higher than during a time of peace, just as the complexity of navigating a reproductive health system to access family planning is more difficult for migrants in a foreign state than is accessing those same services within a more familiar system.

In many cases, such as the aftermath of a natural disaster or in areas experiencing high incidence of HIV/AIDS, the local state may be assisted in meeting its obligations to provide access to SRHR and GBV prevention and response services by multilateral organisations, foreign states, and civil society organisations (CSOs). This diversity in actors can be a great help in ensuring rights, but it can also act as a barrier to young persons with disabilities who fall through the cracks if those actors on the ground are uncoordinated or are not held accountable for being disability inclusive. Local states are obligated to develop laws, policies, and programmes that ensure that young persons with disabilities are included in SRHR and GBV prevention and response services regardless of the multiplicity of organisations and states involved in implementing SRHR and GBV programmes.

CHAPTER OVERVIEW

This chapter will highlight specific contexts that may disproportionately heighten the risk of young persons with disabilities to GBV or prevent their access to and enjoyment of their sexual and reproductive health and rights (SRHR). The following sections build off of the intersectional framework presented in Chapter 1, which identified the specific identities related to age, gender, disability, and other characteristics to similarly highlight the role that specific localities and circumstances and the identities associated with them play in shaping the experiences of young men and women and adolescent boys

and girls with disabilities. The following sections will include a focus on local situations and circumstances of humanitarian crisis, rurality, high poverty communities, areas with high HIV prevalence, and institutionalisation. The chapter will then discuss country field visits to Ecuador, Morocco, Mozambique, and Spain that provide examples of the challenges many states face in promoting the rights of young persons with disabilities at home.

KEY POINTS

- Young persons with disabilities experience **context-specific barriers** that prevent them from exercising their rights on an equal basis with others.
- States have an **obligation to design context-specific laws, policies, and programmes** that address humanitarian crises, poverty, rurality, high HIV/AIDS prevalence, institutionalisation, and other circumstances that disproportionately increase the risk that the rights of young persons with disabilities will be violated.
- Young persons are at **disproportionate risk of GBV and sexual exploitation** in conflict and post-conflict environments and in the aftermath of natural disasters.
- **States have a positive obligation** to protect the rights of persons with disabilities during and in their **responses to humanitarian crises.**
- **Poverty itself is a barrier** to young persons with disabilities in accessing and enjoying SRHR and GBV prevention and response services on an equal basis with others.
- The majority of young persons with disabilities in developing countries live in **isolated rural areas that lack access to disability-inclusive SRH and GBV services** in comparison to urban-based services.[212]
- In high HIV prevalence communities, young persons with disabilities are often **excluded from HIV/AIDS prevention and treatment services**, including services implemented by international CSOs and through foreign assistance.
- Young persons with disabilities living in **institutions are at heightened risk** of violations of their rights, including heightened risk of GBV and denial of decision-making over their SRHR.
- **Every country has its unique contexts and circumstances** that it must address when designing laws, policies, and programmes ensuring the rights of young persons with disabilities. **No country has achieved total implementation** of the full rights of young persons with disabilities. Young persons with disabilities face specific barriers in each of the field visit countries. Each field visit country is proactively addressing those barriers.

- Young persons with disabilities living in rural areas in **Ecuador** are disproportionately at risk of GBV and have higher adolescent fertility rates than do those in urban areas. Ecuador is developing new SRHR and GBV policies and programmes to promote **disability inclusion in rural areas.**
- Young persons with disabilities in **Morocco** experience culturally based barriers to SRHR. The state, however, has **developed new laws and policies** to promote the rights of young persons with disabilities, including the right to health care, but faces challenges with implementation.
- Young persons with disabilities in **Mozambique** are at disproportionate risk of HIV but are often excluded from prevention, testing, and treatment programmes. The government is engaging **civil society and promoting disability inclusion** across all actors to ensure young persons with disabilities are included in HIV/AIDS services.
- Young persons with disabilities in **Spain** have significant legal protections, but SRHR and GBV policies and programmes are implemented through a decentralised system of government. Many of **Spain's regional authorities and local governments have developed new strategies for promoting disability inclusion** in SRHR and GBV services that can provide models to other regions and cities.

II. HUMANITARIAN CRISES AND FRAGILE CONTEXTS

> Too often invisible, too often forgotten and too often overlooked, refugees with disabilities are among the most isolated, socially excluded and marginalised of all displaced populations.
>
> –United Nations Secretary-General António Guterres, then UN High Commissioner for Refugees[213]

The World Bank estimates that more than 2 billion people today live in situations that are fragile, in conflict, or violent,[214] and the United Nations Development Programme (UNDP) estimates that 75 per cent of the world's population live in areas that were affected by earthquakes, tropical cyclones, flooding, or drought over the 20-year period between 1980 and 2000.[215] These estimates may, in fact, be low, and the number of people affected by or vulnerable to humanitarian crises may be much higher. For example, of the 163 countries ranked by the 2017 Global Peace Index, just 10 were identified as completely conflict-free and fully at peace,[216] and a recent report on natural disasters noted a steady increase in the number and magnitude of natural disasters in recent years as a result of global climate change.[217] Whether the number and magnitude of areas facing humanitarian crisis is large or small, it is undeniable that young persons with disabilities are disproportionately affected by barriers to accessing their human rights within the context of conflict or natural disaster. This situation of risk is compounded by many other factors that affect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youth and adolescents with disabilities and their ability to access GBV prevention and response services and access and exercise SRHR on an equal basis with others.

> 80% of people with disabilities live in developing countries, and 20% of the poorest people living in developing countries have a disability.
>
> –World Report on Disability, 2011[218]

Humanitarian crises disproportionately occur in the developing world, which is where the majority of youth and adolescents, persons with disabilities, and women and girls live. The majority of displaced persons around the world are young people. For example, of the 22.5 million people living as refugees in the world today, more than half are under the age of 18.[219] Young people are also disproportionately exploited by the perpetrators; tens of thousands of adolescents have been recruited and are currently serving as child soldiers today in conflict zones around the globe.[220] Many of these youth and adolescents are persons with disabilities, including those who have developed new disabilities as the result of trauma and violence experienced in conflict zones. Sexual violence against adolescent and even younger girls is recognised as one of the most common grave violations against children in times of conflict.[221] Persons with disabilities are also disproportionately affected by floods, hurricanes, and natural disasters,[222] often experiencing mortality rates two to three times higher than the general population does.[223] Because persons with disabilities are more likely to be poor, they are also overrepresented in housing and communities at risk because of poor construction or location in a flood, landslide, or otherwise vulnerable area. Once again, young persons with disabilities are disproportionately living in communities affected by natural disaster, and those disasters, through physical injuries and mental trauma, grow the population of youth and adolescents with disabilities.[224] Disability inclusion following natural disasters or during conflict saves lives, yet many persons with disabilities are excluded during periods of humanitarian crises. Persons with disabilities are less likely to be evacuated by humanitarian workers or have their own means to flee to safety,[225] and women and girls are insufficiently protected from specific forms of GBV, including violence perpetrated in refugee camps and emergency shelters.[226] Young women and adolescent girls who have been displaced are also often targets of sex traffickers and others. It is also during these periods that young persons with disabilities, especially adolescent girls and young women with disabilities, experience the greatest barriers to SRHR, which is rarely accessible during a crisis and often the last form of health care to be re-established in its aftermath of a crisis.[227]

Historically, the guidelines on GBV in humanitarian crises have lacked any specific acknowledgements of the heightened vulnerability of persons with disabilities or guidance on disability inclusion for humanitarian workers.[228] Only recently has this need been addressed through the development and dissemination of new training tools.[229] Fortunately, new instruments are now being developed, and there is an increasing amount of information and practical tools for promoting the access and enjoyment of SRHR and GBV prevention and response services for young persons with disabilities during humanitarian crises. The CRPD provides a framework in international law for inclusion during humanitarian situations. The CRPD contains crucial articles that together ensure the rights of young persons, particularly young women and girls, with disabilities to SRHR and GBV prevention and response services.

Article 11 on 'Situations at risk and humanitarian emergencies' clearly states that it is the States Parties' responsibility to implement 'all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.' This right intersects with the obligations of States Parties to take positive measures to ensure the full and equal treatment of women and girls with disabilities (Article 6), guarantee their freedom from gender-based exploitation, violence, and abuse (Article 16) and eliminate discrimination in access to SRH and population-based public health programmes (Article 25a). Under the CRPD, all States Parties, which not only includes the countries where the crises occur but also all the other states that respond with humanitarian assistance, have a responsibility to ensure the rights of young persons with disabilities during crisis.

The identities of young men and women and adolescent girls and boys with disabilities intersect with the identity of refugees and displaced persons in ways that compound the discrimination they face. Refugees, as a group, experience discrimination. This discrimination itself can create new disabilities within the refugee population. For example, adolescent Somali refugees living in the United States developed new mental health conditions, or existing ones were exacerbated as a result of the stress and trauma caused by experiences of discrimination, such as bullying in schools for being identified as refugees.[230] Refugees with disabilities are more likely to experience this discriminatory behaviour than are refugees without disabilities, making them even more vulnerable, yet refugees with disabilities often remain invisible to those providing refugee services.[231] When gender is included, refugees and displaced young women and adolescent girls with disabilities face even greater multiples of discrimination and vulnerability.[232] This is particularly true regarding access to and enjoyment of SRHR and GBV prevention and response services.

New studies and resources are now increasing the awareness of the need and availability of concrete actions that can ensure young persons with disabilities access to and enjoyment of SRHR and GBV prevention and response services in humanitarian settings. Both quantitative and qualitative data have been collected in humanitarian settings, bringing previously 'hidden victims' into the light[233] and clearly showing the disproportionate numbers of young persons with disabilities within displaced populations.[234] New guidelines that are rapidly disseminating and being implemented, including recommendations that actors not only develop their own capacity for disability inclusion during crises, but also proactively address social attitudes of discrimination toward persons with disabilities, especially women and girls. New guidelines also recognise the need for GBV prevention and response and SRHR specialists, disability advocates, humanitarian emergency responders, donors, and governments to work together, building relationships prior to crises and working cooperatively during humanitarian responses.[235]

III. POVERTY AND DISABILITY

As the most vulnerable and least vocal members of any society, poor [persons with disabilities] are often not even perceived.[236]

The specific context of poverty creates unique barriers and additional vulnerabilities that directly affect the access young persons with disabilities, especially women and girls with disabilities,

have to SRHR and GBV prevention and response services. Communities with high concentrations of poverty often receive fewer public services, despite equal or greater needs. This is true for all services, including SRH and GBV prevention and response services. In addition to the direct barriers that inadequate SRH and GBV service provision represents, young persons with disabilities also face other barriers within poor communities that increase their need yet decrease their enjoyment of and access to SRHR and GBV prevention and response services. Those indirect barriers and increased needs to SRHR and GBV prevention and response services often include a lack of accessible public transportation, fewer options for employment in the formal economy, and higher levels of crime and violence. Factors such as these disproportionately affect youth, women and girls, and persons with disabilities compared with other residents living in contexts of poverty, making young women and girls with disabilities in contexts of poverty particularly vulnerable to having their human rights denied. For example, the International Labour Organisation recently identified a sharp rise in youth unemployment globally, which tends to be exacerbated in already high unemployment environments.[237] Women and girls in low-income countries and poor communities in wealthier countries are overwhelming targeted by sex traffickers and others involved in the sexual exploitation of women. Lastly, in poor communities disproportionately affected by crime, persons with disabilities often become targets by criminals. For all these reasons, states have an important obligation to invest in SRHR and GBV prevention and response services in their poorest communities and to ensure those services include young persons with disabilities.

Despite having greater needs for public and private investment, poor neighbourhoods rarely receive equitable levels of investment in infrastructure and services compared with wealthier communities, including neighbouring districts within the same city or neighbouring villages within the same rural zone. Whether it is basic utilities, such as water and electricity, or more advanced services such as internet connections,[238] this lack of access to infrastructure is universal within poor communities, cutting across both rural and urban settings.[239] Across the developing world, just 60 per cent of persons living in the context of poverty in urban areas have access to water piped into their home, and just 50 per cent of the rural population has access to a shared clean water supply.[240] Similarly, health, education, and even policing services are denied poor communities in both rural and urban areas. Poor neighbourhoods experiencing high levels of crime are often denied police protection and basic access to justice, such as being able to file reports following a crime having occurred,[241] which increases residents' vulnerability to experiencing violence and exploitation. This inequality is exacerbated by gender and disabilities. For example, within poor households, which are disproportionately less likely to have access to basic education, children with disabilities are less likely to attend schools. But across children with disabilities, boys are still more likely to be enrolled in schools by their parents or local authorities than are girls with disabilities. As a result, less than 10 per cent of children with disabilities globally are enrolled in primary school, and of those enrolled, just half complete their primary school educations.[242] For young women and adolescent girls with disabilities, however, the level of education is even lower. The United Nations Educational, Scientific, and Cultural Organisation (UNESCO) estimates that just 1 per cent of women and girls with disabilities worldwide are literate, which is significantly lower than the literacy rate for boys with disabilities. This means that just 5 per cent

of adolescents and youth with disabilities have completed elementary school and, of that 5 per cent, very few are women and girls. The result of this denial of education is the inability to fully participate in societies, including their local economies.

There is a higher disability prevalence in lower-income countries than in higher-income countries. People from the poorest wealth quintile and women have a higher prevalence of disability.[243]

Despite a profound degree of research and policymaking on poverty and poverty reduction in recent decades, very little is known about the relationship between poverty and disability, much less what policies work for ensuring or addressing the needs of persons with disabilities experiencing poverty and/or living in high poverty contexts, such as low-income countries or in urban slums or isolated villages in middle- and high-income countries. According to the World Bank, the vast majority of persons with disabilities (80 per cent) live in still developing economies, and an estimated 20 per cent of the world's poorest have some form of disability.[244]

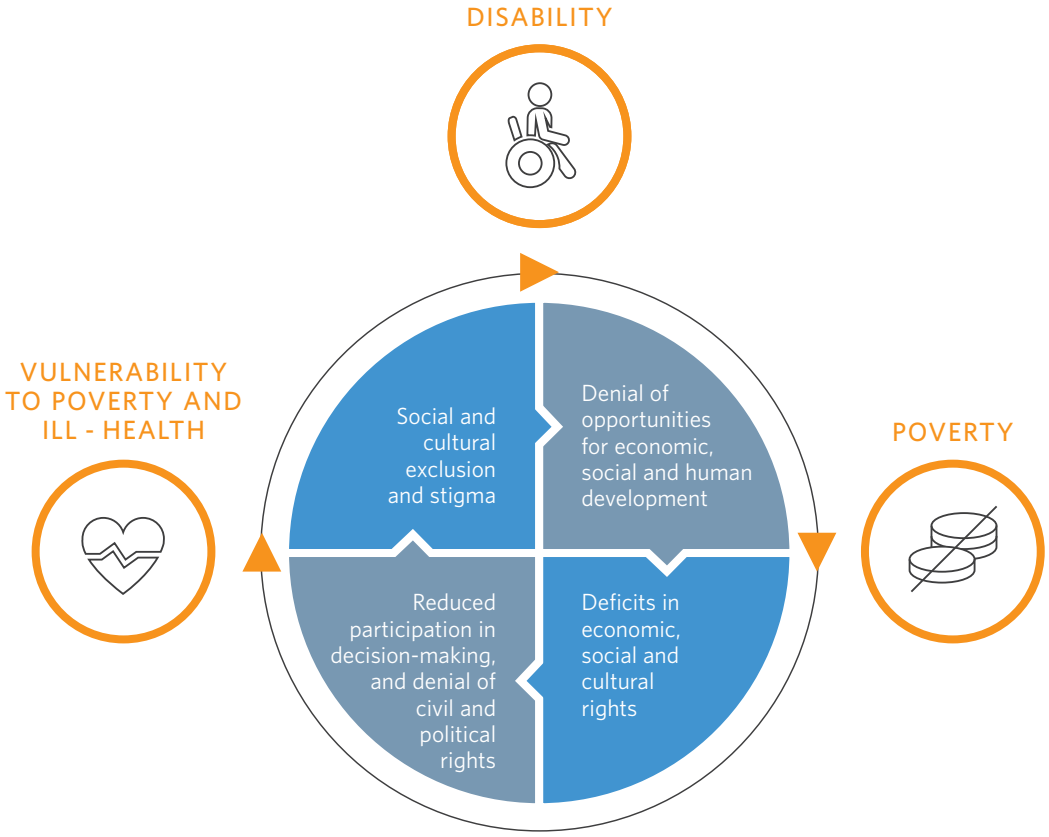
Poverty intersects with age, disability, and gender in complex ways that add another dimension of discrimination experienced in the everyday lives of young persons with disabilities. Persons living in the context of poverty are often denied a voice in public affairs and openly discriminated against by other community members. Unfortunately, little systematic data have been collected on the relationship between poverty, age, disability, and gender. The relationship between poverty and disability is not only different across and within economies but also across gender lines. For example, research on poverty and disability has revealed that:

The issues facing [persons with disabilities] in rich technological countries, with highly developed welfare provision, are indeed different from those in the [developing] world. In a global context, most [persons with disabilities] encounter both disabling barriers and barriers to scarce resources. Access to resources is highly gendered, and the life experiences of disabled women require specific attention.[245]

The gendered aspects of the intersection between poverty and disability require different policies to address uniquely gendered vulnerabilities, including discrimination from SRHR and increased risk of GBV.[246] For example, women and adolescent girls with disabilities are often specifically vulnerable to GBV because of marriage norms within communities. In cultures that require a dowry or bride price, women with disabilities are considered less marriageable and are thus more likely to be married into poor households and to less desirable partners. They are also less likely to be valued within their new households and to be at greater risk of GBV. In other cases, women with disabilities who are unable to marry and unable to find formal employment may engage in risky activities such as sex work or sex for survival that increase their vulnerability to sexually transmitted infections (STIs) and GBV. Men with disabilities, however, may not encounter the same barriers and vulnerabilities in marriage or the job market, particularly if they are physically strong or have employable skills.[247]

Impoverished persons with disabilities have simply been ignored within mainstream

LINK BETWEEN DISABILITY AND POVERTY: HOW DISABILITY CAN EXACERBATE CONDITIONS THAT LEAD TO INCREASED LEVELS OF POVERTY FOR VULNERABLE POPULATIONS



Note: A text alternative for this infographic is available as an annex here.
Source: DFID (2000). *Disability, poverty, and development.*

development economics because they have historically been assumed to be a small group best understood by medical specialists and best addressed through medical rehabilitation rather than via social and economic policies developed for the general population.[248] This is an example of the medical model of disability, wherein the experiences of persons with disabilities are reduced to the assumed need for rehabilitation rather than being understood from a wider array of social experiences, including discrimination in the economy and economic policy. This invisibility in research and policy is a testament to the marginality that persons with disabilities who are also poor experience.

What is known about the relationship between poverty and disability is that there is often a mutually reinforcing relationship between the two. For example, persons with disabilities are more likely to be poor, and poor people

are more likely to be persons with disabilities. The World Disability Report notes that people living in poverty experience worse health, on average, than those who are better off and that poverty often leads to conditions associated with disability, such as unsafe living and working conditions.[249] Indeed, poverty may increase the likelihood that a health condition becomes disabling.[250] That same relationship between poverty and disability can also make the poverty deeper and existing impairments more severe.

This relationship, however, may not be the same everywhere. For example, one of the very few comparative studies on the economic well-being of persons with disabilities across 15 developing countries found that the relationship between poverty and disability was weaker in low-income countries compared with that in middle-income countries. What this meant was that despite the relative greater number of economic opportunities in middle-income countries, the economic consequences of disability discrimination were higher. The same study also found that when looking across a range of data, the inequalities experienced by persons with disabilities varied from country to country. For example, in some countries poverty, disability, and lower levels of education were strongly linked, whereas in other countries that linkage was not significant.[251]

In addition to cross-national comparative research on the relationship between poverty and disability, there is also a need for more nuanced approaches to research and measurement within one national economy. For example, Nobel Prize-winning economist Amartya Sen has importantly pointed out that gross comparisons based on income and wealth miss important factors regarding differences in expenditures among different households. Sen argues that a person with a disability may need a greater income to achieve the same standard of living as a person without a disability.[252] For example, a young person with a disability may have to spend money on a private taxi to access an SRH service in a neighbourhood that lacks accessible public transportation, whereas a young person without a disability would not have to pay those extra costs to access the same SRH service. Therefore, even if they have the same incomes, the person with a disability is in effect poorer and has less access to the SRH service even if the service itself is free and its facility is accessible. As such, the young person with a disability is not enjoying their equal rights on the same basis as others are as a consequence of the young person with a disability's relatively greater level of poverty. Similar examples could be made about the relative extra cost regarding access to information for persons with sensory or communication impairments or in regard to the costs associated with a young person with disabilities accessing justice, such as reporting GBV to police or participating in a court proceeding.

// IV. RURAL SETTINGS

Young persons with disabilities living in rural areas experience unique barriers to enjoyment of and access to SRHR and GBV prevention and response services in comparison to their peers in urban and semi-urban communities. Not only is access to information and services more limited in rural areas but also access to representation in civil society is more limited. Young persons with disabilities living in rural areas are less likely to know about their rights, have access to transportation and accommodations necessary for them to claim their rights, or be part of a

disabled persons' organisation (DPO) or other group through which they can advocate for their rights. This is particularly true with regard to SRHR and GBV.

The rights of young persons with disabilities in rural areas are disproportionately violated by a host of 'geographical, physical, cultural, social and psychological factors within the external environment' that are not present or as detrimental in the lives of their peers in urban areas.[253] The overwhelming majority of persons with disabilities in developing countries today are living in isolated rural areas[254] where basic accommodations are less likely to be available from service providers, and public transportation is either entirely absent or inaccessible.[255] In a study of access to health care in rural areas in the United States, persons with disabilities reported that many physicians maintain offices in inaccessible buildings, medical staff were less knowledgeable about their specific disabilities or basic methods for accommodations than medical staff in urban areas were, and the majority of rural medical facilities were inaccessible by public transportation.[256] In regard to SRHR, a study of the attitudes of nurse-midwives providing SRH services in Kenya and Zambia found that providers in rural areas were less youth-friendly than in urban areas. Lastly, research on gender mainstreaming within European Union rural development policies found that women and girls' issues were often ignored or not taken seriously by policymakers and programme implementers.[257] In all of these ways, youth with disabilities, especially young women and adolescent girls, are prevented from exercising and accessing SRHR and GBV prevention and response services on an equal basis with others, regardless of whether they were in a low-income or high-income country context.

The relative lack of investment in ensuring the rights and promoting opportunities for people in rural areas has been well-documented. Development studies scholarship has drawn attention to 'urban bias' through analyses of public investment in developing countries and have found that governments often disproportionately invest public resources in urban areas because urban dwellers have more political power than their rural peers do.[258] Simply put, people in urban areas can more effectively organise and lobby the state than can people spread out across a large region. Civil society organisations, including international nongovernmental organisations (NGOs), also disproportionately invest in urban areas, often because they believe that it is more cost efficient to implement programmes in cities than in the countryside.[259] This lack of investment in rural areas includes a lack of investment in both SRHR and GBV prevention and response services along with disability inclusion initiatives. The results of this underinvestment can be alarming. For example, a study on maternal mortality rates for rural women in Gambia found that women experiencing obstetric emergencies in rural areas were either denied care entirely or the care they received was only provided after long delays. As a result, mortality rates of rural women in Uganda were many times higher than the already high mortality rates of women in urban areas experiencing the same or similar needs.[260] Persons with disabilities are often disproportionately excluded from all services in rural areas, including in areas and sectors where there have been improvements for the general population. For example, the International Labour Organisation found that persons with disabilities are rarely included in rural development strategies and programmes.[261] That means that young persons with disabilities are not benefitting from vocational training, investments in agriculture

and other industries, and other resources on an equal basis with others in their community, thus exacerbating already existing inequalities. This also means that young persons with disabilities in rural areas are far more likely to be poor than their peers in urban areas are, which indirectly affects their enjoyment of and access to SRHR and GBV prevention and response services.

In relation to access to health services for persons with disabilities in rural areas, a systematic review of the available literature found that even when health care, including SRH, is available to the rural population at large, persons with disabilities who access care receive far poorer care because they are often unaccommodated or referred to inadequately trained paraprofessionals in the absence of health-care providers knowledgeable of disability.[262] Lastly, not only are persons with disabilities left out of opportunities or denied services available to other community members in rural areas, but persons with disabilities living in rural areas are also denied opportunities and services that are available to their peers with disabilities in urban areas. For example, persons with disabilities living in rural areas are often excluded from DPOs, which tend to be based in urban areas.[263] As a result, voices from rural areas are left out of advocacy for greater disability inclusion and are often left out of programmes and initiatives that states and other actors engage in and undertake in partnership with DPOs.

Discriminatory attitudes and practices are sometimes more pronounced in rural areas than in urban areas. For example, a CSO promoting SRHR in Uganda cites cultural attitudes that limit women's ownership of land and access to resources in agrarian areas as contributing factors to the risk of GBV and denial of rights to SRHR experienced by rural Ugandan women and girls.[264] Similar observations have been made about attitudes toward persons with disabilities in other rural communities. For example, a study of women with disabilities in Cambodia found that traditional practices and beliefs related to marriage prevented many women with disabilities from being able to marry, and thus establish families, or, when married, they were married to men who often became abusive.[265] This may be because traditional social structures have remained in place in rural communities because they have been less affected by modernisation or have been left out of gender, disability, and other awareness campaigns that have been implemented in more urbanised places.

States Parties to the CRPD have a positive obligation to ensure enjoyment of and access to SRHR and GBV prevention and response services for young persons with disabilities. To fulfil their obligations, states must ensure that their SRHR and GBV policies and programmes are inclusive of young persons with disabilities in rural areas. These policies and programmes include States Parties providing international development assistance.

// V. INCLUSION IN HIV PREVENTION AND RESPONSE

Several countries today have an HIV prevalence rate that exceeds 20 per cent and several more where it exceeds 10 per cent. The majority of countries with a high HIV prevalence rate are clustered in Sub-Saharan Africa, a region that hosts 60 per cent of all persons living with HIV in the world. Within these contexts, young persons with disabilities are disproportionately at risk because they are less likely to be included

in HIV/AIDS services, including services provided by international CSOs. For that reason, states have a special obligation to ensure that all HIV/AIDS service providers include persons with disabilities in their awareness-raising, education, testing, and treatment programmes. Many HIV/AIDS service providers also provide services related to SRHR and GBV prevention and response. For this reason, not only do young persons with disabilities directly affected by HIV experience specific barriers to their SRHR and right to live free from violence in contexts of high HIV prevalence, but also all young persons with disabilities do.

The lack of inclusion of persons with disabilities in HIV policies and programmes has put young persons with disabilities at disproportionate risk of HIV infection. For example, a comparative study of young persons with disabilities and young persons without disabilities in Swaziland, which has the highest prevalence of HIV in the world today at 27 per cent, found that youth with disabilities had extremely limited information on HIV compared with their peers without disabilities and that the information young persons with disabilities did have was often inaccurate, including information as to how they could become infected.[266] This inequality was the result of HIV/AIDS awareness campaigns that were not accessible and inclusive of persons with disabilities. The findings in Swaziland are echoed throughout the literature and inclusive of every high HIV prevalence context around the world: Young persons with disabilities are at disproportionate risk of HIV, often because HIV interventions exclude them. This includes prevention programmes, access to comprehensive sexuality education (CSE), and HIV testing and treatment being either directly refused or being inaccessible and unable or unwilling to offer basic accommodations.[267]

Another dimension of the intersectionality between age, disability, and gender is HIV status. Many societies stigmatise persons affected by HIV/AIDS. The majority of research on HIV and intersectionality has focused on the multiple dimensions of discrimination faced by racial and ethnic minorities, LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex) persons, sex workers, and other traditionally discriminated against groups.[268] It is rare for HIV/AIDS-related literature to use an intersectional analysis to consider the intersection between HIV-related stigma and disability discrimination, much less the specific intersection between HIV-related stigma and young persons with disabilities. There are a few important exceptions written from a disability studies' perspective that highlight the fact that many HIV-related service providers and advocates discriminate against persons with disabilities, creating a double discrimination of persons with disabilities affected by HIV/AIDS.[269] This includes the belief by HIV/AIDS advocates and service providers that persons with disabilities are nonsexual, thus their awareness campaigns and other services rarely utilise multiple formats for information and communication.[270] Persons with disabilities and their representative organisations can also discriminate against persons with disabilities living with HIV, including by rejecting individuals living with HIV from membership in DPOs and refusing to make their rights to HIV services a priority in DPO advocacy. There are, however, positive signs of disability organisations and HIV-related organisations collaborating and creating policies and programmes addressing this important intersection, including the way that both HIV and disability stigma intersect with youth and gender.[271]

The human rights model of disability perspective shows that the participation of young persons with disabilities in HIV/AIDS services goes beyond a narrow focus on access and inclusion in health services delivery but requires an approach that recognises the interconnection of all rights. The CRPD provides a template for developing national legal and policy approaches to the inclusion of young persons with disabilities in HIV-related services by highlighting the importance of a comprehensive approach to rights.[272] It is necessary to recognise that all rights are interconnected and must be promoted to ensure that young persons with disabilities, especially young women and adolescent girls, can fully enjoy their right to HIV/AIDS services. For example, the economic right to an adequate standard of living addresses poverty, the social right to education provides the tools to access information, the civil right to access to justice is necessary for GBV protections to be effective, the political right to vote is needed to hold governments accountable for delivering accessible services, and so forth. The realisation of each of these rights directly contributes toward addressing young persons with disabilities' increased vulnerability to HIV. Such persons also require positive measures, such as ensuring the right to education through inclusive education or the right to access to justice through the provision of accommodations and the capacity development of police, courts, and other justice personnel.

A final factor regarding HIV/AIDS and disability that must be considered is the particularly large role CSOs play in providing HIV-related services. This is particularly true in low-income developing countries where many international NGOs and their local partners are major actors in regard to the provision of HIV-related services. This means that although states may have established strong laws and policies mandating the inclusion of young persons with disabilities in HIV-related services, CSOs may be the primary providers of those services in some communities. It is important that states, which have the responsibility to ensure equal access for all of their citizens to HIV-related services, develop policy guidelines for CSOs to ensure that they include persons with disabilities. States Parties to the CRPD providing foreign aid and other means of international cooperation are also obligated under Article 32 to ensure that all international development activities, such as HIV/AIDS services, are accessible and inclusive of persons with disabilities, including young persons and adolescents with disabilities.

VI. INSTITUTIONS

An estimated 2.7 million children and adolescents are living in institutional care around the world.[273] Additional millions of young persons from 18 to 24 are also institutionalised. A disproportionate number of institutionalised persons are persons with disabilities. Adolescents and young persons with disabilities are living in nursing homes, group homes, mental health hospitals, residential schools, orphanages, and prisons. Institutionalisation represents a major barrier to young persons with disabilities enjoying their human rights on an equal basis with others, including their SRHR and access to GBV prevention and response services. Institutionalisation itself, which limits the freedom of both children and adults to exercise choice and decision-making in daily life and prevents them from participating in their communities on an equal basis with others, is increasingly recognised as a human rights violation in and of itself. Institutions are often

the context of direct SRHR and GBV violations, where access to CSE is limited or nonexistent, sexual violence is covered up, and forced sterilisation continues to occur. Within these institutions, not only are all young persons with disabilities at heightened risk of human rights abuses, but also both young women and adolescent girls and persons with intellectual and psychosocial disabilities are at an even greater risk.

Institutionalisation is contrary to the human rights model of disability and increasingly recognised as a violation of the rights of the child. The United Nations Children's Fund (UNICEF) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) have called for an immediate end to the practice of placing children in institutions,[274] and the Committee on the Rights of the Child has called upon States Parties of the CRC to implement active measures to prevent the separation of children from their families and to provide support to parents in their parenting role to further the goal of deinstitutionalisation.[275] The Convention on the Rights of Persons with Disabilities promotes the right of persons with disabilities to 'have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others' (Article 19) and obligates States Parties to 'ensure that a child shall not be separated from his or her parents against their will' and in cases 'where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting' (Article 23). With the advance of human rights for both children and persons with disabilities, many states have sought to develop community-based supports for persons with disabilities and their families as an alternative to institutionalisation. This progress, however, has been uneven and is increasingly affecting persons with specific impairment types more than others. Institutionalisation today, for example, disproportionately affects persons with intellectual and psychosocial disabilities, whereas in the past it was used cross-disability. Institutionalisation also persists in some regions of the world more than in others, such as Eastern Europe and Central Asia.[276]

In addition to institutionalisation itself being counter to international norms, living within an institution places young persons with disabilities in a situation of extreme risk of further violations of their human rights, including their reproductive rights and right to live free form violence. These specific rights violations disproportionately affect young women and adolescent girls and persons with intellectual and psychosocial disabilities.

Discriminatory attitudes and false beliefs regarding persons with disabilities have traditionally depicted persons with disabilities, especially women and girls, as either nonsexual or as incapable of the responsibilities of motherhood. Histories of eugenics around the world have also led to harmful practices preventing the rights of persons with disabilities to enjoy their right to sexuality, marriage, reproduction, and parenting. Whereas many laws explicitly based on eugenics have been remediated, the ideology of eugenics still informs many of the policies and procedures in place within institutions for persons with disabilities. As a result, young persons with disabilities living in institutions are often denied access to basic SRH information and services, including information regarding family planning and STIs.[277] Institutions are also overwhelmingly

based on the medical model of disability. As a result, medical professionals often make decisions and implement procedures without the consent of persons with disabilities, which is a violation of Article 12 of the CRPD, which recognises the legal capacity of persons with disabilities to make decisions. The United Nations (UN) Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment has noted that acts of serious discrimination and violence against persons with disabilities are often committed by medical professionals who subject persons with disabilities placed under their care to medical treatments that are intrusive and irreversible in nature without the free and informed consent of the person concerned. These procedures include actions such as forced abortion and sterilisation.[278] Families are also complicit with medical professionals in coercing persons with disabilities to undergo these procedures, particularly in states where the legal capacity of persons with disabilities is not recognised or within institutions where supported decision-making protocols are not in place. A Disability Rights International report on the institutionalisation of women with psychosocial disabilities found that 40 per cent of interviewees had been subjected to forced or coerced sterilisation.[279]

Institutions are also sites of heightened risk of GBV. Children and adolescents with intellectual impairments have been estimated to be subjected to sexual abuse at rates as much as four times higher than those of their peers without disabilities.[280] Other residents and staff members are the most common perpetrators in institutions. Both states and CSOs often exclude institutions from GBV awareness-raising campaigns and monitoring activities, meaning that despite being sites of heightened risk, institutions are often left without necessary oversight.[281] Procedures such as forced abortion and sterilisation and the perpetuation of sexual violence often go hand in hand because institutions can effectively cover up the consequences of sexual violence by ending pregnancies that would otherwise alert others to the fact that rape had occurred. Institutions are also sites of other SRHR violations and GBV, including the production of child pornography, sex trafficking, and other forms of sexual exploitation.[282] In addition to placement in mental health hospitals and other residential facilities, persons with mental health and intellectual disabilities are often inappropriately imprisoned, exposing them to another institutional environment of heightened risk of sexual violence, exposure to STIs, and limited enjoyment of and access to SRHR and GBV prevention and response services. Institutionalisation within prisons also exacerbates existing mental health conditions and can create new trauma and mental health disorders.[283] The United States Department of Justice estimates that 26 per cent of the United States federal prison population are persons with disabilities,[284] an estimate many believe may vastly undercount the number of imprisoned persons with undiagnosed intellectual or psycho-social disabilities.[285] Within prison, young persons with disabilities are often subjected to violence, including GBV, and other rights violations.

Though there has been a decrease of institutionalisation around the world, it is still prevalent, particularly in Eastern Europe and Central Asia. In many states, CSOs, donors, and even medical professionals and family members choose institutionalisation, especially for young persons with intellectual and psychosocial disabilities. To promote the rights of young

persons with disabilities and prevent their institutionalisation, States Parties to the CRC and CRPD are obligated to raise awareness in the community and provide the necessary community-based supports to ensure the right of young persons with disabilities to live at home or independently in their communities. States Parties also have an obligation to promote SRHR and GBV prevention and response services in those extreme circumstances when institutionalisation is necessitated.

VII. COUNTRY FIELD VISITS

To gain a broader understanding of how states are working to support the rights of persons with disabilities in specific national contexts, the study included field visits to Ecuador, Morocco, Mozambique, and Spain. The field visit sites were preselected to ensure regional, geographic, and economic diversity. Although each country hosting a field visit has taken some important steps to advance the rights of young persons with disabilities, none was presumed to have entirely eliminated barriers to the full inclusion of young persons with disabilities. Rather, they offered an opportunity to assess how any one state is implementing the CRPD, the International Conference on Population and Development (ICPD) Programme of Action, and other international instruments relevant to the inclusion for young persons with disabilities in SRHR and GBV prevention and response services.

Although each field visit was subject to time and resource constraints and the data gathered were thus limited, each offered researchers the opportunity to consider how context matters as diverse policies and practices are being pursued to reduce the marginalisation of young persons with disabilities. Core takeaways and examples of positive practices adopted by each state are highlighted throughout this report. However, the following sections offer a richer description of the challenges each state faces in assuring every young person with a disability has an equal chance to succeed, and none are left behind.

ECUADOR

Ecuador provides a unique context for understanding the rights of young persons with disabilities. In many ways, it is broadly representative of the Latin American and the Caribbean region and of middle-income countries more generally. But it also represents a specific context wherein the state must address unique circumstances, including that more than one-third of its population still lives in rural areas, where some communities have social attitudes and practices that create specific barriers for ensuring the rights of young persons with disabilities. Ecuador has one of the highest adolescent pregnancy rates in the Latin American region, particularly in its rural areas and among its indigenous population. But it has developed and undertaken positive steps to address the significant challenges it faces regarding promoting SRHR and GBV prevention and response services for young persons with disabilities across the country. In this way, Ecuador demonstrates the importance of states in adapting practices and localising laws, policies, and programmes to address their respective specific contexts.

Ecuador is a middle-income country. It ranks 89 out of the 188 countries listed on the UNDP Human Development Index.[286] It represents both

a region and level of economic development whereby many states are actively developing new institutions to promote its citizens' human rights. These new developments include laws promoting the equality of persons with disabilities and women and girls and new policies and strategies ensuring inclusion within SRHR and GBV prevention and response services. Ecuador also has a unique inter-cultural makeup. Of its population of 14.5 million, 65 per cent identify as mestizo, 13 per cent as indigenous, 7.2 per cent as afro-descendent, 7.4 per cent as Montubio, and 19 per cent as white. Many of these communities have their own culture and languages, requiring the state to develop separate strategies for each population to ensure knowledge of and access to their rights.

Ecuador, despite being a middle-income country, has an adolescent fertility rate that is much higher than what is common across middle-income countries and within the Latin American and Caribbean region. According to the 2015 census, the adolescent fertility rate in Ecuador was 75.60 per 1,000 adolescent women (15–19 years old).[287] That makes Ecuador's fertility rate more than 50 per cent higher than that of its closest neighbours, Colombia and Peru (48.45 and 48.58 per 1,000, respectively) and significantly higher than the regional average for Latin America and the Caribbean. Some of the fertility rate is attributable to sexual violence perpetrated against children, adolescents, and young persons. According to a 2012 national survey, one out of four women has experienced sexual violence, and those women most vulnerable to violence are young women between the ages of 16 and 20 years old.[288] Evidence suggests that women and girls with intellectual disabilities are at a disproportionate risk of sexual violence. Research also suggests that there are significant social, economic, cultural, and institutional barriers that disproportionately affect persons living in rural areas and indigenous persons from enjoying and accessing SRHR and GBV prevention and response services.

Ecuador has developed an important framework of laws and policies for promoting the rights of young persons with disabilities, including access to and enjoyment of SRHR and GBV prevention and response services; however, there are significant cultural barriers in place that can stigmatise young persons, especially young persons with disabilities, from seeking SRHR, including access to contraceptives. Indeed, despite policies and strategies implemented by the Ministry of Public Health to increase the usage of family planning, significant portions of the young persons' population do not practice safe sex. For example, a recent national survey found that 97 per cent of adolescents were aware of modern contraceptive methods, yet 89 per cent of those who were sexually active before they were 17 years old had not used a condom during their first sexual encounter.[289] A prior report found that in rural areas, 50 per cent of all respondents who were sexually active reported having never used a condom.[290] The discrepancy between knowledge and practice is indicative of a taboo among young persons seeking out and using contraceptives. The stigma around family planning and reporting GBV is compounded for young persons with disabilities, who are often seen as nonsexual beings.

Ecuador has demonstrated its dedication to advancing the rights of its citizens, including the equal rights of young persons with disabilities, through its ratification of international legal instruments and national law. Ecuador has also taken proactive steps to ensure that persons with disabilities have equal enjoyment of and access

to SRHR and GBV prevention and response services. Ecuador was an early signatory and ratifier of both the CEDAW (signed in 1980, ratified in 1981) and the CRPD (signed 2007, ratified in 2008). Furthermore, the international standards of disability and gender equality are reflected in the 2008 Constitution of Ecuador, which specifically promotes the rights and equality of persons with disabilities, women and girls, and young persons. The protection and promotion of rights for these groups is further specified in legislative acts and public policies.

The National Constitution addresses all three constituencies of persons with disabilities, women, and youth. Article 11(2) of the Constitution prohibits discrimination on the basis of sex, gender identity, sexual orientation, and disability, and Article 27 requires the state to adopt affirmative action policies for all persons who suffer from inequality. Article 47 specifically affirms the rights of persons with disabilities, and numerous additional provisions specifically affirm the rights of persons with disabilities, including assuring them priority in health care, particularly for the elderly (Arts. 35 and 38), and equal opportunities for social inclusion (Art. 47). With respect to gender equality, Article 66(4) affirms 'the right to formal equality, material equality and non-discrimination'. Article 69 provides for equality within marriage and daughters to have the same rights within the family as sons do, and Article 70 directs the state to develop policies to achieve gender equality and calls for gender mainstreaming in state planning and policy development. Specifically, in respect to this study, Article 66(9–10) guarantees women 'the right to freely take informed, voluntary, and responsible decisions on one's sexuality and one's sexual life and orientation . . . and [t]he right to take free, responsible and informed decisions about one's health and reproductive life and to decide how many children to have'. In regard to youth, Article 39 states that the state shall guarantee the rights of young people and shall promote the effective exercise of these rights by means of policies and programmes, institutions and resources that ensure and uphold, on a permanent basis, their participation and inclusion in all sectors. Article 46 requires the state to adopt measures to support adolescents, including 'preferential care for the full social integration of persons with disabilities' and to ensure 'protection and care against all forms of violence, mistreatment, sexual exploitation or exploitation of any other kind or against neglect' of children and adolescents. These constitutional obligations are complemented by the Disability Act, Comprehensive (or *Organic*) Disability Act, National Agenda for Women and Gender Inclusion, and so forth.

One way by which law and public policy has been institutionalised is by the creation of specific public agencies and/or offices with existing ministries. These include the National Council for Disability Equality (CONADIS); the National Council for Gender Equality (CNIG); and specific offices and positions within the Ministry of Public Health such as the Coordinator of Sexual and Reproductive Health Promotion; the Director of Human Rights, Gender and Inclusion; and Director of Disability. Each agency and office has participated in promoting disability inclusion in SRHR and GBV prevention and response services, providing a strong institutional foundation. One noted challenge, however, is that the specific intersection of gender, disability, and adolescents and youth with disabilities has not been fully institutionalised. Persons with disabilities, for example, including women and girls and adolescents and youth with disabilities, are primarily identified first and

foremost as persons with disabilities rather than an intersecting identity. As such, agencies often defer to the CONADIS and the ministry disability directorate rather than recognise that all have an equal responsibility for young persons with disabilities who are represented within their own constituency. The creation of these agencies and positions for disability, gender, and so forth, however, provides an organisational framework in which the intersections can be easily institutionalised through their continued cooperation with one another.

Despite the important legal, policy, and programming developed by the state, progress ensuring the SRHR and right to live free from violence of its citizens has been limited, particularly in rural areas. Women and girls in rural areas represent a disproportionate share of unintended pregnancies. One recent study of pregnancy in Ecuador's rural Amazon Basin revealed that 73.7 per cent of indigenous women reported having had at least one unintended pregnancy.[291] Past studies have attributed Latin America's high fertility rate, despite the creation of new rights and increased socio-economic development, to a conservative religious culture that stigmatises individuals seeking some forms of family planning.[292] Similarly conservative attitudes toward sexuality are especially strong in Ecuador's indigenous communities throughout the Amazon basin, where the traditional family is celebrated and where pregnancy at an early age is a cultural norm and often celebrated as a necessary rite of adulthood.[293] In these same communities, contraceptive usage is low and often taboo, and sexual violence is prevalent, although often unaddressed and unreported.[294] Ecuador is also has a pluralist legal system. The 2008 Constitution recognises the rights of indigenous communities to maintain and practice their own legal systems. Although this is an important cultural right, it can indirectly prevent women and girls, along with men and boys, from fully enjoying and accessing SRHR and GBV prevention and response services. This is particularly true because Ecuador has not harmonised indigenous jurisdictions with the national justice system through a 'Coordination Act' or other legal mechanism that would ensure all human rights standards are equally localised into indigenous legal practice.[295]

Social attitudes toward accessing family planning, the passive acceptance of GBV, and social beliefs about persons with disabilities – including adolescent girls and young women with disabilities – present major barriers to young persons with disabilities in Ecuador accessing their SRHR. Ecuador, however, has been proactive in addressing these barriers at the local level. In Chapter 4: Preventing and Responding to Gender-Based Violence, Ecuador's new mandatory GBV training course, *Atención Integral a la Violencia de Género* (Comprehensive Attention to Gender Violence), will be discussed as an important state practice for including young persons with disabilities in GBV prevention and response services. As a virtual training course, it is able to reach all Ministry of Public Health employees, including those in isolated rural areas who often were unable to easily attend trainings in the past. The course also dedicates one of its five modules to GBV and disability. All Ministry of Public Health employees are required to complete the course on-line, ensuring that the Ministry of Public Health can monitor employees' completion of the training. Another positive step, which is highlighted in Chapter 5: Achieving Sexual and Reproductive Health and Rights for Young Persons with Disabilities, is Ecuador's Inclusive Health Centre certification programme. This new certification programme for Ministry of

Public Health facilities includes ensuring that all facilities are both 'adolescent-friendly' and 'disability-friendly'. This new certification programme has made significant progress, including in increasing access and realising SRHR for young persons with disabilities in rural areas.

MOROCCO

Morocco is broadly representative of Arab states and of lower-middle income countries more generally. Morocco ranks 123 out of the 188 listed on the UNDP Human Development Index.[296] It represents both a region and level of economic development wherein many states are developing new institutions to promote their citizens' human rights but also face challenges. These new developments include laws promoting the equality of persons with disabilities, but also specific considerations, notably the stipulation that state policies and practices do not conflict with the provisions of the Islamic Shariah law, which can have an effect on the policies and strategies implemented regarding SRHR and GBV prevention and response services. Morocco, however, was chosen for this study because of the progress it has made promoting the rights of young persons with disabilities, including enjoyment of and access to SRHR and GBV prevention and response services.

Research shows that the national prevalence rate of people with disabilities in Morocco is 6.8 per cent[297] with the most common disabilities reported as visual and mobility related. The ratio of males and females is similar, showing 49.7 per cent for males and 50.3 per cent for females. Further, 60.8 per cent of people with disabilities reported difficulties in accessing health services generally, from which 62.9 per cent was attributed to financial factors. Only 34.1 per cent of persons with disabilities benefited from social protection systems,[298] and only 10.6 per cent reported knowing their rights.[299]

Morocco has made significant achievements in developing the necessary legal and policy framework for promoting the rights of young persons with disabilities related to SRHR and GBV prevention and response services in recent years. Many laws in this framework are currently in the final stages of approval. Morocco has signed and ratified CEDAW, CRC, and the CRPD and has been developing a national legal framework for their implementation. The new 2011 national Constitution includes the right to health to all citizens, and it states the state's intention to mobilise all available means to facilitate the equal access of citizens to the rights of treatment, health care, social protection, health coverage, solidarity, and to living in a healthy environment. The Constitution also recognises the principle of gender equality in all civil, political, economic, social, cultural, and environmental rights and freedoms; the right to physical and moral integrity of individuals; and the principle of equality and combating all forms of discrimination. Morocco adopted Law N° 103-13 on combating violence against women in 2018.[300] The Criminal Code of 2003 has also been amended to prohibit and punish discrimination on the basis of disability.

As a result of these laws, many policies and cross-sectoral governmental strategies have been formulated, but implementation continues to be challenging. The Ministry of Solidarity, Family, Equality and Social Development, which is responsible for coordinating both policies for women and girls and for persons with disabilities, has taken important steps by developing national plans of action that bring all

government ministries and other stakeholders together to implement policies and programmes. Currently, however, SRHR are not specifically addressed in the National Disability Plan, and persons with disabilities are not specifically included in the Ministry of Health's Sexual and Reproductive Health plan. Civil society organisations play an important role in these strategies and policies by actively engaging with the government through participation in public forums and workshops and through their own advocacy. These organisations are providing many of the educational, medical, psychological and legal services to persons with disabilities at this time. This is an important distinction, as premarital sex is against the law in Morocco, and State provision of services has its challenges. Civil society organisations are also considered to play a role in improving proximity of services because they are present in most of regions, especially the smallest ones.

There is a significant gap between different types of disability in the field to having access to health services, including some SRH services; thus, persons with intellectual and psychosocial disabilities are more excluded, whereas blind people have reported similar levels of service as their peers without disabilities have. In addition, a significant disparity exists between urban and rural regions.

There is an absence of statistics in the field of health services, including SRH services related to persons with disabilities. Most of the time, disability is not included in data, which makes it impossible to evaluate strategies accordingly and prevents implementation of policies related to persons with disabilities as a result. Additional resources are needed to strengthen access and awareness of services, including developing the knowledge and skills of service providers regarding the inclusion of persons with disabilities in SRH services.

There are many misrepresentations and false beliefs regarding persons with disabilities and sexuality, such as believing in the asexualisation of persons with disabilities, especially those with intellectual disabilities. Those representations pose barriers to young persons with disabilities from having a healthy sexual and reproductive life and from being protected from sexual violence or GBV. Persons with disabilities are often dependent on their families. This is considered to be a major obstacle for their having a normal and healthy sexual life. Because of this dependence, and challenges accessing services, their enjoyment of and access to SRHR and GBV prevention and response services often depend on their family's perceptions, projections, and fears regarding their sexuality.

MOZAMBIQUE

Mozambique represents an important context to consider when understanding the rights of young persons with disabilities. It is one of the lowest-income states in the world and has one of the highest prevalence rates of HIV/AIDS. These two factors contribute to the barriers young persons with disabilities in Mozambique face and also highlight the importance of state coordination with civil society actors. Because of Mozambique's status as a developing economy with high HIV prevalence, many foreign states and international CSOs are active as funders and implementers of SRHR- and GBV- related programming. Some of these international development actors are not disability inclusive. Mozambique, thus, must not only promote the rights of young persons with disabilities through its own policies and institutions, but also it must

coordinate with foreign and non-state service providers that may not have disability inclusion policies in their SRHR and GBV prevention and response initiatives.

Mozambique is broadly representative of sub-Saharan Africa and of low-income countries more generally. As such, it represents a region and level of economic development wherein states face significant challenges developing new institutions promoting their citizens' human rights. Mozambique faces unique challenges due to its low-income status and high HIV/AIDS prevalence. It ranks 181 out of the 188 countries listed on the UNDP human Development Index[301] and has one of the highest HIV/AIDS prevalence rates in the world (estimated at 10.5 per cent for adolescents and adults 15–49 years old).[302] Although there is no current systematic data on the prevalence of HIV/AIDS among persons with disabilities in Mozambique, there is anecdotal evidence that the prevalence is equal to or greater than that of the general population. In response to this nascent evidence, Mozambique's government included a specific provision in Law 12/2009 on the rights and duties of persons living with HIV/AIDS to state that persons with disabilities have an equal right to HIV/AIDS prevention, protection, and treatment. A specific challenge that Mozambique faces in ensuring the participation of young persons with disabilities in HIV/AIDS-related and more general SRH and GBV prevention and response services is the number of CSOs that provide health-care services. This presents a barrier to implementing rights because only the government is obligated to carry out the public mandate to protect the rights of all its citizens equally and to implement disability inclusive laws, policies, and strategies; CSOs, such as international nongovernmental organisations and grassroots associations, do not share that same responsibility, nor are they accountable to the state in the same way, yet they are often the primary implementers of the national SRHR plan. Despite these challenges, Mozambique has been proactive in developing a legal and policy framework that promotes the rights of young persons with disabilities including SRHR and access to GBV prevention and response services through its commitment to international and regional laws, policies, and strategies and its development of a national legal framework to implement policies and programmes ensuring that young persons with disabilities have equal access to services and fully enjoy their rights. This includes the allocation of specific responsibilities within government ministries for the implementation of those laws, policies, and strategies.

Mozambique has signed and ratified all relevant international conventions, including the CEDAW, the CRPD, and the CRC. It has also signed and ratified regional instruments, including the African Charter on Human and People's Rights, which protects the rights of women and Children (Article 18, Clause 3); the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, which specifically refers to special protections for women with disabilities (Article 23); and the African Charter on the Rights and Welfare of the Children, which specifically refers to the rights of 'handicapped children' (Article 13), protection against children abuse (Article 16) and protections of Children against sexual exploitation (Article 27). Furthermore, Mozambique is also a signatory of the ICPD Programme of Action.

Mozambique has also developed a progressive national legal framework, beginning with its constitution through to laws, decrees, and strategies. The 2004 Constitution of

Mozambique grants equal rights to persons with disabilities (Article 37), equal rights of women (Article 36), a state obligation to promote the development of women (Article 122) and development of youth (Article 123), and rights to health, although not specifically SRH (Articles 89 and 116). In national legislation, Law 12/2009 on the rights and duties of persons living with HIV/AIDS specifies that persons with disabilities have a right to HIV/AIDS prevention, protection, and treatment that takes account of their special needs including communication and informational needs (i.e. sign language). Decree 78/2009 creates a National Disabilities Council, National Law 29/2009 on domestic violence, and a number of additional laws and strategies promoting the rights of persons with disabilities, children, and women and girls. Responsibility for the implementation of these laws has been institutionalised within public agencies through the creation of specific offices and positions with responsibility. This includes a Disability Department and a HIV/SRRH focal point with a mandate to ensure equal access to HIV prevention and treatment for persons with disabilities in the Ministry of Gender, Children, and Social Action. The Ministry of Gender, Children, and Social Action facilitates a civil society forum that includes DPOs. The Human Rights Office of the Ministry of Justice is responsible for disability inclusion, which includes rights and protections related to GBV.

In recent years, international development aid has been increasingly funnelled through CSOs, such as international nongovernmental organisations and grassroots associations, rather than through government ministries. Mozambique's health sector includes a significant number of CSOs delivering SRHR-related and GBV prevention and response services. Although many CSOs execute excellent work in low-resource environments, they can create a challenge to the state in terms of ensuring that the rights of young persons with disabilities and other groups are protected and that all of Mozambique's citizens have equal access to the services delivered. For example, the number of CSOs delivering health care has led to a fragmented health-care sector that presents significant challenges to the state to ensure coordination and that its comprehensive health-care plan is implemented.[303] This is because nongovernmental organisations may specialise in specific services or focus on specific groups in response to donors or as a result of their organisational mission or expertise rather than the needs on the ground or the government's priorities or national plan. International nongovernmental organisations also often locate themselves in capitals and other major cities based on ease of access, communications infrastructure (telephone and internet), the health and security needs of international personnel, the location of government ministries and international organisations, and other considerations that are not direct responses to need.[304] This can result in an urban bias whereby the population in rural communities or conflict affected environments are left out. Lastly, CSOs providing HIV/AIDS services have been noted as playing such an outsized role in some developing contexts that they can siphon off public health-care personnel or redirect public resources away from more comprehensive approaches to SRHR.[305]

As a result of the relatively large presence of CSOs participating in the implementation of Mozambique's national SRHR and GBV programming, young persons with disabilities have been overlooked by organisations that do not emphasise disability inclusion. During the course of undertaking this study's research, several mainstream nongovernmental organisations

providing SRHR made distinctions between their objectives and the government's objective, stating that their donor-funded programmes targeted other marginalised populations, such as sex workers and LGBTQI persons, and not persons with disabilities. Disabled persons' organisations have tried to implement their own programmes, such as providing HIV-related education to their members, but noted that their scarce resources only allowed them to focus their activities in the capital Maputo and other major cities because it was too financially difficult to work in rural communities, where they often had loose connections to members or other persons with disabilities and few resources to carry out organising and awareness activities.

Despite these challenges, Mozambique has developed and undertaken several positive steps towards partnering with civil society to better ensure disability inclusion within civil society's work and work toward ensuring that younger persons with disabilities are included in several crucial SRHR programmes. In Chapter 6 on Inclusion of Civil Society, Mozambique's Ministry of Gender, Children, and Social Action's partnership with the Youth Coalition Mozambican Association (ACJM) and Associação Moçambicana para Desenvolvimento da Família/Mozambican Association for Family Development (AMODEFA) will be highlighted. Through this state-civil society partnership, young persons with disabilities have been mainstreamed as peer counsellors within the Geração Biz ('busy generation') initiative, which is discussed in some detail in Chapter 6.

SPAIN

Spain provides an important context to consider in ensuring the rights of young persons with disabilities. Spain is a high-income country and an important international human rights and international development actor. As such, Spain has advanced the inclusion of young persons with disabilities at home and abroad through law, policies, and programmes. Domestically, it has made significant strides to integrate the rights recognised in the CRPD in national legislation and policies. Spain however faces the challenge of ensuring that the rights of young persons with disabilities are achieved equally across the country. Spain's decentralised legal system grants autonomy in education and health policy development, among other things, to regional authorities, which have varied in their attention to the needs of young persons with disabilities. While a decentralised system of governance offers opportunities for highly localised programmes and outreach to persons with disabilities, in the absence of national standards or guidelines, Spain risks leaving the rights of young persons with disabilities unmet in parts of the country.

Spain ranks 27 out of the 188 countries listed on the UNDP Human Development Index[306] and has been a leader within the OECD in providing official development assistance (ODA). In 2016, Spain's net ODA reached more than U.S. Dollar 4 billion, making it the 10th largest donor within the Organisation for Economic Cooperation and Development (OECD).[307] Spain has also been actively involved in ensuring that the 2030 Agenda for Sustainable Development is inclusive, takes a rights-based approach, and is sustainably financed. In 2007, Spain signed a landmark agreement with the UN system and provided a generous Euro 528 million (U.S. Dollar 710 million) contribution to establish the Millennium Development Goals Achievement Fund.[308] The Spanish government has also taken active steps to include the private sector in

development financing and increasing its ODA to support the development and management of global public goods.[309]

As a major international donor, Spain has advocated for the mainstreaming of disability, gender, and youth in development programmes and policies globally. In its 2016 review, the OECD's Development Assistance Committee called for exactly this leveraging, suggesting Spain adopt and improve mechanisms to more effectively mainstream gender, among other things, in field operations.[310] Where Spain is actively engaged in funding efforts to alleviate poverty and redress inequalities, it has the ability to put a priority on projects and programmes that are designed to be inclusive of young persons with disabilities in all their diversity and promote inclusive development among its grantee partners.

Spain's commitment to the rights of persons with disabilities is long-standing. It was the first country to submit a state party report to the Committee on the Rights of Persons with Disabilities in 2010 and in 2011, Spain passed a landmark piece of legislation, Law 26/2011, which incorporates the language of the CRPD into Spanish law and promotes the full recognition of the rights of persons with disabilities.[311] This law was quickly followed by Royal Decree 1276/2011 which adapts the current regulations regarding disability to the guidelines of the CRPD, in line with Law 26/2011.[312] Although Spain has since made significant progress adapting its national legal framework to meet the standards set by the CRPD, it still faces challenges ensuring rights equally among women, men, and young persons with disabilities throughout the country.

Spain has developed a positive national framework regarding SRHR and GBV prevention and response services for young persons with disabilities. The 1978 Spanish Constitution specifically promotes gender equality (Article 14) and the social participation of youth (Article 48), and Spain passed the General Law on the Rights of Persons with Disabilities and their Social Inclusion in 2013. The implementation of these rights, however, is filtered through Spain's decentralised system. Article 2 on the State of Autonomies of the 1978 Constitution recognises the right of self-government of 17 autonomous communities (consolidated provinces) and two autonomous cities. The federal features of the State of Autonomies have created 19 locally distinctive implementations of many national laws.[313] Both formal decentralised systems such as Spain's and less formal decentralised systems that simply devolve responsibilities for the implementation of laws and policies to provincial, district, and other local authorities, highlight both the opportunities and the challenges of implementing rights through decentralised systems of governance. It is an opportunity because local governments are empowered to develop policies and programmes best suited for their specific population and context. It is a barrier because in practice it can mean that there is no standardisation of how the protection and promotion of rights is achieved across communities, and national-subnational coordination can create an additional bureaucratic burden in the allocation of resources, flow of information, and general management of programmes.[314]

In Spain, regional authorities have been at the forefront of advancing SRHR, but the benefits of programmes have typically been limited within the regions and have not been expanded much beyond them. In field interviews, for example, advocates for young persons with disabilities expressed concern about the limited number of

sources of family planning services for young persons with disabilities around the country and the lack of high-quality, CSE, both of which fall under regional mandates. Although some urban centres had adopted pregnancy prevention plans, there was no national strategy to ensure that all young people, including young persons with disabilities, had access to appropriate SRH services. Women in rural areas were particularly underserved.

Even accessibility can differ substantially among regions. In Barcelona, where persons with disabilities are represented on the town council, all public transportation is accessible for multiple disabilities, and local and regional legislation on accessibility has been in place since 2014. In addition, there is a 'door-to-door' service for persons with disabilities that includes four taxi rides for the cost of one bus ticket. In other parts of the country, however, particularly in rural areas, access to public transportation is far more limited, making it considerably more difficult for persons with disabilities to receive health care and actively participate in social activities.

In surveys, young persons with disabilities report that their biggest challenges are having the freedom to leave home and have access to work and leisure activities.[315] There is a significant gap in educational achievement between young persons with disabilities and their peers without disabilities. Only 8 per cent of young persons with disabilities in Spain have university degrees, and a sizeable percentage is functionally illiterate.[316] Illiteracy among young women with disabilities is four times higher than among young men with disabilities in Spain.[317]

Access to information on sexuality and SRH services can also depend on location. The Family Planning Federation supports four youth centres around the country, all of which are in urban areas. Though at least some of the centres are physically accessible, the streets on which they are located have high curbs and cobblestones, making them impossible to reach for a significant number of young persons with disabilities. Although members of this federation make occasional field visits to rural areas, these depend on connections with local or provincial governments or agencies and do not replace consistent, accessible health-care services. There have also been reports that forced sterilisations and coerced abortions have occurred in the case of women and girls with disabilities, particularly girls and women with intellectual or psychosocial disabilities. This means that these services were provided without their consent, without their understanding the specific purpose of the operation, and often under the pretext of looking after the welfare of the person with disabilities rather than recognising the individuals' right to make their own reproductive health decisions.[318]

A study conducted under the National Strategic Plan for Children and Adolescents by the General Directorate for Social Policy, the Family and Children, and the *Centro Reina Sofía* for the study of violence found that disability is a principal factor that greatly increases the risk of child abuse. Among the core data the research provides are that abuse is more prevalent when the child has 'some type of physical or mental illness (7.8 per cent compared with 3.57 per cent when no such illness is present), and children with some type of disability suffer higher rates of violence than do those without disability (23.08 per cent and 3.87 per cent, respectively)'.[319]

Although the national government has enacted relevant national policies, there are few provisions to ensure regular monitoring

and evaluation, making it difficult to assess compliance or the quality of implementation. For example, whereas national law provides for CSE for all young people, the implementation is left up to local and regional authorities, with the result being that actual programming depends on the interest and knowledge of school staff. In field interviews, advocates noted that sexuality education in many schools is offered after young people are already sexually active and focuses on risky behaviours rather than healthy relationships. Some noted that in some places, the only sexuality education students receive is limited to presentations by feminine hygiene sales personnel.

Yet some regional authorities have been actively promoting the rights of persons with disabilities locally. The Andalusian School of Public Health, for example, developed a programme to train medical professionals working on providing SRH services that are inclusive of persons with disabilities, particularly with respect to the promotion of healthy sex lives, the use of family planning, and SRH services. Hospitals throughout the region have at least one room equipped for gynaecological exams for women with disabilities.

With respect to GBV, there are a number of important initiatives at the regional level to empower women with disabilities who are vulnerable to GBV. In Aragon, CSOs of and for women with disabilities are collaborating with the regional governmental Aragon Women's Institute to develop new local policies on GBV that include women with disabilities. Similarly, in Barcelona, the Associació Dones no Estàndards has produced guidelines on preventing GBV against women with disabilities and helped the regional government develop a compulsory protocol for medical professionals designed to identify suspected cases of violence and to support referrals of victims. The Spanish Committee of Representatives of Persons with Disabilities (Comité Español de Representantes de Personas con Discapacidad, CERMI) Andalusia is likewise working with the regional government to develop comparable guidelines for medical professionals and promote more widespread tracking of challenges faced by women with disabilities accessing health care and justice services, among other things.

As a case, Spain's system of decentralised governance offers examples of both the potential of decentralised governance to adapt policies and practices to meet the needs of local populations along with the challenge of ensuring that all citizens receive equal access to services and enjoy the same rights. This is particularly true regarding the actualisation of SRHR and implementation of a comprehensive approach to preventing and responding to GBV among young persons with disabilities. For example, a study on decentralised governance has been noted in relation to SRHR in diverse contexts as creating tensions between national and subnational (local) bodies over what aspects of laws and policies should be given priority, what the responsibilities are of different parties, and what the proper standards are by which implementation will be held accountable to.[320] A study of SRHR and decentralisation in Ghana, for example, found that the implementation of SRHR programmes was often more dependent on the commitment of local authorities than on national policies.[321] Similarly, a study of Uganda, which has increasingly devolved governance to the district level, noted tensions between resources regarding the distribution of resources for gender mainstreaming that were allocated to the central government but not adequately shared with district-level authorities responsible

for implementing the policy.[322] A case study of Brazil's federal health-care system had a similar finding, wherein federal health ministry staff had been trained by both international and national experts on implementing a new SRHR policy, but little training was provided to the state Health Ministry staff most in need of the information.[323]

VIII. CONCLUSION

This chapter has highlighted the important role that specific contexts play in the lives of young persons with disabilities and the unique barriers humanitarian crises, rurality, poverty, areas where there is high HIV prevalence, and institutionalisation present in enjoyment of and access to SRHR and GBV prevention and response services. Each context and circumstance may be different, but states are obligated to ensure the same rights in all cases. Therefore, it is important that states develop laws, policies, and programmes that respond and adapt to the specific contexts wherein the rights of young persons with disabilities are violated. In the following chapters, state responses to violence and states' promotion of SRHR will be discussed. Case studies, including those drawn from field visits to Ecuador, Morocco, Mozambique, and Spain, will highlight positive state practices implemented in national and local contexts that all states and non-state actors can learn from.

// CHAPTER 3

THE RIGHTS OF YOUNG PERSONS WITH DISABILITIES – INTERNATIONAL AND REGIONAL NORMATIVE FRAMEWORKS

I. INTRODUCTION

International norms articulate the priorities and responsibilities of states with respect to the protection of human rights and offer a guide for how to achieve these rights in practice.[324] They establish minimum standards against which states can assess progress in achieving the rights recognised in international conventions and evaluate where further action is needed. Treaty law sets the highest standard for state accountability toward human rights and requires states to take affirmative action and exercise due diligence to realise the rights to which they have committed.[325] Under the due diligence standard, states are obliged not only to adopt laws and policies protecting rights but also must ensure that they function effectively in practice and are diligently enforced.[326] The due diligence standard is explained in greater detail in the text box on page 114 below.

Norms recognising and protecting the rights of young persons with disabilities are grounded in principles articulated in nearly all the core international human rights treaties that collectively provide a powerful interlocking framework for state action.[327] The human rights treaty system is complementary and interdependent, with many rights receiving recognition and protection in more than one instrument, and subject to regulation and monitoring by several treaty bodies and the Human Rights Council.[328] At the same time, human rights are recognised as interrelated, such that the realisation of one right may depend on the realisation of others.[329] For young persons with disabilities, the realisation of their right to live full and satisfying lives depends on respect for rights guaranteed in treaties focused on protecting the rights of persons with disabilities, of children and young people, and of women and girls, among others.

CHAPTER OVERVIEW

This chapter first provides a brief overview of the core international normative frameworks that protect the rights of young persons with disabilities in three areas: (1) the right to equality and non-discrimination, (2) the related right to be free from gender-based violence (GBV) and harmful practices that discriminate against young women and girls, and (3) the right to attain the highest level of sexual and reproductive health (SRH). These rights find recognition in the terms and guidance of the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on Civil and Political Rights (ICCPR), the Convention on Economic, Social, and Cultural Rights (ICESCR), the Beijing Declaration and Platform for Action, the International Conference on Population and Development (ICPD) Programme of Action, and the 2030 Agenda for Sustainable Development, along with others at the international and regional levels. Throughout the chapter, the mechanisms and standards that advocates and stakeholders can use to ensure that states meet their treaty obligations are discussed.

II. ENSURING EQUALITY AND NON-DISCRIMINATION

International law has long recognised the right of all people to live their lives free from discrimination and equal in dignity and rights. Universal respect for human rights and fundamental freedoms for all is enshrined in the Charter of the United Nations, and the

THE HUMAN RIGHTS-BASED APPROACH TO DEVELOPMENT COOPERATION – THE UNITED NATIONS COMMON UNDERSTANDING

In 2003, the United Nations (UN) adopted a Common Understanding of a Human Rights-based Approach to Development Cooperation. The Common Understanding emphasises the following:

- All programmes of development cooperation, policies, and technical assistance should further the realisation of human rights as laid down in the Universal Declaration of Human Rights (UDHR) and other international human rights instruments.
- Human rights standards contained in, and principles derived from, the UDHR and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process.
- The core human rights principles highlighted in the Common Understanding include:
- **Universality and inalienability.** Human rights are universal and inalienable. All people everywhere in the world are entitled to them. The human person in whom they inhere cannot voluntarily give them up. Nor can others take them away from him or her.
- **Indivisibility.** Human rights are indivisible. Whether of a civil, cultural, economic, political or social nature, they are all inherent to the dignity of every human person. Consequently, they all have equal status as rights and cannot be ranked, *a priori*, in a hierarchical order.
- **Interdependence and Inter-relatedness.** The realisation of one right often depends, wholly or in part, upon the realisation of others.
- **Equality and Non-Discrimination.** All individuals are equal as human beings and by virtue of the inherent dignity of each human person. All human beings are entitled to their human rights without discrimination of any kind, such as race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status as explained by the human rights treaty bodies.
- **Participation and Inclusion.** Every person and all peoples are entitled to active, free and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realised.
- **Accountability and Rule of Law.** States and other duty-bearers are answerable for the observance of human rights. In this regard, they have to comply with the legal norms and standards enshrined in human rights instruments. Where they fail to do so, aggrieved rights-holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by law.

principle of non-discrimination is affirmed in the UDHR, the ICCPR (Preamble and Arts. 2, 3, 24, and 26), the ICESCR (Preamble and Arts. 2 and 3), and the Convention on the Elimination of All Forms of Racial Discrimination (Art. 2 and 5), *inter alia*.[330] Although disability was not formally recognised as a basis for discrimination in these early documents, the rights they recognised extend to all people, 'without distinction of any kind'.[331] Subsequent guidance by treaty monitoring bodies and the adoption of the CRPD in in 2006 have affirmed that persons with disabilities are entitled to the same rights and fundamental freedoms as their peers without disabilities are and that states must take affirmative action to acknowledge and respond to the particular needs of persons with disabilities, including young persons with disabilities.[332]

Young persons with disabilities face multiple forms of discrimination on the basis, at least, of their age, their sex, and their disability. They may also face discrimination on the grounds of race, religion, ethnicity, or a host of other factors. For young people to achieve the full enjoyment of their human rights, it is essential to account for the ways in which discrimination and related human rights abuses may have disability-specific components that may be exacerbated by age or gender, among other factors.[333] State action, in other words, must take disability, age, *and* gender into account to fully address and eliminate barriers to the achievement of human rights for all. The normative basis for mainstreaming the rights of young persons with disabilities is grounded in the CRPD, CRC, and CEDAW, as discussed further below.

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES[334]

Ratified by 175 parties, the CRPD includes 33 core articles that cover all areas of life, from the inherent dignity of all persons with disabilities to their right to inclusion in all aspects of social, political, and economic life.

The CRPD adopts a rights-based approach that focuses on ensuring the human rights of persons with disabilities. It highlights the intersectional discrimination to which persons with disabilities are subject, with articles dedicated to the rights of women and young persons with disabilities, and requires States Parties to 'ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind' (Art. 4).[335]

Article 7 requires States Parties to 'take all necessary measures to ensure the full enjoyment by children and adolescents with disabilities of all human rights and fundamental freedoms on an equal basis with other children', whereas the Preamble and Articles 3, 6, 8, 16, and 25 expressly adopt a gender perspective. The CRPD recognises particularly in Article 6 that 'women and girls with disabilities are subject to multiple discrimination', and requires states to 'take measures to ensure the full and equal enjoyment by [women and girls] of all human rights and fundamental freedoms'. It further provides that 'States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.'

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND OPTIONAL PROTOCOL: SIGNATURES AND RATIFICATIONS

- Afghanistan
- Albania
- Algeria
- Andorra
- Angola
- Antigua and Barbuda
- Argentina
- Armenia
- Australia
- Austria
- Azerbaijan
- Bahamas
- Bahrain
- Bangladesh
- Barbados
- Belarus
- Belgium
- Belize
- Benin
- Bhutan
- Bolivia (Plurinational State of)
- Bosnia and Herzegovina
- Botswana
- Brazil
- Brunei Darussalam
- Bulgaria
- Burkina Faso
- Burundi
- Cabo Verde
- Cambodia
- Cameroon
- Canada
- Central African Republic
- Chad
- Chile
- China
- Colombia
- Comoros
- Congo
- Cook Islands
- Costa Rica
- Côte d'Ivoire
- Croatia
- Cuba
- Cyprus
- Czech Republic
- Democratic People's Republic of Korea
- Democratic Republic of the Congo
- Denmark
- Djibouti
- Dominica
- Dominican Republic
- Ecuador
- Egypt
- El Salvador
- Equatorial Guinea
- Eritrea
- Estonia
- Ethiopia
- European Union
- Fiji
- Finland
- France
- Gabon
- Gambia
- Georgia
- Germany
- Ghana
- Greece
- Grenada
- Guatemala
- Guinea
- Guinea-Bissau
- Guyana
- Haiti
- Holy See
- Honduras
- Hungary
- Iceland
- India
- Indonesia
- Iran (Islamic Republic of)
- Iraq
- Ireland
- Israel
- Italy
- Jamaica
- Japan
- Jordan
- Kazakhstan
- Kenya
- Kiribati
- Kuwait
- Kyrgyzstan
- Lao People's Democratic Republic
- Latvia
- Lebanon
- Lesotho
- Liberia
- Libya
- Liechtenstein
- Lithuania
- Luxembourg
- Madagascar
- Malawi
- Malaysia
- Maldives
- Mali
- Malta
- Marshall Islands
- Mauritania
- Mauritius
- Mexico
- Micronesia (Federated States of)
- Monaco
- Mongolia
- Montenegro
- Morocco
- Mozambique
- Myanmar
- Namibia
- Nauru
- Nepal
- Netherlands
- New Zealand
- Nicaragua
- Niger
- Nigeria
- Niue
- Norway
- Oman
- Pakistan
- Palau
- Panama
- Papua New Guinea
- Paraguay
- Peru
- Philippines
- Poland
- Portugal
- Qatar
- Republic of Korea
- Republic of Moldova
- Romania
- Russian Federation
- Rwanda
- Saint Kitts and Nevis
- Saint Lucia
- Saint Vincent and the Grenadines
- Samoa
- San Marino
- Sao Tome and Principe
- Saudi Arabia
- Senegal
- Serbia
- Seychelles
- Sierra Leone
- Singapore
- Slovakia
- Slovenia
- Solomon Islands
- Somalia
- South Africa
- South Sudan
- Spain
- Sri Lanka
- State of Palestine
- Sudan
- Suriname
- Swaziland
- Sweden
- Switzerland
- Syrian Arab Republic
- Tajikistan
- Thailand
- The former Yugoslav Republic of Macedonia
- Timor-Leste
- Togo
- Tonga
- Trinidad and Tobago
- Tunisia
- Turkey
- Turkmenistan
- Tuvalu
- Uganda
- Ukraine
- United Arab Emirates
- United Kingdom of Great Britain and Northern Ireland
- United Republic of Tanzania
- United States of America
- Uruguay
- Uzbekistan
- Vanuatu
- Venezuela (Bolivarian Republic of)
- Viet Nam
- Yemen
- Zambia
- Zimbabwe

Note: A text alternative for this infographic is available as an annex here.

Source: Database of the United Nations Office of Legal Affairs. Accessed at untreaty.un.org/ola. Data as of 19 February 2018.

MAINSTREAMING THE RIGHTS OF YOUNG PERSONS WITH DISABILITIES

The CRPD obligates States Parties to 'take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes'. (Art. 4(1)(c)) At the international level, it mandates that 'international cooperation, including international development programmes [be] inclusive of and accessible to persons with disabilities'. (Art.32(1)(a)) The Convention thus imposes a duty to mainstream the human rights of persons with disabilities at all levels of state law and policy development.

Mainstreaming is 'the process of assessing the implications for [persons with disabilities] of any planned action, including legislation, policies or programmes, in any areas and at all levels'.[336] It requires fully integrating the rights of persons with disabilities into *all* laws, policies, programming, and practices. This goes beyond merely mentioning persons with disabilities or limiting consideration of disability rights to disability-specific policies or programming.[337] The 'twin-track approach' calls on states to both:

a. Integrate disability-sensitive measures into the design, implementation, monitoring and evaluation of all policies and programmes; and

b. Provide disability-specific initiatives to support the empowerment of persons with disabilities.[338]

For particularly excluded groups like young persons with disabilities, who may suffer intersecting discrimination based on age and gender or other grounds, along with disability, combating discrimination requires recognising each ground of identity on which it is based. In other words, law makers and others must take into account the unique vulnerabilities that accompany childhood and disability, adolescence and disability, and young adulthood and disability.[339] The Committee on the Rights of the Child's General Comment No. 20 on the implementation of the rights of the child during adolescence, for example, calls out the unique vulnerability to discrimination of adolescents with disabilities and urges states to take active steps to overcome the particular barriers such adolescents face to ensure their full inclusion into society.

The Committee on the Rights of Persons with Disabilities has expanded on the marginalisation in particular of young women and girls to discrimination and the extent of states' obligations under the treaty.[340] It noted that discrimination against women and girls with disabilities can take many forms, including: (a) direct discrimination, which occurs when women and girls with disabilities are treated less favourably than their peers without disabilities or men and boys with disabilities are; (b) indirect discrimination, such as facially neutral laws being implemented in a discriminatory way or

with a discriminatory impact; (c) discrimination by association, such as that against mothers of children including adolescents with disabilities; (d) denial of reasonable accommodation; and (e) structural or systemic discrimination. Structural discrimination in the form of harmful gender and disability stereotyping can exacerbate women's vulnerability to violence and abuse and make it more difficult for them to report complaints or achieve justice from law enforcement officials and courts.

The Committee emphasised that States Parties' obligations to respect, protect, and fulfil the human rights of women and girls with disabilities requires them to exercise due diligence to guarantee their rights are not infringed by state actors or third parties and to prevent all forms of discrimination against them. It mandated the 'twin-track' approach, requiring states to both mainstream women and girls with disabilities in all national action plans, policies, and strategies concerning women, children, disability, gender equality, SRH prevention of violence and access to justice, among others, and to also develop separate policies, programmes, provisions, and activities specifically targeting women and girls with disabilities.

I am a woman with an intellectual disability. I went to school and college; I am a self-advocate and a trainer on the Convention on the Rights of Persons with Disabilities. I want to say, "Find your dream and realise it within your community, as this is the right place to live in your life."

–Mia Farah, Lebanon[341]

UNDERSTANDING DISCRIMINATION

A 1997 decision by the Canadian Supreme Court offers useful guidance on the nature of state obligations to ensure equality for persons with disabilities. Robin Eldridge and John and Linda Warren had all been born deaf. All three preferred to communicate through sign language and had received free interpretive services from a local civil society organisation (CSO) when receiving medical services. In 1990, the CSO, the Western Institute for the Deaf and Hard of Hearing discontinued the services because of a lack of funding. As a result, Ms. Eldridge was unable to communicate with her doctor on a subsequent visit, and the Warrens endured the birth of twins without the ability to fully understand what doctors and nurses were telling them. All three claimed that the government's failure to provide medical interpretation services violated their constitutional rights to equality and constituted discrimination against them. The Canadian Supreme Court agreed and held that because effective communication is a necessary component of health services, the failure to provide interpretation for deaf persons was discriminatory because it prevented them from getting effective access to government health services on the same basis as do their peers without disabilities.[342] The decision called attention to the barriers in accessing health care faced by persons with disabilities and highlighted the degree to which policies that do not explicitly discriminate but appear on their face to treat persons with disabilities the same as their peers without disabilities risk causing or reinforcing discriminatory treatment.[343]

CONVENTION ON THE RIGHTS OF THE CHILD

A century that began with children having virtually no rights is ending with children having the most powerful legal instrument that not only recognises but protects their human rights.

–Carol Bellamy, Former Executive Director of UNICEF

The CRC is one of the most widely ratified human rights treaties in history, currently with 196 States Parties.[344] The CRC adopts a 'child[345]-rights approach' built around four core principles:

A child rights approach is one which furthers the realisation of the rights of all children . . . by developing the capacity of duty bearers to meet their obligations to respect, protect and fulfil rights (Art. 4) and the capacity of rights holders to claim their rights, guided at all times by the rights to non-discrimination (Art. 2), consideration of the best interests of the child (Art. 3), life, survival and development (Art. 6), and respect for the views of the child (Art. 12).[346]

The CRC was the first human rights convention to explicitly prohibit discrimination on the basis of disability and, prior to the CRPD, was unique for its express recognition of the human rights of children with disabilities. Not only does Article 2 prohibit discrimination against children with disabilities, but also Article 23 further recognises: 'A mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.'

In its guidance on Article 23, the Committee emphasised the importance of States Parties to include disability in provisions prohibiting discrimination in national laws and policies, and developing effective policies that account for the needs and rights of children with disabilities under the Convention.[347]

The Committee has also published guidance that calls for a special focus on adolescents: 'To promote the realisation of their rights, strengthen their potential contribution to positive and progressive social transformation and overcome the challenges they face in the transition from childhood to adulthood in an increasingly globalised and complex world.'[348]

Noting that 'adolescence itself can be a source of discrimination', the Committee urged states to pay particular attention to ensure the rights of adolescents are respected.[349] It highlighted the increased vulnerability of adolescents with disabilities to discrimination and social isolation and called on states to 'guarantee equal respect for the rights of adolescents with disabilities, promote their full inclusion and facilitate effective transitions from adolescence to adulthood'.[350]

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The CEDAW, adopted in 1979 by the UN General Assembly, prohibits discrimination against women and girls in all areas of life, including political, social, economic, and cultural spaces.[351] Although the treaty does not specifically reference the rights of women or

girls with disabilities, the CEDAW Committee General Recommendation No. 18 calls on States Parties to: 'provide information on disabled women in their periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life'.

> The women's movement must be intersectional otherwise they're excluding an important group. We are women, too. We have the skills, potential and we want to become more visible. Let's work together, let's unite, let's partner. We want to be given a seat at the table where decisions are being made. I want to see women with disabilities in leadership positions even in the mainstream women's movement globally, regionally and locally.
>
> –Irene Ojiugo Patrick, Ogbogu, Nigeria[352]

The CEDAW Committee stressed that women with disabilities may be subject to double discrimination on account of gender and disability and must be considered a group at risk of facing discrimination and exclusion.

Since issuing that recommendation, the CEDAW Committee has continued to recognise disability as one among many factors that can contribute to discrimination against women and affect how different women may experience discrimination.[353]

DECLARATIONS, RESOLUTIONS, AND INTERNATIONAL NORMS

Many of the human rights recognised in the conventions discussed here, including the fundamental rights to equality and non-discrimination, are grounded in and supported by various declarations, resolutions, and other documents, along with the work of special procedures mandate holders under the Human Rights Council. Adopted by consensus by nearly all of the world's governments, and endorsed through reporting practices, all of these instruments contribute to the development of a comprehensive framework through which to achieve human rights. For example, the Vienna Declaration and Programme of Action (1993) was crucial to the recognition of women's rights, including the right to accessible and adequate health care, family planning services, sexuality education, and placing the elimination of VAWG at the top of the international agenda. With regard to the rights of persons with disabilities, the 1982 World Programme of Action concerning Disabled Persons and the subsequent adoption of the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993) laid the groundwork for the eventual development of the CRPD. The work of the UN Special Rapporteurs on violence against women, its causes and consequences, and on the rights of persons with disabilities, and the Special Representative of the Secretary-General on Violence against Children has led to a clearer understanding of state obligations under international human rights law. These represent just a few examples of the many means through which the international norms articulating the rights of young persons with disabilities have been promoted, interpreted, and developed.

> For women with disabilities, disability inclusion and gender equality cannot be achieved without addressing their sexual and reproductive health and rights . . . . Girls and young women with disabilities are able to develop their own identities and realise their full potential when their sexual and reproductive health needs and rights are met. That contributes to ensuring their health and well-being, reducing the existing gaps in their access to education and employment and achieving their empowerment.
>
> –Special Rapporteur on the Rights of Persons with Disabilities[354]

The following section offers a brief overview of three important declarations of global priorities, the ICPD Programme of Action; the Beijing Declaration and Platform for Action, adopted by consensus at the Fourth World Conference on Women in 1995; and the 2030 Agenda for Sustainable Development, adopted unanimously by the UN General Assembly in 2015, which sets ambitious targets for realising an inclusive future.

International Conference on Population and Development Programme of Action

The Programme of Action agreed to by 179 countries at the 1994 ICPD represents a landmark in the recognition by governments of SRH as a human right. Like the CRPD, the CRC, and CEDAW, the ICPD emphasises the right of all people to be free and equal 'in dignity and rights', without distinction of any kind, and further recognises the right of all to 'life, liberty, and security of the person' (Principle 1). The Programme of Action identifies the advancement of gender equality and the elimination of violence against women as among the 'cornerstones' of international development programmes and recognises the human rights of women and girls as 'inalienable, integral and indivisible part[s] of universal human rights' (Principle 4). It also affirms the right of all to 'the highest attainable standard or physical and mental health' and calls on states to ensure universal access to health-care services, on an equal basis, for all women and men, including reproductive health-care services, family planning, and sexual health services (Principle 8).

The Programme of Action directly addresses the needs of persons with disabilities and calls on governments to:

- Consider the needs of persons with disabilities in terms of ethical and human rights dimensions and recognise needs concerning, *inter alia*, reproductive health, including family planning and sexual health, HIV/AIDs, information, education, and communication;
- Eliminate specific forms of discrimination that persons with disabilities may face regarding reproductive rights, household and family formation, and international migration;
- Develop the infrastructure to address the needs of persons with disabilities, in particular, regarding their education, training, and rehabilitation;
- Promote mechanisms ensuring the realisation of the rights of persons with disabilities and reinforce their capabilities of integration; and
- Implement and promote a system of follow-up and social and economic integration of persons with disabilities.[355]

It also recognises the unique needs of young people and urges governments to involve them in: 'the planning, implementation and evaluation

of development activities that have a direct impact on their daily lives . . . [including] activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other sexually transmitted diseases'.[356]

The Programme of Action notes that access to SRH services 'must be ensured . . . in line with the Convention on the Rights of the Child'.

The Programme of Action articulated an understanding of the content of reproductive rights that has informed the understanding of SRHR adopted by the ICESCR Committee (see General Recommendation No. 22), the CRC, and the CRPD. Provisions relating to sexual and reproductive health and rights (SRHR) will be discussed in more detail below.

Beijing Declaration and Platform for Action

The Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women in 1995, similarly recognises the ways in which women and girls with disabilities may be subjected to multiple forms of discrimination both as a result of their gender and their disability. The Declaration takes 'note of the diversity of women and their roles and circumstances', while acknowledging the need to respond to 'the voices of all women everywhere' (Para. 3). The participating governments affirmed their commitment to 'the equal rights and inherent dignity of women and men' and to ensuring the full implementation of the human rights of women and girls (Paras. 8 and 9). The commitment included to 'intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their age . . . or disability' (Para. 32).

The Platform for Action, which provides a global framework to act on the rights recognised in CEDAW, committed governments to a number of steps to reduce discrimination against women and girls with disabilities and to promote their empowerment and social inclusion. These include ensuring equal access to education and appropriate, affordable, and quality health care; reducing illiteracy among women with disabilities; and promoting research and sharing information about women's health, among other things.

The Sustainable Development Goals and the 2030 Agenda for Sustainable Development

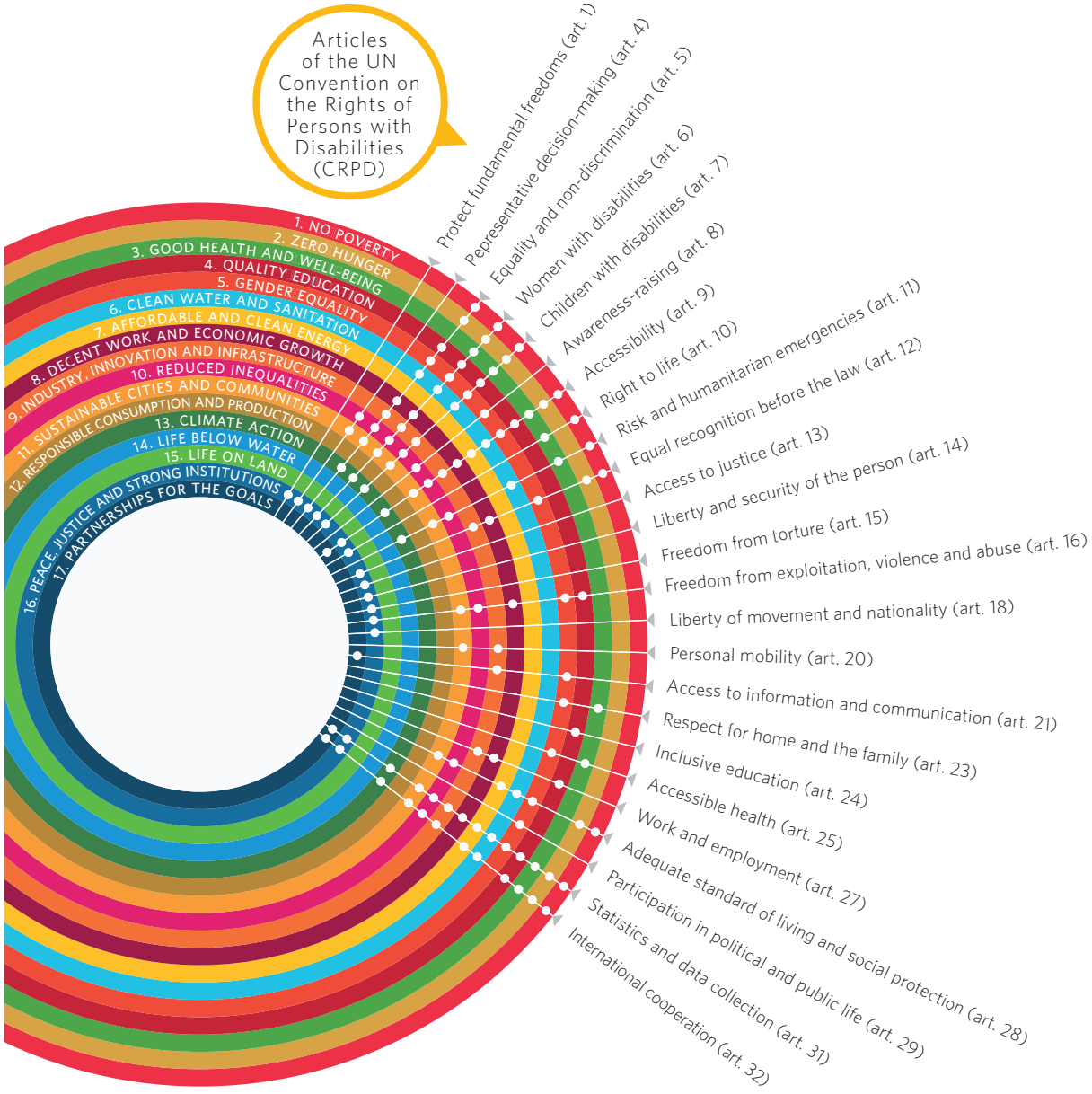
The 2011 World Report on Disability concluded that one in five of the world's poorest people have disabilities. The world community's commitment to a transformative agenda to end poverty thus has the potential to lift millions of persons with disabilities, including young persons with disabilities, out of poverty and enable them to realise the rights articulated above.

The 2030 Agenda for Sustainable Development adopted as a critical principle that the world community must *'leave no one behind'*. Member states pledged to take 'bold and transformative steps' to realise human rights for all, including those most marginalised. Of the 17 Sustainable Development Goals (SDGs) agreed on by all 193 UN Member States in August 2015, five goals include targets that explicitly reference persons with disabilities. In addition, six other targets among the 17 goals refer to persons in vulnerable situations, which include persons with disabilities, and 12 indicators measure progress with express reference to persons with disabilities.[357] Target 17.18 under SDG 17 also calls on states to produce

high-quality data that are disaggregated by disability, *inter alia,* to measure progress under the goals. All should be read beside the requirements of the CRPD, CRC, and CEDAW described above.

The graphic below, created by CBM International, highlights the interconnectedness that the SDGs and CRPD have.

LINKS BETWEEN THE SUSTAINABLE DEVELOPMENT GOALS AND ARTICLES OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES



Note: A text alternative for this infographic is available as an annex here.

Source: CBM International (2016). *CRPD and SDG infographic*. Retrieved from https://www.cbm.org/New-resources-on-Agenda-2030-and-the-CRPD-501728.php.

RELEVANT SUSTAINABLE DEVELOPMENT GOALS AND TARGETS:

GOAL 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES	**Relevant targets:** 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information, and education and the integration of reproductive health into national strategies and programmes
GOAL 4: ENSURE INCLUSIVE AND QUALITY EDUCATION FOR ALL AND PROMOTE LIFELONG LEARNING	**Relevant targets:** 4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples, and children in vulnerable situations. 4.A Build and upgrade education facilities that are child, disability, and gender sensitive and provide safe, nonviolent, inclusive, and effective learning environments for all.
GOAL 5: ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS	5.1 End all forms of discrimination against all women and girls everywhere. 5.2 Eliminate all forms of violence against all women and girls in the public and in private spheres, including trafficking and sexual and other types of exploitation. 5.3 Eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation. 5.6 Ensure universal access to sexual and reproductive health and reproductive rights.
GOAL 8: PROMOTE INCLUSIVE AND SUSTAINABLE ECONOMIC GROWTH, EMPLOYMENT, AND DECENT WORK FOR ALL	**Relevant target:** 8.5 By 2030, achieve full and productive employment and decent work for all women and men, including for young persons and persons with disabilities, and equal pay for work of equal value.
GOAL 10: REDUCE INEQUALITY WITHIN AND AMONG COUNTRIES	**Relevant target:** 10.2 By 2030, empower and promote the social, economic, and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion, or economic or other status
GOAL 16: PROMOTE PEACEFUL AND INCLUSIVE SOCIETIES FOR SUSTAINABLE DEVELOPMENT, PROVIDE ACCESS TO JUSTICE FOR ALL, AND BUILD EFFECTIVE, ACCOUNTABLE, AND INCLUSIVE INSTITUTIONS AT ALL LEVELS	**Relevant targets:** 16.1 Significantly reduce all forms of violence and related death rates everywhere. 16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children. 16.3 Promote the rule of law at the national and international levels and ensure equal access to justice for all. 16.9 By 2030, provide legal identity for all, including birth registration[358] 16.B Promote and enforce non-discriminatory laws and policies for sustainable development.
GOAL 17: REVITALISE THE GLOBAL PARTNERSHIP FOR SUSTAINABLE DEVELOPMENT	**Relevant target:** 17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small-island developing states, to increase significantly the availability of high-quality, timely, and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location, and other characteristics relevant in national contexts

III. PREVENTING VIOLENCE AND ENDING HARMFUL PRACTICES

Gender-based violence is an extreme form of discrimination. It includes multiple forms of discrimination, such as economic, psychological, and social abuse in addition to physical abuse, along with harmful practices that prevent young women and girls from achieving the full expression of their human rights and dignity. Harmful practices such as early and forced marriage, female genital mutilation, and forced or coerced abortion and contraception are all forms of violence that have their roots in gender stereotypes and unequal power relations between men and women.[359]

Young persons with disabilities are almost four times more likely than their peers without disabilities to be victims of abuse, with young persons with intellectual disabilities, especially girls, at greatest risk.[360]

International law ensures the right to live free from violence for all persons without discrimination.[361] Not only do multiple conventions prohibit GBV,[362] but also landmark policy statements adopted by UN Member States such as the 1993 Declaration on the Elimination of Violence Against Women, the 1995 Beijing Declaration and Platform for Action, UN Security Council Resolution 1325, adopted in 2000, and the 2030 Agenda for Sustainable Development, adopted in 2015, all call for an end to GBV. The 57th Session of the Commission on the Status of Women in 2013 closed with a historic agreement that states needed to take urgent action to respond to violence against women. Indeed, the recognition that GBV is a violation of the human rights of its victims has become so widely accepted as to have become a principle of customary international law.[363]

Like other forms of discrimination, disability, age, and sex are all factors that can increase vulnerability to violence, affect the way in which violence is experienced, and affect the ability of those suffering violence to respond. In the case of young women and girls with disabilities, for example, the Human Rights Council has noted the degree to which the intersecting discrimination they face puts them at greater risk of violence:

Double discrimination pervades all aspects of their lives. When compared with men with disabilities, women with disabilities are more likely to experience poverty and isolation, and tend to have lower salaries and be less represented in the work force. As a result, they are also more likely to be victims of violence and/or less able to escape the cycle of violence.[364]

Young persons with disabilities are at particular risk of violence. They are almost four times more likely than their peers without disabilities are to be victims of abuse, with children with intellectual disabilities, especially girls, at greatest risk.[365] The CRPD, CRC, and CEDAW each address these intersections through express provisions prohibiting violence and abuse against all persons with disabilities, children and adolescents, and women and girls with disabilities.

Prohibitions on violence in international conventions

The CRPD prohibits violence and abuse and inhuman and degrading treatment against all persons with disabilities (Arts. 15 and 16). Recognising the vulnerability of young people and the gendered nature of violence in many cases, the CRPD mandates states to take age and gender into account in steps to prevent and respond to violence and obliges them to ensure

ENGAGING YOUNG MEN AND BOYS WITH DISABILITIES IN ACTION AGAINST VIOLENCE

Men and boys are an essential part of a comprehensive response to GBV. The ICPD Programme of Action emphasised that: 'Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.'[366]

Globally, the evidence shows that the majority of intimate partner and sexual violence is perpetrated by men against women and girls and that such violence is most often associated with traditional notions of masculinity.[367] Programmes that engage men and boys in violence prevention and adopt a critical focus on gender-related norms and expectations, particularly those around masculinity, are leading to changes in attitudes and behaviour.[368]

Such programmes must be made accessible and available to young men and boys with disabilities on an equal basis with their peers without disabilities to ensure the former group's members have the knowledge and tools they need to speak up against violence and participate in preventive action and response. Inclusion also enables men and boys with disabilities to be exposed to programmes that help them challenge harmful notions of masculinity in ways that may be beneficial to them as well.

protection, recovery and rehabilitation services are all age- and gender- sensitive. In particular, states must put in place 'effective . . . child-focused legislation and policies to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted' (Art. 16(5)).

The CRC also recognises the vulnerability of children to violence and, like the CRPD, calls on States Parties to 'take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence or abuse . . . including sexual abuse' while in the care of any other person (Art. 19). In its General Comment No. 13, the Committee emphasised that states must recognise the gendered dimensions of violence and the different risks faced by girls and boys in various settings and must take them into account when developing policies.

Although CEDAW does not directly address VAWG in the convention itself, the Committee has taken the position for several decades that GBV is a violation of CEDAW's prohibition of discrimination against women and girls. States reporting to the Committee have accepted that finding and adapted their own practices in response. General Recommendations 12 and 19 urge states to include information about steps taken to eliminate violence against women, and General Recommendation 19 reiterates the Committee's conclusion that VAWG is a form of discrimination within the meaning of Article 1 of the Convention. States Parties are accordingly required to 'take appropriate and effective measures' to prevent GBV by public and/or private actors.

In a 2017 update to General Recommendation 19, the Committee noted that whereas most states have adopted legislation to address GBV, reductions in public spending, shrinking democratic spaces, and an erosion in the rule of law have all permitted the continued pervasiveness of GBV and a culture of impunity for perpetrators.[369] Recognising that GBV violates the principle of non-discrimination at the core of CEDAW, the Committee concluded that states have an immediate obligation under the Convention to pursue by all appropriate means the elimination of VAWG, whether by state actors or third parties. Specific actions identified by the Committee to satisfy the Convention include:

- Adopting legislation prohibiting all forms of GBV and harmonising national legislation, religious, indigenous, and customary justice systems with the Convention;
- Designing focused public policies, with adequate budgetary support and monitoring mechanisms;
- Establishing and funding competent national tribunals;
- Providing accessible, affordable, and adequate services to protect women and girls from violence; and
- Ensuring all legal procedures involving claims of GBV are free from gender stereotypes and discrimination and strictly applying relevant criminal laws.

The Committee's recommendation highlighted certain areas of overlap between GBV and SRHR, such as forced or coerced abortion or sterilisation, early and child marriage, and female genital mutilation. These issues will be taken up in the following section on the right to SRH.

The Beijing Declaration and Platform for Action also recognised that violence against women prevented them from achieving the full enjoyment of their rights and that particular groups of women, including women with disabilities, were more likely to become targets of violence. To counter this threat, the Platform commits governments to 'take special measures to eliminate violence against women, particularly those in vulnerable situations' (Para. 126(d)). It also requires them to ensure that women with disabilities have access to information regarding preventing and responding to violence and that appropriate services be made available to survivors of violence. Information about their rights must be made available in accessible formats for women with physical and intellectual disabilities (Para 233[b]).

The Platform makes special provision for the girl child, requiring that states should: 'facilitate the equal provision of appropriate services and

devices to girls with disabilities and provide their families with related support services, as appropriate'.

It also calls on states to eradicate violence against all girls, including sexual abuse, and to promote gender sensitisation training of service providers and others to support girls who are victims of violence (Para. 283[b]).

The 2030 Agenda for Sustainable Development also makes the eradication of GBV a priority for state action. The targets for SDG 5, achieving gender equality and empowering women and girls, call for state action to end all forms of discrimination against women and girls, including the elimination of violence and harmful practices like child and early marriage and female genital mutilation.[370]

IV. ACHIEVING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The right to SRH is addressed in multiple instruments: It is an essential part of the right to health recognised in the ICESCR (Art. 12) and in CEDAW (Art. 12), the CRC (Arts. 17, 23-25 and 27), and the CRPD (Arts. 23 and 25). The ICESCR, for example, recognises the right of all persons 'to the enjoyment of the highest attainable standard of physical and mental health', a right that includes 'the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.'[371] These rights extend to all persons with disabilities, who are further entitled to be free from discrimination in health services.[372]

The CRC, like the ICESCR, guarantees all children the right to 'the enjoyment of the highest attainable standard of health' (Art. 24). In its General Comment No. 20, the Committee called on States Parties to adopt comprehensive gender and sexuality-sensitive SRH policies for adolescents, and affirmed that: '[A]ll adolescents should have access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education . . . including on family planning, contraception, including emergency contraception, prevention, care and treatment of sexually transmitted infections, counselling, pre-conception care, maternal health services, and menstrual hygiene.'[373]

Notably, the Committee emphasised that adolescents with disabilities are widely and unfairly denied access to SRH information and services and may be subjected to forced sterilisation or contraception in direct violation of their rights under the Convention. One consequence of this failure to provide adequate information is the increased vulnerability susceptibility of adolescents with disabilities to HIV/AIDS.[374] The Committee called on states to guarantee equal respect for the rights of adolescents with disabilities and 'promote their full inclusion and facilitate effective transitions from adolescence to adulthood'.

The CRPD is the first human rights convention to explicitly recognise the importance of SRH for persons with disabilities, noting that: 'States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities

to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall: a) Provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes . . .'[375]

KEY DEFINITIONS IN THE ICPD PROGRAMME OF ACTION

The understandings of SRHR recognised in the ICPD Programme of Action have informed the understandings adopted in subsequent human rights instruments and guidance. Key definitions include the following:

Reproductive health

[A] state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition is the right of men and women to be informed and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, along with other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and that provide couples with the best chance of having a healthy infant.

Reproductive health care

[T]he constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Reproductive rights

[R]est on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of SRH. It also includes their right to make decisions concerning reproductive health free of discrimination, coercion, and violence, as expressed in human rights documents.

REPRODUCTIVE RIGHTS OF YOUNG MEN AND BOYS

Much of the focus on reproductive rights in international human rights discourse has been on the rights of women and girls. The rights of women and girls to control their fertility, receive appropriate, accessible and quality reproductive health care, including pre- and post-natal care, and make decisions about their sexual and reproductive lives, among others, are essential human rights. But men and boys are also entitled to reproductive rights and health and are important partners in achieving the SRH of women and girls.

Men have a stake in reproductive rights through their multiple roles as sexual partners, husbands, fathers, family and household members, community leaders, and gatekeepers to health information and services.[376]

Young men and boys with disabilities have the same rights and needs related to their SRH as their peers without disabilities do but often have less access to information about SRH services.[377] To meet their commitments to promote gender equality and ensure SRHR for all, states must ensure that reproductive health policies and programmes are inclusive and accessible to both women and men with disabilities at an early age. By involving young men and boys with disabilities, programmes can:

- Enhance equity and gender equality
- Promote shared responsibility for SRH
- Promote satisfying sexual lives for both men and women
- Ensure both young men and boys and young women and girls with disabilities have equal access to information about male and female anatomy, contraception, sexually transmitted infections (STIs) and HIV/AIDs prevention, and women's health-care needs during pregnancy and childbirth; and
- Ensure young men and boys have appropriate information and access to care for matters related to male sexuality.[378]

A study by the World Health Organisation in partnership with Instituto Promundo concluded that programmes that include young men and boys lead to changes in behaviour and attitudes and have a higher rate of effectiveness than programmes as a whole have.[379]

The CRPD Art. 23 additionally recognises the rights of persons with disabilities to marry and found a family and decide for themselves on the number and spacing of their children. It requires states to recognise the right of all persons with disabilities to have access to age-appropriate information on SRH, and reproductive and family planning education, and to protect the right of

persons with disabilities, including young persons with disabilities, to retain their fertility on an equal basis with their peers without disabilities.

The ICPD Programme of Action also calls for state action to guarantee the reproductive rights of persons with disabilities, urging governments to: 'take effective action to eliminate all forms of coercion and discrimination in policies and practices' and that 'assistance should be provided to persons with disabilities in the exercise of their family and reproductive rights and responsibilities.'

The CRPD and CEDAW both require states to ensure that women and girls with disabilities have access to reproductive health care and are likewise protected from coercive pressures. General Recommendation 24 of the CEDAW, for example, holds that: 'States-Parties should take appropriate measures to ensure that health services are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity.'

The CEDAW General Recommendation 19 separately calls on States Parties to take preventive measures to ensure women are not subjected to coercive pressure regarding fertility and reproduction, including being forced to seek unsafe medical procedures because of lack of access to contraceptive services. In its 2017 update to General Recommendation 19, the CEDAW Committee emphasised that certain violations of women's SRHR, such as forced sterilisation, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion where it is not against the law, and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women, and girls seeking SRH information and services constitute GBV prohibited by international law.

REGIONAL MECHANISMS

The following section provides an overview of the major regional laws and policies concerning the rights of young persons with disabilities with respect to SRH services and protection from GBV. A complete discussion of each convention and policy statement will not be possible within the space permitted; however, this section includes highlights of relevant instruments identified during the preliminary mapping exercise and summarises the rights recognised in major instruments.

Latin America and the Caribbean

- The American Convention on Human Rights (1969) and Protocol of San Salvador
- American Declaration of the Rights and Duties of Man (1948)
- The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Belém do Pará) and Follow-Up Mechanism
- Montevideo Consensus
- Charter of Civil Society for the Caribbean Community

Thirty of the 33 states in Latin America and the Caribbean are parties to the CRPD, and 20 have ratified the Optional Protocol.[380] Each of the 33 states in the region has ratified CEDAW and the CRC.[381] Most governments have created national mechanisms for implementation and follow-up on the CRPD and have adopted policies and legislation to meet its standards.[382]

In addition to the conventions referenced above, a number of regional initiatives address the rights of persons with disabilities, including the right

to be free from GBV. The American Declaration of the Rights and Duties of Man recognises the right of all people to equality before the law (Art. II) and 'life, liberty and the security of his person' (Art. I). The Declaration also recognises the right of all persons to have a family (Art. VI) and to be recognised as a holder of rights (Art. XVII). The American Convention on Human Rights, adopted in 1969 obligates States Parties to respect the rights of all people within their jurisdiction, without discrimination (Art. 1). The Additional Protocol to the American Convention, the Protocol of San Salvador, explicitly recognises the right of persons with disabilities 'to receive special attention designed to help [them] achieve the greatest possible development of [their] personality'.

The Panama Commitment to Persons with Disabilities in the American Hemisphere, adopted in 1996, calls on governments to 'defend and promote the human rights of persons with disabilities'. The Panama Commitment provided the framework for the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, adopted in 1999.[383] The Convention affirms the rights of persons with disabilities to 'the same human rights and fundamental freedoms as other persons' and calls for the elimination of all forms of discrimination against persons with disabilities (Preamble, Art. II). It also calls on governments to take affirmative steps to eliminate barriers to access public and private facilities and the administration of justice (Art. III).

In addition to these foundational documents recognising the rights of persons with disabilities to equality and non-discrimination, there are two core regional instruments addressing GBV and SRHR. The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará) entered into force in 1995. It affirms that every woman has the right to be free from violence and the right to the recognition and enjoyment and protection of all human rights, including the right to 'have the inherent dignity of her person respected' (Arts. 3 and 4). The Convention emphasises that the right to be free from violence includes the right to be free from all forms of discrimination, including 'stereotyped patterns of behaviour and social and cultural practices based on concepts of inferiority or subordination' (Art. 6 [a] and [b]). It obligates States not only to condemn violence but also to act 'without delay' to punish and eradicate violence (Art. 7) and take affirmative steps, outlined in the text box below, to promote the progressive realisation of women's rights. As states develop laws and policies implementing the Convention, they are required to take into account the particular vulnerability of certain groups of women, including women with disabilities. (Art. 9)

A series of decisions by the Inter-American Commission of Human Rights and the Inter-American Court of Human Rights has provided explicit guidance to governments regarding the extent of their duties to ensure the rights of women and girls to be free from discriminatory violence, holding states responsible for, *inter alia*, failing to protect women and children from domestic violence when the state knew the survivors were at risk;[384] failing to exercise due diligence in the investigation of the deaths of three children at the hands of their father;[385] and failing to prosecute those responsible for violence against women.[386]

The Montevideo Consensus, adopted at the First session of the Regional Conference on Population and Development in August 2013, reaffirmed the principles of the ICPD Programme of Action and

CONVENTION OF BELÉM DO PARÁ

Article 8 of the Convention of Belém do Pará obligates States Parties to take specific measures that include:

a. Promoting awareness and observance of the right of women to be free from violence and the right of women to have their human rights respected and protected;

b. Modifying social and cultural patterns of conduct of men and women, including the development of formal and informal educational programmes appropriate to every level of the educational process, to counteract prejudices, customs, and all other practices that are based on the idea of the inferiority or superiority of either of the sexes or on the stereotyped roles for men and women that legitimise or exacerbate violence against women;

c. Promoting the education and training of all those involved in the administration of justice, police, and other law enforcement officers along with other personnel responsible for implementing policies for the prevention, punishment, and eradication of violence against women;

d. To provide appropriate specialised services for women who have been subjected to violence, through public and private sector agencies, including shelters, counselling services for all family members where appropriate, and care and custody of the affected children;

e. Promoting and supporting governmental and private sector education designed to raise the awareness of the public[;]

f. Providing women who are subjected to violence access to effective readjustment and training programmes to enable them to fully participate in public, private, and social life;

g. Encouraging the communications media to develop appropriate media guidelines to contribute to the eradication of violence against women in all its forms and to enhance respect for the dignity of women;

h. Ensuring research and the gathering of statistics and other relevant information relating to the causes, consequence, and frequency of violence against women to assess the effectiveness of measures to prevent, punish, and eradicate violence against women and to formulate and implement the necessary changes; and

i. Fostering international cooperation for the exchange of ideas and experiences and executing programmes aimed at protecting women who are subjected to violence.

directly addressed the rights and needs of young people. States agreed to, among other things:

- Guarantee for all boys, girls, and adolescents, and without any form of discrimination, the chance to live a life free from poverty and violence and to enjoy protection and exercise of their human rights;

- Ensure the effective implementation from early childhood of comprehensive sexuality education programmes . . . with respect for the evolving capacity of boys and girls and the informed decisions of adolescents and young people regarding their sexuality . . . from a gender-sensitive and human rights perspective;

- Implement comprehensive, timely, good-quality sexual health and reproductive health programmes for adolescents and young people, including youth-friendly SRH services with a gender, human rights, intergenerational, and intercultural perspective, which guarantees access to safe and effective modern contraceptive methods . . . to enable adolescents and young people to access and exercise their SRHR;

- Review legislation, standards, and practices that restrict access to SRH services, including the provision of comprehensive user-friendly services for adolescents and youth, and guarantee access to full information on all of the service options available to all persons, without any form of discrimination, in order to ensure that the highest international standards of protection of human rights and fundamental freedoms are met in the region; and

- Guarantee universal access to good-quality sexual health and reproductive health services, bearing in mind the specific needs of men and women, adolescents and young people, lesbian, gay, bisexual and transgender persons, older persons, and persons with disabilities[.][387]

The Montevideo Consensus also commits states to act to eradicate all forms of discriminatory violence against women, especially women at high risk of violence such as women with disabilities (Para. 57).

The Inter-American human rights institutions have highlighted the degree to which violations of SRHR may be grounded in discrimination and gender stereotypes.[388] In agreements approved by the Commission, states have committed to implement training courses for health-care personnel to reduce gender discriminatory practices and take other measures to ensure autonomy in reproductive decisions.[389]

Sub-Saharan Africa[390]

- The African Charter on[391] Human and People's Rights (1981)

- The Protocol to the African Charter on Human and People's Rights on the Right of Women in Africa (Maputo Protocol) (2003)

- The African Charter on the Rights and Welfare of the Child (1990)

- Treaty of the Southern African Development Community (1992)

- Declaration on the Rights and Welfare of the African Child (1979)

- Gender and Development: A Declaration by Heads of State or Government of the Southern African Development Community (1997)

- The Prevention and Eradication of Violence against Women and Children: An Addendum

to the 1997 Declaration on Gender and Development (1998)

- Economic Unit of East Africa Recommendation No. 03/00/CM/UEMOA on the role of women (1999)
- Treaty of the Economic Community of West African States (1993) and Protocol on Democracy and Good Governance
- Grand Bay (Mauritius) Declaration and Plan of Action (1999)
- Constitutive Act of the African Union (2002)
- Kigali Declaration (2003) of the African Union
- African Union Solemn Declaration on Gender Equality in Africa (2004)

Most states in sub-Saharan Africa are parties to the CRPD.[392] All but one of the countries in the region, Somalia, have ratified CEDAW, and all have ratified the CRC.[393] Most governments have created national mechanisms for implementation and follow-up on the CRPD and have adopted policies and legislation to meet its standards.[394]

The African Charter on Human and People's Rights (the Banjul Charter) recognises a full range of civil and political, socio-economic, and cultural rights and proscribes discrimination in the enjoyment of those rights on the basis of sex or 'any status' (Art. 2).[395] It further requires States Parties to protect the rights of women and the children and those with disabilities to be free from discrimination (Art. 18) and acknowledges the obligation of each individual 'to respect and consider his fellow beings without discrimination' (Art. 28).

With respect to violence, the Banjul Charter powerfully states, 'Human beings are inviolable. Every human being shall be entitled to respect for his life and integrity of his person' (Art. 4). The Maputo Protocol to the Banjul Charter expands on the Charter's prohibition of discrimination and respect for the rights particularly of women and girls. The Protocol reaffirms the principle of gender equality and mandates states to combat all forms of discrimination against women by, in part, integrating a gender perspective in national legislation and policy and taking corrective action where discrimination is known to exist.[396] The Protocol is notable for its expansive definition of discrimination, which is similar to that in CEDAW's Article 1, and for its inclusion of girls within its understanding of women.[397] The Maputo Protocol also recognises the structural dimensions of gender discrimination and calls on states to: '[M]odify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.'[398]

It obligates states to 'ensure the prevention, punishment and eradication' of all forms of violence against women and girls (Art. 4) and calls for the elimination of harmful practices, including female genital mutilation (Art. 5). Like the African Charter on the Rights and Welfare of the Child, the Protocol specifies a minimum age of marriage (18) (Art. 6).

The Protocol is one of the first human rights instruments to contain substantive provisions on reproductive rights and adopts much of the

programme laid out in the ICPD Programme of Action.[399] It obligates states to protect and respect SRHR, including the right to control one's own fertility, to choose any method of contraception, and to have family planning education (Art. 14). The Protocol also directly addresses the rights of women and girls with disabilities, calling on states to take affirmative steps to protect the right of women and girls with disabilities to be free from violence and discrimination on the basis of disability (Art. 23).

The African Charter on the Rights and Welfare of the Child reinforces the Banjul Charter's commitment to the principle of non-discrimination and recognises the right of every child to be free from discrimination regardless of sex or other status (Art. 3). It guarantees to every child under the age of 18 the right to an education and the 'best attainable state of physical, mental and spiritual health' (Arts. 11 and 14). Persons with disabilities are entitled to special protection under conditions that ensure their dignity and promote their inclusion as active members of society (Art. 13 and 18). States Parties are required to take active measures to protect children from all forms of degrading treatment, including sexual abuse (Art. 16) and harmful practices (Art. 21). With regard to the latter, the Charter obligates states to eliminate 'harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child', including those practices like female genital mutilation that are discriminatory on the grounds of sex or other status. The Charter also bans child marriage and obligates states to take 'effective action' to specify 18 as the minimum age for marriage for both boys and girls (Art. 21).

In 2012 the African Union Conference of Ministers for Social Development developed the Continental Plan of Action as part of the African Decade of Persons with Disabilities (2010-2019), and chartered an African Union Disability Institution to provide technical support to member states.[400] Significantly, children, youth, and women with disabilities are each specified as strategic themes within the Continental Plan of Action's strategic theme on mainstreaming.[401] Under the theme on women with disabilities, both combating sexual violence and access to SRH are given priority.[402]

The African Union has since adopted a Draft Protocol to the Banjul Charter that supplements the Charter's promises of equal rights for all and special attention to the needs of persons with disabilities.[403] The Draft Protocol mandates states to mainstream disability in national legislation and policy in all spheres of life and to outlaw harmful practices against persons with disabilities (Art. 2). It prohibits discrimination against persons with disabilities and requires states to guarantee 'equal and effective' legal protection against all forms of discrimination (Art. 3). The Draft Protocol also recognises the right of every person with a disability to be free from cruel or degrading treatment, including forcible confinement, forced medical treatment such as sterilisation without informed consent, and exploitation and abuse both within and outside the home (Art. 5). States must take effective steps to prevent violations of these rights (Art. 5) and shall ensure that persons with disabilities are recognised as equal before the law with legal capacity to object to deprivations of their rights (Art. 8 and 9). To facilitate the exercise of their rights, States Parties must provide age- and gender-appropriate accommodations within the legal system and prevent the use of traditional systems as a means of denying rights to persons with disabilities (Art. 9).

The Draft Protocol calls for steps to make public facilities and services accessible, including health-care services, and obliges states to take effective measures to ensure persons with disabilities have equal access to SRH services, including by prohibiting discrimination by health-care providers and mandating the use of accessible formats and communication (Art. 13).

Articles 22, 23, and 24 adopt explicit gender- and age-sensitive perspectives, calling on states to ensure women, children, and youth with disabilities are able to fully enjoy the same rights and freedoms as their peers without disabilities are and that States Parties take effective measures to integrate gender and the interests of children and youth into all national legislation and policies. Article 22 further guarantees women with disabilities the right to sexual and reproductive freedom and control over their fertility, and Article 24 obligates states to promote SRH education for youth with disabilities. The Draft Protocol calls for the protection of women and children with disabilities from sexual violence and GBV the removal of all barriers to effective participation and inclusion in social life for all three groups.

Arab States[404]

- The Arab Charter on Human Rights (1994)
- The Cairo Declaration on Human Rights in Islam (1990)
- The Covenant of the Rights of the Child in Islam
- The Organisation of the Islamic Conference (OIC) Plan of Action for Advancement of Women (Cairo Plan of Action)
- Independent Permanent Human Rights Commission of the Organisation of Islamic Cooperation (2011)

Currently, 18 out of the 20 countries within the Arab States Region have ratified the CRPD.[405] All countries within the Arab States Region, with the exception of Somalia and Sudan, have ratified CEDAW. All, countries are parties to the CRC.[406] At present, the Arab States Region is unique in two respects related to the rights of women and girls with disabilities. The first is the historic number of refugees in the region. According to Handicap International's 2014 report *Hidden Victims of the Syria Crisis,* 30 per cent of refugees have specific needs due to impairment, chronic disease, or injury, the vast majority of which are directly related to conflict.[407] Women and girls with disabilities face particular levels of threat as refugees.[408] The second (and more long-standing) unique circumstance is the application of religious law to matters of marriage, divorce, and other aspects of family law, which have presented barriers to the full implementation of CEDAW.[409] There have, however, been both positive trends in the region with increasing participation of women in representation and governance along with negative trends with the rise of religiously conservative movements that tend to restrict women's rights[410] and the persistence of political instability, conflict, and economic inequality, which have increased the incidence of all disabilities, including mental health disorders from psychological stress. [411]

The Arab Charter on Human Rights (2004), which preceded the CRPD, represented a significant step forward for the rights of persons with disabilities. Article 40 is dedicated to disability rights and recognises the rights of persons with disabilities to a decent life, dignity, active participation in society, and free social services, including material support, health and rehabilitation, education, and job opportunities. In 2014, however, League of Arab

states' members reported that prevalence rates of disability in region range from 0.4 to 4.6,[412] raising concerns that many of the countries have adopted particularly narrow definitions of disability.[413] The World Bank estimates that there are as many as 30 million people, or about 15 per cent, living with disabilities in the Middle East and North Africa (MENA) region.[414] The Arab League also declared 2004 to 2013 as the Arab Decade for Persons with Disabilities, which produced specific objectives regarding the inclusion of disability and spurred national adoption and/or reform of disability laws.[415] The majority of MENA states include provisions in their constitutions regarding persons with disabilities. Many states, such as Jordan, have progressive social protection policies ensuring access to health care, although women and girls with disabilities are often denied access to both general and reproductive health care.[416]

Asia and the Pacific

- The Association of Southeast Asian Nations (ASEAN) Declaration of Human Rights
- ASEAN Declaration on the Elimination of Violence against Women (2004)
- Declaration on the Elimination of Violence against Women and the Elimination of Violence against Children in ASEAN (2013)
- ASEAN Intergovernmental Commission on Human Rights (2009)
- ASEAN Commission on the Promotion and Protection of the Rights of Women
- The Bali Declaration on the Enhancement of the Role and Participation of Persons with Disabilities in the ASEAN Community
- The Incheon Strategy 'Make the Right Real' for Persons with Disabilities in Asia and the Pacific
- The Proclamation on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region
- The Biwako Framework for Action Towards and Inclusive, Barrier-free and Rights-based Society for Persons with Disability
- The ASEAN Declaration on Strengthening Social Protection

One in every six persons in the Asia Pacific region, or 650 million women, men, and children, are living with a disability.[417] They are over-represented within the region's poorest, making up an estimated 20 per cent of the poorest citizens.[418] Despite the prevalence of disability in the region, it has one of the lowest rates of ratification of the CRPD, with just 54 per cent of eligible states acceding to the Convention. Beginning in 1993, governments in the region have sought to promote the rights of persons with disabilities through a series of action plans, beginning with the first Decade of Persons with Disabilities 1993–2002. In 2003, the governments of the Asia Pacific region adopted the Biwako Millennium Framework, which set targets for the inclusion of persons with disabilities and included support for women with disabilities as one of seven priority policy areas. The Framework notes that women and girls with disabilities suffer multiple forms of discrimination and are at greater risk of physical and sexual abuse, among other things.[419]

In 2012, the region launched a new Decade of Persons with Disabilities (2013–2022) and adopted a regional framework, the Incheon Strategy, to

guide national and regional efforts to promote the rights of persons with disabilities throughout the decade. The Incheon Strategy puts a priority on equality for women and girls with disabilities, and the empowerment of diverse disability groups, including girls and youth with disabilities.[420]

Europe and Central Asia

- The European Convention on Human Rights (1953)
- Charter of Fundamental Rights of the European Union (EU) (2000)
- The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)
- Council of Europe Convention on the protection of children against sexual exploitation and sexual abuse (Lanzarote Convention) (2012)
- Council of Europe Strategy for the Rights of the Child 2016–2021
- Treaty of Amsterdam (1997)
- Treaty of Lisbon (2007)
- European Disability Strategy 2010–2020: A Renewed Commitment to a Barrier-Free Europe
- European Pact for Mental Health and Well-Being
- Council of Europe Disability Strategy 2017-2023: Human Rights: A Reality for All
- Council of Europe Guidelines on Child-Friendly Justice (2010)
- Council of Europe Gender Equality Strategy 2014–2017
- European Union Guidelines for the Promotion and Protection of the Rights of the Child (2017): Leave No Child Behind

The European Convention on Human Rights, drafted by the Council of Europe shortly after the UDHR was approved by the new UN General Assembly, aims to implement the fundamental principles the UDHR enshrined. It includes 17 key articles affirming equal rights and freedoms, including Article 14, which prohibits discrimination against any person on any ground; Article 12, which guarantees the right of all men and women of marriageable age to marry and found a family; and Articles 3 and 5, which prohibit torture and inhuman or degrading treatment and guarantee the right to liberty and security of the person, respectively. The Convention created the European Court of Human Rights, which has been instrumental in articulating the due diligence standard as a basis for holding states accountable for violations of human rights, particularly GBV.[421]

The Council of Europe, an intergovernmental human rights organisation with 47 member states including states in Eastern Europe, has also been a leader in establishing a framework to counter GBV that adopts a disability perspective. The Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) has been recognised as among the most comprehensive international agreements on violence against women and domestic violence.[422] It recognises that unequal power relations are the root of GBV and calls for states to take specific actions to counter gender stereotypes. It also explicitly recognises that men and boys can be victims of

violence and thus must be subject to the same rights and protections recognised for women and girls. (Preamble and Article 2: 'Parties are encouraged to apply this Convention to all victims of domestic violence.')

The Convention explicitly obligates States Parties to protect the rights of all victims of domestic violence or GBV 'without discrimination on any ground', including, notably, disability, (Art. 4) and acknowledges by reference the CRPD as among the core human rights treaties setting standards relevant to the prevention of GBV (Preamble). In the Explanatory Report accompanying the convention, the drafters note their intention to acknowledge the increased risk women and girls with disabilities face with regard to violence and the corresponding need for urgent action.[423] The Explanatory Report also stresses the requirement in Article 4 of the Convention that States Parties take affirmative steps to prevent violence against those with increased vulnerability, including persons with disabilities.[424]

The Council of Europe Convention on the protection of children against sexual exploitation and abuse (Lanzarote Convention) is similarly comprehensive. It obligates states to protect the rights of all child victims of exploitation and abuse, without discrimination on any ground (Art. 2). It requires states to take necessary measures to ensure that children receive age-appropriate information on the risks of sexual exploitation and sexual abuse and on the tools they can use to protect themselves (Art. 6) and provides clear guidelines on actions states must take to protect children from exploitation and abuse, intervene on behalf of victims, provide short- and long- term support for victims, and investigate and punish offenses.

At the policy level, the European Disability Strategy 2010–2020: A Renewed Commitment to a Barrier-free Europe commits the European Commission to promoting the elimination of discrimination on the basis of age and disability, including by supporting equal access to health care for persons with disabilities.[425],[426]

The Council of Europe Disability Strategy 2017–2023: Human Rights: A Reality for All emphasises that persons with disabilities are entitled to enjoy the full range of human rights and proposed five rights-based areas for priority action by member states:

- Equality and non-discrimination
- Awareness-raising
- Accessibility
- Equal recognition before the law
- Freedom from exploitation and abuse[427]

It highlights a number of cross-cutting themes, including the risk many persons with disabilities face of multiple and/or intersecting forms of discrimination.[428] The Strategy calls on Member States to both acknowledge the existence of multiple forms of discrimination and to take it into account in work and activities at regional, national, and local levels. It also calls on Member States to promote increased access to information by young persons with disabilities and to mainstream the rights of young persons with disabilities in all activities and work to prevent and respond to exploitation, abuse, and discriminatory violence.[429]

COUNCIL OF EUROPE CONVENTION ON PREVENTING AND COMBATING VIOLENCE AGAINST WOMEN AND DOMESTIC VIOLENCE (ISTANBUL CONVENTION)

The Convention in brief[430]

Adopted in May 2011 and entered into force in August 2014, the Convention created a holistic and comprehensive legal framework to prevent violence against women, protect survivors of violence, and end impunity for perpetrators.[431] The Convention includes 81 articles within 12 chapters and is based on the 'four Ps': Prevention, Protection and support of victims, Prosecution of offenders, and Integrated Policies.

Prevention of all forms of violence against women

The Convention requires Parties to promote awareness-raising, education, training of professionals, preventive intervention and treatment programmes, and participation of the private sector and the media in changing social and cultural patterns of behaviour to eliminate prejudicial norms and practices.

Article 16 requires states to take the necessary legislative or other measures to set up or support programmes aimed at teaching perpetrators of domestic violence to adopt non-violent behaviour in interpersonal relationships with a view to preventing further violence and changing violent behavioural patterns.

Protection against all forms of violence against women

Parties commit to take legislative action to ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand, have access to necessary services, including health care and social services, and safe accommodation.

It offers particular protections to children, particularly those who may need to serve as witness and/or require psychosocial counselling (Article 26).

Prosecution against all forms of violence against women

Chapter V mandates that Parties shall take the necessary legislative or other measures to provide adequate civil remedies against perpetrators, to ensure that victims have the right to claim compensation from perpetrators, and to ensure that the intentional conducts are criminalised.

Articles 38 and 39 respectively require States to pass legislation criminalising female genital mutilation and forced abortion and forced sterilisation.

Integrated policies[432]

The Convention aims to end violence against women through both criminal law and proceedings and policies aimed at promoting equality between men and women, thus operating dualistically as both a human rights treaty and criminal law treaty. In doing so, it seeks to build cooperation among all relevant actors including law enforcement, the judiciary, NGOs, service providers, and so on.

As a human rights treaty, the Convention approaches violence against women as a form of gender-based description. Doing so reinforces states' obligation under international human rights law to end all forms of discrimination and guarantee equality between women and men.

As a criminal law treaty, the Convention recognises the many sites where violence against women occurs (family, community, state) and the perpetrators (both state and non-state actors).

Monitoring

The Convention established a two-pillar system for monitoring to assess and improve the implementation of the Convention:

- The Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO), an independent expert body composed of 15 members.
- The Committee of the Parties, a political body, composed of representatives of the Parties to the Convention.

The Group of Experts on Action against Violence against Women and Domestic Violence is tasked with monitoring the implementation of the Convention by the Parties and may also adopt general recommendations on themes and concepts of the Convention. The Committee of Parties is tasked with following up on GREVIO reports and conclusions including adopting recommendations to the Parties concerned.

Lastly, Parties of the Convention are also obligated to invite their parliaments to participate in the monitoring process and to submit the reports of GREVIO to them.

A Europe free from violence against children is one of the five strategic objectives of the current Council of Europe Strategy on the Rights of the Child (2016–2021). The Strategy includes steps to:

- promote an integrated approach to the protection of children from violence, including children with disabilities, and
- to combat sexual exploitation, sexual abuse and trafficking, and GBV against children.

It explicitly commits the Council to protect the rights of children with disabilities and ensure their full inclusion into society.[433]

The EU has also developed a set of guidelines for the protection of the rights of the child, which includes among its priorities support for the fulfilment of existing legal obligations under the CRC and other human rights instruments by EU member states, and support for the implementation of the 2030 Agenda for Sustainable Development.[434]

A number of initiatives by the Council and the EU have sought to integrate young persons with disabilities into policy development. The European Disability Forum, established in 1996, has a Youth Committee that is tasked with mainstreaming youth in the European Disability Forum's work and working with the Youth Network to represent the interests of young persons with disabilities at the EU level. Members of the European Disability Forum's Youth Committee also participate in the European Youth Forum, which is a platform organisation representing 104 youth organisations in Europe.

MONITORING TREATY OBLIGATIONS AND HOLDING STATES ACCOUNTABLE

International and regional conventions articulate standards of behaviour that are agreed to by States Parties, with the expectation that these norms will be incorporated into national legislation and policy. States Parties are required to take action to satisfy the obligations specified in the treaties they sign and realise the rights those treaties recognise. Each of the treaties referenced above establishes a committee to monitor compliance by States Parties through periodic reporting. Civil society organisations, domestic courts, and national stakeholders all play an essential role in holding states accountable for meeting treaty obligations.

International human rights tribunals have also been crucial actors in explaining what states must do to protect human rights, especially the right of women to be free from violence. The due diligence standard, recognised by UN Special Rapporteurs, the European Court of Human Rights, and the Inter-American Court of Human Rights, among others, as a universal principle of international and customary law, requires states to take essential actions to prevent VAWG, to protect survivors of violence, to prosecute and punish perpetrators, and to ensure survivors have access to redress. A detailed explanation of the due diligence principle is in the text box below.

International norms recognise that States have the power and responsibility to respect, protect and fulfil the human rights of all their citizens, including the rights of young persons with disabilities. To fully implement the international commitments outlined above, states must recognise by law the rights of young persons with disabilities to equality and freedom from discrimination, the right to live lives free from violence, and the right to attain the highest level of SRH. They must take prompt and effective action to remove all barriers to the full enjoyment of these rights for young persons with disabilities and ensure to the extent of their ability that all services and programmes available to young people are equally available to and inclusive of young persons with disabilities. And they must mobilise resources to invest in inclusive programmes that have the potential to support young persons with disabilities to achieve the full enjoyment of their human rights and enable them to become active and engaged members of societies worldwide.

WHAT IS DUE DILIGENCE?

In 2001, 15-year-old Esmeralda Herrera Monreal, 17-year-old Laura Berenice Ramos Monarrez, and 20-year-old Claudia Ivette Gonzalez disappeared in the city of Ciudad Juarez, Mexico. Their bodies were found weeks later in a cotton field, with signs they had been sexually abused. Their families argued that public authorities had failed to act with due diligence to investigate their disappearance and death because of discriminatory stereotypes against women. In a 2009 decision, the Inter-American Court of Human Rights agreed and found that Mexico had violated the American Convention on Human Rights and the Convention of Belém do Pará by not acting with due diligence to protect the lives of the three girls and their right to be free from violence, and by failing to adequately investigate their disappearance.[435]

Under international law, States are obligated to exercise due diligence to promote, protect and fulfil human rights. The duty of due diligence imposes obligations on States for both their own and the acts of third parties that violate human rights. The Declaration on the Elimination of Violence against Women, for example, calls on States to 'exercise due diligence to prevent, investigate and...punish acts of violence against women, whether those acts are perpetrated by the State or by private persons'.

To satisfy the due diligence standard, States should focus on the 'Five Ps':[436] 1. Prevention; 2. Protection; 3. Prosecution; 4. Punishment that is sufficient and fair; and 5. Provision of redress and reparation. Survivors of violence must have the ability to obtain some form of enforceable protection, such as a restraining order, and law enforcement must respond effectively to requests for help.[437]

The Inter-American Court on Human Rights has concluded that *'[w]hat is decisive is whether a violation of the rights recognised by the Convention has occurred with the support or acquiescence of the government, or whether the State has allowed the act to take place without taking measures to prevent it or punish those responsible'*.[438] Ineffective judicial action that permit the impunity of perpetrators are likely to violate treaty obligations.[439]

// CHAPTER 4

PREVENTING AND RESPONDING TO GENDER-BASED VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

I. INTRODUCTION

The elimination of all forms of gender-based violence (GBV) is widely recognised as a global priority. Not only do multiple international instruments call on states to take action to end discriminatory violence, but also specific targets have been included within the 2030 Agenda for Sustainable Development. A 2014 review of progress under the International Conference on Population and Development (ICPD) Programme of Action found that governments have been taking action against GBV in higher proportions than with respect to any other issue addressed in the Programme of Action (88 per cent).[440] Overall, rates of beliefs and practices not conducive to human rights such as female genital mutilation and early, child, and forced marriage have seen declines in some contexts, as have attitudes toward husbands abusing their wives and partners.[441] Yet rates of violence remain unacceptably high, especially against those most marginalised.

As discussed in detail in Chapter 1 of this report, young persons with disabilities are far more likely to become victims of violence than are their peers without disabilities.[442]

- Children with disabilities are almost four times more likely to experience violence than are children without disabilities and nearly three times more likely to be subjected to sexual violence.[443] In one study across five countries in Africa, nearly every young person (between 18 and 24) interviewed had been sexually abused at least once and most more than once in their lifetimes.[444]

- Children who have psychosocial and intellectual disabilities, severe impairments, or multiple impairments are at the greatest risk.[445] Studies have found that children with intellectual disabilities are five times more likely to be subjected to abuse than are other children and are far more vulnerable to bullying.[446]

- Girls and young women with disabilities are more likely to experience violence than either their male peers with disabilities or girls and young women without disabilities are.[447] One study in Australia found that among women with disabilities under 50 years old, 62 per cent had experienced violence since the age of 15, and women with disabilities had experienced sexual violence at three times the rate of those without disabilities.[448] Women with disabilities in the United States are 40 per cent more likely to experience abuse than women without disabilities are,[449] and studies in Nepal and Bangladesh found that violence against women and girls (VAWG) with disabilities was widespread.[450]

- Belonging to a racial, religious, or sexual minority or living in poverty increases the risk of sexual violence for girls and young women with disabilities.[451]

> There are still attitudes in society that this group does not really exist. It is not visible. . . . It is thought that they are cared for. They live in care homes. So there is an assumption that it is impossible that they are subjects to violence.[452]

Existing inequalities and discriminatory norms and attitudes regarding gender and disability intersect to make young persons with disabilities, especially young women and girls with disabilities, more vulnerable to violence and to have the effects of violence they experience compounded.[453] In a survey within the European Union (EU),

respondents from all 13 Member States reported feeling that prejudice against children with disabilities is widespread and that they are at greater risk of becoming victims of violence.[454]

Ending violence against young persons with disabilities requires comprehensive and long-term strategies that focus on both prevention of violence and on appropriate and supportive

THE TWIN-TRACK APPROACH TO PREVENTING GENDER-BASED VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

The 'twin-track approach' is particularly important for ensuring inclusion of young persons with disabilities in policies to prevent and respond to GBV. The twin-track approach is broadly recognised throughout the United Nations (UN) system as an important strategy for promoting the rights of persons with disabilities in law, policy, and programme implementation and for ensuring their participation in their rights on an equal basis with others.

Put simply, it means assessing mainstream laws, policies, and programme initiatives to be certain that they include young persons with disabilities and do not discriminate, even unintentionally. Alongside this, the approach also calls for targeted steps that speak to the specific needs of young persons with disabilities and seek to address the vulnerabilities to violence they may experience or obstacles they may face accessing preventive mechanisms of response services.[455]

To ensure the rights of young persons with disabilities to live free from violence, a twin-track approach may include mainstreaming language within national laws or policies that prohibit discrimination on the basis of age and gender, among other factors, and a separate law or policy that details the state's responsibility to respond to violence against young persons with disabilities through, among other policies, ensuring access to justice and providing necessary support services to survivors of violence.

Similarly, in programme initiatives, a twin-track approach to the prevention of GBV may include mainstreaming disability through including persons with disabilities in public campaigns to raise awareness and prevent GBV and ensuring that information about available response and support services is disseminated in multiple formats, such as sign language communication in television announcements and the use of Braille in print materials, along with promoting a disability-specific campaign in partnership with disabled persons' organisations (DPOs) representing young persons with disabilities in recognition of the fact that these young persons are often socially isolated and thus less likely to be reached by broad, mainstream public outreach campaigns.

responses to it. Such strategies often begin with the adoption and implementation of strong and comprehensive legal and policy frameworks that recognise and prohibit all forms of violence against all women and girls, including explicitly women and girls with disabilities. But they should also include the commitment of sufficient resources to ensure adequate support for implementing programmes and a recognition that prevention and responses to violence must be integrated within multiple policy frameworks, including health and education programmes, justice and policing policies, and national development plans, among others. To ensure that young persons with disabilities are provided the same protections from violence afforded to their peers without disabilities, laws, policies, and programmes addressing GBV should explicitly recognise the multiple forms of discrimination to which young women and girls with disabilities, along with other marginalised groups, are routinely subjected and should outline clear strategies to target those forms of violence, while providing support to young persons with disabilities at risk of violence or to those who have been victims of it.

CHAPTER OVERVIEW

This chapter opens with a brief discussion of the principles underlying prevention and response and discusses evidence of policy and programmatic interventions associated with changes in the social norms that underlie GBV. As noted in Chapter 1 of this report, gender norms and stereotypes contribute to the risk of violence young persons with disabilities face and hinder their ability to access violence prevention mechanisms and response services.

The chapter continues with case studies of promising initiatives adopted by governments to address GBV against young persons with disabilities. Nearly all these initiatives are the products of partnerships with civil society and advocacy by them on behalf of the rights of women and persons with disabilities. Civil society organisations (CSOs) have been essential leaders in the movement to end GBV globally and are critical partners in efforts to implement the human rights of young persons with disabilities.

The case studies reflect a conception of state action that covers a broad spectrum of possibilities, ranging from providing an enabling legal framework to adopting implementing strategies or plans of action, designing or supporting programmatic interventions with or in support of CSOs, collecting relevant data to inform policy development, and monitoring progress to ensure accountability.

The case studies highlight initiatives considered promising to the extent they conform to recognised guidelines for good practices or are considered to be positive steps by activists or shown to be such by published evaluations. The examples provided are not exhaustive, nor can they be assumed to work in all locations and for all individuals.

Likewise, each initiative discussed here is acknowledged as a single step in a broader, interdependent process to access and exercise the rights of young persons with disabilities. It should be noted that although each of these steps may be necessary, no one of them is sufficient on its own. Laws that are not implemented may have little effect, and policies to which resources are not committed or for which no one is held accountable are unlikely to achieve their goals. For governments to ensure that young persons with

RESPONDING TO GENDER-BASED VIOLENCE AGAINST GIRLS AND YOUNG WOMEN WITH DISABILITIES

In a focus group with young deaf women who were members of a DPO in Maputo, Mozambique, participants painted a bleak picture of the justice system in cases of violence. One participant, who was in her early 20s and raising a child as a single mother, described her own experience trying to report physical abuse she had suffered at the hands of her ex-husband. 'I went to the police, but they did nothing. They have no sign language, so I had to bring someone with me, but still they did nothing. The police don't take them [the perpetrators] to jail; they just send you back home.'

Experiences such as these are not unique to Mozambique, as the literature discussed in Chapter 1 makes clear. In Spain, representatives of DPOs described an overall lack of services for girls and young women with disabilities who experienced violence and multiple barriers preventing women from reporting violence. Many shelters were inaccessible or in inaccessible areas. Protection measures for women with disabilities who sought protective orders were often insufficient and left them vulnerable to further abuse. Women with disabilities also reported an inability to access information and guidance when confronting violence and fear of the consequences of reporting abuse, especially the risk that they may lose custody of or support for their children.

In each of the countries visited during field work for this study, governments and CSOs were taking steps to eliminate GBV. Interviews with DPOs, judicial authorities, legislators, and others in Spain revealed ongoing advocacy among the judicial branch and legislature for important reforms to increase access to justice for survivors of violence with disabilities, which are described in more detailed below.

In Ecuador, the adoption of the National Plan for the Eradication of Gender-Based Violence against Children, Adolescents and Women (2008) committed the government to provide sufficient financial resources to support each of the plan's activities and the agency responsible for carrying out that activity.[456] The national plan also specifies that persons with disabilities must be included in the GBV prevention and response services included in the plan. Ecuador has also taken active steps through a national online training programme to ensure that every single public health employee is not only trained in GBV but also is aware of the heightened risk persons with disabilities are to violence and understands how to ensure that GBV prevention and response services are accessible and inclusive.

Data on specific programmes that represent positive steps in eliminating GBV against young persons with disabilities are incorporated into the sections below.

KEY POINTS

- The Convention on the Rights of Persons with Disabilities (**CRPD), the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC) obligate states to exercise due diligence** to prevent and respond to gender-based violence against young persons with disabilities. To satisfy the due diligence standard, states must take action to **prevent violence, protect its victims, prosecute perpetrators, and provide redress to survivors**.
- Young persons with disabilities, especially young women and girls with disabilities, are more vulnerable to violence than their peers without disabilities are and face **persistent inequalities** to accessing response services, including SRHR services, that are compounded by discrimination on the basis of age, gender, and disability.
- States should pursue a **twin-track approach** to ensuring that the needs and interests of young persons with disabilities are met by **mainstreaming young persons with disabilities** into all laws, policies, and programmes relating to promoting gender equality and by preventing and responding to GBV while also developing, where appropriate, **targeted** programmes addressing the risks that young persons with disabilities face in terms of violence and eradicating barriers to multisectoral services.
- A **coordinated, rights-based, and victim-centred approach to the prevention and response to violence is essential** and requires effective communication and participation among stakeholders. Core elements of such an approach include **comprehensive legal frameworks, governance, oversight and accountability, resources and financing, training and workforce development, monitoring and evaluation, and gender-sensitive policies and practices**. Such policies should **address discrimination at all levels of government and across all sectors**, including health, education, policing and justice, and economic policies.
- **Promising strategies** for states to effectively prevent and respond to GBV against young persons with disabilities include:
  - **Partnering with CSOs** representing young persons with disabilities in the development of policies and programmes on the prevention of and responses to violence;
  - **Raising awareness** of the rights of young persons with disabilities within government, across the range of service providers, and within their families and the broader community;
  - **Ensuring young persons with disabilities understand their rights and develop skills** to ensure they can claim their rights to GBV prevention and response.
  - **Ensuring access and inclusion to existing GBV prevention and response programmes,** as the majority of young persons with disabilities can and should benefit from the same GBV programmes as the general population does;
  - **Ensuring effective implementation of laws and policies aimed at the elimination of GBV**, including the prosecution of perpetrators;

- **Guaranteeing the rights of young persons with disabilities to access legal systems** by ensuring accessibility of legal proceedings and facilities, providing adequate training for law enforcement personnel including judges and police officers, ensuring the availability of quality no-fee legal services, and promoting legal literacy among families and health-care providers;
- **Ensuring young persons with disabilities have access to the full range of multisectoral services, including psychosocial services and SRHR services,** in the event of violence on the same basis as their peers without disabilities do;
- **Address inclusion in GBV policy, laws, and budgets** at the national and local levels by ensuring they are youth and disability inclusive; and
- **Build a base of evidence** by continuously collecting and disseminating research data on GBV against young persons with disabilities.

- All GBV prevention and response programmes and policies should be **youth friendly and disability inclusive** to ensure they are available, accessible, affordable, and of appropriate quality for young persons with disabilities.
- States should **collect data and monitor compliance in a disability, gender, and youth-inclusive manner** that allows researchers to disaggregate by disability status, gender, and age to clearly identify gaps and inequalities across groups.

disabilities can enjoy their rights and freedoms on the same basis as their peers without disabilities, governments must adopt a comprehensive approach that informs and engages stakeholders across multiple sectors, including young persons with disabilities themselves. Steps toward that engagement are discussed below.

Promising practices were identified during a literature review that included state reports to the international treaty monitoring bodies and special procedures of the Human Rights Council; field visits in Spain, Ecuador, Morocco, and Mozambique; and through communication with regional and country experts and advocates.[457]

II. PREVENTION OF AND RESPONSE TO GENDER-BASED VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

FOCUSING ON PREVENTION OF GENDER-BASED VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

Efforts to prevent violence against young persons with disabilities are most likely to be effective

when they address discriminatory attitudes at the root of gender- and disability- based discrimination and violence.[458] Gender-based violence can take many different forms but has its foundations in unequal power relations that contribute to the subordination, especially of women and girls, and discriminatory norms and attitudes about gender that shape social, economic, political, and cultural structures. As described in detail in Chapter 1, discriminatory gender stereotypes intersect with prejudices and stigma relating to disability and age to compound the risks of violence young persons with disabilities face. As a result, efforts to prevent violence against young persons with disabilities must address each of these forms of discrimination to be effective.

The CRPD requires States Parties to raise awareness and foster respect for the rights and dignity of all persons with disabilities, including young persons with disabilities (Art. 8). This includes challenging discriminatory stereotypes and prejudices that present obstacles to young persons with disabilities. States Parties must also ensure young persons with disabilities and their families have gender- and age-sensitive assistance, support, and education about how to avoid, recognise, and respond to violence when it happens.

> Obviously all those who work in government at all levels, civil service or ministers . . . , their attitudes are reflective of society as a whole. So if you are focusing on changing attitudes in society towards disabled people, you actually need to change attitudes of those within government as well.
>
> –National focal point for CRPD implementation, United Kingdom[459]

The 'ecological model' distinguishes the risk factors for violence based on four levels in which they occur: societal, institutional, community, and individual.[460] The model illustrates which risk factors are most likely to be influenced by state policy changes.[461] Figure 1, below, has been modified to reflect risk factors specific to girls and young women with disabilities and explores policy implications.

Research suggests a number of strategies can be effective at shifting discriminatory social norms around gender among young people. Increasing levels of education and growth in economic opportunities, among other things, can go far toward changing gender relations. Among adolescent girls and boys and young men and women, education, especially secondary education, is one of the strongest factors correlating with reductions in discriminatory attitudes toward traditional gender roles and related harmful practices.[462] Studies have found that girls and boys who have had a secondary education or completed high school are much more likely to reject practices such as female genital mutilation (FGM) and to oppose norms that legitimise domestic violence.[463]

Evidence exists that programmes supportive of social movements, such as campaigns against FGM and early, forced, and child marriage, can influence social norms and reduce support for harmful practices.[464] Strategies that promote positive role models, such as celebrities, athletes, or political leaders, can also be effective, as can media approaches that focus on modelling positive behaviour.[465] Effective implementation of laws prohibiting discrimination on the basis of gender or disability can also be an important step to changing discriminatory attitudes and reducing the vulnerability of young women and girls with disabilities to violence.[466]

FIGURE 1: FACTORS CONTRIBUTING TO VIOLENCE AGAINST YOUNG WOMEN AND GIRLS WITH DISABILITIES[467]

KEY CONCEPTS IN PREVENTION AND RESPONSE:[468]

Gender refers to the social attributes and opportunities associated with being male or female, the relationships between women and men and girls and boys, and the relations between women and those between men. These attributes, opportunities, and relationships are socially constructed and are learned through socialisation processes.

Gender equality means that all human beings, regardless of sex, are equal in dignity and rights and free to develop their personal abilities, pursue their professional careers, and make choices without discrimination and the limitations set by stereotypes, rigid gender roles, and prejudices.

Gender-transformative approaches are strategies that encourage critical awareness of gender roles and norms. They include ways to change harmful gender norms to foster more equitable power relationships between women and men and between women and others in the community. Such strategies promote women's rights and dignity, challenge unfair and unequal distribution of resources and allocation of duties between men and women, and consider the specific needs of women and men.

Social norms refer to contributing factors and social determinants of certain practices in a community that may be positive and strengthen its identity and cohesion or may be negative and potentially lead to harm. A social norm may be a rule of behaviour that members of a community are expected to observe. Social norms can create and sustain a collective sense of social obligation and expectation that conditions the behaviour of individual community members, who may feel they risk ostracism or stigmatisation if they reject the norm or expect to be rewarded if they conform with the norm.

Systems approach refers to the bringing together of a range of structures, functions, and capacities across sectors to respond to and prevent GBV in a given context. The system is organised around a common goal, and attention is paid to coordinating the actions of different actors, organisations, and subsystems so that each is mutually reinforcing.

In each of these instances, the inclusion of young persons with disabilities can promote recognition of persons with disabilities as rights holders and foster attitudes of respect and greater social awareness toward young persons with disabilities in ways that are likely to lead to reductions in violence.

ACCESS TO MEDIA AND TECHNOLOGY AND CHANGING SOCIAL NORMS

Information and communication technology (ICT) have offered new avenues for inclusion of persons with disabilities, breaking through some barriers and offering new opportunities for persons with disabilities in education and employment, among other things.[469] But there is also growing evidence that young people's access to mass media and ICT is associated with changes in gender norms and attitudes toward gender equality, some positive and some not, which suggests new possibilities for countering gendered discrimination.[470]

In one promising example, Ibis Reproductive Health – South Africa, an international nongovernmental organisation (NGO) with the mission to improve women's reproductive autonomy, choices, and health worldwide, partnered with the Community Media Trust in 2014 to launch the *Mmoho* campaign for the specific purpose of harnessing the power of the media to promote the rights of young persons in South Africa to SRHR and GBV prevention and response services.[471] *Mmoho* is a campaign that utilises a rights-based approach to change the conversation about adolescent pregnancy and to advocate for comprehensive and accessible SRHR services for young women and men. *Mmoho* is an inclusive initiative that brings together dozens of organisations, government agencies, and grassroots groups. This broad-based partnership includes DPOs, such as the Johannesburg Society of the Blind.

The campaign has three major activities: disseminating SRHR messages using radio, print media, websites, and social media; mobilising young people in partnership with the National Teenage Pregnancy Partnership (NTPP); and engaging government and policymakers. Some of its most important work has focused on the prevention of GBV.[472]

Media Engagement Workshops are one of the *Mmoho* campaign's main tools. In August 2017, *Mmoho* hosted a workshop on GBV that brought together adolescents and youth drawn from secondary schools and advocates and media personalities, including Ayanda Makayi, an actor from the popular drama series *Shuga*, which airs on MTV-South Africa, and Wandile Molebatsi, the star of the popular movies *Chappie* and *A Million Colours.* The young persons participating were able to ask the panels of activists and media personalities about their thoughts regarding GBV.

Actors and producers from *Shuga* discussed the steps they themselves can take to include the specific concerns of young persons in the soap opera's storylines that touch upon SRHR and GBV topics. As one of South Africa's most popular television shows for young people, *Shuga* is aware of its power and its responsibility to inform young people and positively shape their attitudes regarding sexuality and gender.

The South African government has been an active participant in the *Mmoho* campaign. The Departments of Health, Basic Education, and Social Development are part of the NTPP and active participants in the media engagement workshops, including sending high-ranking administrators as speakers and panelists to directly engage with the youth participants.

RESPECTING THE RIGHTS OF YOUNG PERSONS WITH DISABILITIES IN RESPONSES TO GENDER-BASED VIOLENCE

A comprehensive strategy addressing violence against young persons with disabilities must ensure that laws, policies, and programmes designed to respond to GBV include and are supportive of the rights and needs of young persons with disabilities on the same basis as include their peers without disabilities. In keeping with the principles articulated in the CEDAW, the CRC, the Declaration on the Elimination of Violence Against Women, the Beijing Declaration and Platform for Action, the ICPD Programme of Action, and the CRPD, among other instruments discussed in Chapter 3,[473] the United Nations (UN) Joint Global Programme on Essential Services for Women and Girls Subject to Violence recognises the following fundamental components of an effective response to GBV, adapted here to be inclusive of young persons with disabilities:[474]

- Delivery of all services must take a rights-based approach and respect the inherent dignity and humanity of persons with disabilities;
- Services should respect difference and accept persons with disabilities as holders of rights on the same basis and to the same extent as are persons without disabilities;
- Services must advance gender equality and women's empowerment;
- Services must be culturally and age appropriate and sensitive to the evolving capacities of children and adolescents with disabilities of all kinds;
- Services must be provided with a victim-centred approach and must be accessible to and accommodating of victims and survivors with disabilities of all kinds;
- Safety is paramount; and
- Services must effectively hold perpetrators accountable, including by supporting victim and survivor participation with the justice process and fostering victim and survivor agency.[475]

The UN Population Fund (UNFPA) and Women Enabled International (WEI) recently partnered on the forthcoming *Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young People with Disabilities*. These comprehensive guidelines provide practical and concrete steps that policymakers, programme implementers, and service providers can take to ensure that young persons with disabilities, including young women and adolescent girls with disabilities, have equal access to and are fully included in GBV prevention and response and SRHR services. The guidelines also ensure that states, CSOs, and other actors providing services have the necessary knowledge to develop targeted approaches to meet the disability-specific needs of women and young persons with disabilities. They were developed to put into effect the AAAQ Framework for young persons with disabilities, discussed in more detail in the text box below.

As with SRHR services, young persons with disabilities can face particular challenges in accessing services responding to GBV, which can be effectively unavailable as a result of physical inaccessibility, lack of accessible means of

THE AAAQ FRAMEWORK AND RESPONSE SERVICES FOR YOUNG SURVIVORS OF GENDER-BASED VIOLNCE WITH DISABILITIES

The delivery of services to young persons with disabilities who are survivors of violence must be created and maintained to ensure none are subjected to discrimination no matter where they might be located, including remote and rural areas, and that even the most marginalised receive necessary care. The AAAQ Framework is a useful tool to assess whether services meet the needs of women and girls with disabilities. The acronym AAAQ stands for availability, accessibility, acceptability, and quality. This rights-based framework has been utilised throughout the UN system and applied to a broad range of issues, including assessing health facilities, goods, and services for inclusion of persons with disabilities.[476] The UN Committee on Economic, Social, and Cultural Rights (CESCR) has defined four normative components of the right to health and all the underlying determinants of health.[477] These norms have been adapted to young persons with disabilities as follows:

- **Availability:** Functioning public health and health-care facilities, goods, and services, including, for example, hospitals, clinics, trained health workers, psychosocial service providers, essential medicines, emergency contraception, access to HIV/AIDS prevention programmes, and so on, must be available and sensitive to the particular needs and human rights of all adolescents and young persons with disabilities, including those experiencing violence.
- **Accessibility:** Health facilities, goods, and services should be known and easily accessible (economically, physically, and socially) to everyone, including young persons with disabilities, without discrimination, especially to the most marginalised people. Accessibility also includes the right to seek, receive, and impart information on health-care needs, and confidentiality should be guaranteed, when necessary.
- **Acceptability:** All health facilities, goods, and services should respect cultural values, be gender sensitive, be respectful of medical ethics, and be respectful of young persons with disabilities and the communities in which they live. Medical treatment must be explained in an understandable manner, and health workers need to be aware of cultural sensitivities.
- **Quality:** Health services must also be scientifically and medically appropriate and of good quality, which requires medical personnel trained to care for adolescents and young persons with disabilities. Quality also extends to the manner in which people are treated, and the underlying determinants of health must be appropriate and of good quality.[478]

THE AAAQ FRAMEWORK AND GENDER-BASED VIOLENCE RESPONSE SERVICES FOR YOUNG PERSONS WITH DISABILITIES

Note: A text alternative for this infographic is available as an annex here.

Source: Adapted from the Committee on Economic, Social, and Cultural Rights (2000). General Comment 14, The right to the highest attainable standard of health. U.N. Doc. E/C.12/2000/4.

The AAAQ Framework provides a human-rights based framework through which states and health-care and social service providers, among others, can assess and evaluate policy interventions. Implementation of the AAAQ Framework necessarily requires sensitivity to the particular needs and characteristics of those accessing services, including sexual and reproductive health (SRH) and psychosocial support services, as what is acceptable to a 40-year-old woman is likely to be different from what is acceptable to a 10-year-old girl who is a survivor of violence.[479]

communication, transportation barriers, poverty, and a host of other factors. The CRPD sets important standards for the appropriateness of services for persons with disabilities and requires that States Parties ensure persons with disabilities have the right to have access to justice, including procedural and age-specific accommodations to facilitate their participation in legal proceedings (Art. 13), and that persons with disabilities have the right to equal recognition before the law (Art. 12). Steps states have taken to ensure these rights are met are discussed further below.[480]

III. MULTINATIONAL AND REGIONAL INITIATIVES ON VIOLENCE PREVENTION AND RESPONSE

Although the focus of this report is on the promising steps national actors are taking to provide access to and promote the exercise of the rights of young persons with disabilities, multinational and regional initiatives provide important mechanisms for the development of programmes and guidance on implementing policies. Some of these, led by the UN and other multilateral organisations, are highlighted in the text box below. In addition, initiatives adopted by the Council of Europe, the African Union, and the Inter-American human rights institutions offer states specific guidance on how to meet their obligations to prevent and respond to violence against young persons with disabilities.

The Council of Europe Disability Strategy 2017–2023: Human Rights: A Reality for All emphasises that persons with disabilities are entitled to enjoy the full range of human rights. It highlights a number of cross-cutting themes, including the risk many persons with disabilities face of multiple and/or intersecting forms of discrimination.[481] The Strategy calls on Member States to both acknowledge the existence of multiple discrimination and to take this into account in work and initiatives at regional, national, and local levels. It also calls on Member States to promote increased access to information by young persons with disabilities and to mainstream the rights of young persons with disabilities in all activities and work to prevent and respond to exploitation, abuse, and discriminatory violence.[482]

In 2012, the African Union Conference of Ministers for Social Development developed the Continental Plan of Action as part of the African Decade of Persons with Disabilities (2010–2019) and chartered an African Union Disability Institution to provide technical support to member states.[483] Significantly, youth and children with disabilities are each specified as strategic themes within the Continental Plan of Action's strategic theme on mainstreaming.[484] Under the theme on women with disabilities, both eliminating sexual violence and increasing access to SRH are given priority.[485]

A series of decisions by the Inter-American Commission of Human Rights and the Inter-American Court of Human Rights have provided explicit guidance to governments regarding the extent of their duties to ensure the rights of women and girls to be free from discriminatory violence, holding States responsible for, *inter alia*, failing to protect women and children from domestic violence when the state knew the survivors were at risk;[486] failing to exercise due diligence in the investigation of the deaths of three children at the hands of their father;[487] and failing to prosecute those responsible for violence against women.[488]

Each of these policies is significant to the extent that it explicitly recognises women and girls with disabilities as holders of rights, especially the right to be free from violence. Too often, women and girls with disabilities are left out of regional—and national—initiatives to prevent and respond to GBV and harmful practices, a failing that must be corrected for the human rights of women and girls to be fully respected.

THE WORK OF MULTILATERAL ORGANISATIONS ON PREVENTION AND RESPONSE TO GENDER-BASED VIOLENCE

The UN Joint Global Programme on Essential Services for Women and Girls Subject to Violence, a partnership of the UN Entity for Gender Equality and the Empowerment of Women (UN Women), UNFPA, the World Health Organiation (WHO), the UN Development Programme (UNDP) and the UN Office on Drugs and Crime (UNODC), aims to provide greater access to a coordinated set of essential and quality multi-sectoral services for all women and girls who have experienced GBV.

The Programme identifies the essential services to be provided by the health, social services, police, and justice sectors along with guidelines for the coordination of essential services and the governance of coordination processes and mechanisms. The programme also developed and is rolling out the service delivery guidelines for the core elements of each essential service. These guidelines have been identified to ensure the delivery of high-quality services, particularly for low- and middle-income countries, for women and girls experiencing violence. The Programme is being implemented in more than 40 countries in Latin America and the Caribbean, Africa (East and Southern Africa and West and Central Africa), Asia-Pacific, and the Arab States regions.

The Spotlight Initiative to Eliminate Violence against Women and Girls: The EU-UN Spotlight Initiative to Eliminate Violence against Women and Girls, implemented by the UN (including UNFPA, UN Women, and UNDP) will respond to all forms of violence against women and girls (VAWG), with a particular focus on domestic and family violence, sexual violence and GBV and harmful practices, femicide, trafficking in human beings, and sexual and economic (labour) exploitation, in Asia, Africa, the Caribbean, Latin America, and the Pacific.

Joint UNFPA and the UN Children's Fund (UNICEF) Programme to Accelerate the Abandonment of FGM: This programme is part of the global effort to address FGM and aims to play a strategic and catalytic role in the abandonment of the practice. The Joint Programme, which is the largest global programme providing support to countries for the elimination of FGM since 2008, is currently in its Phase III, supporting national initiatives in 17 countries: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Somalia, Sudan, Uganda, and Yemen. It is guided by a theory of change that strongly emphasises a holistic and integrated approach, collaborating with government, civil society, and communities to promote policy and legal reform, support service provision, and work with communities to galvanise a new social norm that supports the abandonment of FGM.

Joint UNICEF and UNFPA Global Programme for Accelerated Action to End Child Marriage: Child marriage is a global challenge, influenced by religious beliefs and cultures, with almost 750 million women and girls alive today being married off before their 18th birthday. Each year, 15 million more girls are married before they turn 18, prevalence rates being lower among boys than girls. Eliminating child marriage is part of the gender equality goal within the 2030 Sustainable Development Goals (SDGs) framework, under Target 5.3 on harmful practices. To Implement this

goal, UNICEF and UNFPA developed the joint Global Programme for Accelerated Action to End Child Marriage. The effort is currently underway in 12 countries and aims to ensure that all girls fully enjoy their childhood free from the risk of marriage and that they experience healthier, safer, and more empowered life transitions in control of their own destiny, including making choices and decisions about relationship formation/marriage and childbearing. The Theory of Change for the programme relies on leveraging existing infrastructure to build capacity of regional partners, to increase government commitments, and to target whole communities for attitudinal change to sustainably alter intergenerational transmission of child marriage behaviours.

IV. PROMISING NATIONAL STRATEGIES TO PREVENT AND RESPOND TO GENDER-BASED VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

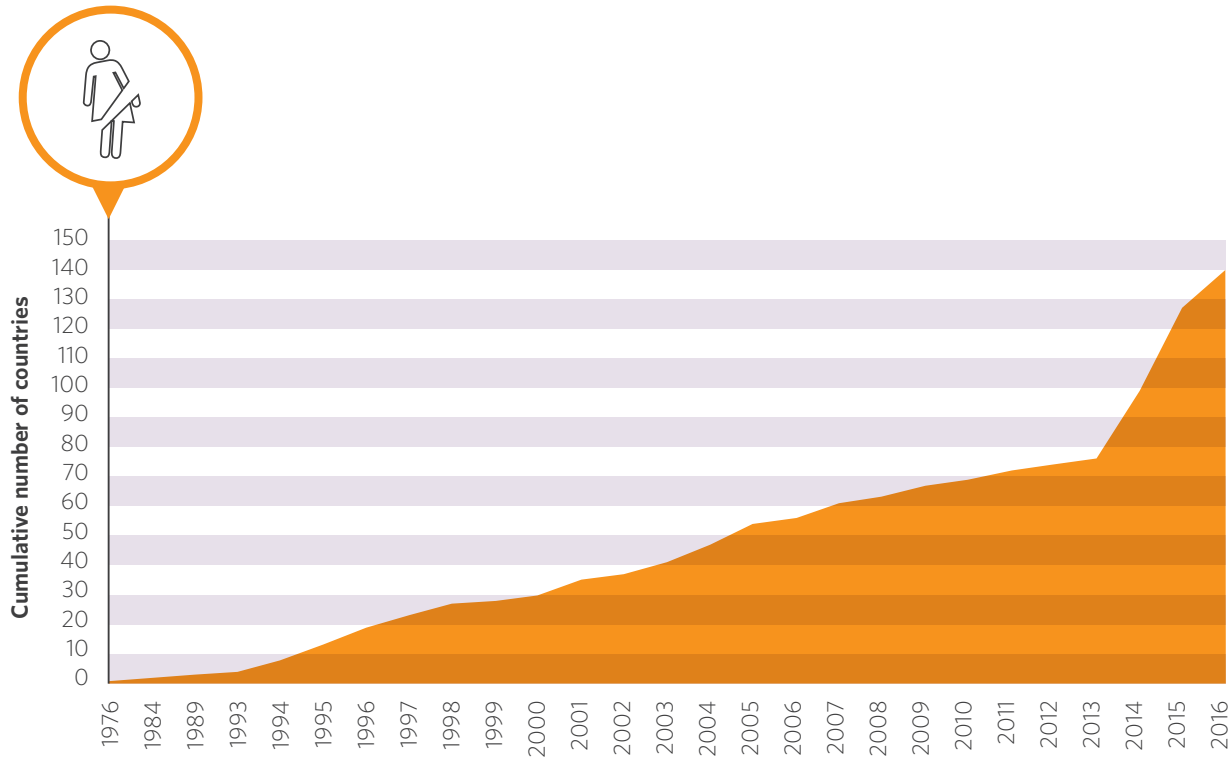
COMPREHENSIVE LEGAL FRAMEWORKS

Since the adoption of the ICPD Programme of Action in 1994 and the Beijing Declaration and Platform for Action one year later, and through the combined efforts of civil society advocates, government officials, and international organisations and networks, states have made significant progress reforming national legislation to increase respect for the rights of women and girls. Most countries in the world now have legislation that recognises gender equality and prohibits discrimination against women and girls, including women and girls with disabilities.[489] Most countries also have some form of legislation that addresses GBV in some form, often specifying domestic violence or violence against women.[490]

Guidelines proposed by the UN call for a comprehensive approach to national legislation that, *inter alia*:

- Acknowledges violence against women as a form of gender-based discrimination and a violation of human rights;
- Defines discrimination against women as any distinction, exclusion, or restriction made on the basis of sex that has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, on an equal basis with men, of human rights and fundamental freedoms;
- Provides that no custom, tradition, or religious consideration may be invoked to justify violence against women;
- Is comprehensive and multidisciplinary, criminalising all forms of violence against women and encompassing issues of prevention, protection, survivor empowerment, and support along with adequate punishment for perpetrators and remedies for survivors; and
- Protects all women without distinction as to race, colour, language, religion, political

CUMULATIVE NUMBER OF COUNTRIES WITH LEGISLATION AGAINST DOMESTIC VIOLENCE, 1976-2016



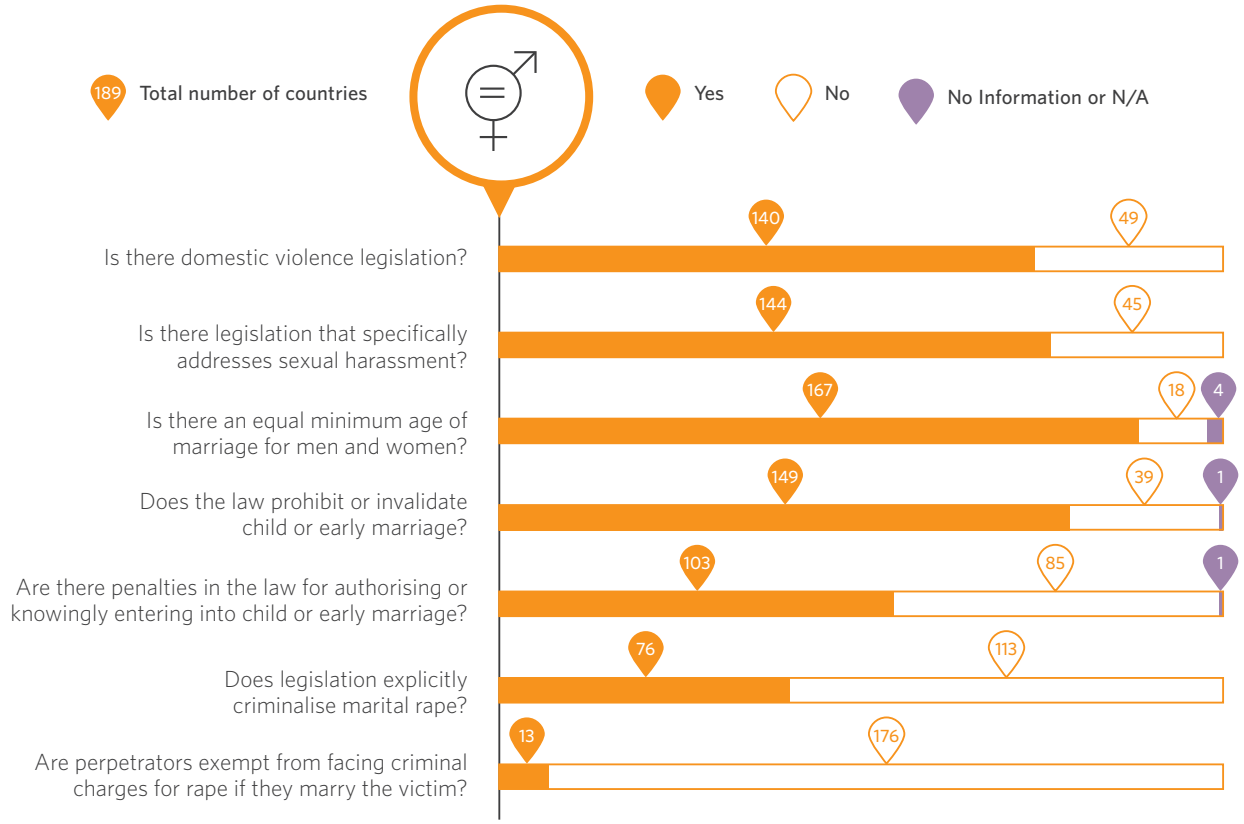
Note: A text alternative for this infographic is available as an annex here.
Source: World Bank (2015). *Women Business and the Law: Getting to Equal* and the Women and Business and the Law database (updated 2016).

> or other opinion, national or social origin, property, marital status, sexual orientation, HIV/AIDS status, migrant or refugee status, or disability.[491]

While much national legislation focuses on domestic violence and most often addresses physical violence, closely followed by emotional violence (124 and 122 countries respectively),[492] the most comprehensive of laws addressing GBV go much further, targeting not only criminal acts of VAWG but also mandating changes in educational policy or programming to target discriminatory attitudes and promote gender equality.[493] For example, the Mexican Law on Access of Women to a Life Free of Violence (2007) requires the development of educational programmes at all levels of schooling to promote gender equality and prevent the reinforcement of discriminatory attitudes.[494] The Chilean Law on Intra-Family Violence similarly calls for the inclusion of lessons on intra-family violence in school curricula, and Brazil's Maria da Penha Law (*Lei Maria da Penha, Law No. 11.340*) mandates programmes to raise awareness about the risks and consequences of GBV and requires educational programmes on issues of sexuality and violence.[495]

Some national legislation also mandates services for survivors of violence. Guatemala, Mexico, Turkey, Mauritius, the United States, Austria, and India all have adopted mechanisms to provide for

NUMBER OF COUNTRIES WITH OR WITHOUT SELECT GENDER EQUALITY PROVISIONS



Note: A text alternative for this infographic is available as an annex here.
Source: World Bank (2016). Women, Business and the Law Project (last updated August 2016). Available at: wbl.worldbank.org.

housing and shelters for survivors of GBV, and 45 countries have laws that guarantee these survivors free legal assistance.[496]

For women and girls with disabilities, protections against GBV can be found in both laws specific to the prevention of violence and in laws guaranteeing the rights of persons with disabilities. For example, in India, the 2013 Criminal Law (Amendment) Act incorporated new protections against sexual assault for women and girls with disabilities, including those in institutions, while also requiring that victims of violence who have disabilities receive support and assistance while registering a complaint, identifying the perpetrator, and providing testimony.[497] The new Rights of Persons with Disabilities Act (2016) reinforces these protections, prohibiting violence against and exploitation of persons with disabilities, guaranteeing the right to file a complaint and receive free legal assistance, and compelling law enforcement to act on complaints of violence against persons with disabilities.[498]

Spain's Organic Act 1/2004 on Integrated Measures against Gender Violence guarantees all women protection from violence, including women with disabilities. The law prohibits 'all acts of physical and psychological violence, including deprivation of sexual freedom, threats, coercion

and the arbitrary deprivation of freedom' and incorporates measures to promote awareness raising and intervention in formal education to reinforce respect for the equality and dignity of women.[499] The law guarantees that women with disabilities have access to information on their rights and available resources in accessible formats and promotes incorporating women with disabilities in information campaigns and awareness-raising efforts to eliminate violence.[500]

Spanish law also contains multiple guarantees of the rights of the persons with disabilities, including the right to be free from violence. The rights of persons with disabilities to be free from violence and discrimination are guaranteed by the Spanish Constitution of 1978, for example, and the General Law on the Rights of Persons with Disabilities, which explicitly prohibits multiple and intersecting forms of discrimination against persons with disabilities.[501] Similarly, the rights of children with disabilities to be protected from violence are guaranteed by the Spanish Criminal Code and by the Civil Code, which specifically addresses violence against children by parents.[502]

Laws are also being used as tools to improve overall responses to violence, setting standards for police responses to claims, for example, and establishing guidelines for health-care providers to recognise and report potential incidents of violence. As noted in Chapter 2, the failure to promptly and thoroughly investigate claims of violence against women, including women with disabilities, violates the state obligation of due diligence under international law. Some states have responded by requiring police to investigate claims and penalising them if they do not. Article 7 of Ghana's Domestic Violence Act (2007) requires police officers to 'respond to a request by a person for assistance from domestic violence' and obligates them to 'offer the protection that the circumstances of the case or the person who made the report requires'.[503] Similarly, Article 5 of the Costa Rican Criminalisation of Violence against Women Law (2007) requires public officials who deal with violence against women to 'act swiftly and effectively, while respecting procedures and the human rights of women affected' or risk being found in dereliction of duty.[504] Legislation in the Philippines imposes a fine on village officials or law enforcement personnel who fail to report an incident of violence and, in South Korea, the Special Act for the Prevention of Domestic Violence and Victim Protection Act (1997) requires investigation by police and treatment of survivors for any physical or psychological injuries.[505]

Some states have also imposed mandates requiring support services for survivors of violence. For example, Article 17 of the Guatemalan Law against Femicide and other Forms of Violence against Women (2008) obligates the government to guarantee survivors access to integrated service centres, as do similar laws in Mexico, Turkey, Mauritius, and Austria.[506] Legislation in Spain and Australia, among others, ensures financial support for survivors of violence, including in some places requirements that perpetrators contribute toward survivors' housing expenses.[507] And as of 2012, laws on domestic violence in at least 45 countries included guarantees of free legal aid for women.[508]

In its thematic study on the issue of VAWG with disabilities, the Human Rights Council noted that prohibitions of discrimination on grounds of sex in national legislation is insufficient to protect women and girls with disabilities from GBV. Such legislation, in practice, 'often fails to recognise the range of domestic or family settings in which women with disabilities may live (such as group

or nursing homes) and the variety of possible perpetrators in such contexts' along with the varieties of forms of harm, some of which may be disability specific. In much the same way, legislation that prohibits violence against women may fail to protect the rights of young women and girls with disabilities if it fails to recognise the unique forms of violence to which they can be subjected as a result of disability. While much of the legislation detailed above may therefore advance the rights of some young women and girls to be free from violence, where it is not expressly inclusive of the rights and needs of young women and girls with disabilities, or where it is inaccessible to them, it may be insufficient to guarantee them freedom from violence.

LEGAL PERSONHOOD AND THE POWER TO CONSENT – ENDING FORCED STERILISATION IN COLOMBIA AND ARGENTINA

There are certain areas in which sexual and reproductive health and rights (SRHR) and the right to be free from violence intersect for young persons with disabilities; one of the most significant of these is when the denial of SRHR leads to forced or coerced sterilisation, contraception, or abortion. The Committee on the Rights of Persons with Disabilities has condemned these practices and unequivocally called them out as violations of the CRPD and the human rights of persons with disabilities. Not only are these practices recognised as forms of GBV,[509] in practice, sterilisation and forced contraception can increase young women and girls' vulnerability to sexual abuse, in part because the abuse is more difficult to detect.[510] Nevertheless, many states still permit sterilisation without consent, something legal advocates have made progress changing in Colombia and Argentina.

Since 2012, *PROFAMILIA*,[511] the Colombian Association of Down Syndrome (la Asociación Colombiana de Síndrome de Down, ASDOWN),[512] the Colombian Autism League (la Liga Colombiana de Autismo, LICA),[513] and the Programme of Action for Equality and Social Inclusion (el Programa de Acción por la Igualdad y la Inclusión Social, PAIIS) of the University of the Andes[514] have been working to ensure and promote the SRHR of persons with disabilities in Colombia. The coalition, which brings together health-care providers with expertise in SRH, persons with disabilities and their families, and legal professionals working to defend human rights, has been instrumental in raising awareness about the rights of persons with disabilities to make decisions for themselves, especially regarding their SRH. One of the primary goals for the coalition has been to strengthen advocacy actions before judicial and administrative authorities for the elimination of the violations of SRHR of persons with disabilities, specifically against forced sterilisation. Based on research findings that suggested judges and health-care providers were permitting guardians assigned to protect the economic interests of persons with disabilities to make health-care decisions for them, the coalition developed materials to train persons with disabilities, health-care providers, and legal professionals about the rights of persons with disabilities and the need for supported decision-making especially with regard to SRH decisions.

In a 2016 decision prompted by legal advocacy by the group, the Constitutional Court ordered the Ministry of Health to regulate the accessibility of SRH services, including for persons with disabilities. After an extended consultation with relevant stakeholders, including organisations representing persons with disabilities and their families, the Ministry adopted a new regulation in May 2017 that prohibits sterilisation of persons with disabilities without their informed consent. The regulation requires health-care providers to consult directly with patients with disabilities, instead of their guardians or parents, and provide supported decision-making to ensure that all decisions regarding the patient's health and well-being are undertaken with the patient's fully informed consent.

The Ministry of Health has incorporated members of the coalition in its internal meetings, and the Justice Ministry has also promoted a training course developed by the coalition to sensitise judges on the rights of persons with disabilities, particularly the standards applicable to findings of legal capacity and the consequences of its denial.

The Government of Argentina has also taken steps to protect the rights of young persons with disabilities to make decisions for themselves, particularly with respect to their bodily autonomy and reproduction. Recent amendments to Argentina's Civil and Commercial Code recognise the right of young people to make their own decisions on health care and treatment. Article 26 of the Code provides that young people between the ages of 13 and 16 must be presumed able to give or withhold consent about any treatment that is not invasive (defined as imposing a serious risk to their life or health) without consulting with or receiving the consent of a parent or guardian. For any invasive treatment, they still must be consulted and their consent sought, but it may be done so with the assistance of parents or guardians. Young people over the age of 16 are recognised as adults and fully capable of making decisions for themselves with regard to all forms of health care.

Resolution 65/2015 adopts a similar approach toward progressive autonomy, authorising all young people to have access to information on SRH, but limiting access to certain forms of contraception for children under the age of 13, unless they are assisted by a parent or adult caregiver. Young people between 13 and 16 are entitled to access most temporary contraceptive methods, and at the age of 16, young people are presumed to be adults and are entitled to access the full range of SRH services.

These rules offer new protections for the rights of young persons with disabilities, particularly with respect to their reproductive rights. Under Resolution 65/2015, medical professionals must presume that young persons with disabilities are legally capable and authorised to give or withhold informed consent to SRH services. Medical centres must provide any necessary support measures to enable young persons with disabilities to make autonomous and informed decisions about their care and cannot sterilise them without their knowledge and consent absent a judicial finding they lack capacity under a newly stringent standard.[515]

IMPLEMENTING POLICIES TO PREVENT AND RESPOND TO VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

Laws are most likely to be implemented effectively when they are integrated with a national strategy or action plan and comprehensive policy framework. Effective policies can originate in many places and take different forms. They include and depend on political ownership within government institutions, partnerships with CSOs, support for research, and the development of and reliance on practical and policy expertise and evidence-based analysis.[516] This section will consider guidelines for national action plans and strategies to prevent and respond to GBV that are inclusive of young persons with disabilities and will explore examples of how those guidelines have been put into practice in particular contexts, including through the adoption of health-care protocols that work to identify likely victims of abuse among young persons with disabilities, programmes to build capacity within law enforcement and judicial systems to respond to the needs of young persons with disabilities who are survivors of violence, and programmes that offer care and support for survivors. It concludes with a brief discussion of the critical importance of resources to ensure that laws and policies promoting the rights of young persons with disabilities are put into action.

NATIONAL ACTION PLANS TO PREVENT AND RESPOND TO VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

Many of the international and regional instruments discussed in Chapter 2 of this report require states to take active measures to address GBV, particularly VAWG. Under the CRPD, for example, states are obligated to ensure women and girls with disabilities are able to enjoy all the rights and freedoms to which they are entitled (Art. 6) and to 'take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities . . . from all forms of . . . violence and abuse', including GBV (Art. 16).[517] The CEDAW Committee, among others, has regularly called on states to develop national action plans that detail how they will satisfy their obligations to eradicate VAWG, including women and girls with disabilities.[518] National Action Plans can provide 'comprehensive, multi-sectoral and sustained blueprints for ending violence against women', including women and girls with disabilities.[519]

To ensure that young persons with disabilities receive the same care and support as peers without disabilities do, and are incorporated within prevention and response programmes, national action plans must also explicitly address intersectional forms of discrimination such as age and disability discrimination. Given the frequent marginalisation of young women and girls with disabilities, many are unlikely to be reached by generalised strategies.[520] They are also less likely to be reached by services and programmes those strategies promote and have specific needs general strategies may not address. A comprehensive national action plan should address the different inequalities and forms of discrimination young women can face, especially young women and girls with disabilities, and tailor strategies to address intersectional discrimination.[521]

PACIFIC ISLANDS FORUM AND THE PACIFIC FRAMEWORK ON THE RIGHTS OF PERSONS WITH DISABILITIES (2016-2025)

The Pacific Islands Forum, a membership organisation of 18 Pacific Island nations, produces policy advice and guidance for member states to promote integrated approaches to shared challenges. Recognising that persons with disabilities were among the most marginalised groups in Pacific states and were disproportionately represented among the region's poorest citizens, the Pacific Island Forum endorsed a regional strategy on disability for the years 2010–2015. That strategy led to the adoption of the Pacific Framework on the Rights of Persons with Disabilities in 2016.

The new Framework is the product of extensive consultation with relevant stakeholders, including DPOs, government officials responsible for implementing the CRPD and protecting the rights of persons with disabilities in Pacific Island Forum member countries, and other interested organisations. According to the Pacific Island Forum Secretary General, it 'attempts to capture the unique features of the CRPD, as both an instrument of human rights and of social and economic development' in part by ensuring a central role for persons with disabilities in the Framework's elaboration and implementation.[522] It establishes a vision of 'an inclusive, barrier-free, and rights-based society for men, women and children with disabilities, which embraces the diversity of all Pacific peoples'.

The Framework is notable for its inclusion of women with disabilities and its call for the mainstreaming of disability in all government policies on prevention and responses to GBV. It recognises women with disabilities as a particularly marginalised group among persons with disabilities and integrates specific targets and objectives for the inclusion of women with disabilities in leadership capacity-building programmes and organisations promoting economic development initiatives.

Among eight foundational principles, the Framework recognises:

- Respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence;
- Equality between men and women;
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities; and
- Respect for the dignity and value of youth and older persons with disabilities.

It emphasises the multiple and intersecting forms of discrimination often faced by women with disabilities and urges member states to explicitly take women into account when mainstreaming disability into national policies, programmes, and services, especially those targeting VAWG. Among the intended outcomes of the Framework is the inclusion of women with disabilities in the development of new policies and their participation in programme and policy reviews and evaluations at national and regional levels of government.

The National Action Plan to Prevent Violence against Women adopted by Cambodia in 2014 is one such example. It recognises violence against women as a violation of human rights and provides for an integrated, multi-sectoral response explicitly responding to and acknowledging its obligations under international human rights treaties. It also acknowledges the multiple and intersecting forms of discrimination to which women with disabilities are vulnerable and calls for different response strategies and actions to target prevention and response measures to their needs.[523]

Sri Lanka's Policy Framework and National Plan of Action to Address Sexual and Gender-based Violence in Sri Lanka 2016–2020 similarly targets the intersection of gender and disability but also recognises the vulnerability of young persons with disabilities to GBV. The Policy Framework tasks the Ministry of Women and Child Affairs with preventing the abuse of children in institutional care, including children with disabilities, and establishing new protection mechanisms to prevent sexual violence and GBV against children with disabilities.

In Australia, both national and regional strategies to prevent violence recognise the different vulnerabilities and experiences of violence young women and girls with disabilities have. Victoria's strategy to prevent all forms of violence against women recounts the findings in research done by Women with Disabilities Australia about the vulnerabilities and compounding nature of oppression against women and girls with disabilities and outlines a vision for future action that tailors strategic actions to known risks and vulnerabilities.[524] The National Plan to Reduce Violence against Women similarly recognises the intersectional nature of discrimination against women and girls with disabilities and reserves community action grants to meet the needs of women with disabilities experiencing violence.[525]

To accomplish their objectives, national plans and strategies should adopt not only an intersectional but also an intersectoral approach that engages multiple actors across government in preventing and responding to violence. One example of such an approach is that taken by Uruguay's Ministry of Social Development, discussed in the text box below.

INTEGRATING WOMEN AND GIRLS WITH DISABILITIES IN RESPONSE TO SEXUAL VIOLENCE – URUGUAY'S NATIONAL DISABILITY PROGRAMME

In 2008, a small team of researchers supported by the local government in Montevideo in collaboration with Uruguay's University of the Republic partnered with CSOs to conduct a broad study on the experiences of women with disabilities accessing SRH services. The study found that more than 84 per cent of women who had sought services at least once never tried to again, almost entirely because of the way they were treated by service providers. Focus group interviews conducted as part of the study also revealed that women with disabilities were commonly subjected to sexual violence, often at the hands of caregivers.

Publication of the study generated new appreciation of the challenges facing women with disabilities and in 2013 led to the creation of a new office within the Ministry of Social Development's National Disability Programme to focus on the intersection of gender and disability. The National Disability Programme has also added access to SRH services for women with disabilities as a central theme in its work plan and has developed multiple cross-sectoral initiatives to integrate women with disabilities into governmental policies and plans addressing SRHR and the prevention and response to GBV.

In partnership with the Ministry of Health and health-care providers, the Gender Office prepared a chapter on the appropriate SRH services for women with disabilities for inclusion in the 'Green Guide', the primary resource used by medical students and clinicians, and distributed detailed flyers to medical professionals and medical schools for use in their practices and curricula.

Under the umbrella of the 'Barriendo Barreras' programme, the Gender Desk of the National Programme on Disability initiated a project to reach women with disabilities and ensure they were aware of their SRHR. The project created spaces for women with disabilities, their families and caregivers, and service providers to talk about sexuality and reproduction, understand their rights, and learn more about the services available to them. The Gender Desk has also provided workshops to young persons with disabilities in schools, with basic information about sexuality, puberty, and healthy relationship practices.

The Gender Desk has worked with the Ministry of Social Development's office on sexual violence to ensure women with disabilities were incorporated into their programmes and policies. In 2014 and 2015, the group prepared flyers on the risks and prevalence of sexual violence against women with disabilities and has also drafted a manual providing technical guidance to medical and social service providers working with survivors of violence to ensure such services were open to and inclusive of women with disabilities. The National Programme on Disability now offers technical support for survivors and support service providers through teams of consultants that can support women with disabilities from the moment they bring a claim of sexual or other violence through the collection and presentation of evidence in court and to the ultimate resolution of the case. Technical support teams include lawyers, psychologists, and social workers trained to support survivors and their families, law enforcement personnel, and social service providers.

The National Disability Programme also has an agreement with the Faculty of Law to provide legal aid services for persons with disabilities, and the new National Plan for Access to Justice for Persons with Disabilities provides for training of judicial staff and law students on the rights and needs of persons with disabilities.[526]


10

PUTTING STRATEGIES INTO ACTION

An effective response to GBV requires that all entities involved in responses work together in a coherent, integrated way. States can and have used national action plans to strengthen and standardise training and education for professionals who are or are likely to be involved in prevention or response programmes so that they can recognise violence when and where it is most likely and take appropriate steps to intervene, respond, and care for survivors when necessary.[527] The following sections discuss actions states have taken to strengthen health care and legal systems to respond to violence, especially violence against young women and girls with disabilities, and ensure that young women and girls with disabilities have access to adequate support services, such as shelters, legal assistance, and support groups.

Setting protocols for health care providers

Capacity development for health-care providers particularly important, as health-care providers are frequently the first ones to recognise and serve survivors of violence.[528] They provide critical medical care to women and girl survivors and can refer them to additional services, including shelters or other social services, psychosocial services, and justice-related services. As part of a comprehensive national strategy to respond to GBV, the CEDAW Committee has called for the removal of all barriers to women's access to health services and information relevant to their health and has called on states to ensure women's right to autonomy, privacy, and confidentiality in health services and care.[529]

For young women and girls with disabilities, who may be marginalised in their homes or for whom travel may be restricted or impossible without a companion, private visits with health-care providers can provide an essential opportunity to share experiences of abuse that may otherwise go unrecognised. National policies that integrate health-care providers into strategies to prevent and respond to violence against women, including young women and girls with disabilities, can therefore offer young women and girls with disabilities much-needed support in responding to and escaping violence.

WHO clinical guidelines for the care of survivors of violence highlight the importance of providing 'women-centred care' that recognises the different needs of women survivors of violence, including young women and girls with disabilities.[530] The guidelines recognise the importance of establishing links between health-care providers and CSOs along with ensuring inter-sectoral collaboration and maintaining clear referral pathways.

These standards are mirrored in the forthcoming guidelines developed by UNFPA and WEI. The UNFPA/WEI guidelines are based on and align with the UN Essential Services Package for Women and Girls Subject to Violence. Further, they emphasise the importance of the AAAQ Framework for services for young persons with disabilities who have experienced violence and the necessity that services such as emergency medical care be available and accessible to survivors of GBV with disabilities.[531] Both the WHO and UNFPA/WEI guidelines propose training programmes that can ensure health-care providers have the skills to recognise the potential for GBV in patients they see and then respond appropriately. One strategy to establish just such a training course in Ecuador is described in the text box below.

INSTRUCTIONAL COURSE ON GENDER-BASED VIOLENCE IN ECUADOR

To fight against GBV, the Ecuadoran Ministry of Public Health created a Technical Norm of Comprehensive Attention to GBV (2014) and an Instructional Course directed to health providers to be trained in GBV issues. The aims of the course are to: a) Allow public health providers to develop their capacities and abilities to ensure medical care for GBV victims; b) Provide knowledge on the concepts, tools, methodological techniques, and procedures related to attending GBV victims; and c) Learn how to identify and recognise the realities of GBV victims. It is explicitly inclusive of young persons with disabilities, incorporating examples from their lives and including sections on the specific health needs of young persons with disabilities experiencing violence.

The course has five modules:

1. Conceptual and legal framework: Students learn what is understood by discrimination and GBV and are provided with the legal framework that binds them to provide integral care to all GBV victims, including victims with disabilities, with a focus on the rights that people who access health care have.

   This module makes visible the structural problems that the Ecuadorian society has in regard to inequality and access to exercise human rights, such as gender inequality, poverty, racism, homophobia, the lack of access to education, the issues regarding disabilities, and so on. To overcome such problems, the module states that health providers shall work through the lenses of social justice, have a gender/intergenerational/intercultural approach, and respect the rights of persons in human mobility.

   The case studies for this section portray scenarios where different persons suffer discrimination because of their contexts as minorities or because they do not fit the normalised standards of society. The students are supposed to solve questions regarding each case study so that it can be measured whether or not they can identify situations of discrimination.

   For example, one of the case studies revolves around the vulnerability in which Emilia, a 28-year-old woman, who has indigenous origins and speaks Kichwa, lives in a rural area and is taken care of by her parents (who are Kichwa speakers as well), and has never had access to education or work due to her language-based learning disability, has been the victim of sexual violence. The students are asked to identify what the situations of vulnerability in which Emilia lives are and what the challenges she faces are in the access to integral health, education, and work.

Students are also asked questions about the concepts of sex, gender, gender equality, and racism. It is important to notice that those questions tend to clarify that the gender-equality approach does not focus on efforts to make women be considered 'better than men'; therefore, the online course deconstructs the myths around feminism.

2. Comprehensive care to GBV victims (focus on sexual violence): Students learn the basic procedures they have to follow to provide integral care to victims of sexual violence. They are given tools to identify sexual violence cases that may appear before them; the protocols they shall follow after identifying a case; and the importance of confidentiality, non revictimisation, informed consent, and the inter-institutional work that exists to attend to the victim and survivors.

3. Comprehensive care to GBV victims (focus on physical violence): Students are given tools to identify physical violence cases that may appear before them, learn comprehensive care procedures, and the inter-institutional work that exists to attend to the victim and survivors.

4. Integral care to GBV victims (focus on physiological violence): Students learn comprehensive care procedures to identify and assist victims of psychological violence and learn to use the inter-institutional network to help the victims.

5. Comprehensive care to GBV victims who are persons with disabilities: Students learn the legal and conceptual framework on disabilities and study how to proceed according to the forensic protocol for sexual crimes.

   In this module, students are reintroduced to the case of Emilia, which they analysed first in module 1. This time, Emilia has been brought by her parents to the Health Centre after she was found unconscious and with signs of having been victim to violence. The module portrays step by step what the procedure that health providers should follow entails when they face a case of sexual violence suffered by a person with disabilities.

   They are instructed to attend to the urgent necessities of the victim, keep the evidence intact, and contact the prosecutor's forensic doctor to proceed with the medical examination (for only one time, as the person shall not be re-victimised). Students are reminded that the informed consent of the victim is necessary to be able to execute the medical examination. As the person has a disability, health providers shall determine whether the person is able to consent or if the parents need to consent on their behalf.

   As the medical examination is finalised and evidence has been collected, they enter a state of custody, as part of the criminal procedure. After this, the victim shall be sent to receive the medical care needed for her recovery from the violent episode.

STRENGTHENING LEGAL SYSTEMS

The vast majority of women and girls who are subjected to violence never seek formal help or report the violence.[532] A recent review of survey data by the World Bank found that fewer than half of women who experienced violence told anyone, and just 6 per cent sought help from authorities such as police or lawyers.[533] In many cases, women do not report violence because they do not know where or how to make a claim. But for some survivors of violence, experiences with law enforcement personnel and the judicial system can be traumatic. Persons with disabilities in particular are often denied access to fair and equal treatment in courts and by law enforcement officials, making it more difficult to claim their rights.

The CRPD mandates that states ensure persons with disabilities have equal access to justice and provide whatever assistance is necessary to enable them to act as witnesses in all legal proceedings, at all stages (Art.13). Strengthening legal systems to ensure that young persons with disabilities who are affected by violence can take steps to protect themselves and attain some measure of justice is thus an essential component of a comprehensive response to violence and an important step in meeting state obligations under international law.

Among the most obvious barriers for persons with disabilities seeking access to justice are physical barriers within courthouses, police stations, and other institutions of the legal system.[534] Many states now mandate accessibility of public institutions, and some have improved the physical accessibility of courthouses. In Spain, for example, the General Council of the Judiciary established the Disability and Justice Forum to review and advocate for removal of obstacles that persons with disabilities might face within the legal system.[535] As of June 2017, most judicial buildings had been made physically accessible to persons with mobility impairments, and some were being modified to ensure accessibility for persons with visual impairments.[536]

Spain has also established specialised courts to hear cases of GBV, and the General Council of the Judiciary and Observatory against Domestic Violence and Gender-Based Violence offer compulsory training courses for judges about GBV that include training on how to work with women and girls with disabilities as claimants and witnesses in the courtroom.[537]

Other efforts to sensitise law enforcement personnel and ensure young persons with disabilities are recognised as having the same rights to justice as are others are detailed in the text boxes below.

PACIFIC DISABILITY FORUM TOOLKIT ON RECOGNISING AND PREVENTING GENDER-BASED VIOLENCE[538]

In 2014, the Pacific Disability Forum and the Fiji Disabled People's Federation, both NGOs, published the Toolkit on Eliminating Violence against Women with Disabilities in Fiji. The Toolkit was the culmination of an extensive programme to raise awareness among DPOs and their members, family members and caregivers of persons with disabilities, and community

workers across Fiji about the rights of persons with disabilities, especially women and girls with disabilities, to live free from violence and the vulnerabilities they faced. The programme incorporated training on violence prevention and legal services and policies available to survivors of violence along with research strategies so that DPOs could collect and analyse data on the prevalence and experience of violence by women and girls with disabilities in their communities.

The data collected by these organisations, and ongoing consultations with interested groups and government officials, informed the development of the toolkit while promoting a new understanding among stakeholders of the extent and nature of the problem. The Fijian Ministry of Women, Children and Poverty Alleviation was an essential partner on the project, as was the Regional Rights Resource Team, an organisation that provides technical support and guidance on the implementation of human rights in the Pacific region. A meeting of the latter organisation gave lawyers and other stakeholders from across the region the opportunity to hear from women with disabilities about their own stories of abuse and to discuss steps they could take to address violence against women with disabilities in their own countries.

The Toolkit offers clear guidance on how to address the barriers women with disabilities face when they are affected by violence along with guiding principles to increase awareness about the extent of such abuse and how to prevent it. It insists that those working to eliminate violence against women take the voices and experiences of women with disabilities seriously and include women with disabilities in strategies to respond to violence.

Among its most concrete action items, the Toolkit provides a list of DPOs in Fiji that can help with efforts to respond to violence along with details about their specific areas of expertise, such as sign language interpretation or mobility aids or accessibility audits, and relevant contact information. The Toolkit also provides important information about disability-inclusive development and gender transformative approaches along with practical guidance on how to prepare an appropriate and inclusive venue and ensure accessibility of training materials. It provides useful examples of how a human rights-based approach can be applied to the prevention of violence, such as by ensuring that health-care providers recognise and respect the rights of women with disabilities to make their own decisions about reporting abuse, or taking legal action, and ensuring that police understand it is their responsibility to respond to and intervene in situations of violence, when requested by a woman with a disability.

The Toolkit has had important impacts, not only on the lives of women with disabilities living in Fiji, but also in the way in which women with disabilities are interacting with government officials. The Pacific Disability Forum has been partnering with an organisation of senior police officers to promote training of legal personnel and justice officials using the Toolkit, and Fiji's Ministry of Women, Children and Poverty Alleviation has included a local DPO in its taskforce on eliminating violence against women.

SUPPORTING ACCESS TO JUSTICE FOR SURVIVORS OF VIOLENCE – KENYA AND SOUTH AFRICA

Although young women and girls with intellectual disabilities are at much higher risk of sexual violence than their peers without disabilities are, it is very rare for cases against perpetrators to be brought to court. Two projects in Southern Africa have sought to change that by offering support to survivors of sexual violence and their families and to law enforcement personnel and judicial officers.

The Sexual Assault and Victim Empowerment project was started by Cape Mental Health in 1990 in response to requests for help from the South Africa Police Service and prosecutors in the Department of Justice.[539] The programme assists persons with learning disabilities who have been sexually assaulted. The programme offers social work services to survivors and their families to support survivors in getting over the trauma and to assist families in preventing further abuse. Participants in the programme also receive support before and during court cases against alleged perpetrators, including preparation for court, psychological evaluations, including with respect to the ability of the survivor to testify as a witness, and expert testimony when necessary.

A 2005 evaluation of the first 14 years of the programme concluded that the number of cases of violence against persons with intellectual disabilities prosecuted increased steadily after the programme was established, and a significant number of those cases led to convictions of perpetrators. Law enforcement personnel told researchers that without the programme, fewer claims would be brought to trial, drawing a clear line between the services the programme offers and access to justice for survivors of violence.

In a similar programme, the Kenyan Association for the Intellectually Handicapped (KAIH) partnered with the Coalition on Violence against Women (COVAW) in Kenya to support victims of violence with intellectual disabilities and their families in bringing claims against perpetrators.

The Access to Justice Project works at three levels of legal proceedings. At the pretrial stage, participants identify barriers that persons with intellectual disabilities face in reporting GBV and assist them in getting their cases to court. During trials, KAIH supports victims to ensure they are able to fully participate. Finally, the project collects post-trial data to ensure that perpetrators are brought to justice and sentenced. The concrete means of support that KAIH provides its members include providing communications support to ensure effective communication in court, preserving evidence to ensure that it is admissible, and working with investigators and prosecutors in understanding the case, gathering evidence, and effectively representing persons with intellectual disabilities.[540]

KAIH has also become an important partner to police, prosecutors, and judges along with health-care providers, providing training on how to receive complaints from persons with intellectual disabilities and supporting their efforts in court to pursue perpetrators. KAIH is partnering with Kenya's National Council for Persons with Disabilities on a training programme for members of the judiciary and their staffs on how to work with survivors of violence who have intellectual disabilities and has coordinated with multiple state actors, including Kenya's Judiciary Training Institute and the National Commission on Human Rights. In response to input from proponents of the Access to Justice Project, the Ministry of Justice is promoting training on the inclusion of persons with intellectual disabilities for judges and magistrates.[541]

SUPPORTING AND EMPOWERING SURVIVORS OF VIOLENCE

Care, support, and protection for young persons with disabilities who have been subjected to violence must be an essential component of any national strategy to respond to GBV. Such care should include emergency medical and mental health care, safe accommodation, and long-term access to evidence-based and adequately resourced counselling and empowerment programmes that should be available to young persons with disabilities on an equal basis with others.

'One-stop centres' and other coordinated care models that allow women and girls affected by violence to meet with police officers, make complaints and give testimony, receive necessary medical care and counselling, and secure safe shelter have been shown to be effective strategies for responding to violence in different contexts.[542] But ensuring that such services are available to young women and girls with disabilities requires sustained attention to accessibility. The DisAbled Women's Network (DAWN) Canada, an organisation promoting the rights of women and girls with disabilities, developed a survey tool for governments and other organisations to use to evaluate the response services available to women and girls with disabilities. That tool is the subject of the text box below.

PROMOTING ACCESSIBLE WOMEN'S SHELTERS IN CANADA

The DisAbled Women's Network (DAWN) of Canada has been promoting accessibility in women's shelters for more than 25 years.[543] Safe and accessible shelters are a vital GBV prevention and response service. Whereas there has been increased attention on protecting women with disabilities from GBV and promoting access to justice so that the perpetrators can be prosecuted, very little attention has been paid to ensuring that shelters are accessible and can accommodate women with disabilities.

Shelters can be an important resource for women threatened by GBV, especially intimate partner violence.[544] Shelters provide women a safe place to go for short periods and can prove vital in supporting women's ability to connect to other GBV prevention and response services and justice.[545] The beneficial effects of shelters, however, are not equally shared. Research has shown that shelters disproportionately benefit women who fit into a normative ideal.[546] Women with disabilities represent one group that is often denied full and equal access to shelters and related services, such as temporary housing.

The DisAbled Women's Network began surveying shelters and transitional housing programmes in Canada in 1992. The DisAbled Women's Network is a DPO founded in 1985 by women with disabilities in Canada. The DisAbled Women's Network's mission is to end the poverty, isolation, discrimination, and violence experienced by women with disabilities and deaf women. The office of the Canadian Minister on the Status of Women is a supporter and sponsor of DAWN.

An early pilot study conducted by DAWN on shelters revealed that the vast majority of shelters in Canada were inaccessible to women with disabilities. The DisAbled Women's Network developed an accessibility manual for shelters. Next, DAWN decided to develop a comprehensive survey tool as part of its long-term strategy to raise awareness and to hold shelters accountable across Canada. Using a highly participatory process that brought together all stakeholder groups (women with disabilities and shelter administrators and staff), DAWN developed the National Accessibility and Accommodation Survey. The survey goes into depth asking the staffs of the shelters about their experience providing services to persons with disabilities over the past four years, including specific groups of persons with disabilities and detailed questions regarding the current accessibility and available accommodations within shelters.

The survey, sent by email to shelters, is a freely available resource on DAWN's webpage (link below). It is thorough but extremely easy to use. For instance, the survey asks specific questions about the types of doorknobs or light switches used throughout the premises but then provides helpful photographs or illustrations that survey respondents can simply 'check' or 'tick' off.[547]

The survey's findings revealed that less than one-quarter of shelters provided telephones accessible to persons with hearing impairments, only 17 per cent provided sign language interpretation services, and just 5 per cent provided reading materials in Braille. Results such as these provide a powerful tool for holding GBV prevention and response service providers and the state accountable.

The survey also provides an important tool for governments implementing positive state practices in GBV prevention and response services to conduct baseline and ongoing accessibility assessments of shelter and transitional housing services.

The National Accessibility and Accommodation Survey may be accessed at: www.dawncanada.net/issues/issues/national-accessibility-and-accommodation-survey/

PEER SUPPORT GROUPS FOR WOMEN WITH DISABILITIES IN THE PHILIPPINES

Many initiatives promoting the right of persons with disabilities to GBV prevention and response services focus on direct barriers by advocating for the inclusion of persons with disabilities in GBV laws and policies; improving physical access to police stations, court rooms, and even shelters; ensuring that supported communication is provided when reporting cases; and so forth. The Women with Disability taking Action on Reproductive and Sexual Health promotes many of these same actions, but it also goes further by promoting the agency and rights awareness of women with disabilities. Simply put, laws can be in place, and courtrooms can be accessible, but in many cases, for those laws and courtrooms to be effective, women with disabilities need to know their rights and feel individually empowered in order to claim them. Women and Disability Taking Action on Reproductive and Sexual Health has established a number of peer support groups in the Philippines that bring women with disabilities together to give participants confidence when accessing GBV prevention and response services.

Women and Disability Taking Action on Reproductive and Sexual Health is a collaborative project between Australia and the Philippines that is led by a research team based at the University of Melbourne, Australia and De La Salle University, Philippines. The project works in partnership with DPOs, mainstream SRHR and women's rights organisations, and multiple levels of government, including both national and local policymakers and service providers.[548] Women and Disability Taking Action on Reproductive and Sexual Health originally implemented a participatory research study regarding women with disabilities and SRHR and GBV prevention and response services and then went on to develop and implement pilot strategies to promote women with disabilities' rights on the basis of research findings. Different pilot projects implemented have included awareness-raising workshops for SRHR and GBV prevention and response service providers, developing more effective referral policies to ensure women with disabilities access to services, and, importantly, peer support groups that empower women with disabilities to claim their rights.[549]

Women and Disability Taking Action on Reproductive and Sexual Health's Participatory Actions Groups (PAGS) are peer support groups made up of and facilitated by women with disabilities or, in one group's case, parents of children with disabilities. Every two weeks, these small groups, which are based in Quezon City and Ligao City, meet to discuss SRHR, including GBV. Together, they learn about their rights, voice concerns, discuss personal experiences, refer one another to services, and work together to build up their skills. These include both their individual self-advocacy skills and collective advocacy skills to claim their rights to SRHR and GBV prevention and response services and to speak out about violence against women with disabilities.

As a result of these peer support groups, participants report feeling emotionally supported and having developed the knowledge and confidence they need to report GBV and to demand services. The groups have also met with local government officials and service providers to discuss the changes they need to ensure they have the same access to SRHR and GBV prevention and response services as their peers without disabilities do. [550]

This is a positive practice because it focuses not only on the 'supply' side of ensuring that states have disability inclusive laws, policies, and services in place but also makes sure that the 'demand' side of the relationship between the state as duty bearers and its citizens as rights holders has been addressed by raising the consciousness and supporting persons with disabilities to access those services and to claim their rights to SRHR and a life free from violence.

BUDGETING FOR IMPLEMENTATION

One of the most critical elements for effective implementation of laws and policies addressing GBV is adequate resources. National legislation and national action plans focused on preventing and responding to GBV must take into account the funding necessary to see government commitments through.[551] Laws, policies, and strategies cannot have the effect they are intended to have if they do not ensure adequate resources for their implementation. Budgeting for the inclusion of young persons with disabilities in GBV involves two important national budgeting practices: ensuring that resources are allocated to addressing GBV and ensuring that those resources are disability inclusive. In all cases, resource allocations should be ongoing to ensure the necessary resources to address GBV on a continuous basis. Ensuring ongoing funding is essential because GBV is deeply entrenched in all societies and cannot be adequately addressed in a single or even several funding cycles.[552]

Legislation can be used to ensure adequate budgets aimed at eliminating GBV. This is accomplished through both specific laws aimed at eliminating GBV and broader gender equality legislation. Family laws, for example, should be harmonised with guarantees of gender equality so that women and girls, including those with disabilities, are not discriminated against within these laws in terms of divorce, inheritance, and other rights. For example, Mexico's Law on Access of Women to a Life Free of Violence (2007) clearly states that both the national government and municipalities must ensure adequate budgets for addressing GBV.[553]

Other countries address GBV through broader legislative gender-based budgeting processes. For example, countries are increasingly adopting gender budgeting practices. Similarly, states are also obligated to ensure disability inclusion in budgeting. This is a far less developed practice but includes similar principles of legally obligating the state to develop budgets and allocate resources from a disability perspective to ensure that disability inclusion is mainstreamed into national and subnational budgets, including GBV and gender equality budgets.

Many laws and national action plans also go further by clearly identifying the specific ministries and agencies that will either receive new funds or must take administrative measures to earmark adequate resources for including persons with disabilities in GBV prevention and response services within their regular budgets. Ecuador's National Plan for the Eradication of Gender-Based Violence against Children,

Adolescents and Women (2008), for example, clearly states budgetary commitments for each of the plan's activities and the agency responsible for carrying out that activity.[554] The national plan also specifies that persons with disabilities must be included in these GBV prevention and response services.

ACCOUNTABILITY AND DATA COLLECTION STRATEGIES

Gathering evidence on how national laws are being implemented and enforced in practice is an essential tool for policymakers, helping ensure that policies are benefiting those they

INCLUDING GENDER AND DISABILITY IN FOREIGN ASSISTANCE - AUSTRALIA

States providing international cooperation are obligated to ensure that persons with disabilities are included in their international development programmes under CRPD Article 32. Australia's Department of Foreign Affairs and Trade has emphasised both disability inclusion and gender equality among its budgetary priorities for foreign assistance. The 2017-2018 foreign aid budget allocates Australian Dollar 55 million to the Gender Equality Fund.[555] Australia has also committed itself to being a global leader in disability inclusive development, which is clearly articulated in its *Development for All 2015–2020* strategy. *Development for All* outlines four core principles to Australia's disability inclusive development strategy, included supporting an active role for people with disabilities, developing policies and programmes based on evidence, improving inclusion of a diverse range of people with disabilities, and very importantly, taking into account the interaction of gender and disabilities.[556] These two funding priorities ensure that women and girls and persons with disabilities are mainstreamed across Australia's foreign assistance. They also ensure targeted programmes specifically focused on women and girls with disabilities, including their inclusion in GBV prevention and response services.

In 2013, AusAID published the *Triple Jeopardy: Gender-based violence and human rights violations experienced by women with disabilities in Cambodia* report.[557] This report was funded by the AusAID Development Research Awards Scheme, which is a competitive grants scheme soliciting research that will increase the effectiveness of Australia's aid to developing countries. The call for proposals for this award was specifically designed to produce research that would increase AusAID's effectiveness in addressing GBV for women and girls with disabilities. The research project importantly included both a disability perspective and a gender perspective by partnering with the Cambodian Disabled People's Organisation and the International Women's Development Agency.

The *Triple Jeopardy* research included both quantitative data collecting the prevalence of violence against women with disabilities in comparison with their peers and qualitative data on the unique experiences of violence and the barriers and facilitators accessing services. The

report identified important issues, including women with disabilities experiencing equal rates of violence as women without disabilities and the former's being approximately four times more likely than women without disabilities to also experience controlling behaviour from their partners, such as having to seek permission to leave the home. It also found that more than half of women with disabilities experienced emotional abuse, one quarter experienced physical violence, and nearly 6 per cent experienced sexual violence perpetrated by a family member. The report also found that women and girls with disabilities' dependence on and controlled by family presented a major barrier to these women's ability to report violence and access services. What the report suggests is that both Cambodia and states supporting international development projects, such as Australia, urgently need to ensure that women and girls with disabilities are mainstreamed into their GBV-focused policies and programmes. The report also notes that targeted programmes are necessary to reach persons with disabilities experiencing GBV because of the specific barriers they encounter.

Australia's foreign assistance budgeting represents a positive state practice for including young persons with disabilities in GBV prevention and response services. First, gender equality and disability inclusion are clearly indicated as budget priorities within the foreign assistance budget, and gender and disability mainstreaming are deeply integrated into Australia's development policy. Secondly, Australia has allocated resources specifically on gender, disability, and violence, such as the *Triple Jeopardy* report. Importantly, the *Triple Jeopardy* report forms an evidentiary basis for future budgeting allocations targeting disability inclusion in GBV prevention and response services.

are intended to serve, resources are being effectively used, and governments are meeting their obligations under international and national laws. There are multiple mechanisms for monitoring compliance with national, regional, and international commitments to human rights, especially the right to be free from violence. Some of these are discussed in the following paragraphs.

Monitoring state performance

At the national level, laws can serve as an important tool in guaranteeing effective monitoring and accountability. Several national laws addressing GBV require governments to monitor implementation of the law and to set up institutions to assist. Under Rwanda's 2003 Constitution, for example, the Gender Monitoring Office was established to support government offices implementing new gender equality standards. Its responsibilities now include monitoring the quality of services offered to survivors of violence and monitoring the effectiveness of the government's prevention and response efforts.[558] The Philippine Anti-Violence against Women and their Children Act (2004) created an interagency council on violence against women that brings together representatives from different government agencies to coordinate and monitor implementation of the law.[559]

National human rights institutions (NHRIs) are state-sanctioned and state-funded public bodies with a legal mandate to protect and promote human rights within the state. They can promote young persons with disabilities' right to GBV prevention and response services utilising a variety of strategies. National human rights institutions can implement protection strategies, which can include collecting data and monitoring young persons with disabilities' access to GBV prevention and response services, investigating complaints submitted by individuals and civil society, recommending or providing remedies to address systemic discrimination and ongoing violations, facilitating alternative dispute resolution, and issuing advisory opinions on proposed laws and policies. National human rights institutions can also implement promotion strategies, including public education and awareness raising, research and publication, and training and capacity building across state institutions to understand and fulfil their human rights obligations to ensure the rights of young persons with disabilities. Finally, NHRIs can advise and assist the government, providing advice regarding law, policies, and programmes that should be in place to ensure the government meets its obligations under the CRPD, CEDAW, and other international human rights instruments to which the state is a State Party.[560]

Civil society organisations can also be critical partners in any monitoring strategy. A 2012 review of global policies combating GBV concluded that feminist movements have had a profound influence on the development of policies prohibiting GBV, from raising it as an issue of global concern, advocating for government action on multiple fronts, to ensuring that the elimination of violence remains at the top of international and national agendas.[561]

Recognising the importance of civil society, Brazil's *Maria da Penha Law*, for one, explicitly provides for monitoring of its terms by civil society.[562] Canada's Ministry of Sport and Persons with Disabilities provided funding for DPOs to prepare shadow reports to submit to the Committee on the Rights of Persons with Disabilities and flew representatives to Geneva so they could attend and participate in the government's meeting with the Committee in 2017.[563] At least one DPO, DAWN (Canada), submitted shadow reports to two other committees in addition, including the Committee on the Elimination of Discrimination against Women and the Committee on Economic, Social, and Cultural Rights, leading to strong findings on Canada's responsibilities across a spectrum of human rights.[564] Canada's Minister of Sport and Persons with Disabilities also accompanied Canadian DPOs to the 2017 Conference of States Parties to the CRPD in June 2017 and has solicited Disabled persons' organisations to assist with research on priority issues, including reforms and potential programmes to ensure persons with disabilities are able to exercise legal capacity, to support women and girls with disabilities and eliminate discrimination against them, and to understand and respond to intersectional discrimination against persons with disabilities.[565]

Regional bodies have also developed mechanisms for monitoring compliance with regional commitments to eliminate GBV. The parties to the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women agreed to an independent evaluation process called the Follow-up Mechanism to the Belém do Pará Convention. The Foll-up Mechanism is a systematic evaluation methodology that depends on the exchange of information and

GUIDELINES FOR NATIONAL HUMAN RIGHTS INSTITUTIONS PROMOTING DISABILITY INCLUSION IN ASIA PACIFIC

In 2017, the Asia Pacific Forum for National Human Rights Institutions published *Human Rights and Disability: A Manual for NHRIs.* This important document provides clear guidance to NHRIs regarding their responsibilities and positive implementation practices for promoting the rights of persons with disabilities, including their right to GBV prevention and response services.

The Asia Pacific Forum (APF) is an international organisation with 24 member states. As such, it is a diverse body that includes countries as different in size, culture, and economy as India and Samoa and Australia and Jordan. All member states, however, share a commitment to promoting the human rights of their citizens through NHRIs. The APF supports its member NHRIs through training and skill-building activities, capacity assessments, specialised programmes, and high-level dialogues.[566] The *Human Rights and Disability* manual represents an important training and skill-building tool.

The manual covers the basic concept of disability as a human rights issue, international law promoting disability rights and, most importantly, positive practices NHRIs can implement to promote the rights of persons with disabilities. It clearly delineates NHRIs' responsibility to ensure that States Parties to the CRPD implement 'action to prevent, monitor and prosecute instances of violence, including GBV, against persons with disabilities and to provide support to persons with disabilities who have been the subject of violence'.[567] The manual then provides recommendations and examples of NHRIs promoting the rights of women with disabilities, GBV prevention services, and GBV response services. The manual, for example, recommends that NHRIs analyse their state's penal code and, if necessary, advise the legislature to include language in its domestic violence statutes specifying women and girls with disabilities as a key marginalised group. [568] The manual also cites NHRIs, such as Australia and Portugal's NHRIs, that have conducted studies and issued reports on GBV and women and girls with disabilities to understand the issue and raise awareness. Finally, it recommends that not only NHRIs investigate violations, advise the government, and raise awareness regarding women and girls with disabilities and GBV, but also, when appropriate, refers persons with disabilities affected by GBV to counselling and support services.[569]

technical cooperation between states that are party to the Convention and a committee of experts. States Parties commit to providing information on steps they have taken to satisfy six action areas, including legislation, national plans, access to justice, specialised services, budgets, and information and statistics.[570] At the international level, treaty monitoring bodies provide the same opportunities for oversight and the exchange of information.

The SDGs also include important indicators against which to measure progress on ending VAWG. Though the SDGs are not legally binding, governments are expected to 'take ownership and establish national frameworks for the achievement of the 17 Goals'.[571] The 2030 Agenda for Sustainable Development follows a holistic approach to sustainable development and makes gender equality a priority as both a standalone goal and cross-cutting issue. Sustainable Development Goal 5 specifically targets gender equality and women's empowerment; however, mutually reinforcing linkages between this goal and others exist. For example, registering females at birth (SDG 16.9) provides legal backing against beliefs and practices not conducive to human rights (e.g. child, early, and forced marriage, which is covered under SDG 5.3). Data collected under the SDGs are also required to be disaggregated by income, gender, age, race, ethnicity, migratory status, and disability, among other characteristics, as a way of ensuring that progress under the goals is enjoyed by all, including those most marginalised.

Although data are not yet available on trends that illustrate SDG 5 implementation, the table below details the GBV-related targets under SDG 5.

SUSTAINABLE DEVELOPMENT GOAL 5: ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS

Targets under SDG 5 related to GBV

TARGETS	INDICATORS
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
	5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.3 Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation	5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18
	5.3.2 Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care
	5.6.2 Number of countries with laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information, and education

Data collection and accountability

Data on the prevalence of GBV, particularly violence against children and adolescents, are difficult to access, largely because such violence often goes unreported, and because data collection is often uneven and of differing reliability across countries. Data comparability is complicated by the use of varied definitions of violence and mechanisms for tracking and recording injuries. Young persons with disabilities, especially adolescent girls and young women with disabilities, have been virtually invisible in quantitative and qualitative data regarding GBV, with few states disaggregating the data the states do collect by disability. This invisibility makes it difficult for states to confirm that they are fulfilling their obligations to prevent violence against young persons with disabilities and ensure that they have equal access to necessary response services. The lack of data also prevents policymakers and programme implementers from identifying where appropriate interventions might be needed and robs CSOs representing young persons with disabilities from having important tools for holding their governments accountable.

Efforts should be made to ensure that when GBV incidence data are collected through administrative data, and GBV prevalence data are collected through surveys, that young persons with disabilities are included in this data collection, analysis, and use. Indeed, disability should be mainstreamed in all data collection efforts to ensure the rights of young persons with disabilities are recognised and respected.

The collection of data is a necessary component of a monitoring strategy and is essential to holding states accountable for their commitments under the CRPD, among other international instruments. Article 31 of the CRPD obligates states to 'collect appropriate information, including statistical and research data, to enable them to formulate and implement policies' giving effect to the rights recognised in the Convention. To meet these requirements, states must gather data that are disaggregated not only by gender and age but also by disability. Under Article 31, states are also obligated to disseminate that data and make them accessible to persons with disabilities to ensure such persons' role in monitoring states. Article 31, along with the general principles and Articles 6 (Women with Disabilities) and 7 (Children with Disabilities), requires that data collected are gender and age sensitive, meaning that the data can be disaggregated for purposes of ensuring that women and girls and adolescents and young persons with disabilities are accessing their rights on an equal basis with others. A 2017 report by the UN Secretary General notes, 'Data disaggregation by disability, sex and age is indispensable for understanding the situation of women and girls with disabilities and informing policies to insure their social inclusion.'[572]

In 2016, the United States Agency for International Development (USAID), The Demographic and Health Surveys Programme, and the Washington Group on Disability Statistics released the Demographic and Health Surveys Disability Module. The module is simply inserted into household questionnaires to collect data for all persons in the household age five and older across six core functional domains: seeing, hearing, communication, cognition, walking, and self-care. The module is being piloted in Angola, Haiti, South Africa, Timor-Leste, and Uganda, with potentially promising results.[573]

V. PREVENTING AND RESPONDING TO VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES IN HUMANITARIAN CRISES

In its General Recommendation No. 32 on the gender-related dimensions of refugee status, asylum, nationality, and statelessness of women, the Committee on the Elimination of Discrimination against Women recognised, 'Displacement arising from armed conflict, gender-related persecutions and other serious human rights violations that affect women compounds existing challenges to the elimination of discrimination against women.'[574] As noted in Chapter 1 of this report, young persons with disabilities who are refugees or migrants or otherwise living in vulnerable circumstances are at substantially higher risk of violence than are others. A number of organisations and governments have been working together to respond to the needs of particularly vulnerable populations in humanitarian contexts. The Women's Refugee Commission (WRC) has been an influential advocate for women and girls with disabilities in humanitarian settings, generating necessary research and proposing strategies for service providers. One example of a promising strategy developed in Russia is detailed in the text box below.

MAINSTREAMING WOMEN WITH DISABILITIES INTO REFUGEE GENDER-BASED VIOLENCE PREVENTION AND RESPONSE SERVICES IN RUSSIA

States, NGOs, and international organisations are increasingly addressing GBV within refugee populations. Refugees with disabilities, especially adolescent girls and young women, are at greater risk of violence but are also less likely to be included in efforts to address GBV in refugee camps and other humanitarian settings. The International Rescue Committee (IRC) and WRC recently studied this issue and piloted disability inclusion projects to identify positive practices that states and organisations can implement to ensure that refugees with disabilities access GBV prevention and response services on an equal basis with others.

There are a large number of refugees living throughout the Northern Caucasus region of the Russian Federation. The IRC and WRC partnered with the Chechen Women's Network to implement disability inclusion within the network's GBV programming. This collaboration was based on a comprehensive approach to addressing GBV that included identifying the needs and assessing the barriers faced by women and girls with disabilities, training women with disabilities as GBV awareness trainers, coordinating advocacy for inclusion in GBV prevention and response services, sharing communication tools designed to accommodate specific impairment types, and coordinating action planning workshops. Specific activities included partnering with women from the All-Russia Society of Disabled People to ensure involvement of women with disabilities from the very beginning of the project, developing a handbook for caregivers of children with disabilities, raising awareness by through a disability inclusive performance headlined by a Chechen singer,

and developing inclusive peer networks by hosting social events that brought adolescent girls and young women with disabilities together with women and girls without disabilities.[575]

One of the most important outcomes of the disability inclusion project was raising awareness among GBV prevention and response and refugee service professionals who had not had experience working with women and girls with disabilities. For example, one practitioner commented on what she had learned through her involvement in the collaborative project: 'I never thought that we could do something in a mixed group [girls with and without disabilities], and now I see that it is possible and acceptable, and people need this.'[576]

This project represents an example of positive practices utilising a mainstreaming approach to disability inclusion in refugee services. Mainstream refugee and women's organisations were brought together in partnership with a DPO to address barriers persons with disabilities encountered accessing GBV prevention and response services already being implemented for refugees in the area. The project also includes several disability-specific activities targeted at addressing the specific needs and vulnerabilities of persons with disabilities, such as developing a handbook educating caregivers of children with disabilities about their children's rights and available services.

VI. CONCLUSION

This chapter has focused on promising steps that states have taken to prevent and respond to violence against young persons with disabilities, especially young women and girls with disabilities. As noted above, nearly all these steps have been in partnership with and often come to fruition because of the advocacy and push from CSOs and non-state actors. Throughout, this chapter has argued that states, as duty-bearers, must take responsibility to ensure that young persons with disabilities can live free from violence. One of the main priorities for state action to accomplish this goal is addressing norms and stereotypes that promote gender inequalities and permit gendered discrimination against young persons with disabilities. To ensure that young persons with disabilities are provided the same protections from violence afforded their peers without disabilities, laws, policies, and programmes addressing GBV and violence against women should explicitly recognise the multiple forms of discrimination to which young persons with disabilities, especially young women and girls with disabilities, are routinely subjected, and outline clear strategies to target those forms of violence, while providing support to those at risk of violence or who have been victims of it. That includes the mainstreaming of young persons with disabilities into all policies and programmes intended to promote gender-equality and respond to GBV. Youth-friendly and disability inclusive provide two service concepts important for ensuring that not only are services accessible but also inclusive from the perspective of the intended rights holders: young persons with disabilities. The next chapter will focus on accessing and exercising SRHR for young persons with disabilities. As with prevention and response to GBV, ensuring the inclusion of young persons with disabilities in core SRHR programmes and services is an essential step.

// CHAPTER 5

REALISING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR YOUNG PERSONS WITH DISABILITIES

I. INTRODUCTION

All individuals have the right to decide when to enter into a sexual relationship and with whom, whether and when to marry, and if and when to parent a child. They should also have the knowledge and means to protect themselves from sexually transmitted infections (STIs) and live a healthy and fulfilling sexual life. Research shows that young persons with disabilities have the same concerns and interests with regard to sexuality, relationships, and identity as their peers do, and engage in similar sexual activities and behaviours, yet have far less access to the means to have healthy and satisfying sexual lives.

They face numerous barriers to achieving these rights. Misconceptions about disability and sexuality, discriminatory laws and policies, and inaccessible or insensitive services can prevent young persons with disabilities from fully enjoying their sexual and reproductive health and rights (SRHR).

- Studies show that adolescents with disabilities feel socially isolated and lack social confidence and sexual self-esteem.[577] Parents, teachers, and health-care providers report feeling anxious, untrained, and unconfident about discussing sexuality with children and adolescents with disabilities, particularly children and adolescents with intellectual disabilities, which makes it less likely that children with disabilities will receive necessary information about puberty and sexuality.[578]

- Young persons with disabilities have been found to have low levels of sexual and reproductive health (SRH) knowledge, with girls and young women having the least knowledge.[579] Girls and young women with disabilities are not seen as needing information about their SRHR or as capable of making their own decisions about their sexual and reproductive lives, which puts them at risk for sexual abuse, unplanned pregnancy, and STIs.[580]

- Low levels of sexual education, including education about human immunodeficiency virus (HIV) and STI transmission and prevention, can lead to risky sexual behaviours. Studies have shown that adolescents with disabilities report a low level of condom and contraceptive use, engage in casual and transactional sex, and have multiple partners during their lifetime.[581] Evidence indicates that young persons with disabilities have the same or higher risk of contracting STIs as their peers without disabilities do, but testing for HIV is lower among young persons with disabilities.[582]

- Young persons with disabilities also report low levels of access to family planning and reproductive health-care services. In one study in India, only 22 per cent of women with disabilities reported having had regular gynaecology visits,[583] and in Uganda, 77 per cent of sexually active women with disabilities between the ages of 15 and 25 who participated in a study reported never having used any form of contraception.[584]

This chapter focuses on how states can promote access to and exercise of SRHR for young persons with disabilities. It begins from the premise recognised by the international frameworks discussed in Chapter 3 that SRHR should never be viewed separately from other human rights. Rather, SRHR should be understood as one fundamental element of an integrated framework of human rights. Realisation of SRHR necessarily requires states to meet their obligations with respect to other rights, such as the rights to education, employment, and health.[585]

> Sexuality and disability cannot be left to a simple mandate —these are such sensitive issues; they cannot be left simply to law but need a broader, systemic approach.
>
> –Nidhi Goyal,
> Gender and Disability Rights Activist

This integrated approach recognises that ensuring that young persons with disabilities have access to human rights, including high-quality education or economic opportunities, promotes their ability to exercise their rights to SRH. Quality education supports young persons with disabilities' ability to read and understand information on SRHR presented in public awareness campaigns or offered to them by a health-care provider.

SEXUALITY AND DISABILITY AMONG YOUNG PERSONS WITH DISABILITIES IN MADRID AND QUITO[586]

In interviews with young persons with disabilities[587] in Madrid, Spain, and Quito, Ecuador, they discussed how they learned about sex, when they became sexually active, and changes they would like to see in education about SRH. Among those interviewed in Spain, all were sexually active and had been since their early teens. Their formal education on sexuality and reproduction was limited and typically did not begin until age 14–15, by which time all had engaged in some sexual behaviour. One young man did not talk about sex with his mother until he was 18, long after he had become sexually active. Some had engaged in risky practices, which they recognised, but had not felt comfortable discussing these practices with their health-care providers.

Most of the participants learned about sex and sexuality from television, the internet, friends, and online social networking sites, and not all the information they received was accurate. Some in Spain had had experiences with youth centre hotlines offering counselling on family planning services but said there were few places they could go to talk with someone with medical knowledge about family planning services. None of them had received any training or information on gender-based violence (GBV), including how to recognise it, prevent it, or respond to it.

In Ecuador, young persons with disabilities had had similar experiences. Members of a sports club reported that no one ever talked about sexuality and persons with disabilities. They had not received any formal sexuality education until high school, and then it had been very general and did not include any mention of persons with disabilities. According to one, 'What I know is through the internet.'

Parents of children with disabilities participating in a focus group acknowledged that they had not thought about talking with their children about sex. One mother in Quito said, 'This topic is a taboo, even for young persons without disabilities. For my kids, [sex] is abstract. As a thing we never consider that it is a possibility.'

SRHR service providers in Spain reported that the quality of sexuality education in schools depends on the providers and that in many cases, the information provided is brief and basic. Sexuality education for persons with disabilities and their families is very limited and typically informal. According to one national disabled persons' organisation (DPO) working with young persons with intellectual impairments, information on sexuality education, support, or services for maternal or sexual health for persons with intellectual disabilities is difficult to find and rarely adapted for their needs.

Those interviewed in Madrid advocated starting sexuality education much earlier than age 14 so that young people have information they need when their bodies begin to change. They also recommended making information about sexuality and disability easily available for parents of children with disabilities and giving these parents the tools to talk about sex with their children. Information about sexuality also needed to be made accessible to young persons with different impairment types, especially for those with intellectual disabilities, and shared widely among DPOs and SRHR service providers. Representatives from DPOs and SRHR service providers advocated for greater collaboration and a national forum through which they could share information and learn about each other's activities, initiatives, and programmes.

Among the young people interviewed, those working and living in Madrid realised they had access to far more resources than did young persons with disabilities who were more isolated, especially those in rural communities. To reach those young people, they called for a national campaign to promote education and share information widely on SRH for all young people, especially those with disabilities.

When young persons with disabilities are able to exercise their human rights on the same basis as young persons without disabilities are, they are more likely to become active, engaged, and productive members of their communities in ways from which all will benefit. Ensuring SRHR for young persons with disabilities thus advances all civil, political, economic, social, and cultural rights by ensuring young persons with disabilities can exercise agency in decisions about their own lives and freely and fully exercise all of their human rights on an equal basis with others.[588]

> Because of the family planning method I availed of, I have more freedom to go where I want to go, as [I] no longer am constantly pregnant and can overcome the fear of becoming pregnant again . . . . The first one in relation to work, I applied to factory work. I have also enrolled in alternative learning system . . . and can graduate from school . . . after [the initiative improving knowledge and access to SRHR], there has been many opportunities.
>
> –W-DARE Project participatory action group female participant, Quezon City, Philippines[589]

CHAPTER OVERVIEW

This chapter opens with a discussion of the international standards applicable to SRHR and continues with a review of national strategies to achieve these rights for young persons with disabilities. As in Chapter 4 of this report, each section incorporates case studies to illustrate specific steps states have been taken to advance SRHR for young persons with disabilities. The strategies discussed range from adopting an enabling legal environment through the passage of laws ensuring rights to SRHR for all people, including young persons with disabilities, to policy directives that incorporate the needs of young persons with disabilities. They also include direct programmatic interventions such as providing comprehensive sexuality education (CSE); offering access to SRH services, including maternal health, family planning, and contraceptive services; inclusion in HIV/AIDS and STIs policies and programmes; and devising accountability and data collection strategies to ensure effective monitoring and implementation of state commitments.

Many of the initiatives described are the products of partnerships with civil society and reflect coordination of services with multiple stakeholders, itself a good practice. Each is acknowledged as a single step in a broader, interdependent process to achieve the rights of young persons with disabilities. For governments to ensure that young persons with disabilities can enjoy their rights and freedoms on the same basis as young persons without disabilities, they must adopt a comprehensive approach that informs and engages stakeholders across multiple sectors, including young persons with disabilities themselves. Steps toward that engagement are discussed below.[590]

KEY POINTS

- The **International Conference on Population and Development (ICPD) Programme of Action** affirms that young persons with disabilities have a right to receive, on an equal basis with others, at a minimum, contraceptive services, access to safe abortion where it is not against the law, maternity care, and prevention and treatment of STIs and HIV, as services necessary for sexual health.
- Young persons with disabilities, especially young women and adolescent girls, face **persistent inequalities to access to and enjoyment of SRHR** that are compounded by discrimination on the basis of age, gender, disability, and other identities and characteristics, such as poverty, race and ethnicity, membership in an indigenous group, caste, and so forth.
- States should pursue a **comprehensive approach** that ensures both **formal and substantive equality for young persons with disabilities in enjoyment of SRHR by mainstreaming** young persons with disabilities into all SRHR laws, policies, and programmes **and developing, when appropriate, targeted programmes** addressing the most important barriers to SRHR for young persons with disabilities.

- **Promising strategies** for states to effectively ensure SRHR for young persons with disabilities include:
  - **Partner with civil society organisations (CSOs)** representing young persons with disabilities in the development of SRHR policies and programmes;
  - **Raise awareness** of the rights of young persons with disabilities within government and among service providers;
  - **Ensure access to and inclusion in existing SRHR programmes,** as the majority of young persons with disabilities can and should benefit from the same SRHR programmes as the general population does;
  - **Address inclusion in SRHR policy, laws, and budgets** at the national and local levels by ensuring they are youth- and disability-inclusive; and
  - **Build a base of evidence** by continually collecting and disseminating research data on SRHR for young persons with disabilities.
- **Ensure young persons have access to and are included in CSE** that is based on human rights, addresses gender equality, is thorough and scientifically accurate, takes place in safe and healthy environments, links to comprehensive services, is taught using participatory methods, strengthens youth advocacy and civic engagement, is is culturally sensitive, and reaches across formal and informal sectors.
- **All SRHR programmatic interventions should be youth-friendly and disability-inclusive** to ensure they are accessible, acceptable, equitable, appropriate, and effective for young persons with disabilities.
- States should **collect data in a disability-, gender-, and youth- inclusive manner** that allows researchers to disaggregate by disability status, gender, age, and other appropriate characteristics and identities to clearly identify gaps and inequalities across groups.

EQUAL RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR YOUNG PERSONS WITH DISABILITIES

Inequality is a strong predictor of ill health, including sexual health.[591] It manifests in differential access to health-care services and resources, ability to participate in the making of laws and policies, and ability to seek remedies in the event of abuses or violations of rights. The Convention on the Rights of Persons with Disabilities (CRPD) mandates that all persons with disabilities be recognised as equal, with the same rights and fundamental freedoms of persons without disabilities, including with respect to their sexual and reproductive lives.

To achieve this goal for young persons with disabilities requires not only the elimination of discriminatory laws and regulations and the guarantee of equality as a matter of law (formal equality) but also attention to the distinct needs of young persons with disabilities. The latter concept refers to substantive equality that recognises that even policies and practices that meet the needs of most rights holders may nevertheless fail to address the specific needs of marginalised groups. [592]

Substantive equality with regard to SRHR requires recognition that young persons with disabilities should be able to enjoy not only the same range and quality of SRH services as their peers without disabilities do, but also those services they may need specifically because of their disabilities. It also requires reasonable accommodations where necessary to enable young persons with disabilities to fully access SRH services on an equal basis. Accommodations might include ensuring facilities are physically accessible, information is available in accessible and age-appropriate formats, and young persons with disabilities have support appropriate for their age to make decisions about their health. Substantive equality also demands that health care be provided to young persons with disabilities in a respectful and dignified manner that does not discriminate against young persons with disabilities or perpetuate their marginalisation.[593]

II. GLOBAL NORMS AND STANDARDS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND THE INCLUSION OF YOUNG PERSONS WITH DISABILITIES

There is a strong international framework recognising the importance of SRHR to the fulfilment of human rights overall and the achievement of sustainable development. The right to SRH is a core component of the right to health recognised in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) (Art. 12), in the Convention on the Elimination of Discrimination against Women (CEDAW) (Art. 12), in the Convention on the Rights of the Child (CRC) (Arts. 17, 23-25, and 27), and in the CRPD (Arts. 23 and 25), but is also indivisible from other human rights, including rights to life, liberty, and security of the person and rights to privacy, non-discrimination, and equality.[594]

The CRPD in particular affirms the right of all persons with disabilities to make decisions for themselves about their SRH, freely and without coercion (Arts. 12 and 25.) It prohibits discrimination against persons with disabilities in all aspects of their lives, including in matters relating to marriage, family, parenthood, and relationships and protects the rights of persons with disabilities to make decisions about their SRH, including deciding freely on the timing and

spacing of their children (Art. 23.) The CRPD calls on states to respect the inherent dignity and humanity of persons with disabilities, including the reality that persons with disabilities are sexual beings in the same way as their peers without disabilities are, and obligates states to ensure persons with disabilities have access to quality and affordable SRH services (Art. 25.).

The steps for achieving these rights were first outlined and agreed to in the ICPD Programme of Action in 1994 and have been reinforced and expanded on since. As with the realisation of all human rights, the realisation of SRHR for young persons with disabilities requires states as duty-bearers to respect, protect, and fulfil young persons' rights to SRH regardless of the social, political, or cultural norms that may prevail at the national level.[595] State action must satisfy the core human rights principles of equality, non-discrimination, participation, inclusion, accountability, and rule of law to ensure the rights of young persons with disabilities are recognised and respected.

This demands that states:

- Do not act in a way that interferes with the enjoyment of SRHR by young persons with disabilities, including the rights to marry and start a family. States should not restrict access to contraception, withhold or misrepresent health information, or utilise or authorise coercive medical practices.

- Take measures to prevent third parties from interfering with the enjoyment of SRHR by young persons with disabilities and impose sanctions for the violation of these rights. National legislation should ensure equal access to health care, require health-care providers to comply with human rights standards, and protect individuals from beliefs and practices not conducive to human rights.

- Adopt legislative, budgetary, administrative, and judicial measures toward the full realisation of human rights, including SRHR for young persons with disabilities. States should ensure that decision-making processes are transparent and information regarding their rights is available to rights holders in accessible formats.[596]

The implementation of plans, policies, and programmes that support SRHR for young persons with disabilities must consider not only what the law demands but also what the needs of young persons with disabilities require. Formal rights to equal access to SRH services will mean little if such services are not accessible to young persons with disabilities in practice or are of low quality or too costly for them to afford or if health-care providers are not respectful or willing to provide these young people with necessary care. Similarly, if young persons with disabilities are unaware of their rights or have no means to realise them, formal guarantees of non-discrimination will have little effect.

> Sexual and reproductive health and rights are human rights. They are not only an integral part of the right to health, but are necessary for the enjoyment of many other human rights . . . . As such, sexual and reproductive health and rights are universal and inalienable, indivisible, interdependent and interrelated.[597]
>
> –Catalina Devandas-Aguilar, Special Rapporteur on the Rights of Persons with Disabilities

Despite states' obligations to respect, protect, and fulfil the SRHR of young persons with

disabilities, many gaps still exist. Reviews of progress on the ICPD Programme of Action have identified:

- Inequalities in access to and enjoyment of SRHR, education, and information, with the poorest women and adolescents, including those living in rural areas, most frequently denied access to such services;
- Persistently poor quality SRH services that fall far short of human rights standards and of public health and medical standards; and
- Absence of accountability mechanisms to monitor and address inequalities in access to services or to track quality of services available.[598]

For young persons with disabilities, inequalities in access to services are often compounded by discriminatory attitudes and stigma around disability. These lead to these young persons' being excluded from consideration in public campaigns to promote SRH education, including campaigns on the risk of human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) and other STIs, denied information about sexuality and reproduction available to young persons without disabilities, unable to communicate with health-care providers who are inadequately trained to meet young persons with disabilities' needs, and refused the right to maintain their own fertility in the face of coercion or forcible intervention in their reproductive lives. A study on the experiences of deaf people trying to access SRH services in Ghana found that communication barriers, ignorance about deafness, attitudes toward deaf people, illiteracy among deaf people, the absence of privacy and confidentiality at SRH service centres, limited time for consultation, and poor interpretive skills among sign language interpreters and a lack of trust combined to discourage persons with disabilities from seeking needed SRH services and denied them access to high-quality and accurate information about their SRH.[599]

THE AAAQ FRAMEWORK FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR YOUNG PERSONS WITH DISABILITIES

Sexual and reproductive health and rights for young persons with disabilities should be assessed from multiple perspectives. One framework for doing so is the AAAQ Framework. AAAQ stands for availability, accessibility, acceptability, and quality. This rights-based framework has been utilised throughout the United Nations (UN) system and the broader health and development systems globally, which then apply it to a broad range of issues, including assessing health facilities, goods, and services for inclusion of persons with disabilities.[600] The UN Committee on Economic, Social, and Cultural Rights (CESCR) has defined four normative components of the right to health and all the underlying determinants of health.[601] These norms have been adapted to young persons with disabilities as follows:

- **Availability:** An adequate number of functioning health-care facilities, services, goods, and programmes should be available to provide the population with the fullest possible range of SRH care. This includes ensuring the availability of facilities, goods, and services for the guarantee of the underlying determinants of the realisation of the right to SRH, such as safe and potable drinking water and adequate sanitation facilities, hospitals, and clinics.

  Ensuring the availability of trained medical and professional personnel and skilled providers who are trained to perform the full range of SRH services is a critical component of the right to health.[602] In addition, essential medicines should be available, including a wide range of contraceptive methods such as condoms and emergency contraception, medicines for abortion where it is not against the law, and medicines for post-abortion care regardless of whether abortion is legal, and medicines, including generic medicines, for the prevention and treatment of STIs and HIV,[603] along with essential, life-saving medicines and commodities to ensure maternal and newborn survival and health.

  Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services; an adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.[604]

- **Accessibility:** Health facilities, goods, information, and services related to SRH should be accessible to all individuals and groups without discrimination and free from barriers so that persons in need can receive evidence-based and timely services and information. Accessibility includes physical accessibility, affordability, and information accessibility.

- **Acceptability:** All facilities, goods, information, and services related to SRH must be respectful of the culture of individuals, minorities, peoples, and communities and sensitive to gender, age, disability, sexual diversity, and life-cycle requirements. However, this cannot be used to justify the refusal to provide tailored facilities, goods, information, and services to specific groups.

- **Quality:** Facilities, goods, information, and services related to SRH must be of good quality, meaning that they are evidence based and scientifically and medically appropriate and up to date. This requires trained and skilled health-care personnel and scientifically approved and unexpired drugs and equipment. The failure or refusal to incorporate technological advancements and innovations in the provision of SRH services, such as medication for abortion, where it is not against the law,[605] assisted reproductive technologies, and advancements in the treatment of HIV and AIDS and other STIs, along with interventions to prevent maternal and newborn mortality and morbidity, jeopardises the quality of care.

THE AAAQ FRAMEWORK FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PERSONS WITH DISABILITIES

AVAILABILITY

An adequate number of functioning health care facilities, services, goods, and programmes should be available to provide the population with the fullest possible range of sexual and reproductive health services.

ACCESSIBILITY

Health facilities, goods, information, and services related to sexual and reproductive health services should be accessible to all individuals and groups without discrimination and free from barriers. Accessibility includes physical accessibility, affordability, and information accessibility.

ACCEPTABILITY

All facilities, goods, information, and services related to sexual and reproductive health must be respectful of the culture of individuals, minorities, peoples and communities, and sensitive to gender, age, disability, sexual diversity and life cycles requirements.

QUALITY

Facilities, goods, information, and services related to sexual and reproductive health must be of good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date.

Note: A text alternative for this infographic is available as an annex here.

Source: Committee on Economic, Social, and Cultural Rights (2016). *General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights).*

The AAAQ Framework provides a human-rights based framework through which states and health-care providers, among others, can assess and evaluate policy and programmatic interventions. Implementation of the AAAQ Framework necessarily requires sensitivity to the particular needs and characteristics of those accessing health services, including SRH services, as what is acceptable to a 40-year-old woman is likely to be different from what is acceptable to a 10-year-old girl.[606]

The AAAQ Framework can be used for identifying and monitoring all SRHR state practices from the perspective of access and equality for young persons with disabilities.

KEY DEFINITIONS

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, along with the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the reproductive rights of all persons must be respected, protected, and fulfilled.

Sexuality is a central aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease of infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

Reproductive rights include the right of all men and women to be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice along with other methods of their choice for regulation of fertility that are not against the law and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and that will provide couples with the best chance of having a healthy infant.

Reproductive health care is the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and STIs.

Source: WHO, Sexual health, human rights and the law, 2015; Programme of Action adopted at the International Conference on Population and Development (1994).

Fully realising the rights articulated in the ICPD Programme of Action, the Beijing Declaration and Platform for Action, the CEDAW, the CRC, the ICESCR and the CRPD, along with the 2030 Agenda for Sustainable Development, requires states to meet their commitments to respect, protect, and fulfil the human rights of young persons with disabilities in all their dimensions. The following sections describe promising steps states are taking to satisfy their obligations and fulfil the rights of young persons with disabilities.

III. PROMISING NATIONAL STRATEGIES AND REGIONAL INITIATIVES TO ENSURE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR YOUNG PERSONS WITH DISABILITIES

Recognising that SRHR are vital to the ability of young persons with disabilities to realise their full potential, the following sections discuss promising steps states are taking to advance those rights and to incorporate new guidance for policymakers, service providers, and relevant stakeholders.

COMPREHENSIVE RIGHTS-BASED LEGAL FRAMEWORKS

The obligation to respect, protect, and fulfil human rights, including the right to the highest attainable standard of heath, requires states to bring their laws, regulations, and policies into compliance with international and regional human rights standards.[607] This requires both the elimination of all laws and regulations that restrict the free access of young persons with disabilities to SRH services[608] and the adoption of laws and regulations that support the rights of young persons with disabilities to freely pursue fulfilling sexual lives and attain SRH.

Laws matter because they set the rules of society and can provide the framework for the implementation of sexual-health-related policies, programmes, and services. They can provide guarantees, but they may also create limitations.[609]

Particular barriers to achieving SRHR that legal regulation can eliminate include the following:[610]

- **Discrimination on the basis of age.** In many countries, adolescents under the age of 18 are not permitted to consent to sexual or reproductive health treatment on their own, and social norms prohibit premarital sexual activity, making it difficult for young persons to obtain necessary services. States are required by international and regional human rights laws to ensure medical counselling and advice is available and accessible to all adolescents, regardless of age, marital status, sex, or disability. They should also recognise the rights of adolescents, including adolescents with disabilities, to take increasing responsibility for decisions about their health and guarantee the rights of adolescents to give or refuse consent to treatment.[611]

- **Discrimination on the basis of marital status.** In some countries, laws and policies restrict access to contraceptive and other SRH services to married women and require a husband's consent prior to permitting treatment. National laws should eliminate all restrictions on women's and young people's access to health services and ensure that all women, including young women with disabilities, have access to contraceptive and reproductive health services.

- **Discrimination on the basis of disability.** All persons with disabilities should be provided the same range, quality, and standard of affordable health care as persons without disabilities receive, including with respect to their SRH. National laws can ensure that health services are provided in accessible places and that health information is available in accessible formats for all types of disabilities,

REGIONAL STRATEGIC GUIDANCE TO INCREASE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR YOUNG PERSONS WITH DISABILITIES IN EAST AND SOUTHERN AFRICA[612]

In October 2017, the United Nations Population Fund (UNFPA) and UKaid (through the United Kingdom's Department for International Development) introduced the **Regional Strategic Guidance** as a tool for policymakers and advocates to guide planning, programming, and resourcing to advance the SRHR of young persons with disabilities within East and Southern Africa. The Regional Strategic Guidance adopts a theory of change that will lead to young persons with disabilities being empowered to access SRH services and to be free to enjoy their SRHR, with increased agency and autonomy, reducing vulnerability and risk.

Key recommendations include that:

- Governments should ensure that young persons with disabilities are represented in mainstream responses to SRHR, HIV, GBV, social protection, and economic development while also addressing the SRHR needs of young persons with disabilities in disability-focused programmes.
- The rights of young persons with disabilities should be mainstreamed across all relevant CSOs, such as women's rights organisations and human rights organisations, and across multiple sectors, such as health, education, labour, infrastructure, and justice.
- Relevant workforce, such as health-care providers and educators, should be trained and sensitised on the needs of young persons with disabilities as part of existing efforts to train providers on youth-friendly services and CSE. Governments should seek to train and engage persons with disabilities to be part of the workforce to provide services to young persons with disabilities.
- Governments and relevant stakeholders should develop materials to help assess service delivery. These may include checklists and criteria to assess whether clinics offer accessible services and information to young persons with disabilities, to identify 'hotspots' where no youth- and disability-friendly services are available, and to guide financial and technical support to areas of greatest need.

The Regional Strategic Guidance offers a starting point for governments and stakeholders to develop and assess national plans of action to ensure that young persons with disabilities are fully included within national and regional policies and programmes and are no longer at risk of being left behind.

including the visually and hearing impaired and those with intellectual disabilities. Young persons with disabilities should have access to the support they may need to make decisions for themselves about their SRH.

- **Availability and quality of health-care facilities and providers.** Some countries have laws that restrict who can provide certain services, including those for which nurses, midwives, and others can be competently trained. Where there are few qualified doctors, national laws can permit different levels of appropriately trained and competent providers to perform needed reproductive services.

- **Ensuring privacy and confidentiality.** The right to privacy and confidentiality protects young persons, especially young persons with disabilities, from interference in sensitive decisions about their SRH. Privacy protections can encourage young persons with disabilities to seek SRH services without risking intimidation or coercion by caregivers or family and community members.

- **Fostering informed decision-making.** National laws should protect young persons with disabilities from pressure, coercion, or force with respect to decisions about their SRH and should ensure that they have sufficient information available to them, in fully accessible formats, to enable them to make decisions freely and without undue influence. Policies or practices that permit the censoring, withholding, or intentional misrepresentation of information about sexual or reproductive health should be eliminated.

- **Skilled health care personnel.** National laws and regulations can ensure that all health-care providers are adequately trained to provide services to relevant populations, including young persons with disabilities. Health-care providers who are unfamiliar with impairment types or are untrained in supported communication with young persons with disabilities might be unable or unwilling to provide appropriate health care. States are obligated to ensure the adequate training and support of health-care providers to enable competent care for all, including young persons with disabilities.

- **Discrimination on the basis of HIV status.** Some countries have criminalised transmission of or exposure to HIV, which can inhibit access to health services by young persons with disabilities who test positive and which contributes to discriminatory attitudes. In some places, women living with HIV report having been sterilised without their consent as a means of preventing transmission from mother to child. National laws can prevent HIV status from being used as the basis of differential treatment or denial of health services.

This is a non-exhaustive list of the areas in which legal regulation may be most effective in promoting young persons with disabilities' access to SRH and necessary services. It is grounded in the obligations contained in the international and regional instruments discussed at length in Chapter 3 that commit states to respect, protect, and fulfil the rights of young persons with disabilities, on the same basis as states do others.

Many states have acted on these commitments. The right to health care is incorporated in many national constitutions and other laws,[613] and states have acted to ensure the fulfilment of particular rights such as the right to contraception. India's new Rights of Persons with

Disabilities Act, adopted in December 2016, recognises the rights of persons with disabilities to have access to information about reproduction and family planning and expressly prohibits any procedure to restrict or eliminate the fertility of a person with a disability without free and informed consent.[614] It also recognises the right of children with disabilities to freely express their views on matters affecting them and prohibits discriminatory treatment of women and children with disabilities.[615] The Act calls for financial support for women with disabilities who choose to have children and requires 'barrier-free access in all parts of Government and private hospitals and other health care institutions and centres'.[616] Finally, it obligates the government and local authorities to take active steps to promote SRH for women with disabilities.[617]

In Portugal, the Constitution guarantees a right to family planning, and national legislation requires that condoms be available in schools because of their importance in preventing HIV and STI transmission and that all hospitals providing obstetric or gynaecological care in the national health service offer family planning counselling and free contraceptives.[618]

The principle of non-discrimination is also widely recognised. The Constitution of Mozambique prohibits discrimination against children with disabilities, and national legislation offers protections for persons with disabilities living with HIV/AIDS and guarantees the right of children with disabilities to education.[619] The Persons with Disabilities Act 14 of 2003 in Kenya provides for equality of rights and opportunities for persons with disabilities in Kenya, and the National Adolescent Sexual and Reproductive Health Policy, discussed in detail below, recognises the particular needs and rights of young persons with disabilities. Egypt's current constitution, adopted in 2014, recognises the equal rights of persons with disabilities, including the right to health, and commits the state to providing quality, comprehensive health-care services that are accessible to all, including persons with disabilities. The Constitution of Morocco similarly recognises the principle of equality, including for those with disabilities, and obligates the state to integrate persons with disabilities into social and civil life and to facilitate their enjoyment of those rights and freedoms available to all.

A recent review of the first cycle of reporting under the Universal Periodic Review mechanism found that states have taken a number of additional actions to advance SRHR in national legislation.[620] Azerbaijan increased the minimum age of marriage to 18 years and criminalised the act of forcing women into marriage, and Cuba introduced a sexuality education curriculum throughout the national education system for all levels of education. Pakistan criminalised forced marriages, child marriages, and other customary practices that discriminate against women and girls, and in Turkmenistan, the government expanded education on HIV prevention for young people.[621]

As noted in Chapter 4, laws are most likely to be put into effect when they are supported by implementing policies and programmes. At the regional level, strategies adopted by Member States in the African Union and health and education ministers in Latin America and the Caribbean affirm the importance of CSE in the realisation of SRHR and the prevention of HIV and STIs, respectively.[622] The 2006 Maputo Plan of Action implemented the Sexual and Reproductive Health and Rights Continental Policy Framework, which led to significant improvements in certain areas of SRHR, including reductions in HIV prevalence among young people aged 15–24.[623]

Both South Africa and Kenya have recently adopted national policies to address access to SRH by young persons that expressly include young persons with disabilities. The strategies adopted are detailed in the text boxes below.

NATIONAL ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH POLICY (2015) – KENYA[624]

In part in response to changing demographics that have rapidly expanded the youth population in Kenya, and in part to align with changes in its governance structure, the Kenyan government adopted a new National Adolescent Sexual and Reproductive Health Policy in 2015 to meet the needs of adolescents. The policy is designed to provide guidance to government ministries and development partners and to support an integrated approach that improves the SRH of adolescents and supports the realisation of their full potential to contribute to development.

It is grounded in six core principles:

- **Respect for human rights and fundamental freedoms**, including the right to life, human dignity, equality, and freedom from discrimination on the basis of gender, sex, age, disability, health status, geographical location or social, cultural, and religious beliefs and practices.
- **Responsiveness to varying SRH needs of adolescents** in provision of care.
- **Provision of holistic and integrated [adolescent] SRH information and services** through multipronged and multi-sectoral approaches that are effective and efficient in reaching adolescents with information and services.
- **Recognition of the critical role parents, guardians, and communities play** in the promotion of SRHR of adolescents.
- **Involvement of adolescents in the planning, implementation, monitoring, and evaluation of adolescent SRHR programmes** for effective programme implementation, promotion of partnerships, and creation of open channels of communication for achievement of mutual goals.
- **Utilisation of evidence-based interventions and programming**.

The policy explicitly recognises the unique challenges young persons with disabilities face in accessing health services, including SRH services, and the related risks to their SRH. It calls for provision of disability-friendly SRH information and services; collection and use of data on marginalised adolescents to guide future programming; support for linkages between SRH programmes and livelihood opportunities, especially for marginalised adolescents; and the development of data tools that capture evidence on adolescents with disabilities.

NATIONAL ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FRAMEWORK STRATEGY (2014-2019) – SOUTH AFRICA[625]

South Africa's National Adolescent Sexual and Reproductive Health and Rights Framework Strategy commits stakeholders to a multi-stakeholder and multi-sectoral approach that targets the needs of all adolescents, including adolescents with disabilities. The Framework Strategy sets five priorities:

- Increased coordination, collaboration, information and knowledge sharing on adolescent SRHR amongst stakeholders;
- Developing innovative approaches to comprehensive SRHR information, education and counselling for adolescents;
- Strengthening adolescent SRHR service delivery and support on various health concerns;
- Creating effective community supportive networks for adolescents; and
- Formulating evidence-based revisions of legislation, policies, strategies and guidelines on adolescent SRHR.

To address these priorities for adolescents with disabilities, the Framework Strategy commits to providing 'non-conflicting, gender sensitive, culturally appropriate and positive SRHR messaging' to adolescents, including those with disabilities; devising 'effective and appropriate communication mediums on adolescent SRHR for adolescents with disabilities, especially those in rural areas; creating effective community support networks in part by working with parents and caregivers of adolescents with disabilities on how to support reproductive health functions and rights; and creating safe platforms that promote gender equality and encourage socialisation to reduce stigma and discriminatory prejudices.

The Framework Strategy proposes to 'inculcate[e] a core value system [in adolescents] that does not ascribe to gender stereotyping or other prejudices but instead promotes and emphasises non-discriminatory attitudes, respect for human dignity, gender equality, gender equity, [and] receipt of rights with responsibility, accountability, empathy and tolerance', along with building the capacity of adolescents to make informed decisions about their own SRHR and feel free to access and enjoy SRHR, without fear of stigma.

It vests oversight for implementation, monitoring, and evaluation of the progress of the Framework Strategy in an inter-ministerial committee that is supported by a technical committee tasked with regular reporting on progress.

SERVICES AND PROGRAMMATIC INTERVENTIONS

Substantive equality in SRH demands that young persons with disabilities not only have recognition under national laws and policies on the same basis as their peers without disabilities, but also that they have equal access to the same SRH information and services available to their peers, and services that address their specific needs. This means at a minimum that adolescent-friendly SRHR policies should explicitly be made disability inclusive, and disability inclusive SRHR policies should also be made adolescent friendly.

DIVERSITY AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS[626]

Young people are often discussed as though they are a homogenous group, but in reality, they are a diverse population whose SRH needs and desires are complex, changing, and varied. In the context of SRHR programming, 'diversity' usually refers to the distinctive (gender) identities, expressions, backgrounds, and circumstances of different groups and individuals within a population. In general, these characteristics influence what a (young) person needs.

Girls and young women with disabilities face unique challenges with respect to the management of menstrual hygiene, for example, and need appropriate sanitation facilities and education, resources, and support to manage their health.[627] Similarly, young persons with hearing impairments or who are deaf have unique communication needs that are often ignored in SRH policymaking, programme design, and service delivery.[628] For programmes to be successful, they must recognise and address communication barriers that may be common to groups with specific needs.[629]

But **sexual diversity** is often a missing aspect within SRHR programming. Traditional concepts of gender are based on and reinforce heterosexuality; therefore, young persons with disabilities who identify and express their gender and sexuality in ways that do not fit within this construct are often stigmatised, marginalised, and discriminated against on this basis which, in turn, can further restrict their agency and access to services, programmes, and rights.

Recognising all forms of diversity within SRHR programming is essential to fulfilling the human rights of *all* young persons with disabilities, especially the rights to equality and the highest attainable standard of health.

To help realise the obligations and objectives related to SRHR as set out in the normative frameworks, states must ensure young persons with disabilities have access to a core set of services which includes:[630]

1. **Family planning:** Access to voluntary family planning and modern contraceptive methods including emergency contraceptives, as well as counselling on how to safely and effectively use them.

2. **Maternal health care:** Access to maternal health services including pre- and post- natal care, skilled birth assistance, and access to emergency obstetric care.

3. **Safe abortion:** Access to safe abortion, where it is not against the law.

4. **Post-abortion care:** Access to post-abortion care, regardless of whether abortion is legally permitted.

5. **Comprehensive sexuality education:** Access to CSE that provides cognitive, emotional, physical, and social aspects of sexuality, including by equipping children and young people with knowledge, skills, attitudes and values that will empower them to: realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives. This includes access to accurate and comprehensive information and education regarding human development, anatomy, and reproductive health as well as information about contraception, childbirth, and STIs, including HIV, and voluntary methods for prevention, treatment, and care.

6. **GBV prevention and response services:** Access to GBV prevention and response including rehabilitation services for survivors of violence, in line with the standards of the UN Essential Services Package for Women and Girls Subject to Violence.

7. **STI prevention and treatment services:** Access to preventative measures regarding STIs, including HIV/AIDS, as well as detection and treatment of and counselling on STIs, including HIV/AIDS.

All efforts should also be aligned with the World Health Organisation's (WHO) *standards for improving the quality of care for children and young adolescents in health facilities*[631] which outlines what is expected in order to respect children's rights including ensuring child, adolescent and family-friendly health facilities and services; evidence-based clinical care; availability of child and adolescent-specific appropriate equipment; appropriately trained, competent staff. The Global Standards for Quality Health-Care Services for Adolescents,[632] developed by the WHO and the Joint UN Programme on HIV/AIDS (UNAIDS), also provides a standardised framework to assist policymakers and health-care providers in improving the quality of health-care services so that adolescents find it easier to obtain the health services that they need to promote, protect and improve their health and well-being.

The following sections discuss promising steps to ensure such services are available, accessible, acceptable, and of high quality for young persons with disabilities. Services relating to prevention and response to GBV are discussed in detail in Chapter 4.

GUIDELINES FOR PROVIDING RIGHTS-BASED AND GENDER-RESPONSIVE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SERVICES FOR YOUNG PERSONS WITH DISABILITIES

Women Enabled International (WEI) and UNFPA have collaborated on a detailed set of guidelines for inclusive SRH services for women and young persons with disabilities. The Guidelines (forthcoming in summer 2018[633]) offer practical and concrete actions that governments, service providers, and other relevant stakeholders can take to meet the needs of young persons with disabilities. The Guidelines use the AAAQ Framework described above as a frame to outline concrete action items to ensure availability, accessibility, acceptability, and quality SRH services, as well as GBV prevention and response services.

A sample of recommended actions for SRHR service providers includes the following:

- Establish disability-sensitive protocols and guidelines for follow-up visits with health-care providers, management of side effects of medication or treatments, and referral guidelines for further assistance when necessary;
- Create accessible informational materials tailored for young persons with different types of disabilities and appropriate at different ages that address the types of contraceptive and SRH services available and consider subsidising such services for low-income young persons with disabilities;
- Develop awareness-raising campaigns and educational materials for caregivers and family members of young persons with disabilities on sexuality among young persons with disabilities, contraceptive use, and available SRH services.
- Ensure that contraceptive information, goods, and services are available to young men and boys with disabilities and young women and girls with disabilities. Men and boys should also receive information to help them understand the rights of young women and adolescent girls to use contraceptives.

The Guidelines are comprehensive and can be used to support programmes providing the full range of SRH and GBV services for young persons with disabilities, including those services needed by survivors of violence.

COMPREHENSIVE SEXUALITY EDUCATION AND YOUNG PERSONS WITH DISABILITIES

Young persons with disabilities have a right to CSE on an equal basis with others. Comprehensive sexuality education is defined as a rights-based and gender-focused approach to sexuality education, whether in school or out of school, that aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to realise their health, well-being

and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.[634] Comprehensive sexuality education is essential for all young persons to have the knowledge they need to understand their sexuality and to make informed decisions about their own SRH and well-being and the health and well-being of their partners. Comprehensive sexuality education also plays a vital role in preventing HIV and STIs and in reducing the risks of unintended pregnancies and coercive or abusive sexual activity.[635]

Research has shown that young persons with disabilities have low levels of sexuality education and little knowledge regarding SRH.[636] Girls with disabilities are likely to have even less knowledge than their male peers do.[637] Differences in levels of knowledge have been attributed to differences in disability type and severity, with young persons with intellectual disabilities having the lowest level.[638] In part, this is attributable to a lack of inclusion of young persons with disabilities in schools, where CSE is often taught, and lower rates of school attendance among young persons with disabilities, especially girls with disabilities.

Just 5 per cent of children with disabilities complete their primary school educations,[639] resulting in their exclusion from school-based sexual education and HIV/AIDS awareness programmes. When children with disabilities are enrolled in school, they are often in special education classes where sexual education is not included in the curriculum.[640]

The United Nations Population Fund has developed core principles for CSE programmes and information materials that require all such programmes to demonstrate respect for human rights and diversity and affirm sexuality education as a right; promote critical thinking skills and support young people's participation in decision-making and strengthen their capacities to be active and engaged citizens; foster norms and attitudes that promote gender equality and inclusion; address vulnerabilities and exclusion; reinforce local ownership; and promote a positive life-cycle approach to sexuality.[641]

To ensure that young persons with disabilities have access to CSE, it is important to provide CSE programmes in non-school settings, especially within settings that are available to and welcoming of young persons with disabilities, particularly girls and young women. Social isolation caused by stigmatisation of persons with disabilities make it difficult for some young persons with disabilities to participate in youth organisations, sports clubs, faith-based organisations, and other youth-oriented initiatives in which CSE providers often target youth without disabilities.[642] Comprehensive sexuality education providers should also develop strategies for reaching young persons with disabilities who are isolated in their homes but still have equal rights to information and services.

Comprehensive sexuality education programmes should also be tailored to the needs of young persons with disabilities with different disability types. The WEI/UNFPA Guidelines recommend creating smaller, supportive, and accessible spaces to allow young persons with disabilities, especially young women and girls with disabilities, to feel comfortable talking about topics that can be sensitive or embarrassing.

Research has also shown that parents, teachers, and peer educators are the most preferred sources of SRHR for the majority of young people.[643] Yet the parents of young persons with disabilities consistently express feeling of incompetence or

NINE ESSENTIAL COMPONENTS OF COMPREHENSIVE SEXUALITY EDUCATION PROGRAMMES MODIFIED FOR YOUNG PERSONS WITH DISABILITIES

1 A BASIS IN THE CORE UNIVERSAL VALUES OF HUMAN RIGHTS, INCLUDING THE RIGHTS OF PERSONS WITH DISABILITIES

CSE may be used not only to promote SRHR, but also to promote gender equality and the human rights of all people. CSE may introduce school-aged children, adolescents, and young persons both with and without disabilities to the ideas of disability equality and the human rights of persons with disabilities at the same time as they are learning about the importance of respect for their own and other's sexuality, gender equality, and human rights.

2 GENDER EQUALITY

For CSE to be effective and meet international standards, it must also promote gender equality. As disability often exacerbates gender inequalities, a disability perspective when examining key subtopics regarding gender is particularly important for the CSE participants to receive and understand.

3 THOROUGH AND SCIENTIFICALLY ACCURATE INFORMATION

Comprehensive and accurate information is essential for young people to fully enjoy their SRHR. Many misconceptions about sexuality and disability exist, including harmful social beliefs that lead to stigmitisation and social isolation. CSE should address false beliefs, such as the belief that persons with disabilities are nonsexual, within the appropriate cultural contexts.

4 A SAFE, HEALTHY, AND DISABILITY-INCLUSIVE LEARNING ENVIRONMENT

For someone to fully participate in CSE, they must have an accessible, safe, and healthy learning environment. Persons with disabilities, especially young persons with disabilities, are often targeted for bullying, discrimination, and even violence by both teachers and their peers. Therefore, it is particularly important that CSE educators have strong disability inclusion policies that make it clear that any form of discrimination will not be tolerated. This should include disability awareness training for all participants and stakeholders and monitoring policies that ensure participants with disabilities have the ability to file confidential reports of discrimination and abuse.

5 LINKING TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND OTHER INITIATIVES THAT ADDRESS GENDER, DISABILITY, EQUALITY, EMPOWERMENT, AND ACCESS TO EDUCATIONAL, SOCIAL AND ECONOMIC ASSETS FOR YOUNG PEOPLE

CSE programmes should be linked to complementary initiatives that support SRHR specifically and larger social factors that affect SRHR of young persons with disabilities. When linking to these initiatives, CSE programmes should ensure that they are disability inclusive so that young persons with disabilities are able to participate on an equal basis. Complementary initiatives could include programmes to create youth-friendly sexual health service policies, disability-accessible health care facilities, awareness-raising campaigns aimed at changing harmful gender norms, and the inclusion of SRHR in disability laws and policies.

6 PARTICIPATORY TEACHING METHODS FOR PERSONALISATION OF INFORMATION AND STRENGTHENED SKILLS IN COMMUNICATION, DECISION MAKING AND CRITICAL THINKING

CSE participants need to learn the skills necessary to deeply think about their sexual decisions and be able to effectively communicate them with others. CSE programmes should be attentive to the fact that many young persons with disabilities may have grown up in overprotective households and may not have developed the same level of autonomous decision-making and self-advocacy skills as their peers. Therefore, CSE programmes may want to develop targeted lessons to ensure that young persons with disabilities are able to fully develop these skills as well as interactive lessons that include both participants with and without disabilities.

7 STRENGTHENING YOUTH ADVOCACY AND CIVIC ENGAGEMENT

CSE programmes should involve young persons both with and without disabilities in the design of programmes and facilitate the participation of young people in positive social change activities, including awareness raising and advocacy regarding SRHR. Including young persons with disabilities in the design of programme activities will help ensure a disability perspective is included in the curriculum and that all advocacy and civic engagement activities are disability inclusive. CSE programmes should also ensure that any civil society partners have disability inclusion policies and that DPOs, especially those representing young persons, are full participants in advising and evaluating CSE policies and programming.

8 CULTURAL RELEVANCE IN TACKLING HUMAN RIGHTS VIOLATIONS AND GENDER AND DISABILITY INEQUALITY

As attitudes and beliefs regarding gender and disabilities are often deeply embedded in socio-cultural norms, all CSE programmes should be developed in a culturally sensitive manner, adhering to the international standards. They should explicitly address myths and misconceptions regarding gender, disability, and other axes of discrimination that exist in the local context. Involvement of stakeholders and others familiar with the local context is key to designing programmes that promote human rights, gender equality, and disability equality in a culturally sensitive manner to ensure that these concepts are understood, accepted, and resonate.

9 REACHING ACROSS FORMAL AND INFORMAL SECTORS AND ACROSS AGE GROUPINGS

Successful CSE programmes use age-appropriate information to engage youth of all ages in a variety of settings, including both in-school and out-of-school young people. CSE programmes should also develop strategies to specifically identify and invite young persons with disabilities who are socially isolated and may not be aware of or comfortable attending CSE without specific encouragement and interventions, including awareness raising of their parents and the other participants in CSE.

Note: A text alternative for this infographic is available as an annex here.

discomfort speaking with their children about sexuality, suggesting that there is a need for basic training programmes targeting parents of children and young persons with disabilities and providing them with tools to support open conversations with their children.[644]

PROMOTING POSITIVE SEXUALITY TO YOUNG PERSONS WITH DISABILITIES AND OTHERS – ASOCIACIÓN SEXUALIDAD Y DISCAPACIDAD AND THE SPANISH MINISTRY OF HEALTH[645]

The Spanish Ministry of Health has partnered with the Asociación Sexualidad y Discapacidad (Association of Sexuality and Disability) to promote healthy sexual lives for persons with disabilities, especially persons with intellectual disabilities. The Association of Sexuality and Disability advocates for recognition that sexuality is an important part of a healthy and fulfilling life for all people, including people with disabilities, and works to counter negative images of persons with disabilities as sexless individuals. In short, it specifically addresses false beliefs about the sexuality, or lack of sexuality, of persons with disabilities. It does so not only promoting awareness among persons with disabilities that sexuality should be a positive aspect of their lives and is a right but also by working with parents, health-care providers, and others.

In centres supported by the Ministry of Health, Association of Sexuality and Disability staff and volunteers provide training to therapists, caregivers, family members, and others who work with persons with disabilities on how to support young persons with disabilities as they experience puberty and assist them in achieving a satisfying sexual life. Staff and volunteers also work with young persons with disabilities in care centres and schools to promote positive sexuality education and awareness so that they can better understand physical changes in their bodies as they mature and are able to include practicing healthy and satisfying sexual lives and relationships.

The Association of Sexuality and Disability publishes materials on healthy sexuality and disability in accessible formats, including simple language formats appropriate for informing persons with intellectual disabilities, and has developed educational materials appropriate for all age groups. It also provides an annual training course for professionals that has been live-streamed on Spanish media.

The Ministry has supported the Association of Sexuality and Disability's work since at least 2012 and has facilitated the inclusion of positive sexuality in professional trainings and conferences related to disability. It has also supported the development of guidelines and best practices for therapists working with persons with disabilities, including a groundbreaking set of guidelines for the inclusion of sexuality in the care and treatment of persons living with rare diseases.

SEXUALITY EDUCATION FOR WOMEN AND GIRLS WITH DISABILITIES IN CENTRAL ASIA

Since 2002, the Association of Women with Disabilities 'Shyrak' Public Association has been promoting the SRHR of women and girls with disabilities through sexuality education. Shyrak is a DPO that was founded by women with disabilities in Almaty, Kazakhstan and implements projects across Central Asia. Shyrak is primarily a development organisation representing the voice of women and girls with disabilities in policymaking. The chair of Shyrak also represents women with disabilities at the state level as a member of Kazakhstan's National Council on Disability and the National Commission for Women's Affairs and advises the Ministry of Health and Social Development of Kazakhstan on disability inclusion.[646]

Beginning in 2002, Shyrak began implementing sexuality education courses that target women with disabilities and parents of girls with disabilities in cooperation with Kazakhstan's Ministry of Health and the Internal Policy Department of the municipal government of Almaty. The 'Steps towards self-sufficiency and reproductive rights of women with disabilities' project is a disability-specific sexuality education training course that targets women with disabilities in Kazakhstan. The 'Steps towards self-sufficiency' project is comprehensive sexuality course that begins by raising the rights consciousness of women and girls with disabilities so that they see themselves as holders of human rights and develop the skills and confidence necessary for them to successfully claim their right to SRH services. The course has three components to ensure sustainability and a broad reach. First, the interactive course covers psychological health, SRHR, and the prevention of STIs. Secondly, it uses a train-the-trainers model by training women with disabilities to be able to conduct the course themselves, which allows Shyrak to train more women with disabilities simultaneously and in different parts of Kazakhstan and Central Asia. Lastly, the project also includes a specific training course for the parents of girls with disabilities that addresses negative stereotypes of women and girls with disabilities and that works to teach parents how to foster a positive home environment for their children with disabilities, to offer them the same opportunities as other children, and to respect their girls with disabilities' right to make their own decisions, including decisions about their SRHR.[647]

In terms of the twin-track approach, Shyrak represents the second track by implementing a sexuality education campaign specifically for women and girls with disabilities because it recognises that women with disabilities in Kazakhstan are often excluded from sexuality education and thus are best reached through a targeted approach. It also highlights the important practice of the state's working with DPOs in recognition that DPOs have expertise and are able to effectively reach participants with disabilities. Through Shyrak's advocacy and role as a representative on national councils and as an adviser to the Ministry of Health and Social Development, Shyrak also pursues the first track of the twin-track approach by advocating for the mainstreaming of women and girls with disabilities into law, policies, and

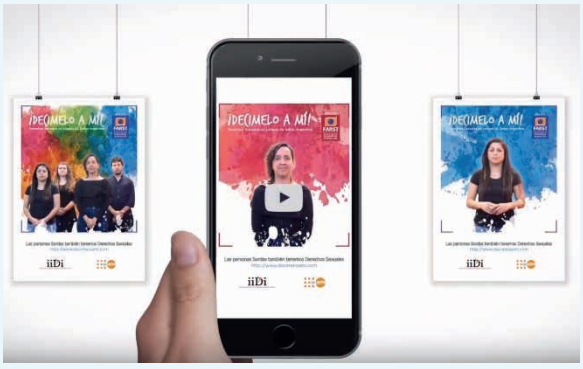
state initiatives promoting SRHR generally and sexuality education specifically. Shyrak also importantly addresses other issues that affect women and girls with disabilities' access to and enjoyment of SRHR, including employment. For example, Shyrak works in cooperation with the Almaty City Department of Employment and Social Programmes to implement a vocational training and job readiness project for women with disabilities.

Many tools and guidelines have been developed regarding the implementation of CSE policies and programmes for young persons, but prior to the WEI/UNFPA Guidelines, few of those tools and guidelines specifically addressed access and inclusion for young persons with disabilities. Even in countries where CSE programmes have been implemented, there is little existing data regarding how, or even whether, such programmes include young persons with disabilities. The *International Technical Guidance on Sexuality Education*[648] is an excellent resource on positive practices in CSE. A model for utilising the twin-track approach in designing CSE per the Technical Guidance is included in Annex 3.

HIGHLIGHT: MAKING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INFORMATION ACCESSIBLE TO YOUNG PERSONS WITH DISABILITIES

Ensuring that young persons with disabilities possess a vocabulary and understanding of SRHR terminology and concepts is a prerequisite to achieving accessibility. Several organisations are actively engaging young persons with disabilities to create materials that detail SRHR terminology and concepts. Select examples include:[649]

Argentina, Costa Rica, and Uruguay: The Instituto Interamericano sobre Discapacidad y Desarollo Inclusivo (Inter-American Institute for Disability and Inclusive Development, iiDi) and UNFPA



The Inter-American Institute for Disability and Inclusive Development and UNFPA's project titled idecimelo a mí! (say it to me!) has created materials that are accessible to persons with hearing

impairments. Materials included posters and postcards that use augmented reality to present SRHR terminology and concepts. All materials were developed by young persons with hearing impairments from Argentina, Costa Rica, and Uruguay with the goal of reducing the inequities that exist in access to information on SRHR.

For more information, visit: http://comosedice.hol.es/web/.

Brazil: The Centre for Health Promotion (Centro de Promoção de Saúde, CEDAPS), iiDi, Simbora Gente, Disque Saúde 136, Sistema Único de Saúde and Federal Government and Ministry of Health (Ministério da Saúde)

Simple language postcards produced through the project entitled 'caminhos da inclusão' (paths of inclusion) convey direct messages around safe sex and other SRHR information. The example to the right states, 'Sex is good, but it has to be safe' on one side with the other stating, 'Prevent HIV/AIDs and other STIs. Let's talk about this.'

For more information, visit: http://cedaps.org.br/projetos/caminhos-da-inclusao/.

Rwanda: The Umbrella of Organisations of Persons with Disabilities in the Fight against HIV/AIDS and for Health Promotion (UPHLS) and UNAIDS

UPHLS is an umbrella of DPOs, focusing on the fight against HIV/AIDS and general health promotion in Rwanda. In partnership with UNAIDS, UPHLS created a guide in several languages that explains how to sign words and concepts related to HIV/AIDS, family planning, and SRH.

For more information on UPHLS, please visit: http://www.uphls.org/.

Technology provides a useful platform for reaching young persons with disabilities by providing them both general CSE and the opportunity to seek out disability-specific information privately. To be accessible to persons with disabilities, however, CSE providers should not only ensure

that all content is disability inclusive and staff and volunteers have received disability-inclusion training and support but also make sure that the internet and mobile platforms themselves are accessible. Organisations providing CSE in these ways should make sure that they follow web and mobile technology accessibility guidelines.[650] Following these guidelines ensures that accessible language is used and that font, images, and so forth are accessible to all potential users including those utilising screen readers. Comprehensive sexuality education providers, however, should be aware that internet and mobile technologies often do not reach some of the most marginalised populations, such as those living in rural areas with no internet or cellular service for those who cannot afford their own cell phones or usage of an internet café and those who do not have the literacy or access to the necessary communication accommodations to read the short message service (SMS) messages sent containing information posted on web pages.[651]

USING THE INTERNET TO INCLUDE YOUTH WITH DISABILITIES IN SEXUALITY EDUCATION[652]

Two websites, both located in India, provide sexuality education to young persons with disabilities around the world. *Love Matters* (lovematters.in) is a mainstream sexuality education website targeting all young people. *Sexuality and Disability* (sexualityanddisability.org) is a disability-specific website that specifically targets young women with disabilities. Both websites were created by organisations based in India and originally focused on providing CSE to young people in India and South Asia, but both have gained worldwide audiences. These platforms are particularly important for providing CSE to groups excluded from CSE in both schools and out-of-school settings.[653] They also offer a forum for all people to ask questions anonymously, thus ensuring the confidentiality of discussions and encouraging people to ask questions that they may feel embarrassed to ask face-to-face in a public setting. In the words of one of the creators of *sexualityanddisability.org,* the website makes users feel that when they ask questions or participate in chats, they are able to be 'intimate and distant at the same time', meaning they feel empowered to ask personal questions, yet simultaneously feel protected by their anonymity.

Love Matters is an India-based website that provides sexuality education in both English and Hindi. The website describes itself as providing 'blush-free information and articles on love, sex & relationships for young adults around the world' and 'as a place to talk about sex with an open, honest, and non-judgmental attitude'. It includes interactive features such as discussion forums and covers topics including Love and Relationships, Our Bodies, Birth Control, Marriage, and Safe Sex. One topic area is dedicated to Sexual Diversity and includes sexual orientation, gender diversity, and sex and disability. All information provided through the website is scientifically accurate, judgement free, and in language that is easily accessible to young persons.

Love Matters' sex and disability section presents persons with disabilities as a group that society often ignores, especially when it comes to sex, 'Yet, they have desires like everyone else.' The web page then links to articles and discussion forums such as 'Myths Busted'; 'Talking about sexuality and disability'; and 'Taking a position, a sex position', which includes resources providing information on having sex as a person with a disability or with a person with a disability. By mainstreaming the sex and disability section into the website as one facet of diversity, users without disabilities have ready access to the information and are more likely to have their awareness raised regarding the sexuality of persons with disabilities.

SexualityAndDisability.org is also an India-based website that provides sexuality education. *SexualityAndDisability.org* describes itself as a website that 'starts from the premise that women who are disabled are sexual beings—just like any other woman'. It was launched in 2012 and was created on the basis of active support from women with disabilities, disability rights advocates, and DPOs, and others. Of the 20 website writers and developers, 15 are women with disabilities. The website is in English, but many of its key blogs and information have been translated into other languages, including Mandarin Chinese and Serbian, by DPOs that discovered it and decided to make its contents available to their members.

SexualityAndDisability.org is organised around questions regarding the Body, Sex, Relationships, Parenting, and Violence. Each question is thoroughly answered, and additional resources and links to information are provided throughout. Some of the material addresses parents of children with disabilities for the specific purpose of raising their awareness and providing them with the resources they need to provide a healthy environment for the development of their child's sexuality. There is also an extensive blog section called 'Voices' that allows website users to share their own experiences or ask questions and receive answers on topics of their choosing. There are also videos and audio postings and links to workshops on sexuality and disability that are offered around South Asia.

ACCESS TO FAMILY PLANNING AND CONTRACEPTIVE SERVICES FOR YOUNG PERSONS WITH DISABILITIES

Young persons with disabilities are engaging in sexual activities in the same ways as their peers are and have the same concerns, needs, and rights to SRH services, including family planning and contraceptive services. Worldwide, there is a significant unmet need for contraception—an estimated 214 million women of reproductive age in developing regions are not using a modern contraceptive method.[654] For young persons with disabilities, accessing contraceptives can be particularly challenging, with significant consequences. In one study in Ethiopia, 35 per cent of the participants admitted they did not use contraceptives during their first sexual encounter, and 63 per cent had had at least one unintended pregnancy.[655]

FAMILY PLANNING 2020[656]

Family Planning 2020 works with governments, civil society, multilateral organisations, donors, the private sector, and the research and development community to support access to contraceptives worldwide. The initiative is an outcome of the 2012 London Summit on Family Planning where more than 20 governments made commitments to address the policy, financing, delivery, and socio-cultural barriers to women accessing contraceptive information, services, and supplies. As part of the summit, donors pledged an additional U.S. Dollar 2.6 billion in funding. Commitments to the initiative have since grown to include 41 countries and dedicated funding for family planning.

Family Planning 2020 promotes recognition and protection of the human rights of women and girls, including the right to non-discrimination. It seeks to enable policies that ensure informed choice among a broad array of contraceptive methods, integration of family planning within the continuum of care for women and children, equity in policy and programme designs and implementation, and the removal of barriers to access to affordable and high-quality information, supplies, and services for family planning.

I went to look for family planning methods at the clinic, and the nurses told me that sex was not meant for the disabled, hence there was no need for me to get contraceptive methods.

–Female with a disability, Zimbabwe[657]

The WHO initiated a global consultation on adolescent health in response to evidence showing that young persons often do not seek out and use health services that are available in their communities. Young people were particularly unlikely to seek out services for SRH. This suggested that even when health care is broadly available, young persons will not use it if the service does not meet their unique needs. These included making services available in locations youth can easily access and that ensure their privacy. It also included ensuring that staff is trained to be able to provide consultation that is non-judgemental and respects confidentiality. As part of the consultation, the WHO conducted surveys of adolescents between the ages of 12 and 19 and primary care providers to assess the former's understanding of health, their priorities among health issues, and the barriers they perceived to accessing and using health services. Based in part on these results, the WHO has developed global standards for quality health-care services for adolescents to serve as a complement to the AAAQ Framework.[658]

The Standards adopt a rights-based approach, recognising that *all* adolescents have the right to the following: care that is considerate, respectful and non-judgemental and that is respectful of adolescents' need for and right to privacy during consultations and examinations; protection from physical and verbal assault; non-discrimination in access to and quality of care, including on the basis of disability; and participation in care processes.[659]

The Standards specify that an adolescent's involvement in care must be respected 'irrespective of whether or not the adolescent has a legal capacity for decision-making', noting that '[a]n adult's judgement of an adolescent's best interests cannot override the obligation to respect all rights of adolescents as stipulated in the Convention on the Rights of the Child'.[660]

GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS[661]

Eight global standards define the required level of quality in the delivery of services, as shown in the table below. Each standard reflects an important facet of quality services, and to meet the needs of *all* adolescents, including adolescents with disabilities, all standards need to be met in ways that are disability inclusive. This means at a minimum that the information and services described below, such as counselling and care services, must be provided in accessible formats appropriate for all adolescents with disabilities, including those with intellectual disabilities.

ADOLESCENTS' HEALTH LITERACY	**Standard 1.** The health facility implements systems to ensure that adolescents are knowledgeable about their own health and they know where and when to obtain health services.
COMMUNITY SUPPORT	**Standard 2.** The health facility implements systems to ensure that parents, guardians, and other community members and community organisations recognise the value of providing health services to adolescents and support such provision and the utilisation of services by adolescents.
APPROPRIATE PACKAGE OF SERVICES	**Standard 3.** The health facility provides a package of information, counselling, diagnostic, treatment, and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.[662]
PROVIDERS' COMPETENCIES	**Standard 4.** Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect, and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude, and respect.
FACILITY CHARACTERISTICS	**Standard 5.** The health facility has convenient operating hours and a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies, and technology needed to ensure effective service provision to adolescents.
EQUITY AND NON-DISCRIMINATION	**Standard 6.** The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
DATA AND QUALITY IMPROVEMENT	**Standard 7.** The health facility collects, analyses, and uses data on service utilisation and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continual quality improvement.
ADOLESCENTS' PARTICIPATION	**Standard 8.** Adolescents are involved in the planning, monitoring, and evaluation of health services, in decisions regarding their own care, and in certain appropriate aspects of service provision.

The Standards highlight the need for services to be developed not only from the perspective of young persons but also from the perspective of young persons with disabilities. Research on the attitudes of family planning clinic staff and other SRH providers has shown that health-care providers often overprotect and infantilise persons with disabilities. This not only results in negative face-to-face interactions between SRH service providers and persons with disabilities, and a lack of trust in health-care providers[663] but also affects space, resulting in many SRH service facilities, including some that may be otherwise deemed 'adolescent-friendly', not taking into account or implementing policies promoting physical, informational, and communicative accessibility.[664] This means that when locations are being assessed for their youth friendliness, they should not only be assessed from the perspective of their accessibility to young persons in general but also according to their accessibility to young persons with disabilities.

REACHING YOUNG PERSONS WITH DISABILITIES IN NEPAL[665]

In 2015, Marie Stopes Nepal conducted a study to assess the SRH needs of young persons with disabilities in Nepal. The study found that only 36 per cent of boys and young men and 21 per cent of girls and young women had adequate information about puberty and SRH during adolescence. Nearly half said they had engaged in sexual activity at some point, and more than 1 in 3 of those were still sexually active but not using any form of contraception. More than half of those surveyed said that the closest centres to receive SRH services were not 'friendly' to young persons with disabilities, that service providers had negative attitudes, or that there were no sign language interpreters, ramps, or lifts and that information was not available in Braille. Most said they preferred to rely on their friends for information about sexuality and reproductive health.

In response, in coordination with the government of Nepal, Marie Stopes Nepal has promoted the incorporation of disability-friendly services in existing youth-friendly service centres and has developed information and materials in multiple accessible formats. It drafted guidelines for disability inclusion and launched a training programme for health-care providers and volunteers to sensitise them to the needs and concerns of young persons with disabilities. Young persons with disabilities have been recruited to act as 'pop-up volunteers' and peer educators to promote outreach to young persons with disabilities and encourage greater participation.

According to a 2017 report, Marie Stopes Nepal had generated more than 100 interventions on behalf of young persons with disabilities since July 2015.

ADOLESCENT-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES CHECKLIST

The WHO and other actors have developed clear guidelines on adolescent-friendly health service policymaking and implementation, including the WHO's 2012 *Making Health Services Adolescent Friendly: Developing national quality standards for adolescent-friendly health services*[666] and WHO's 2015 *Global Standards for quality health-care services for adolescents*.[667]

In 2003, a very easy-to-use resource that was developed by young persons in collaboration with a SRH provider is the African Youth Alliance and Pathfinder International's *Adolescent-Friendly Health Services Checklist*.[668] An adapted version of that checklist is below. It should be noted that this checklist does not specifically include young persons with disabilities. Therefore, the checklist should be used in tandem with disability-inclusion guidelines, and young persons with disabilities should be involved in the use of the adolescent-friendly SRHR checklist to provide their perspective on many of the items assessed. For example, young persons with disabilities should specifically be asked if the location of services is accessible to them, if the SRH staff are respectful to them, and so forth.

	CHARACTERISTICS	YES	NO
Health Facility Characteristics			
1	Is the facility located near a place where adolescents – both female and male - congregate? (youth centre, school, market, etc.)		
2	Is the facility open during hours that are convenient for adolescents – both female and male (particularly in the evenings or at the weekend)?		
3	Are there specific clinic times or spaces set aside for adolescents?		
4	Are RH services offered for free, or at rates affordable to adolescents?		
5	Are waiting times short?		
6	If both adults and adolescents are treated in the facility, is there a separate, discreet, entrance for adolescents to ensure their privacy?		
7	Do counselling and treatment rooms allow for privacy (both visual and auditory)?		
8	Is there a Code of Conduct in place for staff at the health facility?		
9	Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility?		
Provider Characteristics			
1	Have providers been trained to provide adolescent-friendly services?		
2	Have all staff been oriented to providing confidential adolescent-friendly services? (receptionist, security guards, cleaners, etc.)		

	CHARACTERISTICS	YES	NO
3	Do the staff demonstrate respect when interacting with adolescents?		
4	Do the providers ensure the clients' privacy and confidentiality?		
5	Do the providers set aside sufficient time for client-provider interaction?		
6	Are peer educators or peer counsellors available?		
7	Are health providers assessed using quality standard checklists?		
Programme Characteristics			
1	Do adolescents (female and male) play a role in the operation of the health facility?		
2	Are adolescents involved in monitoring the quality of SRH service provision?		
3	Can adolescents be seen in the facility without the consent of their parents or spouses?		
4	Is a wide range of RH services available? (FP, STI treatment and prevention, HIV counselling and testing, ante- and post-natal care, delivery care)		
5	Are there written guidelines for providing adolescent services?		
6	Are condoms available to both young men and young women?		
7	Are there RH educational materials, posters, or job aids on site that are designed to reach adolescents?		
8	Are referral mechanisms in place? (for medical emergencies, for mental health and psychosocial support, etc.)		
9	Are adolescent-specific indicators monitored on a regular basis? (e.g. number of adolescent clients, disaggregated by age and sex)		

As discussed above, adolescent-friendly SRHR services guidelines should be used alongside disability-inclusion guidelines to ensure that services are assessed from both the perspectives of youth friendliness and disability inclusion. Young persons with disabilities must be included in every step of the planning and evaluation to ensure substantive equality in services. Services that are acceptable and effective for their peers without disabilities may not be acceptable or effective for young persons with disabilities without accommodations.[669] Everyone involved in SRHR, from the highest levels of the Ministry of Public Health all the way down to the receptionist who greets young persons with disabilities who come through a local facility's door needs to be aware of the rights of young persons with disabilities, the barriers they face as a group, and basic methods for providing access and inclusion. Utilising a community-based approach to SRHR is important in developing policies and programmes because community members know what their needs are and understand the issues that influence their health.[670]

CAPACITY BUILDING FOR DISABILITY-INCLUSIVE REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICE PROVIDERS IN ETHIOPIA

While there has been significant progress mandating the inclusion of young persons with disabilities in SRHR through the adoption of international standards and passage of national laws and policies, making those rights a reality in developing country contexts has been much more difficult. Although there are many universal barriers faced by young persons with disabilities seeking to access SRHR, there are also many context-specific barriers rooted in local cultures, economies, and SRH service systems. As such, it is necessary for states and other actors to build the capacity of SRH providers to implement disability inclusion at the local level. Young persons with disabilities should be full participants in the development of those resources to ensure that their knowledge, experiences, and interests are represented.

In 2010, the Ethiopian Centre for Disability and Development and the Nia Foundation published the *Resource Manual for Reproductive Health/Family Planning Service Providers on the Inclusion of Persons with Disabilities in Reproductive Health/Family Planning Services.* The manual was designed for the specific purpose of building the capacity of government and nongovernmental health service providers in Ethiopia to provide inclusive reproductive health and family planning services. Both the Ethiopian Centre for Disability and Development and the Nia Foundation are nongovernmental organisations. The Ethiopian Centre for Disability and Development, however, is supported by USAID, and Irish Aid and the Nia Foundation is a partner with the Ethiopian Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Education, and Ministry of Women and Children's Affairs. According to the CRPD, it is a positive state practice for states to support CSOs representing persons with disabilities, such as the Ethiopian Centre for Disability and Development, through international cooperation. It is also a positive state practice for states to partner with CSOs such as the Nia Foundation, which can provide expertise in SRHR and disability in the development of policies and resources promoting disability inclusion.

The Ethiopian Centre for Disability and Development was founded in 2005 with the mission to 'work collaboratively with other organisations to promote and facilitate disability inclusive development in Ethiopia – the inclusion of disability issues and persons with disabilities in mainstream government and nongovernmental service delivery and development programmes'. The organisation has implemented a unique organisational structure that ensures that at least 50 per cent of the board are women and 50 percent of the board are persons with disabilities.[671] The Nia Foundation was founded in 2002 with the mission to 'inspire, empower and improve the holistic well-being of less privileged children, youth, and women mainly through education, rehabilitation, training and awareness raising, dialogue and discussion forums,

entrepreneurship and leadership development programmes'. The Nia Foundation focuses on adolescent and youth empowerment and uses a strategy of partnering with governmental and nongovernmental organisations (NGOs). Three of its primary programme areas are autism awareness, SRH, and women's empowerment.[672]

The *Resource Manual* trains SRH service providers on disability, the SRH needs of persons with disabilities and the barriers they encounter accessing services, the basic concepts and components of disability inclusive SRH service provision, and an individualised approach to providing SRH services to persons with disabilities according to their needs. The training also outlines Ethiopia's responsibilities under the CRPD and specific disability inclusion legislation such as state obligations to persons with disabilities under the Constitution, the national disability policy, and national plans on disability and programme strategies under various national ministries and regional and municipal governments. The most important part of the document, however, is step-by-step instructions for SRH providers to mainstream disability into all of their services and to develop disability-specific targeted approaches. These instructions include specific questions for assessing the disability inclusion of SRHR programmes. For example, the resource model offers direct and easy-to-understand questions for assessing the mainstreaming of disability for reproductive health/family planning service providers at the local level:

- If you are improving the quality of health services, are these services offering the same quality of care to persons with disabilities as to other clients? If not, what should be done?
- Are you assessing facilities from the perspective of persons with disabilities? Have you considered adaptations for persons with disabilities such as ramps, easy-to-understand written or graphic formats for information, Braille, or sign language interpreters, depending on needs?
- Are you updating policies, norms, and procedures from the perspective of persons with disabilities? Do they refer specifically to issues of concern to persons with disabilities?
- Are you integrating disability-related sessions into pre-service training of reproductive health and family planning medical, paramedical, and other staff?

The manual then provides detailed checklists of positive measures and specific directives for SRH workers in particular roles or undertaking particular activities. Key Accessibility Standards are provided in the Manual's Annex, such as standards for ramps, thresholds, doors, chair and tables, and special services.

YOUTH LEARN THAT INACCESSIBILITY AND ATTITUDES TOWARDS PERSONS WITH DISABILITIES ARE FACTORS IN MATERNAL MORTALITY IN GHANA[673]

In 2015, Restless Development-UK partnered with Youth Empowerment Ghana as part of its Youth Power campaign to mobilise young people to hold their governments accountable to the Sustainable Development Goals (SDGs). Youth Empowerment Ghana chose SDG goals 3 on Health and Well-Being and 5 on Gender Equality. Specifically, Youth Empowerment Ghana decided to investigate the causes and effects of maternal mortality in rural Ghana.

Youth Empowerment Ghana brought together more than 40 stakeholders in maternal mortality, including young women and adolescent girls, mothers, community health nurses, and traditional birth attendants in the Ashanti and Brong-Ahofo regions. They learned that three-quarters of deliveries in Ghana were attended by untrained personnel who were unable to handle complications during birth, which accounted for many deaths for both the mother and child. Despite this, more than half of the mothers who participated in the study preferred to use traditional birth attendants rather than their local health centre. The reason for this preference by the focus group participants included the geographic distance and transport costs they would need to incur to access health centres and negative perceptions of the centre staff's attitudes and behaviour toward their patients.

One focus group participant shared a poignant story regarding a friend who had a physical impairment that affected her mobility. The participant explained:

> My friend [with a disability] had to travel for several hours before reaching the health facility. Imagine her condition and the stress she goes through! The hospital had no disability-friendly facilities, which made her stress even more. The midwives were sometimes rude to her; she eventually decided to just stay home and not visit the health facility again. The end result was that she had complications during birth and died.[674]

Richard Dzikunu, one of the leaders of Youth Empowerment Ghana, testified during a Youth-led Accountability in Gender Equality Session at the 72nd General Assembly of the UN in 2017, and he recounted this story, including the detail that the woman was forced to climb three stories of stairs to reach the exam room for her pre-natal appointment. He followed the story by stating, 'When we talk about the Promise of "leaving no one behind", these are the people we should think of.'[675]

Youth Empowerment Ghana was able to collect data on important issues, including on disability and maternal health, and was invited by Ghana's National Youth Authority and the National Health Service's Maternal Health Unit to advise on the development of Ghana's Adolescent Health Service and Policy in 2016, which includes attention to accessibility. It also mainstreamed

disability issues into youth-led research. One of the leaders of Youth Empowerment Ghana explained that now that the organisation is aware of the marginalisation of women with disabilities, disability accessibility in health centres – particularly those with maternity services – had become an important priority in their advocacy and initiatives.[676]

The Restless Development-Youth Empowerment Ghana project on maternal health demonstrates the power of mobilising youth and the importance of collecting data on the experiences of women with disabilities regarding their reproductive health, including the relationship between accessibility and maternal mortality. Importantly, Ghana has been responsive to Youth Empowerment Ghana's findings and involved the organisation in the policymaking process.

MATERNAL HEALTH-CARE SERVICES

Maternal health is a global health priority evidenced through efforts to reduce maternal mortality, most notably reflected in SDG 3. Maternal health care is also a right recognised in the ICESCR, the CRPD, and the ICPD Programme of Action, among other instruments, each of which guarantees the rights to reproductive and maternal health of young women and girls with disabilities. As noted above, the ICESCR calls on sates to ensure the 'highest attainable physical and mental health for all', and the CESCR has directed states to eliminate any policies or practices that obstruct access to SRH services for women with disabilities and to take measures to prevent third parties from directly or indirectly interfering with such access.[677]

Despite these obligations, women with disabilities remain largely excluded from mainstream maternal health services. Communication barriers, physical inaccessibility of facilities, and attitudes of health-care providers all represent significant barriers to young women with disabilities in need of maternal health care.[678]

In one study among persons with disabilities in South Africa, women with disabilities recounted 'horrendous' experiences endured at public hospitals when they went to deliver their babies, in large part due to the insensitivity of service providers.[679] Women with disabilities have also reported a lack of knowledge on the part of health-care providers about their specific needs related to pregnancy, including inaccessible health-care offices, equipment, and birthing facilities.[680]

Yet concerns about care may be shared by health-care workers. In a study in Nepal, women with disabilities reported generally positive experiences with the ante-natal services they received, but health-care workers were concerned that they lacked the requisite knowledge to care appropriately for women with disabilities.[681] Practitioners reported similar concerns in a study in the United States, describing a lack of training and education related to maternity care and the specific clinical needs of women with physical disabilities, a lack of confidence in providing maternity care to women with physical disabilities, and inadequate coordination of care among practitioners.[682]

Lack of access to timely, quality maternal health care and emergency obstetric and newborn care can lead to maternal and newborn mortality but also to maternal and newborn morbidity and a host of complications, such as obstetric fistula with long-term consequences.[683] Limited social support for women with disabilities who give birth can also have profound consequences. A representative of an organisation working to support new mothers with intellectual disabilities in Madrid shared that many women who came to them had had children taken away from them at birth, which she believed was not uncommon for women with intellectual disabilities.[684]

INCLUSIVE CERTIFICATES FOR HEALTH CENTRES IN ECUADOR

Since 2014, Ecuador's Ministry of Public Health has been certifying Health Centres as 'Inclusive'. The 'Inclusivity' designates a centre as accessible to the priority populations of pregnant women, older persons, LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex), adolescents, and persons with disabilities. In this way, the Ministry of Public Health combines the criteria of adolescent-friendly, disability inclusive, and so forth to create one standard of Inclusivity.

For a health centre to be certified, it must complete a series of inclusion capacity-building workshops health provided by the Ministry of Public Health. Each workshop focuses on access and accommodation for each of the priority populations. Secondly, the health centre must then establish links with each population, such as developing a partnership with a local DPO or establishing an adolescent health club in a neighbourhood secondary school. Those relationships then are to be used for outreach initiatives and consultation. Lastly, the health centres must document that it has non-discrimination policies and practices in place, a clean and safe environment, ongoing actions promoting citizen participation, and ongoing actions promoting healthy lifestyles among the population, such as public workshops on nutrition, caregiving, and STIs. As of 2016, a total of 253 Health Centres have been certified as fully Inclusive.

The Tabacundo health centre, which is located in a rural area outside of Quito, exemplifies the types of initiatives common at health centres seeking to maintain their 'inclusive' certification. The Tabacundo health centre has established advisory committees of pregnant women, persons with disabilities and their caregivers, and adolescents. Each of these committees provided advice and received free health education workshops provided by health centre staff. Sexual and reproductive health and rights was a major component of the health education workshops, including lectures on sexual health, family planning, and preventing sexual and GBV. In 2017, the health centre began to develop plans to make the adolescent committee disability inclusive.

The Inclusion Certification represents a positive state practice because it not only ensures that health centres are trained in inclusion and demonstrate non-discrimination and accessibility but also because it requires centres to build relationships with historically excluded groups in the community and to develop ongoing actions benefiting their health.

ACHIEVING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR WOMEN AND GIRLS WITH DISABILITIES IN THE PHILIPPINES

In 2016, The Gender Equality and Women's Human Rights Centre of the Commission on Human Rights Philippines (CHRP) launched a national inquiry on reproductive health and rights in response to concerns voiced by women's rights organisations and reproductive health advocates regarding the continued challenges and barriers certain groups of women in the Philippines still face accessing their reproductive health and rights. The report prepared by CHRP,[685] *'Let our voices be heard',* investigates the effectiveness of the implementation of the Philippines SRHR laws; documents structures, policies, and practices denying access to reproductive health services; identifies the barriers encountered by the most marginalised; and documents discrimination experienced at both state and non-state SRH providers. Persons with disabilities were involved throughout the research process, as were other marginalised groups, such as indigenous peoples, Moro women, LGBTQI, the elderly, and youth.

Input from women and girls with disabilities is integrated throughout the report. The CHRP's inquiry worked from top to bottom, beginning at national law and then through local government units' policies and implementation and all the way down to front-line SRHR service providers' attitudes and interactions with women and girls with disabilities. Most importantly, the CHRP interviewed dozens of women with disabilities themselves and highlighted their testimony in the report. For example, it reports: 'Submissions and sworn testimonies of PWDs [persons with disabilities] complain of the seeming invisibility of the needs of PWDs, the absence of facilities like examination tables, the absence of interpreters in police stations and in courts for PWD victim-survivors of violence against women, and the absence of interpreters as well in health centres and government health facilities. PWDs also complain of not being informed of the processes affecting them and of the disregard for their decision because of their disability. A submission also recounted the denial of health services on the basis of her disability, a clear case of discrimination.'

'Let our voices be heard' concludes with recommendations for all three branches of government, including specific recommendation for the legislature and the executive branch (Department of Health, the Implementation Team on Reproductive Health, etc.) and the supreme court and lower courts regarding changes that must be made to ensure access to and enjoyment of SRHR for women and girls with disabilities. These recommendations include direct and practical steps, such as the directing the Department of Health to 'issue a policy and to provide corresponding budget in order to address the inadequate or lack of accessibility of health facilities and services for women with disabilities' and mandating that 'the response should be institutional, and the accessibility should be ensured at all levels and for all kinds of disability; levels and for all kinds of disability'. The recommendations also specify that accommodations must be provided throughout the justice department, including the provision of sign language interpreters in court.

The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) constitutes a pledge to ensure the health and well-being of every woman and every child, including girls and young women with disabilities.[686] Its objectives include reducing maternal mortality globally and ensuring universal access to SRH services. The WHO has adopted complementary guidelines offering detailed recommendations on the health interventions appropriate for all pregnant women during pregnancy, childbirth, and the post-natal period.[687] The guidelines recognise, *inter alia*, the essential care required for mothers and infants during childbirth (such as labour monitoring), management of difficult labour (through the appropriate use of medical technologies), newborn resuscitation, management of preterm labour and birth, and management of maternal and newborn infections.[688]

Pregnant young women and girls with disabilities are entitled to the same essential care services on an equal basis as are available to all other pregnant women and girls. States are obligated to ensure that such services are accessible, available, acceptable, and of satisfactory quality for young women and girls with disabilities to achieve true substantive equality and fulfil their SRHR.

As noted above, SRHR are inextricably linked with other human rights such that the satisfaction of one necessitates the fulfilment of others, as the case study from Nairobi below attests.

ENSURING MATERNAL HEALTH AND THE HEALTH OF CHILDREN WITH DISABILITIES IN KIBERA AND KOROGOCH SETTLEMENTS, NAIROBI, KENYA – HANDICAP INTERNATIONAL AND THE MINISTRY OF HEALTH, KENYA[689]

Faced with evidence that children with disabilities living in informal settlements in Nairobi were disproportionately showing signs of malnutrition, Handicap International and the Ministry of Health in Kenya partnered on a project to improve access to maternal and pediatric health care. A needs assessment showed that access to health services was a significant challenge for women with disabilities and parents of children with disabilities. Barriers included physical access, challenges communicating with health-care providers, and discriminatory attitudes among providers. The initial project included work to improve physical access and conduct training with the Ministry of Health to ensure that health-care providers could provide inclusive services.

However, although the project made headway, it became clear that women were not seeking care for themselves and their children even where care was accessible, because they did not have the financial means to pay for it. In response, Handicap International launched a complementary programme designed to produce income for women with disabilities and parents of children with disabilities and increase their autonomy and ability to demand rights for themselves. The programme sponsors groups of participants in the development of revenue-generating

businesses. In exchange, participants must commit to visiting government health facilities at least once per month with their children so that the health of all can be monitored. Pregnant women also commit to seeking both pre- and post-natal care and bringing their babies to health-care clinics to reduce the chance of potentially disabling complications both before and after birth.

The programme has made significant inroads into improving health outcomes for children with disabilities by tackling not only negative attitudes among health-care providers through training on inclusive care but also ensuring that parents of children with disabilities have the means to travel to clinics with newly trained and responsive providers. It reflects a systemic response to a complex problem that can serve as a model for inclusive interventions.

DISABILITY INCLUSION IN STI AND HIV PREVENTION, TREATMENT, AND CARE SERVICES

Young persons with disabilities have the same right to participate in HIV prevention, treatment, and care services on an equal basis with young persons without disabilities have. Young persons with disabilities, however, often face specific barriers to inclusion in HIV-related services. This occurs both where HIV-related services are integrated into SRHR law, policies, and services and in contexts where HIV-related services are treated separately. In the latter context, which is common in developing countries with high HIV prevalence rates, young people face even greater challenges because many HIV-related services are provided by CSOs, especially international NGOs, that may not be regulated by the state or held accountable to non-discrimination and disability-inclusion policies.

It is particularly important that STI screening policies and guidelines specify that young persons with disabilities should be offered such screening because research has shown that health-care providers often assume young persons with disabilities are not sexually active and thus do not offer to screen these young persons for STIs, including HIV, or offer them contraceptives or information about preventing transmission of STIs during either regular office visits or for other SRH-related or general health services.[690] This exclusion from screening is particularly high in many developing countries[691] and directly contributes to the risk factor young persons with disabilities face in areas with a high incidence of HIV/AIDS.[692]

In contexts where there are separate HIV-related laws, policies, and services, persons with disabilities should be mainstreamed into all laws, policies, and services and, when appropriate, disability-specific laws, policies, and services should specify that persons with disabilities shall be included in HIV-related services and, if appropriate, implement disability-specific interventions. Disabled persons' organisations should be included in HIV-related advisory councils, integrated into planning and outreach initiatives, and connected to HIV-related civil

society networks.[693] It is important that states explicitly include young persons with disabilities in their national HIV/AIDS policies and strategic plans to ensure all actors, including both state and non-state actors, are aware of the specific vulnerabilities of young persons with disabilities and recognise their right to be included in all HIV-related initiatives.

INCLUDING PERSONS WITH DISABILITIES IN SENEGAL'S NATIONAL AIDS STRATEGIC PLAN

Senegal is held up as a success story in HIV prevention, treatment, and care.[694] Part of its success is due to its inclusion of persons with disabilities in HIV and AIDS services. Senegal has one of the lowest rates of HIV prevalence in sub-Saharan Africa. In 2016, UNAIDS estimated the national HIV prevalence rate to be just 0.4 per cent for adults from ages 15 to 49.[695] Part of this low prevalence rate can be attributed to Senegal following good practice by including persons with disabilities in planning its 2011–2015 National AIDS Strategy.[696]

Prior to 2012, the Senegal's National Strategic AIDS Plan (NSP) did not specifically include persons with disabilities in its implementation guidelines. Beginning in 2008, through the funding of the International Development Agency of France, World Learning/USAID, and Handicap International, persons with disabilities were mobilised and integrated into the broader HIV-related movement. Senegal's national DPO network, the Federation of Persons with Disabilities of Senegal, was brought in as a partner with the National AIDS Council, the Society for Women and AIDS in Africa-Senegal and Outpatience Treatment Centre of Fann, and Handicap International to begin facilitating disability inclusion. A disability-specific regional prevalence survey was also conducted, which showed that in certain areas, the HIV-prevalence among persons with disabilities was more than twice that of persons without disabilities and even higher specifically for women and girls with disabilities. This information provided necessary data for the disability community to advocate to Senegal's National AIDS Council and its Monitoring, Evaluation and Research Department to put a priority on persons with disabilities in its national policies. As a result, the new NSP identified persons with disabilities as a key Vulnerable Population and developed specific policies for mainstreaming persons with disabilities into its HIV-related services along with targeted outreach initiatives. Mainstreaming included an accessibility and disability inclusion policy for all state HIV-related services and disability as a category being included in all information collected by nationwide epidemiological and behavioural surveys, which allows the National Aid Council's Monitoring, Evaluation and Research Department to disaggregate information on the basis of disability. Disability-specific targeted initiatives included specific financial resources being allocated for the inclusion of persons with disabilities in HIV-related services and specific outreach and prevention initiatives.[697]

It is particularly important that young persons with disabilities, especially adolescent girls and young women with disabilities, are aware of HIV-related services because HIV is currently the second leading cause of death for adolescents worldwide,[698] and in many contexts, women with disabilities face specific barriers to HIV-related services and experience increased HIV-related risk factors. For example, in some contexts where belief in the 'virgin myth' is prevalent, women and girls with disabilities are targeted for sexual violence by persons living with HIV who presume they are virgins and target them for intercourse as a cure for HIV.[699] An essential state practice is that persons with disabilities are specifically included in national HIV/AIDS policies and strategies. It is equally important that all epidemiological information collected on HIV prevalence can be disaggregated on the basis of age, gender, and disability. These data are not only important for programme implementers to know that their services are successfully addressing young persons with disabilities, but also important tools for DPOs and other CSOs to hold government accountable. When HIV-related services are provided in separate facilities by the state or CSOs, those facilities should be accessible, and all personnel should be trained in disability inclusion and accommodation.[700] Several states have developed positive practices that include specific guidelines and disability inclusion trainings for HIV-related health-care providers. Policies should also be in place to ensure that persons with disabilities can access and communicate in the centres privately and without the assistance of their own caregivers, such as parents and other family members.

BUILDING THE CAPACITY OF HEALTH PROVIDERS ON DISABILITY AND HIV/AIDS IN RWANDA

In 2015, the Rwanda Biomedical Centre (RBC) and UPHLS published the Training Manual on Disability and HIV & AIDS in Rwanda.[701] The training manual was designed to give local health-care providers the awareness, knowledge, and skills necessary for local health providers to fully implement Rwanda's inclusion policy of persons with disabilities in HIV and AIDS. The inclusion policy is detailed in guidelines disseminated in 2012 by the Ministry of Health and RBC.[702] The guidelines mandate that persons with disabilities are both mainstreamed into general HIV and AIDS programmes and are targeted in disability-specific programming, such as monitoring special education and disability inclusive classrooms to ensure that children with disabilities are included in sexuality education and facilitating the collaboration of DPOs and local health-care facility staff to develop initiatives to identify persons with disabilities in the areas that are not currently reached by local health-care facilities.

The Training Manual itself represents collaboration between the state and disability community. It is also an important step in turning policy into a reality by bringing national policy into the individual practice of health-care workers on the ground. The RBC was established in 2011 by the Rwandan government to be a Centre for Excellence by ensuring quality health-care service, education, and

research. UPHLS was established in 2006 with technical assistance and financial support from the National AIDS Control Commission of Rwanda to bring DPOs together and facilitate their work with the more than 70 organisations in Rwanda addressing HIV/AIDS. UPHLS's mission is to empower DPOs through capacity building, planning, advocacy, coordination, monitoring, and evaluation of HIV and AIDS programme initiatives related to persons with disabilities. The Training Manual on Disability and HIV & AIDS is a part of that mission by ensuring that health providers are aware of the HIV-related risk that persons with disabilities face and are educated in disability inclusion in all aspects of HIV prevention, treatment, and care.

The 75-page manual is the principle training resource for an intensive five-day train the trainers course. The manual provides the course's lecture content, including illustrations and case studies depicting concrete situations in Rwanda; step-by-step guidance to the facilitator for each section; review of key concept notes for students; text boxes of tips on how to practically implement a core lesson, such as how to assist a person with a visual impairment taking a seat or the proper language to use when referring to persons with disabilities; individual and small group exercises that engage participants in thinking through principal points and summarises each section that is used as a transition from one topic to the next. The training is divided into five parts or units. They cover the introduction; disability; physical, communication, and information accessibility; disability inclusion; and HIV/AIDS and disability.

The unit on disability provides detailed demographic data regarding persons with disabilities in Rwanda, including literacy and poverty rates; explains different types of impairments; and dispels popular socio-cultural norms, including myths and misconceptions about persons with disabilities. Small group exercises engage participants in identifying the types of barriers that persons with different types of impairments encounter and the facilitators for physical, communication, and information accessibility.

The physical, communicative, and informational accessibility section provides key strategies for facilitating access. Equal attention is given to addressing attitudinal and institutional barriers as is given to physical, communication, and informational barriers. Each section is detailed in its guidance, including lessons on ways for developing better interpersonal skills for working with persons with disabilities, signs for specific terms regarding SRH and HIV when communicating with a sign language user, and detailed instructions for adding ramps or modifying bathrooms to make existing health-care facilities physically accessible.

The unit on disability inclusion begins by separating out the conceptual differences of exclusion, segregation, integration, and inclusion and then provides exercises for developing mainstreaming initiatives within health-care provision.

The final unit, which is specifically on HIV/AIDS and disability, builds upon all of the past learning to identify the risk persons with disabilities face of HIV/AIDS, the key barriers they encounter in accessing HIV-related prevention, services, and care, and strategies for accessibility and

inclusion. Each of these sections notes specific groups of persons with disabilities, such as by age (children, adolescents, young adults, etc.) and impairment type. The section provides significant attention to gender and disability by explaining the 'double discrimination' that women with disabilities face.

The RBC-UPHLS partnership represents a positive state practice: a state agency and a state-supported DPO network working together to develop a practical resource to ensure that persons with disabilities are included in HIV/AIDS-related health-care practice.

ACCOUNTABILITY AND DATA COLLECTION STRATEGIES

The SDGs commitment to 'Leave No One Behind' requires states to monitor the rights of particularly marginalised groups, including women and children with disabilities, and collect disaggregated data through national data systems. SDG Goals 3 (health), 4 (education), and 5 (gender equality) specifically contribute to the promotion of SRHR. SDG target 3.7 specifically requires states to 'ensure universal access to sexual and reproductive health care services'; SDG target 4.7 requires states to ensure that all learners acquire knowledge and skills needed to promote the SDGs, including human rights and gender equality education, which is inclusive of CSE; and SDG target 5.6 calls upon states to 'ensure university access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and Beijing Platform of Action'. SDG 17 and target 17.18 requires all data to be disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location, and other characteristics. Collecting data that are disability and age sensitive will be instrumental for states achieving these targets by 2030.

The SDGs health and gender equality goals have mobilised a broad base of both state and civil society actors to focus on SRHR. States have a positive obligation to collect data themselves, analyse these data, and make them available and accessible to the public. Civil society actors, however, play an important role in holding states accountable. Participation is an important principle in data collection. When promoting the rights of young persons with disabilities, it is important that both young persons with and without disabilities are mobilised in data collection. Not only does this lead to better data, but also it builds human rights and disability awareness.

Historically, young persons with disabilities, especially adolescent girls and young women with disabilities, have been invisible in data regarding SRHR. This invisibility makes it impossible for states to confirm that they are fulfilling their obligations to ensure that young persons with disabilities have equal access to and enjoyment of SRHR. The lack of data also prevents policymakers and programme implementers from identifying where appropriate interventions may be needed and robs CSOs representing young persons with disabilities from having important tools for holding their governments accountable. Fortunately, the

CRPD and the SDGs have brought new attention to the obligation of states to collect data on SRHR of young persons with disabilities. Significant progress continues to be made, including through the Washington Group on Disability Statistics, which has partnered with a number of states and CSOs to develop new data collection instruments. For example, the United States Agency for International Development (USAID), the Demographic and Health Statistics Programme, and the Washington Group collaborated on developing a new disability questionnaire module that assists countries in collecting disability-inclusive statistics on health, including SRH.[703]

States Parties to the CRPD are obligated to collect data on persons with disabilities. Article 31 (Statistics and Data Collection) of the CRPD obligates states to 'collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention'. Under Article 31, states are also obligated to disseminate that data and make them accessible to persons with disabilities to ensure their role in monitoring states. Article 31, along with the general principles and Articles 6 (Women with Disabilities) and 7 (Children with Disabilities), requires that data collected are gender and age sensitive, meaning that data can be disaggregated for purposes of ensuring that women and girls and adolescents and young persons with disabilities are accessing their rights on an equal basis with others.

USING A SITUATIONAL ANALYSIS ON DISABILITY INCLUSION IN REPRODUCTIVE HEALTH TO INFORM POLICY IN MOLDOVA

In 2016, the Reproductive Health Training Centre in the Republic of Moldova initiated the *'All Equal, All Healthy: Empowering Women and Girls with Disabilities in Moldova to Exercise their Sexual and Reproductive Rights'* project to perform a situational analysis to 'identify the issues confronting women and girls with disabilities in exercising their sexual and reproductive rights'. This report was the first of its kind and shed significant light on the situation of women and girls with disabilities in Moldova. The analysis was subsequently used to advance concrete proposals to the Moldovan Ministry or Health and Ministry of Labour, Social Protection, and Family to ensure the full implementation of Moldova's obligations under the CRPD and its own law on the social inclusion of persons with disabilities (Law no. 60 of March 30, 2012).

The Reproductive Health Training Centre (RHTC) is an NGO in Moldova that trains reproductive health service providers according to WHO recommendations on SRH. The *All Equal, All Healthy* project was initiated by RHTC in response to reproductive health providers who requested training and information regarding how best to accommodate women with disabilities who sought reproductive health services. The Embassy of Finland in Bucharest funded the study, and RHTC received broad support and cooperation from the Ministry of Labour, Social Protection and Family, and Ministry of Health in its project initiatives.

The situational analysis was launched through a participatory planning process that brought together stakeholders and established a working group that included two experts on SRH, one expert on health and disability law, and three representatives from DPOs. Next, a questionnaire was developed for women and girls with disabilities, family members of persons with disabilities, family doctors, and social workers. The questionnaire was then utilised in nine focus groups and 93 semi-structured interviews. On the basis of the data collected, the RHTC working group identified six barriers that limit women and girls with disabilities' access to reproductive health services:

- Insufficient training in disability inclusions of medical personnel
- Women with disabilities' not requesting SRH services
- Unfriendly medical personnel's attitude toward women with disabilities
- Unfriendly family's attitude toward women with disabilities
- Lack of physical access and adapted equipment at SRH facilities
- Women with disabilities' lack of awareness of their right to receive free and confidential SRH services.

Of these barriers, insufficient training and lack of physical access and adapted equipment were the most universal, although all barriers identified were highly significant. Specific barriers identified by women with disabilities ranged from their fear of judgement and embarrassment as a result of bringing up SRH issues to uncertainty on whether or not they as women with disabilities were able to get pregnant through to the fact that gynaecological examination chairs were not accessible for women with physical disabilities. Many family doctors voiced concerns over never having been trained in accommodating persons with disabilities, although some had sought to educate themselves by seeking out sources on providing SRH services to women with disabilities on the Internet or their own reading of international guidelines and medical publications.[704]

The Moldovan government responded to the findings of the situational analysis in several ways. First, it included the RHTC study in its country report to the Committee on the Rights of Persons with Disabilities as part of its reporting on its implementation as a State Party to the CRPD. Secondly, the Ministry of Health organised the First National Conference on the Sexual and Reproductive Rights of Women with Disabilities in Moldova, an event facilitated on 29 May 2017, by the RHTC to discuss country level problems with disability inclusion and SRHR. During this conference, the RHTC issued key recommendations to the government that covered both policy changes at the level of SRH providers' facilities up to changes in the national legal framework regarding SRHR and the rights of women with disabilities.[705] Lastly, government ministries also invited the RHTC to present its findings at a National Conference

on Adolescence. On the basis of the assessment that Moldova's 42 adolescent-friendly SRHR clinics were not accessible, the Ministry of Health responded by allocating funding for increasing the accessibility of adolescent-friendly SRHR clinics, including the placement of disability-accessible gynaecological examination chairs in 30 of those clinics.

This case study demonstrates the role situational analyses can play in building awareness within the government and across the SRHR field of the barriers that women and girls with disabilities face accessing SRHR. It also demonstrates the importance of understanding barriers from a multiplicity of points of view, such as women with disabilities, medical personnel, and family members. On the basis of situational analyses, governments often respond with both immediate and long-term changes to better ensure the SRHR of young persons with disabilities.

Data collected on SRHR and young persons with disabilities should be analysed both quantitatively and qualitatively. Quantitatively, it is important that information can be disaggregated by age, disability, and gender. It is also important that information, when appropriate, can be disaggregated according to other potential axes of inequality, such as poverty, rurality, race and ethnicity, indigenous group, caste, religion, sexual orientation and gender identity, and other characteristics and identities appropriate to the national context. This statistical data provide the information necessary to monitor for equity and to identify key areas and populations for intervention. It is also important to collect and analyse data qualitatively. It is not enough to know that services are available or received. The quality and acceptability of those services from the perspective of young persons with disabilities must also be determined. Young persons with disabilities not only have the right to SRHR services but also the right to exercise choice over the services they receive and the ability to access them in a respectful and dignified manner.

IV. CONCLUSION

This chapter has focused on the ways in which states can foster access and encourage exercise of SRHR for young persons with disabilities. Throughout, this chapter has argued that states can do so by mainstreaming young persons with disabilities into the core set of sexual health services recommended by the ICPD Programme of Action and, when appropriate, developing targeted policies, programmes, and services that reach out to include young persons with disabilities who face specific barriers that cannot be addressed through mainstreaming alone. Youth friendly and disability inclusive are two essential concepts important for ensuring that not only are services accessible but also inclusive from the perspective of the intended beneficiaries: young persons with disabilities. The following chapter will focus on civil society and argue that to achieve fully inclusive SRHR services and GBV prevention and response services, actors need to ensure the participation of young persons with disabilities in the development and ongoing monitoring of laws, policies, and programmes. To do so, states must support civil society and ensure that it is strong, vibrant, and inclusive.

// CHAPTER 6

INCLUSION OF CIVIL SOCIETY

I. INTRODUCTION

Young persons with disabilities have a right to be heard. Participation and inclusion are critical components of a human rights-based approach and essential elements for ensuring access to services and the full enjoyment of rights. In fact, states depend on young persons with disabilities' having a public voice concerning their sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) protections and services because it is their voices that raise critical issues and contribute important insights on how best to ensure enjoyment of and access to SRHR and GBV prevention and response services. For too long, young persons with disabilities, especially young women and adolescent girls, have been absent from policy debates that affect their daily lives, yet their unique knowledge and experience is vital for designing effective services. The disability rights movement's motto—'Nothing About Us, Without Us'—means that the only way to ensure that new laws, policies, and programmes affecting young persons with disabilities truly promote equality is to involve young persons with disabilities from the very beginning. That is because young persons with disabilities are experts about their own lives: They know what the barriers are because they encounter them every day. They also have the insight, creativity, and energy to be principal contributors in the development of legal and programmatic solutions that promote their inclusion in SRHR and GBV prevention and response services and to ensure that they enjoy all of their human rights.

In the preceding chapters, many of the positive steps states that have been highlighted involve partnerships between the state and civil society. For example, in Chapter 3 on GBV, the Access to Justice project in Kenya, which ensures persons with disabilities receive equal treatment in court, highlighted the Kenyan Association of the Intellectually Handicapped's work training police, judges, and other state employees. In Chapter 4 on SRHR, CBM International's *Inclusion Made Easy* checklist for inclusive development programmes was highlighted because it recommends that state ministries developing services are able to affirmatively answer questions such as 'Are people with a disability and DPOs playing an active role throughout the project?' Both of these cases demonstrate that persons with disabilities are critical to ensuring the state does an effective job. Persons with disabilities are the best awareness-raisers, trainers, advisers, and evaluators for states when they are developing new policies and services. Young persons with disabilities are also empowered when the state partners with them because it gives them a leadership role in public affairs. For states to be able to provide that role, however, young persons with disabilities need to be organised and included in civil society in the first place.

A strong and inclusive civil society is a prerequisite for State Parties to fulfil their obligations to promote the human rights of their citizens, especially their rights under the Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and Convention on the Rights of the Child (CRC). For these international human rights instruments to fulfil their promise, persons with disabilities, women and girls, and adolescents and children must be involved in advising states on how to implement effective change on the ground. These conventions, like all human rights instruments, are also the core facilitators for the development of vibrant civil societies around the world because they promote a role for civil society organisations (CSOs) in the implementing and

monitoring of their rights. This is particularly true for disabled persons' organisations (DPOs) through the CRPD because it creates a positive legal obligation for States Parties to include CSOs representing persons with disabilities in the implementation of their human rights, including SRHR and GBV prevention and response services. The CRPD Article 4 on General Obligations and Article 33 on National Implementation and Monitoring specifically mandate that States Parties actively involve CSOs representing persons with disabilities as advisers and monitors on the implementation of disability rights. Article 32 on International Cooperation obligates States Parties to ensure that all international development initiatives are disability inclusive and to actively partner with and support the capacity development of CSOs. These articles open up the opportunity for organisations representing young persons with disabilities to become effective advocates. They also create the opportunity for young persons with disabilities to become full and equal participants in national advisory councils, as authors of civil society 'shadow' reports, and as representatives in other forums in which policies and programmes affecting their rights are evaluated and discussed.

KEY POINTS

- Civil society organisations representing young persons with disabilities are a **prerequisite** for states to effectively fulfil their obligations to ensure young persons with disabilities full and equal access to SRHR and GBV prevention and response.
- Young persons with disabilities, especially young women and adolescent girls with disabilities, face **barriers to full participation** in civil society, including mainstream disability, youth, and women's rights organisations.
- All CSOs need to become more responsive to women and adolescent girls with disabilities. **Disabled persons' organisations need to become more gender responsive**, including ensuring that women are represented within the senior leadership. **Women's rights organisations also need to ensure equal access** to participation and leadership positions for women and girls with disabilities.
- The CRPD is a **key facilitator** for the participation of young persons with disabilities in advising on and monitoring their rights because it creates positive legal obligations that States Parties actively include CSOs in **policymaking and implementation and international development** initiatives.
- Civil society organisations representing young persons with disabilities can do a number of important things supporting SRHR and the right to live free from violence, including:
  - **Advising** states on new legislation and policy related to SRHR and elimination of GBV;

- **Raising awareness** among their members and the larger public regarding the rights of young persons with disabilities;
- **Monitoring and evaluating** the implementation of laws, policies, and services on an ongoing basis; and
- **Delivering services** that support their SRHR and right to live free from violence.

- States should **support a twin-track approach** to ensuring the inclusion of young persons with disabilities in civil society by:
  - **Enforcing legal protections** that protect civil rights to association, assembly, and speech;
  - **Simplifying the registration and renewal process** for all CSOs and ensuring they are disability inclusive;
  - **Facilitating the mainstreaming of young persons with disabilities within mainstream CSOs** including youth organisations, women's organisations, and DPOs;
  - **Supporting the development** of organisations specifically representing young persons with disabilities; and
  - **Including** young persons with disabilities in international, regional, national and local advisory boards, and civil society forums related to disability, youth, gender, health, access to justice, and other SRHR- and GBV- related issues.

Young persons with disabilities, however, encounter many significant barriers that prevent them from playing their vital role as members of civil society as advocates and advisers regarding their rights, including SRHR and GBV prevention and response services. This is particularly true for young women and adolescent girls with disabilities who experience multiple dimensions of discrimination on the basis of gender, age, and disability.

The barriers young persons with disabilities face in representing themselves in civil society can be political, organisational, and social. Young persons with disabilities and their CSOs can face obstacles that prevent them from registering their organisations or using them to call out human rights violations and hold states accountable. Many states continue to deny their citizens the basic rights of association and free speech. The denial of basic civil and political rights may in fact be a growing trend around the world as many regimes increasingly seek to control or outright suppress civil society. Young persons with disabilities can also face difficulties developing the requisite financial and human resource capacity to be effective advocates and/or service providers. Young persons with

disabilities and their organisations are often not included in leadership development trainings or small and large grants that are available to other CSOs. Lastly, young persons with disabilities may face discriminatory social attitudes that exclude them from civil society. For example, overprotective parents may prevent young women and adolescent girls from participating in activities outside the home or mainstream CSOs representing persons with disabilities, women and girls, and, moreover, youth often do not include young persons with disabilities in leadership roles. Many mainstream women's rights and youth organisations discriminate against persons with disabilities and exclude them from membership and activities. Young persons with disabilities, especially young women and adolescent girls, can also encounter discrimination within mainstream DPOs that have leaderships dominated by older men who refuse to include youth- and gender- related issues, especially SRHR and GBV, within their agendas. States, however, can do many things to promote the right of young persons with disabilities to be represented in civil society ranging from actively supporting the development of new CSOs through to actively involving them in all aspects of governance, from development of new laws through to implementing and monitoring the programmes.

CHAPTER OVERVIEW

This chapter will highlight what a strong civil society can do to advance young persons with disabilities' rights including SRHR and access to GBV prevention and response services, will discuss barriers and facilitators that young persons with disabilities face in terms of participating in civil society, and will briefly discuss some positive steps state have taken to support and engage CSOs at the global, regional, and national levels. This chapter is divided into three main sections: What Civil Society Can Do, Barriers and Facilitators, and Supporting Civil Society from the Global to the Local. Each section emphasises the relationship between civil society and the state and uses case studies that demonstrate positive state practices for ensuring that the state and civil society mutually reinforce one another's ability to promote the rights of young persons with disabilities in particular contexts and regarding specific aspects of SRHR and GBV prevention and response.

The most important thing that CSOs representing young persons with disabilities can do is advise governments on legislation and policy that promotes their enjoyment of and access to SRHR and GBV prevention and response services. It is particularly important that young women and adolescent girls are provided a central role in the policy development process because their insight is vital to ensure that the barriers they experience are fully addressed. It is the state's responsibility to include representation of young persons with disabilities in the policymaking process. Civil society organisations can also play an important role in raising awareness regarding the rights of persons with disabilities. This includes addressing negative social attitudes in the larger community and ensuring that young persons with disabilities understand their rights and how to claim them. To continually improve SRHR and GBV prevention and response services and hold state's accountable, CSOs representing young persons with disabilities should also be included in ongoing monitoring and evaluation processes. States can not only support this by inviting young persons with disabilities, especially young women and adolescent girls, to periodically monitor policies and programmes, but also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facilitate these young persons' involvement in the production of civil society or 'shadow' reports on all conventions affecting their rights, including the CRPD, CEDAW, and CRC. Lastly, young persons with disabilities' organisations often play important roles as service providers. This could include doing everything from offering workshops on disability inclusion to operating rotating funds that support income-generating opportunities for their members. States can support these services by including young persons with disabilities' organisations in their international development programmes or directly contracting with CSOs as service providers.

Before civil society representing young persons with disabilities can provide all these essential functions ensuring their participation in the realisation of their reproductive rights and rights to live lives free of violence, barriers to participation in civil society need to be addressed. States have a responsibility to ensure that young persons with disabilities are able to join or organise their own CSOs. It is vital that states promote and protect the basic civil and political rights of association, assembly, and free speech that enable civil society to play its important role in society. Registration and renewal processes for CSOs should be as burden-free as possible to ensure that young persons with disabilities can register their own organisations. This should include state support and accommodation to young persons with disabilities to ensure that registration processes are accessible. New organisations should also be offered capacity-development assistance to ensure that young persons with disabilities have the resources to develop and maintain effective organisations representing their interests. Lastly, states can play an important role in addressing disability discrimination in the home and the larger society that prevents young persons with disabilities, especially young women and adolescent girls, from participating in civil society. This includes ensuring that parents and caregivers understand that young persons with disabilities have a right to join organisations and participate in activities outside of the home and that mainstream CSOs are accessible and inclusive. Negative social attitudes are as prevalent within civil society as they are in other sectors of society, thus states have a responsibility to ensure that young persons with disabilities are able to participate in mainstream youth, women's, and disability organisations and can form their own representative CSOs.

As in other chapters of this report, each subsection incorporates case studies to illustrate specific steps state actors can take to promote the representation of young persons with disabilities in civil society and to ensure that young persons with disabilities participate in advancing their enjoyment of and access to SRHR and GBV prevention and response services. Each case study is context specific but does highlight positive practices within the specific context. The examples provided are not exhaustive nor can they be assumed to work in all locations and for all individuals. Nor is any one example sufficient on its own. Instead, each case study represents a single step in a broader, interdependent process to achieve the rights of young persons with disabilities.

Lastly, there are a number of international and regional CSOs around the world promoting the rights of young persons with disabilities. These include international and regional nongovernmental organisations (NGOs) and global DPO networks promoting the rights of young persons with disabilities. Although there are a growing number of organisations

representing young persons with disabilities and women and girls with disabilities, there remains an immense need for even greater representation. States can play an important role by supporting more opportunities for young persons with disabilities to participate in international and regional policymaking processes, including assisting young persons with disabilities in strengthening their existing organisations and founding new ones.

The types of positive state practices highlighted will include both sides of the twin-track approach. This approach will include examples of states promoting the inclusion of young persons with disabilities into mainstream initiatives supporting SRHR and GBV prevention and response, such as facilitating greater inclusion of young persons with disabilities in mainstream youth organisations. It will also include practices that specifically target the development of CSOs specifically representing young persons with disabilities.

Before moving on, it is important to define the concept of civil society to indicate what an important role it plays in society. The most commonly cited definition of civil society is Cohen and Arato's definition of civil society as 'a sphere of social interaction between the economy and state, composed of actors and organisations that self-organise to advance collective goals'.[706] An important aspect of their definition is their description of civil society as 'between' or outside of the state (government) and market (business). It is within this space that civil society finds its strength. It is a realm of freedom, in which people are not driven by the logic of government nor the motives of the market, but instead are able to come together collectively as people to discuss issues, define problems, and advocate for or implement solutions.

As the 'third sector',[707] nonprofit, nongovernmental, voluntary associations are invaluable in people's lives. Civil society ranges from the churches where they come together to worship through to trade unions that advocate for better working conditions and neighbourhood groups that promote safe places for their children to play. Civil society can be informal associations that momentarily come together around some cause in common through to formalised NGOs that establish offices and carry out campaigns and programmes on an ongoing basis at home and abroad. The disability, women's, and youth movements have all been major forces of positive social change in national contexts and at the international level and have laid the groundwork for young persons with disabilities to exercise their SRHR and access GBV prevention and response services. Each of those movements was led by and sustained by CSOs that were able to bring people together and implement advocacy campaigns that ensured their issues and concerns were known to states and the international community. Although civil society is a broad concept, this chapter will primarily focus on two types of CSOs: grassroots membership-based organisations that represent the voice of their members in the public sphere, such as DPOs and NGOs, including international NGOs, that implement services in communities around the world.

// II. WHAT CIVIL SOCIETY CAN DO

Civil society organisations are an essential partner in the advancement of human rights, including the right to sexual and reproductive health (SRH) and to GBV prevention and response services for young persons with disabilities. Perhaps the most important contribution CSOs can make, especially DPOs, is representing

people with lived experience and first-hand accounts regarding accessing their rights. For laws, policies, and services to effectively address barriers and ensure inclusivity, they must be informed by the everyday knowledge of rights holders who have faced barriers at the local, national, and global levels. Civil society organisations, especially DPOs representing young persons with disabilities, represent everyday people coming together to ensure their voices are heard and that barriers to accessing their human rights are addressed.

The types of actions and activities that civil society can undertake in promoting the rights of young persons with disabilities include giving voice to the issues that concern them most through participation as representatives and advisers in the legislative and policy development process, awareness raising and educating individuals and the public on rights, monitoring and evaluating implementation, and service delivery. These activities can range from very public forms of awareness raising meant to garner the attention of the state and other public authorities through to much more collaborative and institutionalised arrangements, such as active and ongoing partnerships between the state and CSOs. For example, CSOs can do a variety of things ranging from publishing editorials in newspapers or organising marches or rallies through to submitting formal reports to the government or sitting on advisory boards and national councils. Some organisations also directly provide services, often with financial and other forms of support provided by states. For any and all of these initiatives to be effective, it is vital that young persons with disabilities, especially adolescent girls and young women, are active members and fully represented in both transnational civil society networks and local grassroots associations.

GIVING VOICE

International organisations and states are increasingly recognising that civil society is an essential partner when developing sustainable and effective policies and programmes advancing human rights. The UN Office for the High Commissioner for Human Rights has advocated for greater international support of and partnership with CSOs because they recognise the positive contribution CSOs make when they give 'voice to the powerless' and 'scrutinise the implementation of human rights, report violations . . . and campaign for the development of new human rights standards'.[708] At a minimum, states must recognise the basic human rights of freedom of expression, association, peaceful assembly, and right to participate in public affairs. In addition to protecting these rights, however, many states go much further and proactively include civil society in policymaking processes. National governments, including those representing developing countries, are increasingly fostering state-civil society partnerships because they recognise their role in empowering citizens and making governance more effective.[709] For civil society to be successful within these partnerships, however, they must include and represent everyone. Unfortunately, young persons with disabilities have often been underrepresented within civil society, including within the women's movement and disability rights movements.

'Nothing About Us Without Us'[710] is the disability movement's motto because it advances the principle that no law or policy affecting persons with disabilities should be made without the active consultation of persons with disabilities in its development. Historically, disability policy and programmes throughout the world have been

advocated for and implemented by CSOs led by persons without disabilities, such as religious organisations, charities, and groups of medical professionals.[711] These civil society leaders without disabilities were often more concerned with lobbying the state to provide funds for them to 'care for' or 'rehabilitate' persons with disabilities than with ensuring that persons with disabilities received equal rights as citizens and were supported in living independently and fully participating in their communities. As a result, persons with disabilities were marginalised by the very initiatives designed to address their needs.

A central demand of the first disability movements in North America and Western Europe was that their governments pass new laws redressing their discrimination[712] and establish national and local disability rights councils to monitor new laws and policies from the perspective of persons with disabilities.[713] Today, many states are following suit and actively bringing DPOs together for their consultation and advice and creating national advisory councils inclusive of DPOs to facilitate their input into the implementation and development of disability law and policies from the perspective of persons with disabilities themselves. Many of these recent changes are a direct result of the CRPD, which includes articles specifying the role CSOs representing persons with disabilities should play in all aspects of ensuring their rights. The CRPD and the way in which it can facilitate the rights of young persons with disabilities to ensure that 'Nothing About Us Without Us' specifically includes them, too and their role in advancing SRHR and GBV prevention and response services. 'Nothing About Us Without Us' has also increasingly becoming a global norm and is being applied to all marginalised groups, resulting in participatory, inclusive, and rights-based development practices that ensure that all people, including women and girls, young persons, racial and ethnic minorities, displaced persons and others are part of the policymaking and monitoring process from the very beginning.[714]

Exclusion from the legislative and policymaking process has also affected women and youth, who have historically been subjected to laws, policies, and programmes that directly affect them but were written without their consultation. Not only does this result in the exclusion and marginalisation of women in governance, but also the end product is often ineffective and counterproductive. Fortunately, an increasing number of states are including CSOs representing women and youth through public forums, national advisory councils, and other means of consultation, especially when developing legislation and programmes protecting their rights and creating new social and economic opportunities. These practices are supported by research on the development of rights equality law and policies that demonstrates that the most effective policies in the end are those that included the marginalised group from the very beginning of the legislative or policymaking process.[715] This means that if states want to achieve a positive result, young persons with disabilities, especially women and girls, need to be at the table from the very first discussions regarding their SRHR and right to live free from violence. Unfortunately, in many cases, when not all people are at the table, the needs they face, rights violations they are subjected to, and barriers they experience will go unaddressed. That is why it is vital that CSOs themselves are inclusive: to ensure that all voices are heard.

Unfortunately, many DPOs, women's organisations, and youth organisations in the past have not given adequate space or voice to young persons with disabilities.[716] There are, however, important signs of progress addressing that past absence of voices, leading to more effective laws and policies, including those that focus on promoting the SRHR of and preventing and responding to GBV against young persons with disabilities. Every day, women and young persons with disabilities are founding their own networks and existing DPOs, and some youth and women's organisations are increasingly promoting the representation and involvement of persons with disabilities within their organisations, including developing bylaws that ensure they are represented on the board and other leadership positions. Prominent examples include women Enabled International (WEI), a global NGO founded in 2010 specifically to advocate at the intersection of women's rights and disability rights and, at the regional level, the African Youth with Disabilities Network, which was founded in 2011 to unite and give voice to young persons with disabilities in 12 African states.[717] Young persons with disabilities' organisations are being established throughout the world and, according to a recent Global Disabled Women's Rights Advocacy report, dozens of women with disabilities' DPOs have been founded since 2010.[718] In both these cases, young persons with disabilities, including young women and adolescent girls, are making sure that new national legislation and policies being implemented as a result of the CRPD address their rights, including SRHR and the right to live free from violence.

CIVIL SOCIETY AND THE CRPD'S ARTICLE 6 ON WOMEN WITH DISABILITIES: POSITIVE STATE PRACTICE ENGAGING A DIVERSE AND INCLUSIVE GROUP OF DPOS ON GLOBAL LAW AND POLICY

The CRPD itself is the result of partnership between civil society, the UN, and individual states. It is also a direct demonstration of why it is important that States Parties support and include many voices from CSOs representing persons with disabilities when developing laws, policies, and programmes aimed at advancing SRHR of and elimination of GBV against young persons with disabilities.

Persons with disabilities are diverse. Their experiences as persons with disabilities intersect with other aspects of their identity, such as their age, gender, race and ethnicity, and even life circumstance, such as being a displaced person. A positive state practice is not only to consult DPOs in general but also to make sure that persons with disabilities representing different groups are included. Both CRPD Article 6 on Women with Disabilities and the gender-specific aspects of Article 16 on Freedom from Exploitation, Violence and Abuse are directly due to states actively supporting the voice of women with disabilities when they brought DPOs together to review drafts of the CRPD and advise the state how best to represent persons with disabilities in the negotiation process.[719] This process provides a

positive example of why and how states can and should specifically include young persons with disabilities, especially young women and adolescent girls, when developing positions regarding international law and policies.

Throughout the drafting process of the CRPD, civil society was represented by the International Disability Caucus. Whereas many members of the International Disability Caucus included women with disabilities or who were sensitive to gender-based issues, there was no international DPO at that time representing women and girls with disabilities. The 'gendering' of the CRPD instead occurred through states involving their national-level civil societies in the negotiation process by advising them on Working Group drafts of the Convention during the negotiation process. One study[720] documents and demonstrates two state-civil society collaborations: Australia and South Korea. In 2004, the Australian government organised a National Consortium of Australian CSOs to examine the draft text of the CRPD to receive feedback on Australia's participation in the next stages of negotiation. In addition to funding the participations of the Australian Federation of Disability Organisations, People with Disability Australia, and the National Association of Community Legal Centres and enabling them to consult and gather recommendations from their members, other local DPOs, and individuals with disabilities, Australia also supported a specific gender-focused analysis of the text. As a result of that analysis, the Australian NGO specifically recommended that Australia advocate that Article 16 on Freedom from Exploitation, Violence, and Abuse, which did not refer to gender in the draft text, be modified to specifically do so. Australia supported and advocated for these changes to the text at the next Ad Hoc Committee Negotiation meeting, resulting in the final convention's text referring specifically to States Parties' obligation to specifically address 'gender-based aspects' of the exploitation, violence, and abuse of persons with disabilities in national legislation and to 'provide gender-sensitive services and address gender-specific needs'.

South Korea engaged in a similar NGO consultation process. It was during that process that Korean CSOs representing persons with disabilities highlighted the fact that, at that time, the draft CRPD text did not have a specific article recognising the intersection of gender and disabilities. By identifying this gap, South Korean DPOs prompted Korea to propose a specific article on women with disabilities during the 2004 Ad Hoc Committee Negotiation. This proposal was ultimately supported by other states and NGOs, resulting in the inclusion of Article 6 in the final draft of the CRPD obligating states to 'take all appropriate measures to support the advancement, empowerment, and development of women' with disabilities to fully exercise their human rights.[721]

These case studies directly demonstrate how states involving civil society as advisers in the development of law and policy results in stronger and more inclusive rights for persons with disabilities, particularly in issues affecting young persons, including young women and girls, the most.

RAISING STAKEHOLDER AWARENESS

Civil society is also an important instrument for advancing human rights beyond the law and policy development processes by taking laws out of government offices and legislative chambers and into the villages, households, and consciousness of individuals. Human rights are often meaningless in everyday life if people are unaware of the rights they and others have and of how they can access them. Civil society organisations are particularly effective at being able to reach out into society to raise awareness among the members of marginalised groups, such as young persons with disabilities, and motivate them to claim their rights. CSOs are also adept at addressing many of the beliefs and practices not conducive to human rights in households and communities that prevent certain people from accessing their rights. Civil society is able to address misconceptions and stigma by fostering new, affirming attitudes, and providing solid evidence and accurate information. In many places, laws and policies promoting SRHR and the right to live free from violence for young persons with disabilities will have an extremely limited effect if people do not know what the law says and understand what it actually means in day-to-day life. This is because young persons with disabilities are often excluded from both sexuality and human rights education, particularly comprehensive sexuality education (CSE), are socially isolated from their peers whereby they may learn about their rights and live in homes where protective families limit their knowledge of SRHR and GBV. Civil society organisations, especially DPOs, can be effective by directly addressing deep-seated taboos and basic lack of knowledge regarding disability, gender, youth, sexuality, reproduction, and violence.

In many instances, law and policy must be put in terms that local communities can understand and in formats or language that all individuals including persons with specific disabilities can access. Raising human rights awareness is effective when messages resonate with the target population. Civil society organisations at the grassroots level make the most effective intermediaries when translating information about human rights into knowledge that is more accessible, including in terms of SRHR and GBV prevention and response.[722] Both international and national laws need to be framed in ways that those protected by rights and the larger community understand and accept. Civil society organisations that are not only working in local communities but also are led by people from the community itself are often in a better position to design awareness campaigns and programmes that advance and promote existing human rights standards and norms. Local individuals who 'speak the local language' both literally and figuratively, yet also understand and are experienced in the world of international human rights, often make the best intermediaries in translating law into the everyday language of people and motivating their communities to embrace, rather than resist, positive social and legal changes.

Another aspect of ensuring awareness campaigns are effective is format and language. Young persons with disabilities are often socially isolated, have less access to education, or have specific impairments that must be accommodated. The normal means of distributing information, such as publishing laws in newspapers or announcements made in schools, may not reach young persons with disabilities. As a result, CSOs, especially DPOs, are often those in the best position to reach young persons with disabilities and make them aware of important issues, such as SRHR and GBV. Disabled persons' organisations and

other CSOs are often more experienced than governments are in reaching young persons with disabilities in their homes, explaining complex issues in more accessible terms, and answering the questions young persons with disabilities and their families may ask. Disabled persons' organisations also have expertise in putting laws, policies, and information into accessible formats, such as simple language, sign language, Braille, audio file, and so forth and in framing that information in ways appealing to young persons with disabilities.

Harmful beliefs that stigmatise persons with disabilities are at the root of laws, policies, and everyday practices that deny young persons with disabilities of their human rights. This can also include young persons' internalisation of negative social attitudes and beliefs that they themselves are undeserving of their rights. The double discrimination produced at the intersection of disability and gender can have a particularly harmful effect on young women and girls with disabilities who may wrongly come to believe that they are not included or do not have rights in relation to sexuality, reproduction, and living free of violence and discrimination. Civil society organisations are often at the forefront of addressing these harmful beliefs by raising individuals' consciousness and promoting positive ideas regarding the deservingness of all people to equal treatment and access to human rights. Women's CSOs have demonstrated their effectiveness at addressing patriarchy in regional contexts around the world.[723] DPOs, in particular, have been successful implementing sensitisation and education campaigns in developing contexts that transform harmful beliefs about persons with disabilities as dependents or aberrations into positive perceptions of persons with disabilities as leaders and representative of human diversity by addressing stereotypes and erroneous beliefs.[724] Scholars argue that the full exercise of disability rights depends on both 'supply-side' reforms, such as law and policies mandating that public agencies respond to persons with disabilities claiming their rights, and 'demand-side' reforms that encourage and support persons with disabilities choosing to exercise their rights.[725] Disabled persons' organisations can be especially important regarding the latter by informing persons with disabilities about the choices available to them, building their capacities through self-advocacy skills, and collectively advocating on their behalf when necessary to ensure their rights are recognised.

There is a growing body of evidence on public awareness campaigns that effectively reduce violence and abuse directed toward women with disabilities.[726] Civil society organisations have also been effective in addressing the beliefs of parents of children with disabilities, who can act as gatekeepers, limiting their children's access to their rights, especially with regard to SRHR and GBV prevention and response services. Successful public awareness campaigns promoting the rights of young persons with disabilities are often those implemented by DPOs led by young persons with disabilities. This is because the most effective educators and awareness raisers are those most resembling the target population, such as young leaders with disabilities talking to young persons with disabilities and their families and broader public about the inherent value and contributions that young persons with disabilities can bring to communities when given access to the same rights and opportunities everyone else holds.

States can play a vital role in supporting CSOs, such as youth groups and DPOs, in raising awareness and educating their memberships and others about their rights and how to access them.

Positive state practices include bringing CSOs together to develop education and awareness-raising tools and campaigns that facilitate the dissemination of knowledge and encourages the acceptance of new rights at the local level or within specific communities.

INTER-AMERICAN INSTITUTE FOR DISABILITY AND INCLUSIVE DEVELOPMENT COLLABORATION: INFORMATION DISSEMINATION THROUGH SIGN LANGUAGE[727]

States have a positive obligation under CEDAW and the CRPD to ensure awareness of and equal access of women and girls and persons with disabilities to information, including information regarding SRHR and GBV. A specific barrier young persons with disabilities faced in Uruguay was that young persons with hearing impairments were often excluded from or had little access to awareness-raising activities, such as facilitated discussions regarding gender. Moreover, Uruguayan sign language was limited in its vocabulary of signs referring to specific concepts of gender-related human rights, including reproductive rights and the right to live free from violence. There was also the need for language to be developed regarding SRHR and GBV prevention and response. Uruguay, UNFPA, and the Instituto Interamericano sobre Discapacidad y Desarollo Inclusivo (Inter-American Institute for Disability and Inclusive Development, iiDi) initiated a strategy to address this specific barrier.

The Inter-American Institute for Disability and Inclusive Development is a Uruguayan CSO representing persons with disabilities that promotes citizenship and social inclusion using the principles of human rights and inclusive development to work for a 'society for all'. The Inter-American Institute for Disability and Inclusive Development has been recognised by Uruguay's national government for its work with young people from the deaf community in Uruguay. A major part of that work took place in 2013, when iiDi hosted a series of workshops on gender for young deaf persons working as volunteer health promoters in Uruguayan Sign Language. The workshop was part of UNFPA's We Decide!, or *Decimelo a mi!,* initiative, which works with states to promote gender equality and social inclusion of young persons with disabilities.

The iiDi workshops centred around questions about gender, such as how young women and girls have different social expectations and roles from those of young men and boys and how those differences can lead to gender inequality. A major theme was sexual attitudes and the effect these have on women and girls' exercise of SRHR and their vulnerability to experiencing GBV. One barrier identified by young women and men with hearing impairments participating in the workshops was that they did not know how to communicate with health clinicians regarding certain topics related to SRH, even when sign language interpreters were available. Because certain topics, such as family planning and GBV, are taboo, and information regarding them has historically been inaccessible to the deaf community, the language—or vocabulary of signs—regarding them was underdeveloped or not widely known among Uruguayan Sign

Language users. The various partners realised that this presented a unique barrier and worked with young deaf persons to develop new resources, including new signs and materials to disseminate them.

This barrier was also identified in other places, including Argentina and Costa Rica. As a result, a website was developed that covered the topics of gender, sexual rights, false beliefs, and diversity. Each of these topics is covered using videos featuring young persons from the local deaf community speaking about different subjects using Uruguayan, Argentinean, or Costa Rican Sign Language.

This case demonstrates how states can collaborate with CSOs to disseminate information and promote awareness among young persons with disabilities. It also shows the importance of states ensuring that information is accessible to all persons, including persons with sensory impairments who have a right to accessible forms of communication.

MONITORING RIGHTS

The effectiveness of human rights instruments often depends on the ability of CSOs to monitor and report on the protection and implementation of human rights. Civil society organisations regularly submit 'shadow reports' on States Parties' implementation of international human

rights conventions to human rights monitoring bodies, such as the Committees for CEDAW, CRC, CRPD, and other human rights treaties. Civil society organisations also regularly submit petitions that identify possible violations of rights and request international investigation into specific incidents. These reports and petitions hold states accountable because they represent the perspective of the rights bearers themselves and their individual and collective experiences. For CSOs' role in rights monitoring to be fully effective, the CSOs' involved in petitioning and reporting must reflect all groups protected by human rights. Mainstream human rights organisations, women's rights NGOs, and DPOs have increasingly sought to both represent young persons with disabilities, especially women and girls, and to specifically report on issues related to GBV prevention and response in these processes. States play an important role in this process by protecting CSOs' freedom to collect information on potential rights violations, providing resources for CSOs to prepare their own reports, and responding to the information presented and implementing corrective actions.

A shadow report, sometimes called an 'alternative report' or 'civil society report', is a report prepared by NGOs and submitted to a human rights treaty monitoring body of the United Nations. For example, any NGO with knowledge of sex discrimination issues in a state that is a State Party to CEDAW can file a shadow report to the Committee for the Elimination of All Forms of Discrimination Against Women just as any NGO with knowledge of disability discrimination in a State Party to the CRPD can file a shadow report to the Committee for the CRPD. These reports are a powerful means for bringing attention to and advocating for the redress of violations or gaps in the implementation of human rights conventions.[728] It is important that organisations representing young persons with disabilities are involved in all shadow reporting processes and not limited just to the CRPD. Shadow reports are an important alternative to official government country reports, which States Parties of international human rights conventions are required to submit periodically regarding their progress meeting their obligations under specific conventions, because they are prepared by NGOs that are independent from the government. A shadow report importantly provides a bottom-up civil society perspective on human rights as an alternative to states' top-down government perspective.[729]

In addition to the general right of CSOs to submit alternative reports to any human rights monitoring body, there are also Optional Protocols to human rights conventions that include the right for citizens to directly 'communicate' with the UN. Human rights researchers have found that there is a marked decrease of human rights abuses among States Parties that ratify optional protocols that include the right for citizens to directly 'communicate' to the UN, indicating that states' support for this role of civil society is one of the most effective means for ensuring that States Parties to human rights conventions meet their obligations.[730] This finding is in keeping with past research that argues that 'petition systems . . . are generally considered the most effective means for the protection of human rights'[731] and altering state practice.[732] The ability of rights holders to effectively communicate with the UN, however, often depends on the strength of civil society to advocate on individuals' behalf.[733] When CSOs are weak, the right to petition and communicate often goes unused, including in States Parties to conventions and optional protocols that institutionalise petition mechanisms.[734]

Gathering information is often a critical function that both states and CSOs contribute to. The 2030 Agenda for Sustainable Development has emphasised the importance of data collection that is disaggregated to age, gender, incidence of disability, and other characteristics to ensure it can be used to identify and address inequalities. While it is the government's responsibility to gather data and make it publicly available, CSOs representing marginalised groups are often in the best position to collect initial data in partnership with the state through surveys or more qualitative methods, such as interviews and focus groups. This is because CSOs often have the networks to cull information from otherwise-isolated groups and, in the case of communications disabilities, to collect information using accessible means such as sign language interpretation. Presenting evidence of inequality is often a powerful tool used by CSOs for demanding state action on issues of concern to young persons with disabilities and holding local and national governments accountable. States, however, should take responsibility for gathering data that can be disaggregated in order to identify needs and inequalities. This can be done by states developing their own capacity to solicit information as well, in appropriate cases, supporting CSOs as partners with them.

It is particularly important that there is a strong civil society presence representing young persons with disabilities, especially young women and adolescent girls, involved in preparing and submitting shadow reports, petitions, and other means of communicating with human rights monitoring bodies. In many cases, there has been an important increase in the number of DPOs representing women and girls in alternative reporting on CEDAW and the CRPD. Mainstream international and national human rights organisations have also begun monitoring and reporting on the rights of young persons with disabilities. This increased involvement and recognition of young persons with disabilities' experiences in human rights monitoring has increased attention to issues regarding access and equity to SRHR and to GBV prevention and response services.

USING CEDAW TO PROMOTE THE RIGHTS OF WOMEN AND GIRLS WITH DISABILITIES IN NIGERIA

Women Enabled International, Advocacy for Women with Disability Initiative, Legal Defence and Assistance Project, and Inclusive Friends Association joined together to submit a shadow report to the CEDAW Committee's 2017 state review of Nigeria. These four organisations represent both international and local NGOs along with DPOs and mainstream human rights organisations. Several of these organisations were able to do their work because they directly benefitted from support from States Parties to the CRPD, which obligates states to include CSOs advancing the rights of persons with disabilities in Article 32. This case study demonstrates the importance of states supporting the inclusion of DPOs representing women and young persons and adolescents in monitoring all international human rights commitments

through the shadow report process. Though it is common practice for DPOs to report on States Parties' implementation of the CRPD, this case study demonstrates why it is a positive state practice for states to support DPOs' participation in the submission of reports on States Parties' implementation of CEDAW and other human rights conventions.

The shadow report directly cites General Recommendation 18 of CEDAW, which requires States Parties to CEDAW to implement special measures to ensure the rights of women and girls with disabilities are respected, protected, and fulfilled. The report goes on to review Nigeria's legislation and policies regarding women, disability, GBV, access to health services, and access to justice. It then highlights the lack of specific language ensuring the rights of women and girls with disabilities in Nigeria's National Gender Policy (2006) and Gender and Equal Opportunities Bill (2011). The report gives a special focus regarding the lack of special measures taken to protect women and girls with disabilities from coerced reproductive health procedures that disproportionately affect persons with disabilities, such as forced sterilisation, and the lack of specific mandates for accessibility and reasonable accommodation for SRHR services. The report culls available information regarding the SRHR needs of persons with disabilities in Nigeria, including the disproportionate risk that women and young persons with disabilities share regarding HIV/AIDS and GBV and the need for new legislation and better policy implementation to address them.

The shadow report concludes with suggested questions the CEDAW Committee could ask or recommendations it could make to Nigeria's representative to CEDAW during the 2017 Session of the Committee. The suggested questions included those regarding disability inclusion in the 2015 Violence Against Women Act and its sexual and reproductive information health services. Recommendations included specific changes and amendments to existing legislation to ensure special measures ensuring the equality of persons with disabilities regarding access to justice in prosecuting GBV, inclusion in HIV programmes, and so forth. Many of these questions and recommendations were incorporated into the CEDAW Committee's report to Nigeria and are currently being considered by the Nigerian government.[735]

Although the shadow report calls attention to shortcomings in Nigeria regarding its implementation of CEDAW concerning the rights of persons with disabilities, the production of the report itself highlights the strength of Nigeria's civil society. A recent study on state-civil society relations in Nigeria characterised civil society as continuing to 'flower since the inception of democratic rule [beginning in 1999]' and notes that there are more than 46,000 registered NGOs in Nigeria as of 2009.[736] An open civic environment and free civil society is often a prerequisite for CSOs, such as WEI and its local partners in Nigeria, to gather the information and submit shadow reports. In respect to positive state practices, Nigeria's government has created an environment where CSOs have flourished, including organisations representing young women and girls with disabilities.

SOCIAL SUPPORT AND SERVICES

In addition to giving voice, raising awareness, and monitoring human rights, CSOs also provide social support and deliver services. Local grassroots associations are often the front line connecting people in need with others who can help provide them with the informational, material, and emotional resources they need. In many places around the world where states lack capacity, both international and national NGOs provide many basic services, including SRHR and GBV prevention and response services. In many aspects of protecting and promoting SRHR, it is both practical and good practice for states to partner with CSOs that have expertise and relationships with specific individuals and groups of persons with disabilities. It is, however, always a state's duty to take responsibility for protecting and ensuring access to these rights, including when states achieve that by supporting services provided by CSOs in cases where appropriate. That means that it is the states' obligation to ensure that services provided by both non-governmental and government providers are accessible and inclusive, including those related to SRHR and GBV prevention and response for young persons with disabilities.

Many membership CSOs representing marginalised groups, such as adolescents and youth, women and girls, and persons with disabilities, do not have the human resources or facilities to provide all services related to SRHR and GBV prevention and response, but do engage in many activities that directly and indirectly address these issues. First and foremost, CSOs educate community members about their rights and refer them to service providers, sometimes acting as advocates and case managers to assist people in navigating systems and services. Civil society organisations also often partner with government service providers to train them in disability inclusion to ensure that when persons with disabilities are referred, the state is fully responsive. For example, the UN Trust Fund to End Violence Against Women partnered with Leonard Cheshire Disability Zimbabwe Trust to both support women and girls with disabilities who experienced violence and to partner with and train Zimbabwe's police and court system in disability access and inclusion.[737] Many states also institutionalise relationships with CSOs as advocates within state service providers to not only train but also to be on-site as advocates for persons with disabilities to ensure government agencies are responsive.

A major service that CSOs partner with the state to provide is in facilitating supported communication and decision-making. This is particularly important for young persons with intellectual and psychosocial impairments making choices regarding their SRHR. Throughout the CRPD, specific articles obligate States Parties to take appropriate measures to provide equal access to persons with disabilities to all public services and to justice, including Article 12, which requires states to provide persons with disabilities the support they may require in exercising their legal capacity. Supported decision-making is particularly vital in protecting women and girls with disabilities from coercion when making decisions about their SRH. Forced sterilisation and forced abortion, for example, can be the result of women and girls with disabilities being pressured to assent to certain procedures without having had the freedom and understanding required for them to fully exercise their right to make decisions regarding their bodies. Access to justice to report violence and abuse depends on persons with disabilities having the supports they need to communicate with legal authorities and

represent themselves in court. In many places, decision-making authority for persons with disabilities historically has been taken away from persons with specific disabilities, such as intellectual or psychosocial impairments, and given to legal guardians, such as parents, or been retained by medical professionals, including the staff of institutions, such as state hospitals or orphanages. This can be particularly problematic in regard to SRHR and GBV prevention and response services, as some parents and health-care providers may hold negative social beliefs concerning persons with disabilities as sexual beings or, in some cases, may be the perpetrators themselves. Civil society organisations, which by definition stand outside of the state and economy, are often the best situated actors to facilitate supported decision-making services and ensure their supports are fully representative of the individual they are supporting and are fully independent. Having states partner with CSOs to provide supported decision-making services where appropriate is one promising approach to ensure the right of young persons with intellectual or psychosocial impairments to access their rights.

SUPPORTED DECISION-MAKING IN AUSTRALIA

The CRPD empowers individuals with disabilities themselves to make their own decisions rather than that power be exercised on their behalf by guardians. For persons with certain disabilities, the state is obligated to ensure that they have the necessary resources and supports to make decisions, such as persons with hearing impairments being provided sign language interpretation or persons with intellectual and psychosocial disabilities provided with someone who can fully explain and ensure their understanding of the choices they can make and fully express those decisions to the relevant authorities. Facilitating supported decision-making for these latter groups has been especially challenging for states both because supported decision-making is a relatively new concept and because state agencies often lack the expertise, knowledge, and personal relationship with individuals to effectively ensure their freedom of choice.

Some states have chosen to rely on persons with disabilities' social networks, such as friends and relatives, to provide support and assist them in making decisions. This policy, however, has encountered many of the same problems as guardianship has. Other states have sought to fulfil their obligation to the CRPD and support the rights of persons with disabilities by working with CSOs that have the knowledge, expertise, and relationships necessary to fulfil the rights of persons with disabilities when making choices, including choices regarding SRHR. An emergent positive practice has been States Parties to the CRPD partnering with CSOs that are advocates for the rights of persons with intellectual and psychosocial impairments to act as service providers of supported decision-making.

In the wake of the CRPD, Australia began to re-evaluate its laws regarding guardianship, trusteeship, and mental health because many of those laws and policies were potential barriers to the rights of persons with intellectual and psychosocial disabilities making their own independent decisions. In 2014, the Australian Law Reform Commission issued its report entitled Equality, Capacity and Disability in Commonwealth Laws, which includes principles for facilitating supported decision-making. Subsequently, a number of DPOs and other CSOs developed detailed guidelines and other resources specifying how the principles of supported decision-making can be achieved in practice. While Australian states have pursued different models of supported decision-making on the ground, partnering with civil society emerged as one positive practice whereby the right to supported decision-making can be achieved.

The state of Victoria has been the primary advocate for this approach since 2014 when the Office of the Public Advocate in Victoria began a pilot project training and matching volunteers with persons with intellectual impairments who needed supports in decision-making. In 2016, this pilot project initiative was institutionalised as a partnership between the Office of the Public Advocate and the Victorian Advocacy League for People with Intellectual Disabilities (VALID) and other civil society organisations and state ministries. VALID is an advocacy organisation that has developed training tools, information, and resources to help empower people with disabilities. This includes workshops and other supports for both persons with intellectual disabilities to be their own self-advocates along with training service providers and volunteers to support persons with disabilities themselves, including facilitating supported decision-making. VALID's role in its partnership with Victoria is to coordinate, train, and monitor volunteers to ensure that volunteers understand and are skilled in their role as supported decision-makers when they identify and acknowledge, interpret, and act on choices expressed by the individuals with whom they have been matched.

The Victorian government also supports other CSOs vital to the empowerment of young persons with disabilities. This includes Family Planning Victoria, which is an independent CSO that promotes SRH care, education, and advocacy. Family Planning Victoria is partially funded by the government and offers services specifically for persons with cognitive disability, including courses on relationships and sexual decision-making. Family Planning Victoria also provides courses to service providers, caregivers, and others working with persons with cognitive disabilities regarding their SRHR and obligations to ensure that the supported decision-making provided is in compliance.

By working with CSOs, states can ensure that the facilitator is independent from both the state and family of the person with disabilities making the decision and, as such, best positioned to ensure the individual's freedom of expression. By appointing and contracting with CSOs to facilitate these decisions, states are able to more effectively ensure independence and the rights of persons with intellectual and psychosocial disabilities in making decisions regarding their bodies.[738]

Civil society organisations, including youth organisations, women's organisations, and DPOs, address the issues of SRHR and GBV by organising peer support groups, which play a vital role in assisting participants dealing with discrimination- and violence- associated trauma in developing the confidence and skills to confront situations when their rights have been violated and claim the services to which they are legally entitled. Studies on disability social support groups provide ample evidence of the important role these organisations play. For example, a recent report on peer support groups for young women with disabilities concluded that they were essential for young women with disabilities to develop the emotional resources to 'counteract exclusionary messages from the outside world' and assert themselves as independent, right-holding individuals.[739] Survivors of violence support groups have similarly been found essential to the well-being of affected people. The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) identifies peer support groups as part of the Essential Services Package for Women and Girls Subject to Violence Model of Care for survivors of GBV and as an essential service health service states should support.[740] An essential principle of all peer support groups is that they are non-discriminatory. States are obliged to ensure that any peer groups they support, either by organising themselves or as civil society partners, are gender, age, and disability inclusive.

Finally, CSOs, particularly women's empowerment organisations and DPOs, indirectly address SRHR and GBV by operating vocational training and income-generating activities that reduce the risk of their members from engaging in unsafe sexual practices and give them the confidence and financial means to access many services. Both young persons with disabilities and women and girls with disabilities are disproportionately poor, not only in comparison with the general population but also compared with older men with disabilities. Contributing factors toward this economic marginalisation include exclusion from educational and vocational training opportunities, rejection by employers within the job market, and discrimination by economic development projects and organisations, such as grants and micro-credit programmes. In many places, DPOs are partnering with micro-finance organisations and others to mainstream persons with disabilities into their training and lending practices. For example, in Ghana, the Ghana Blind Union is currently working with rural banks to integrate their young persons and women with visual impairments into both their staff and lending portfolio.[741] All States Parties of the CRPD, including those that provide foreign aid, are obliged to ensure all international development programmes are disability inclusive.

III. BARRIERS AND FACILITATORS

It is the state's duty to ensure that civil society actors enjoy their rights to a conducive political and public environment, a supportive regulatory framework, free flow of information, long-term support and resources, and shared spaces for dialogue and collaboration.[742] In many cases, however, CSOs do not enjoy these freedoms and, in some contexts, are actively suppressed and subjects of violence by the state. Civil societies representing young persons with disabilities also face a number of additional barriers to public participation rooted in their identity as young persons with disabilities, who are often more socially isolated and less likely to be employed than older persons with disabilities are. Not only do states present barriers to certain groups, but also society itself can be a barrier. In addition, social attitudes and cultural beliefs can make it

more difficult for young persons with disabilities, especially women and girls, to participate in CSOs either because they face greater barriers at the individual level, such as overprotective parents or spousal control, or more systemic barriers, such as mainstream CSOs, including DPOs, refusing to include them as members or represent their interests. Persons from specific disability groups may also face particular barriers to participating in civil society, including cross-disability DPOs excluding them from their ranks.

All of these barriers to participation in civil society represent violations of the human rights of young persons with disabilities. Individual barriers, such as poverty resulting from exclusion from vocational training or the failure of states to enforce non-discrimination in the job market, represent failures of their rights to inclusive education and decent work. Collective barriers, such as bans on the freedom of association, represent failures of states to protect the most basic political and civil rights. Because all human rights are interrelated,

BARRIERS FACED BY YOUNG PERSONS WITH DISABILITIES IN THEIR PARTICIPATION IN CIVIL SOCIETY

Note: A text alternative for this infographic is available as an annex here.

any denial of individual or collective rights affects the ability for young persons with disabilities to participate in civil society and to exercise and access SRHR and life free from violence. The overarching right people achieve through civil society is to express themselves and influence public decision-making processes. Without a strong civil society representing young persons with disabilities, their needs, interests, and rights will not be made a priority.

The state, including both national ministries through to local authorities at the village or municipal level, can play a pivotal role in addressing both individual and collective barriers to civic participation. It is to the state's benefit and part of its responsibility to ensure that all citizens have the ability to be active members in CSOs and that those organisations are able to communicate with the state regarding citizens' human rights. With regard to SRHR and GBV prevention and response, it is essential that all barriers that young persons with disabilities face in their participation in youth organisations, women's organisations, and DPOs are addressed so that they can work together to advise on laws, policies, and programmes and monitor their implementation. It is also important that CSOs, when needed and appropriate, participate in awareness raising, the dissemination of information, and the provision of social support and delivery of services.

Many protections and supports for civil society exist throughout the United Nations (UN) system, including in many international human rights instruments. The CEDAW and the CRC provide guidance as to how states can support and partner with civil society. The CRPD, however, goes much further than these prior human rights instruments by providing the most advanced blueprint as to how States Parties can ensure that persons with disabilities are participants in civil society and, therefore, have a direct say in how they enjoy and access SRHR and live free from violence.

GATEKEEPING AND SILENCING

States are the most important gatekeepers for determining whether people can come together to organise and establish organisations or if they are shut out of public debate. States can present significant barriers or facilitate ease for groups of people that want to form, register, operate, and fund their own CSOs[743] and can affect the ability of those organisations to communicate their interests to the state and broader public. Governments directly determine the procedures and requirements for initial registration and continual renewal of organisations, thus are responsible for establishing how complicated, expensive, and even arbitrary registration and renewal processes are for citizens seeking to represent themselves in civil society.[744] States also determine *who* can establish a CSO, a right sometimes restricted for minority groups, particularly through anti-terrorism legislation that targets religious or ethnic minorities.[745] In other contexts, LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex) individuals and women and girls, both groups particularly important in the advancement of SRHR and GBV prevention and response services, have been barred from organising.[746] For all marginalised groups, including young persons with disabilities, registration processes that require significant time and resources can present challenges that make it extremely difficult or even impossible to register a new organisation or renew an existing one. States can facilitate participation in civil society by providing a clear, simple, inexpensive, and efficient registration and renewal process.

Another significant set of barriers CSOs face are limitations on their ability to freely

assemble, implement activities, communicate with the state or international organisations, and receive funding, especially from foreign sources. In recent years, a growing concern has arisen about the 'narrowing' or 'closing of civic space' in certain states that seek to suppress CSOs and censor their voice, sometimes with the use of state violence.[747] These barriers are not only violations of human rights, but also counterproductive for states' political and social development and stability because CSOs are often critical in assisting the state in identifying and understanding social problems, developing good laws and policies to address them, and effectively implementing new programmes. Young persons with disabilities exercising their right to publicly communicate with the state will not only lead to their development as individuals, but also their full participation in society will promote the development of all members of their national and local communities.

As the histories of women's movements and disability movements around the world tell us, it is important that the members of historically excluded groups themselves are those who help develop and monitor the laws and policies that most directly affect them. As a result, there is a growing international norm and an increasing number of legal obligations for states to institutionalise a role for CSOs representing women, persons with disabilities, and others in policymaking and governance.

The right for CSOs representing young persons with disabilities is not something newly recognised within international human rights. Basic freedoms of association and peaceful assembly were granted to all persons, including young persons, women and girls, and persons with disabilities in the foundational documents of the UN system. Despite this long history of the right to participation in civil society, however, certain groups were marginalised by the state and other civil society actors. As a result, the right to civic participation has been increasingly defined in international instruments in relation to historically marginalised groups and new positive obligations of States Parties to those instruments have been developed to ensure all voices are heard, included, and supported within civil society and its participation in policymaking and implementation.

Article 20 of the Universal Declaration of Human Rights (UDHR) (1948) states all people have a right to 'peaceful assembly and association', a right reiterated in Article 22 of the International Covenant of Civil and Political Rights (ICCPR) (1966). Despite these important provisions, certain groups, including women and girls, children, and persons with disabilities, have historically been marginalised from full participation in civil society. As a result, additional human rights instruments have specified the right to participate in civil society for specific groups. The CEDAW (1979) Article 7(c) specifically states that women have an equal right to 'participate in non-governmental organisations and associations concerned with public and political life of the country,' the CRC (1989) Article 15 recognises the 'right of the child to freedom of association and peaceful assembly', and the CRPD (2006) Article 29(b i) obligates states to promote persons with disabilities right to participate in 'non-governmental organisations and associations'. The CRPD, however, goes even further than CEDAW, CRC, or any other international human rights instrument to date.

This history of disability movements around the world demonstrated that for the human rights

of persons with disabilities to be recognised, persons with disabilities not only need the right to participate in civil society generally, but require the specific right to form their own organisations as persons with disabilities, where they can come together to discuss their experiences of discrimination in an ableist world and develop their own, collective voice as persons with disabilities to advocate for themselves rather than depend on persons without disabilities to advocate for them. As such, Article 29 of the CRPD on Participation in Public and Political Life also obligates States Parties to encourage persons with disabilities in 'forming and joining organisations of persons with disabilities to represent persons with disabilities at the international, regional, national, and local levels'. In addition to encouraging the development of DPOs, the CRPD goes even further and includes innovative and 'ground-breaking provisions'[748] regarding the specific role DPOs can play in the definition and implementation of their rights that States Parties must recognise. Those roles include DPOs as advisers on legislation and policymaking and monitors of the implementation of their rights (Articles 4 and 33).

CRPD Article 4.3 on General Obligations states, 'In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult and actively involve persons with disabilities, including children with disabilities, through their representative organisations.' Article 33 on 'National Implementation and Monitoring' also outlines a specific role for DPOs by creating a positive legal obligation that States Parties facilitate a role for civil society, stating that: 'Civil society, in particular persons with disabilities and their representative organisations, shall be involved and participate fully in the monitoring process' of the CRPD. What these articles in the CRPD mean is that States Parties' obligations go beyond simply allowing persons with disabilities the freedom to form CSOs and express themselves—the right to association and peaceful assembly, but must also actively involve DPOs in the formulation, implementation, and monitoring of laws and policies protecting and promoting the rights of persons with disabilities. In regard to equity for young persons with disabilities in accessing and being included in SRHR and GBV prevention and response services, this means that they need to be represented by DPOs and other civil society actors to ensure their participation in relevant policymaking and implementation processes.

In addition to the CRPD itself, the Optional Protocol to the CRPD, which has been widely adopted, includes the direct right of persons with disabilities to communicate with the UN Committee for the CRPD and register violations of the CRPD against their states. Article 1 of the Optional Protocol states: 'A State Party to the present Protocol recognises the competence of the Committee on the Rights of Persons with Disabilities to receive and consider communications from or on behalf of individuals or groups of individuals subject to its jurisdiction who claim to be victims of a violation by that State Party of the provisions of the Convention.' The right to communicate is one of the most effective means for ensuring States Parties meet their obligations,[749] but it also often requires the presence of a strong civil society that can support individuals in submitting violation reports to the Committee or can submit a report and communicate on their behalf.[750]

BRAZIL'S NATIONAL CONFERENCES ON THE RIGHTS OF PERSONS WITH DISABILITIES: POSITIVE STATE PRACTICE BY PARTNERING WITH CIVIL SOCIETY

Brazil's National Conferences on the Rights of Persons with Disabilities (Conferência Nacional dos Direitos da Pessoa com Deficiência) demonstrates a positive practice by bringing representatives from the state and civil society together to debate, evaluate, and design public policies addressing disability rights.[751] This is one way that states can empower DPOs by making them integral to the policymaking process, in keeping with CRPD's Article 4.3 States Parties' obligation to 'closely consult and actively involve persons with disabilities' in the development and implementation of legislation, policies, and other processes directly concerning persons with disabilities. It is also a forum where the priorities of young persons with disabilities, especially women and adolescent girls, can advocate for the issues that concern them most. Marineia Corsara de Resende, a Professor at the Federal University of Uberlandia, demonstrates why it is important that the personal experiences of women with disabilities are expressed and used to identify barriers, opportunities, and priorities directly related to SRHR:

> I'm still working, I still date, I still have boyfriends, I'm not married anymore but I used to be married. So, I want the other persons with disabilities to get the same access that I had. I went to the University, I studied so I could run my life the way I choose. But most people with disability don't have this opportunity.
>
> –Marineia Crosara de Resende, Professor at Federal University of Uberlandia

Because of the participation of women with disabilities, such as Professor de Resende, SRHR and elimination of GBV have become central to debates during the national conferences. Brazil is significant for its long history of women with disabilities being founders or becoming leaders of DPOs, including Núcleo de Integração de Deficientes (Centre for the Integration of the Disabled), which was one of Brazil's first DPOs and one of its most significant advocates for the rights of women with disabilities today, including through its participation in the national conferences.

To date, Brazil has organised four national conferences. During the first national conference in 2006, DPOs and government ministries came together around the theme of accessibility. It was during that conference that women with disabilities first began to press for greater accessibility to health facilities.[752] By the second National Conference in 2008, DPOs representing women with disabilities had become much more active, and became leaders around passing resolutions that explicitly called for better disability inclusion policies for maternal and neonatal care, educational and outreach campaigns on SRHR, and a more comprehensive health information system for persons with disabilities.[753] These themes carried over to the third National Conference in 2013, including the passage of Resolution 26, which called for greater action implementing public policies that guarantee the SRHR of persons with disabilities at the municipal and state levels, including greater access to SRH services, including family planning, prenatal and maternal care, and awareness raising programmes on SRHR for persons with

disabilities, their families, and caregivers.[754] Finally, during the fourth and most recent National Conference in 2015, the conference itself was organised around the intersectional themes of gender, race, ethnicity, sexual, and generational diversity.[755]

The national conferences have continually resulted in new policies. The most significant policy may be the National Plan for the Rights of Persons with Disabilities: 'Living Without Limits', which was a result of the first and second national conferences. Living Without Limits directly addresses SRHR and GBV in several ways, including significant policies for expanding maternal and reproductive care for women. It also held the government accountable, resulting in Brazil allocating Brazil Real 7.6 billion (U.S. Dollar 2.4 billion) to the implementation of Living Without Limits and specifying responsibilities for its implementation to all 15 federal agencies.[756]

The national conferences reflect an effective platform of including and giving political agency to DPOs and persons with disabilities at the national level to discuss directly with the government to call for accountability, inclusive legislation, and effective government responses that better meet the needs and aspirations of all citizens.

ORGANISATIONAL CAPACITY AND ACCESS TO RESOURCES

Young persons with disabilities, like all persons with disabilities, are often disproportionately poor, have less access to education, and more socially isolated than their peers.[757] Disabled persons' organisations can play a vital role in addressing these issues by bringing young persons with disabilities into contact with community leaders and others with disabilities who can act as role models. By facilitating new relationships and ongoing interactions among persons with disabilities, DPOs empower their members, instilling both new knowledge and skills and a new consciousness that encourages members to participate in advocacy, pursue educational and employment opportunities, and to actively participate in their communities.[758] Individual and collective empowerment through civil society are important factors in determining if young persons with disabilities pursue their SRHR and access GBV prevention and response services.

While DPOs and other CSOs can have these empowering effects, their capacity to do so is often limited, especially in the Global South. Disabled persons' organisations and other organisations representing marginalised groups, including adolescents and youth and women and girls, often reflect their members who are often disproportionately excluded from formal schooling, socially isolated from their peers, and inexperienced in leadership roles. As a result, DPOs often have low levels of organisational and advocacy capacity.[759] Disabled persons' organisations, for example, often lack the knowledge, financial and human resources, and networks to effectively advocate on behalf of their members when they work with governments in policymaking and implementation processes. Disabled persons'

organisations representing young persons or women and girls, who face double discrimination, often lack organisational capacity more than DPOs led by older men with disabilities. In certain areas of advocacy, DPOs collectively have less access to knowledge than others. For example, DPOs often have greater organisational capacity addressing accessible transportation or building because states frequently partner with them regarding this issue area, but have less organisational capacity to address issues in relation to SRHR and preventing and responding to GBV, where states have often not sought partnership with DPOs.

In many contexts, local CSOs are dependent upon international funders in order to gain both the financial resources and the organisational skills they need to be successful. Unfortunately, an increasing number of countries are barring local CSOs from benefiting from international NGOs and official foreign aid. Other countries do not outright bar local CSOs from affiliating or receiving funds with foreign organisations and governments, but instead require local CSOs to register as 'foreign agents', submit to increased government monitoring, and otherwise make it difficult from local organisations to receive the capacity development resources they need.[760] The increase of these barriers to international cooperation benefiting local civil society is particularly true in states facing significant opposition for their violation of human rights.[761] Disabled persons' organisations, like all CSOs in places facing restrictions, can suffer under these conditions by not being able to access vital resources or to learn important organisational skills.

In the past as well as today, organisations representing persons with disabilities have been left outside of funding and other capacity development opportunities available to others even in areas where there are few or no restrictions on local organisations benefiting from resources from abroad. Many foreign funders and NGO networks traditionally viewed supporting DPOs as a rehabilitation or charity issue rather than part of their democratisation and human rights initiatives. This exclusion extended to foreign funding offered to local organisations focused on increasing exercise of and access to SRHR and GBV prevention and response services. However, an increasing number of both states and international CSOs and networks are seeking to rectify the exclusion of DPOs from capacity development opportunities. International NGOs, such as Handicap International and the Disability Rights Fund and many bilateral aid agencies, have created dedicated programmes towards capacity development for DPOs, including the capacity of DPOs to advocate for SRHR and GBV prevention and response.[762]

In addition to not only lacking the basic resources and capacities that many CSOs need to be effective, from leaders who are skilled advocates through to maintaining office space and internet connections, DPOs and other organisations representing young persons with disabilities also face additional challenges. In places where accessible buildings are rare, DPOs are often limited as to where they can establish an office and other facilities. Organising meetings, collecting information, and implementing outreach activities also require additional resources than other CSOs do, such as subsidising the transportation of members who live in areas without accessible public transportation or ensuring access to information and communication (e.g. through Braille or sign language interpretation). Even when states are committed to implementing participatory policymaking practices, they often do so in ways that can exclude persons with disabilities, such as failing to provide documents in multiple formats or to plan public meetings and forums in accessible

locations.[763] In many instances, states expect the CSOs to cover these costs, such as bringing their own sign language interpreters to events rather than ensuring they are provided as part of the event. In these ways, DPOs and other CSOs representing young persons with disabilities face significant barriers to empowering their members and utilising their right to meaningful participation in policymaking, implementation, and monitoring.

There are several ways that states, especially States Parties to the CRPD, can facilitate the capacity development needs of DPOs to ensure that they can be effective advocates and partners for ensuring the SRHR of young persons with disabilities. The CRPD specifically supports the capacity development of CSOs, particularly in low-income countries, through Article 32 on International Cooperation. Many states have also implemented national and local means of support, such as providing organisational development resources directly to local DPOs, that enable those DPOs to organise persons with disabilities and effectively represent them when advising the state.

The CRPD is the first international human rights treaty to include a specific article on international cooperation. Article 32 not only obligates that States Parties ensure their international development programmes are inclusive and accessible to persons with disabilities, but also obligates States Parties do so, when appropriate, 'in partnership with relevant international and regional organisations and civil society, in particular organisations of disabled people.' Article 32 also obligates States Parties to 'Facilitating and supporting capacity-building, including through the exchange and sharing of information, experiences, training programmes and best practices.' What this means is that of the more than U.S. Dollar 140 billion spent annually on foreign aid,[764] all of those funds, including those related to SRHR and GBV prevention and response should be accessible to and inclusive of persons with disabilities. It also means that States Parties should be contributing towards the capacity development of DPOs to be an effective voice for persons with disabilities. Access to these funds, obviously, can be a vital means for national and local DPOs, including DPOs representing young persons with disabilities and women and girls with disabilities, in building up their general and SRHR-specific advocacy and programme implementation capacity. Because disability inclusion in international cooperation is new, many states are still developing inclusion policies and ensuring their effective implementation. Several states and international NGOs, however, have developed good practices that all major international donors can learn from, such as policies requiring all foreign aid to be disability inclusive or providing guidelines on disability inclusive development for all of its partners.

INCLUSIVE DEVELOPMENT GUIDELINES

A number of international disability NGOs have developed guidelines, including in budgeting, for mainstreaming disability inclusion into all forms of international cooperation. For example, the United States Agency for International Development (USAID) and Mobility International

have published *Building an Inclusive Development Community: A Manual on Including Persons with Disabilities in International Development Programmes.* In addition to covering all aspects of disability inclusion in international development, this important resource specifically addresses best practices regarding the topics of Gender and Disability, Civil Society, Women with Disabilities and Access to Health Care. Two important recommendations made throughout are that all international development programmes should address disability inclusion in their budgeting and that all NGOs and other implementation partners should have a disability inclusion policy. For programme activities, the manual recommends every budget allocate 5-7 per cent for operational costs and 1-3 per cent for administrative costs to ensure that all aspects of the development programme are accessible and inclusive.[765] has also developed a *Guide on How to Integrate Disability into Gender Assessments and Analyses* and all USAID Operating Units are required to perform a gender assessment when planning Mission-wide strategies. With this guide on disability-inclusive gender analysis, USAID missions are being made responsible for ensuring that persons with disabilities are included, particular young persons and women with disabilities. The guide specifically recommends that Mission's include DPOs in the assessment process and that the assessments include the thematic areas of GBV and HIV/AIDS.[766]

DFID GUIDANCE ON DISABILITY INCLUSION IN DEVELOPMENT: POSITIVE STATE PRACTICE IN INCLUDING YOUNG PERSONS WITH DISABILITIES IN DEVELOPMENT

Many countries have developed policies, tools, and funding mechanisms to include young persons with disabilities in international development programmes. The United Kingdom's Department for International Development (DFID) guidelines *Working on Disability in Country Programmes* (2007) is a practical how-to guide for DFID Country Programmes on integrating disability into development practice at the country level. It also represents a positive state practice and proactive step by the UK for meeting its obligation as a State Party to the CRPD. It also specifically addresses the civil society, youth and women and girls with disabilities, and programmes related to SRHR.

The guide recommends several key 'practical ideas for action', including identifying and regularly consulting with DPOs at the country level, including disability in country-level gender equality and social exclusion analyses, disaggregating all indicators collected by disability, including a focus on disability in annual programme reviews, and directly funding capacity development for local DPOs. In regard to civil society, DFID suggests a twin-track approach of implementing specific actions benefiting persons with disabilities while also mainstreaming persons with disabilities throughout civil society. For example, it suggests that DPOs should receive direct financial support in order to raise awareness and engaging in the policymaking and monitoring

process. It also suggests that country offices facilitate partnerships between DPOs and other (non-disability focused) CSOs in order to form stronger coalitions and promote the voice of persons with disabilities within all development issue areas. The guide also suggests DPOs be included in all major analyses and assessments, such as the Gender Equality and Social Exclusion Analysis and the Country Governance Analysis, a process that should include assessing the laws, policies, and practices of partner governments from a disability inclusion perspective.

Finally, the guide highlights the importance of DFID's country-level offices in promoting equal access to general health services and empowering persons with disabilities to make their own choices regarding their health, including having the support of peers and experts to do so. It also notes that persons with disabilities are particularly vulnerable to HIV/AIDS and therefore HIV/AIDS programmes and policies should be prioritised for disability access and inclusion.

This guide serves as a model of what states engaged in international cooperation can do to partner with and strengthen DPOs and meet their obligations to promote disability inclusion in all development initiatives, including activities that promote SRHR and GBV prevention and response services for young persons with disabilities.

SOCIAL EXCLUSION WITHIN THE HOME, COMMUNITY, AND CIVIL SOCIETY

Even in contexts where CSOs are free from state control and DPOs have the capacity necessary to carry out their programming, young persons with disabilities still face significant barriers to participating in civil society. Disability stigma, patriarchy, and paternalistic attitudes towards young people shape the behaviour of family members, peers, and even advocates representing other groups. Parents are often overprotective of children with disabilities and often keep their daughters and sons in the home rather than support them joining organisations and participating in public events. Young persons without disabilities may view a classmate or neighbour with disabilities as an object of charity or someone to be avoided, rather than a peer and someone to invite into their youth groups and integrate into their informal and formal networks. Even human rights advocates, including leaders of NGOs promoting SRHR and eliminating GBV, may hold false beliefs about persons with disabilities and not recognise both their rights and their needs for SRHR and GBV prevention and response. States have a duty to address stigma and other harmful beliefs because addressing negative social attitudes is a necessary step in ensuring individuals and marginalised groups can fully access and exercise their human rights. States can fulfil their duty to address stigma by supporting CSOs that work at the community level and by bringing local and national CSOs together to facilitate new connections and understandings across the leaderships of organisations promoting youth

development, women and girls' empowerment and gender equality, SRHR, and disability rights.

The relationship between caregivers and young persons with disabilities can directly determine the ability of young persons with disabilities to become full participants in society.[767] Parents and other family members of adolescents and young persons with disabilities sometimes view disability through the prism of religion or superstition. This can include beliefs such as believing a child born with an impairment represents a penance from God or that they were cursed by someone practicing witchcraft[768]. As a result, parents and other family may feel that it is their lifelong duty to care and protect a young person with disabilities rather than support them in becoming independent. Alternatively, caregivers may feel a sense of shame, and seek to keep young persons with disabilities in the home and out of the sight of others[769]. In other situations and contexts, parents and caregivers of young persons with disabilities may have a biomedical view of disability and see a young person with an impairment as someone who needs to be 'fixed' rather than someone whose real need is to be supported in accessing their rights.[770] As a result of a medical approach to disability, these parents may participate in advocacy, but limit their advocacy to the state's provision of rehabilitation rather than other issues, such as SRHR or political rights. These attitudes and beliefs directly affect young persons' ability to participate in civil society because they contribute towards social isolation and may make the family members of a young person with disabilities resistant to supporting them in joining organisations and adopting a human rights-based view of disability.

Adolescent girls and young women with disabilities often face double discrimination within the home. Paternalist and patriarchal attitudes towards female children and siblings can result in overprotection or behaviours meant to preserve a young woman or girls' 'innocence'. Young women with disabilities may face even less freedom than young men with disabilities to exercise their independence and join CSOs. Attitudes that emphasise preserving young women and adolescent girls' 'purity' can create particular barriers for young women with disabilities seeking to participate in CSOs promoting SRHR and GBV prevention and response services.

Young persons without disabilities may hold negative attitudes towards their peers with disabilities.[771] These negative attitudes held by youth towards their peers with disabilities can be resilient, including in contexts where young persons without disabilities and young persons with disabilities interact with one another on a regular basis, such as within schools that have implemented inclusive education policies.[772] Active measures, such as disability awareness raising are often required to change attitudes, including among young persons who are friends with persons with disabilities or have a person with disabilities within their family or among their neighbours.

One major barrier young persons with disabilities face is exclusion from being able to participate within or partner with mainstream CSOs and DPOs. Civil society organisations often reflect the cultures and societies in which they are embedded. As a result, young persons with disabilities may face the same social barriers to participating in civil society as they face in other areas of life. For instance, mainstream women's empowerment or youth organisations may discriminate against young persons with disabilities and deny them their ability to join or benefit from their activities. Mainstream DPOs may not believe the issues important to young persons or women and girls

are important and refuse to make issues such as SRHR or GBV prevention and response a priority in their work. The right to participate in civil society for young persons with disabilities is not simply a right to form their own organisations, but to join and participate in other CSOs on an equal basis with others. States can and should promote as inclusive of a civil society as possible. A civil society that includes young persons with disabilities can be achieved by states facilitating connections between organisations and holding their civil society partners accountable to policies promoting inclusion. This is a particularly important practice regarding organisations aimed at promoting the rights of youth, women and girls and those focused on SRHR and GBV prevention and response.

In a study on youth with disabilities in Cambodia and Indonesia, researchers found that in both places, young persons with disabilities were excluded from both mainstream youth groups and DPOs. Civil society organisations representing youth where by and large inaccessible and excluded young persons with disabilities. When asked about including young persons with disabilities, many youth leaders indicated that they had never contemplated youth with disabilities as possible members of their organisations, but instead only thought of persons with disabilities as the possible beneficiaries of volunteer activities. Seeing persons with disabilities as dependents rather than peers is indicative of wider social attitudes of seeing persons with disabilities as objects of charity rather than equal, right-bearing citizens. Similarly, young persons with disabilities were excluded from leadership roles and, in some cases, membership from many of the largest and most influential DPOs. As a result, DPO agendas reflected the interests of persons with disabilities who were middle-aged and older and, in many cases, predominantly male. These exclusions were particularly important because in both countries, the national governments regularly consulted with CSOs in their policy development and implementation processes. For example, Cambodia's Ministry of Youth Education and Sport regularly convened CSOs to solicit their feedback, yet no youth with disabilities were represented. Similarly, both countries had national councils on disability that included DPOs, but neither had a significant presence of young persons with disabilities within the council.[773] As a result, young persons with disabilities had no influence over issues related to SRHR or GBV prevention and response.

The CRPD is a major facilitator for addressing stigma and other harmful attitudes and practices affecting young persons with disabilities' ability to join and participate in civil society. According to the CRPD, States Parties have a positive legal obligation under Article 8 on Awareness-raising to 'foster respect for the rights and dignity of persons with disabilities' throughout society and to 'combat stereotypes, prejudices, and harmful practices related to disability, including those based on sex and age, in all areas of life'. A comprehensive awareness-raising policy should address all issues affecting young persons with disabilities' ability to access the same rights and participate in their communities on an equal basis with others. This would encompass both SRHR and GBV prevention and response services and the right to participate in civil society, including all youth, women's, and disability organisations. A positive state practice that fulfils Article 8 in regard to young persons with disabilities is for State Parties to directly support CSOs, especially DPOs representing young persons with disabilities, to implement awareness-raising programmes. Many DPOs have developed programmes for not only informing their members, but the broader public

regarding issues such as SRHR and GBV. It is also a positive state practice for states to bring CSOs across sectors together and to facilitate dialogues between women's, youth, and disability organisations. A related practice is to actively work with mainstream CSOs to begin including young persons with disabilities within their memberships and activities.

GERAÇÃO BIZ: POSITIVE STATE PRACTICE MAINSTREAMING DISABILITY INTO PEER ADVOCACY IN MOZAMBIQUE

Peer groups have been widely recognised as particularly effective means for educating and guiding adolescents and youth regarding their SRHR. States and community organisations have implemented peer-led SRHR education and advocacy initiatives in many contexts from Western Europe to West Africa and South America to Southeast Asia.[774] Young persons educating other young persons in the classroom or community centre, out in the streets, or even online in chatrooms or through phone text about safe sex can have a dramatically greater effect at addressing risky behaviour than when older adults, such as teachers or health-care providers, disseminate the same information and answering the same questions. This is because young persons are often more comfortable discussing these issues and more likely to listen to people their own age and having the same daily experiences. As a result, many states are, supporting peer programmes implemented by CSOs. These sorts of peer-led initiatives are most commonly used to address adolescent pregnancy or prevention of sexually transmitted infections (STIs), such as HIV/AIDS.[775] Unfortunately, many have excluded young persons with disabilities both in terms of being trained as peer educators and in terms of being the recipients of peer-led outreach. States can have a major impact on advancing SRHR for young persons with disabilities by mainstreaming them into peer-led initiatives.

Geração Biz ('Busy Generation') is a peer-led SRHR programme in Mozambique that began in 1999 and continues to not only operate, but grow, today. The programme has widely been cited as a best practice in increasing the knowledge for adolescents and youth regarding SRH and related practices.[776] Geração Biz represents a collaboration between the state and CSOs. The Mozambican ministries of health, education, and youth and sports implements the programme with a wide range of partners ranging from a national family planning NGO through to a network of more than 300 youth groups. The initiative has also received support from UNFPA and technical assistance from Pathfinder International. Over the years, more than 5,000 adolescents and youth have been trained as peer educators. Today, in addition to peer educators, it also operates a very popular SMS (short message service) text service that allows young persons throughout the country text in questions about their SRH that peer educators respond to from a computer centre in the capital, Maputo.

For the first ten years of Geração Biz's history, it was not disability inclusive. In 2009, however, the Mozambican Ministry of Gender, Children, and Social Action began to implement Project

Inclusion with the help of other ministries and in partnership with CSOs to promote access and exercise of SRHR for persons with disabilities. As part of Project Inclusion, the government worked with DPOs, such as the Mozambican Association of the Deaf to identify young persons with disabilities to join Geração Biz as peer educators. The supports needed to make Geração Biz disability inclusive included working with DPOs to identify young persons with disabilities interested in becoming peer educators, ensuring that Geração Biz training and meeting facilities and information and communication were made accessible, and implementing awareness-raising among Geração Biz participants without disabilities. Despite Project Inclusion's funding only lasting five years, inclusion of young persons with disabilities in Geração Biz not only proved to be sustainable, but the peer educators trained brought their new skills and knowledge into other organisations, including DPOs, and initiated their own SRHR projects.

During an interview with a former Geração Biz peer educator in 2017 who was now an active member of TV Surdo ('Deaf TV', a disability media NGO that produces public awareness clips and a news show on Mozambican state television), a young woman with a hearing impairment described her participation in Geração Biz years earlier as a peer educator. She enjoyed the work and was initially surprised by the training regarding how little she and her peers, whom she soon began educating, knew regarding their SRHR. She felt that as a deaf woman, she had known much less than her peers without disabilities who participated in the same training. For two years she led discussions regarding SRHR in secondary schools throughout Maputo. When she joined TV Surdo in early 2017, however, she saw it as an opportunity to bring her knowledge as a Geração Biz educator to a new audience using a new medium. Once she was trained as a producer, one of the first stories she initiated and scripted was a ten-minute video on HIV/AIDS. It soon became a very popular video on the TV Surdo YouTube channel. Since then, she has produced many more videos on SRHR topics, ranging from explaining menstruation through to discussing what to do in cases of GBV.

Another marker of success in disability inclusion in Geração Biz is the way inclusion can change the attitudes and raise the awareness of persons without disabilities. In 2017, two Geração Biz peer educators without disabilities, who were also part of the Youth Coalition Mozambican Association, discussed their experiences working with young persons with disabilities. Both young persons with and without disabilities integrated into their peer educator teams. The first described a youth activist with a visual impairment that joined his team. It was his first experience working closely with someone with a disability. Through it, he learned that not only do young persons with disabilities have SRHR needs and are at risk of HIV/AIDS too, but that 'they have more needs than us [persons without disabilities]'. The other peer educator, who is a team leader, described a young woman with a hearing impairment wanting to join her team. The peer educator explained that at first, she was 'apprehensive' and did not know if someone with a hearing impairment could 'do the job', but ultimately the young woman convinced her and, despite a speech impediment, has become one of her best lecturers regarding SRHR.

IV. YOUNG PERSONS WITH DISABILITIES REPRESENTED IN CIVIL SOCIETY AROUND THE WORLD

Young persons with disabilities' participation in civil society is vital to ensure their needs, interests, and rights are reflected in laws, policies, and programmes directly affecting them, including their SRHR and right to live free from violence. Article 29 of the CRPD states that persons with disabilities have a right to 'Forming and joining organisations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels'. Under the CRPD, States Parties also have a positive legal obligation to ensure that young persons with disabilities are represented in the public affairs. At each point along the continuum from the global to the local, states should include organisations representing young persons with disabilities to ensure their perspective is known, understand, and taken into account. This includes promoting the participation of young persons with disabilities in everything from negotiations on international agreements through to evaluating the implementation of local ordinances.

In this section, the initiatives CSOs representing young persons with disabilities at the international and regional levels will be highlighted. These networks and organisations and others like them provide a basis upon which partnerships between state and civil society can be built. There is, however, a continuing need to ensure that there are even greater levels of representation of young persons with disabilities, especially young women and adolescent girls, in civil society. States, however, can be instrumental in supporting the development of those organisations and facilitating the mainstreaming of young persons with disabilities into mainstream disability, youth, and women and girls' and gender equality focused CSOs operating internationally, regionally, and nationally. The networks and organisations discussed in this section is not comprehensive, but simply examples of CSOs in each region.

GLOBAL DISABILITY NETWORKS AND INTERNATIONAL DPOS

There are a number of global networks of DPOs and international NGOs representing young persons with disabilities in international forums and developing their capacity at the local level. It is impossible to highlight all of them. There are, however, three that are particularly important. The first is the International Disability Alliance, which has specific programming promoting the participation of youth with disabilities and women and girls with disabilities in civil society. The second is Disabled Peoples' International, which supports a global youth network and a number of regional initiatives related to youth, gender, SRHR, and elimination of GBV. Finally, there is Women Enabled International, which represents the first international DPO exclusively representing women and girls with disabilities. To date, there is no exclusive international young persons with disabilities DPO, although many global DPO networks and international NGOs promote their equality and access to human rights.

The International Disability Alliance is a network of networks, bringing together over 1,000 DPOs through eight global and six regional DPO networks. The International Disability Alliance represents the voice of persons with disabilities at the UN. International Disability Alliance also

supports its DPO members in holding their own states accountable, including through developing civil society or 'shadow' reports, which provide a disability perspective on states' fulfilment of their obligations to international human rights conventions. A number of states directly support International Disability Alliance's work, including Australia, Finland, Sweden, and the United Kingdom, and other states indirectly support International Disability Alliance through support provided by multilateral organisations and private foundations.

In addition to International Disability Alliance's work representing all persons with disabilities around the world, it has developed several initiatives to ensure that persons with disabilities who have historically been marginalised within the disability community itself are represented. These 'Intersectional Activities' include youth with disabilities, women and girls with disabilities, and indigenous persons with disabilities. The main goal of the Youth with Disabilities Programme is to ensure that youth with disabilities are meaningfully represented and involved in the implementation of the CRPD and SDGs. This includes supporting youth's direct participation in international conferences where law and policy are discussed and evaluated. The two main issue areas focused on are SRH and prevention of GBV and information sharing and engagement between youth and the wider disability community. International Disability Alliance also supports the Women and Girls with Disabilities Campaign, which promotes the visibility of women and girls with disabilities as human rights holders and activists. Campaign objectives include reproductive rights, abolition of forced sterilisation, capacity building for autonomy and independence, and other objectives directly relevant to SRHR and GBV prevention and response for young persons with disabilities.[777] International Disability Alliance has also done important work supporting young persons with disabilities participation in developing civil society or shadow reports on the CRPD and other human rights conventions.

Disabled Peoples' International is similar to International Disability Alliance in that it is a network of DPOs that holds special consultative status with the UN. Disabled Peoples' International is committed to the protection of the rights of persons with disabilities and the promotion of their full and equal participation in society. Disabled Peoples' International was established in 1981 and brings together DPOs from over 130 countries. Disabled Peoples' International also has active regional offices in Asia-Pacific, the Middle East, Europe, Africa, Latin America, and North America and the Caribbean that sponsor Regional Assemblies that bring together its members to address region-specific concerns. In 2012, Disabled Peoples' International set up the Global Youth Network to promote the voice of young persons with disabilities. The mission of the Global Youth Network is to build strong, capacity-filled youth with disabilities to become advocates for equal rights and opportunities within their societies. This important network has brought together young persons with disabilities from all regions of the world to share their experiences and to represent young persons with disabilities in international forums. Several members of the network are leaders and/or founder of DPOs, including national young persons with disabilities organisations.

The recently founded organisation WEI represents a landmark achievement as the first international DPO representing women and girls with disabilities. As such, its mission is to work at the intersection of women's rights and disability rights to advance the rights of women

and girls with disabilities around the world. Its work specifically includes drawing international attention to issues such as violence against women and SRHR. It also utilises a strategy of working across movements by drawing the women's rights and disability rights movements together to develop cross-cutting advocacy strategies.

Women Enabled International's *Enabling a Global Human Rights Movement for Women and Girls with Disabilities: Global Disabled Women's Rights Advocacy Report* maps the growing number of women with disabilities' DPOs around the world, many of which are making SRHR and the elimination of GBV their top priorities. Women Enabled International has also published its *accountABILITY Toolkit*, which empowers women with disabilities through the use of human rights mechanisms.[778] This new toolkit builds off of WEI's important work of supporting women with disabilities' participation as contributors to shadow reports for both the CRPD and CEDAW. It is extremely important that a disability perspective is involved in monitoring CEDAW because it is the main human rights instrument for holding states accountable regarding gender-based discrimination, including sexual violence and GBV.

In addition to young persons with disabilities being included in international DPOs and global DPO networks, it is also important that mainstream youth networks and youth-focused international NGOs include young persons with disabilities as members and fully represent their voice. There are a growing number of international initiatives promoting the participation of young persons at the local and global level, including advocating for SRHR and GBV prevention and response. Many, however, have not developed the disability inclusive policies necessary to ensure that young persons with disabilities can participate in their programmes on an equal basis with others. That said, the UN World Programme of Action for Youth, which coordinates its activities with dozens of CSOs representing youth or promoting youth-related issues, identified disability as one of its fields of actions. Importantly, girls and young women is also included among those fields of action.[779] That means that youth organisations around the world are being made aware of the importance of disability and gender inclusivity in their activities.

Supporting the development of such global and national networks and existing DPOs networks and international NGOs promoting the rights of young persons with disabilities is a positive state practice.

LATIN AMERICA AND THE CARIBBEAN

Latin America and the Caribbean is an important region for civil society representing young persons with disabilities. Two of the most prominent networks and organisations are The Latin American Network of Non-Governmental Organisations of Persons with Disabilities and their Families (*Red LatinAmericana de organizaciones no gubernamentales de personas con discapacidad y sus familias* – RIADIS) and iiDi, which is supporting the development of the Latin American Network of Youth and Inclusive Development. Another regional actor is Disabled Peoples' International North America and the Caribbean, which will be discussed in the section for Western Europe and North America. The Caribbean Community (CARICOM) is also a significant site for CSOs representing young persons with disabilities because it has its own regional instrument for promoting an inclusive civil society.

The Latin American Network of Non-Governmental Organisations of Persons with Disabilities and their Families (*Red LatinAmericana de organizaciones no gubernamentales de personas con discapacidad y sus familias* – RIADIS) is a DPO network representing 18 countries in Latin America and the Caribbean. Its mission is to promote the values of non-discrimination and inclusive development based on improving the quality of life and social inclusion of persons with disabilities and their families. RIADIS supports a youth network of young persons with disabilities drawn from its member organisations to represent young persons with disabilities in regional and international forums. RIADIS, through its youth network and other mechanisms, works to promote the rights of women and girls with disabilities, including in the areas of SRHR and elimination of violence against persons with disabilities.

The Instituto Interamericano sobre Discapacidad y Desarollo Inclusivo (Inter-American Institute for Disability and Inclusive Development, iiDi) is a regional organisation representing persons with disabilities and their allies. The Inter-American Institute for Disability and Inclusive Development's mission is to promote the inclusion and independence of persons with disabilities through human rights and international development. In 2014, iiDi began an initiative to develop a Latin American Network of Youth and Inclusive Development to ensure that young persons were represented in the SDGs, which include exercise of SRHR and access to GBV prevention and response[780]

In regard to civil society in general, the Caribbean region is significant because CARICOM adopted a Charter of Civil Society, which is a regional instrument that specifically promotes the rights of civil society as a means of ensuring good governance. The Charter of Civil Society obligated CARICOM's member states to promote the rights of its citizens to freely participate in civil society through basic civil and political rights of association, assembly, and free speech. This document is particularly important because it specifically 'special consideration and support of the young, aged, the disabled and other vulnerable group' in their participation in civil society and includes article on the rights of disabled persons (Article XIV), women (Article XII), children (Article XIII) and specifies freedom of women and children from sexual abuse.

SUB-SAHARAN AFRICA

There are several key CSOs and initiatives supporting the rights of young persons with disabilities or of CSOs working with states to address SRHR and GBV in sub-Saharan Africa. Two significant networks are the African Youth with Disabilities Network and the Southern African Federation of the Disabled.

Headquartered in Nairobi, Kenya, the African Youth with Disabilities Network is a network of youth-led DPOs from ten sub-Saharan African countries. The network's mission is to achieve equal opportunities and enjoyment of rights for youth with disabilities by influencing global laws, policies, and programmes. It achieves this mission by building the capacity of its member organisations across ten countries and by facilitating cooperation between all stakeholders regarding youth with disabilities, including governments, civil society, and the private sector. Two important the African Youth with Disabilities Network programmes directly address civil society-state cooperation and SRHR and GBV. The Access to Sexual Education and Health Services Programme addresses barriers youth with disabilities face accessing sexual

education and health services by working with sexual health educators and medical service providers in each member country and across the region. This includes data collection and documentation used to hold states accountable. The second programme is the Youth Rights and Governance Programme, which promotes youth with disabilities' engagement in all areas of governance by educating and training them on advocacy regarding all relevant national and regional laws, rights, treaties, policies, and programmes. It has had a significant impact in increasing states' engagement with youth with disabilities in civil society consultation activities and monitoring and evaluation processes. Their advocacy is central to promoting strategic partnerships between the state and youth-led DPOs. Through these partnerships, states have worked with civil society on issues such as increasing the access of young persons with disabilities to sexual education and health services by including youth-led DPOs in consultation processes and as representative in national councils and other disability rights monitoring mechanisms.

The Southern African Federation of the Disabled is a sub-regional organisation representing DPOs to the Southern African Development Community. Because sub-Saharan Africa includes 44 countries, the region is not only organised together into the African Union but also has sub-regional political and economic organisations, each of which has its own treaties, policies, and programmes. It is vital that the opinions, needs, and demands of young persons with disabilities are presented to these sub-regional authorities and their rights are acknowledged and protected.

The Southern African Federation of the Disabled's mission is to be an 'organisation that advocates for the rights of Persons with Disabilities as well as nurturing and strengthening its affiliates and other stakeholders in Southern Africa to ensure promotion of inclusive development and human rights for persons with disabilities'. The Southern African Federation of the Disabled represents national DPO networks from ten Southern African countries, including Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. The Southern African Federation of the Disabled has recently engaged in a consultation with youth with disabilities across its ten member states. Through that consultation, young persons with disabilities identified exercise of SRHR and access to GBV prevention and response as important priorities in their lives, thus informing many of the Southern African Federation of the Disabled's initiatives.

Several of the Southern African Federation of the Disabled's current initiatives directly address the rights of youth with disabilities and their SRHR and right to live free from violence, including the Southern African Development Programme for Children and Youth with Disabilities and the Southern African Disability and Gender Mainstreaming Programme. The most significant initiative regarding state-civil society cooperation, however, may be the Southern Africa Programme on Inclusive Policies, Legislation, and Justice. Through this initiative, the Southern African Federation of the Disabled is working with the Southern African Development Community on a regional Disability Protocol which would be more specific than the CRPD regarding state responsibilities towards youth and women and girls with disabilities. For example, it not only includes Article 6 on Women with Disabilities, but Article 7 on Youths with Disabilities. Article 7 requires that all 'State Parties recognise that youth with disabilities face discrimination in

various sectors of development, and in this regard, will take all appropriate measures to ensure that they enjoy and exercise their rights and fundamental freedoms on an equal basis with youth without disabilities' and goes on to specify in 7.2 that States Parties must promote youth with disabilities' participation in public and political life, including supporting 'the formation of and participating in their [youth with disabilities'] own representative organisations and participation in political activity'. In regard to SRHR, Article 23 on Respect for the Family and Relationships obligates states to eliminate discrimination in marriage, family, parenthood and relationships, the rights of persons with disabilities to have children and access reproductive and family planning education and information, and that women and girls with disabilities are never sterilised without their knowledge or against their will. It is a positive state practice of the members of the Southern African Development Community to be working with the Southern African Federation of the Disabled on the development protocol and will be a further positive state practice if it were to be adopted and ratified by member states. It is also a positive practice for states to support regional organisations such as the Southern African Federation of the Disabled through their commitment to international cooperation.

ARAB STATES

Two major regional disability-focused CSOs in the Arab States Region include the Arab Organisation of Persons with Disabilities and the Arab Forum for the Rights of Persons with disabilities.

The Arab Organisation of Persons with Disabilities was established in 1998 with the sponsorship of the League of Arab States. The Arab Organisation of Persons with Disabilities is composed of DPOs operating in Arab countries and has been instrumental in promoting the rights of persons with disabilities throughout the region, including the rights of young persons with disabilities and women and girls with disabilities.

The Arab Forum for the Rights of Persons with Disabilities acts as the regional representative of Disabled People's International in the Arab World. The Arab Forum for the Rights of Persons with Disabilities primarily focuses on working with grassroots organisations of persons with disabilities in 13 Arab countries. The Forum focuses on enhancing the role of the most marginalised groups of persons with disabilities, including women and youth with disabilities, at the leadership level and in decision-making platforms.

ASIA AND THE PACIFIC

There are a number of regional DPO networks in Asia and the Pacific. The two most significant may be Disabled Peoples' International Asia-Pacific and the Pacific Disability Forum. Disabled Peoples' International Asia-Pacific specifically includes women with disabilities and youth leadership as two of its main foci. The Pacific Disability Forum has notably piloted a project on ending GBV against women with disabilities in Fiji.

Disabled Peoples' International Asia-Pacific represents 26 national DPO networks across the region. Like other Disabled Peoples' International regional organisations, it promotes the full participation and equal opportunity of persons with disabilities in society. Promoting youth

leadership and women with disabilities are two of its seven core activities. Disabled Peoples' International Asia-Pacific's gender-related activities, including awareness-raising activities regarding the reproductive rights of women with disabilities and GBV. In the promotion of youth leadership, Disabled Peoples' International Asia-Pacific has partnered with mainstream youth organisations, such as Australia's Youth Ambassadors for Development programme, which Disabled Peoples' International Asia-Pacific provided disability equality training for in 2012. It has also sought to ensure that government ministries associated with youth participate in conference. This includes partnering with the Brunei Ministry of Culture, Youth, and Sport to plan the 2013 Association of Southeast Asian Nations Disability Forum.

The Pacific Disability Forum is a regional NGO of and for persons with disabilities that partners with DPOs in Pacific Island Countries and Territories. The Pacific Disability Forum works with national DPOs, UN agencies, human rights institutions, governments, and intergovernmental organisations to promote regional cooperation advancing disability rights. Both youth and women and girls with disabilities are major foci of The Pacific Disability Forum's activities. The Pacific Disability Forum has created a Pacific Disability Forum Women's Committee and a Pacific Disability Forum Youth Committee. The Women's Committee has been meeting since 2007 and the Youth Committee has been meeting since 2013. These two committees have had a significant impact on the Pacific Disability Forum's priorities, including building youth leadership capacity and engaging youth in policymaking processes at the local, national, regional, and international levels and making prevention of GBV a major goal across the region.

One of the most significant achievements of the Pacific Disability Forum for promoting the rights of young persons', especially women's and girls', including SRHR and the right to live free from violence, was the *Toolkit on Eliminating Violence Against Women and Girls with Disabilities in Fiji*. To develop the Toolkit, the Pacific Disability Forum partnered with the Fiji Disabled People's Federation, the Fiji Women's Crisis Centre, UN Women, and the Australian Government. The creation of the Toolkit was in response to the 2013 research conducted by the Fiji Women's Crisis Centre that revealed high rates of violence against women with 71 per cent of the women in Fiji subjected to physical or sexual violence by partners and/or non-partners in their lifetime. The Toolkit provides multiple group activities for workshops that address human rights, disability, gender, violence against women and girls (VAWG) with disabilities, and inclusion. As a result of the Toolkit and the information and advocacy it engendered, the government of Fiji has made some steps towards disability-inclusive development in their programmes addressing ending violence against women. In 2013, the Fiji Ministry of Social Welfare, Women, and Poverty Alleviation led the revival of the Inter-Agency Task Force on ending violence against women, the leading government body in Fiji addressing strategies, initiatives, and programmes to ending violence against women. Members of the Task Force include government ministries and the Fiji National Council of Women and Fiji National Council for Disabled Persons.

EASTERN EUROPE AND CENTRAL ASIA

Perhaps the most significant regional initiative advancing the rights of young persons with disabilities, including SRHR and the right to live

free from violence, is the Central Asian Disabled Women's Network, which brings together DPOs representing women and girls from across five Central Asian countries: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. The Central Asian Disabled Women's Network specifically focuses on access and exercise of SRHR and promoting women's empowerment including self-esteem. Its primary methodology is peer support and information sharing and it is coordinated by the Kyrgyz disabled women's organisation Ravenstvo and implemented through a partnership between Ravenstvo, Shyrak (Kazakh disabled women's organisation) and Ishtirok (Tajik disabled women's organisation). In addition to its education and peer support activities, each organisation also advocates on behalf of women with disabilities. For example, in 2008 Ravenstvo developed a research report on the Rights of Patients with Disabilities in Issyk-Kul Province with the support of the Open Society Institute.[781] A major part of the report was dedicated to infringements of the reproductive rights of women with disabilities and a call for legal reforms.

WESTERN EUROPE AND NORTH AMERICA

There are many important regional initiatives promoting the voices of young persons with disabilities in Western Europe and North America. Two of the most important are the European Disability Forum's youth initiatives and Disabled Peoples' International North America and the Caribbean's Youth Empowerment Project.

The European Disability Forum was established in 1996 as a platform that brought together organisations across Europe representing persons with disabilities. As such, the European Disability Forum works closely with the Council of Europe and other European institutions and agencies to ensure that persons with disabilities are represented in the development of law, policy, and programming. The European Disability Forum established a Youth Committee and Youth Network 'to ensure that the voice of young persons with disabilities is heard within the European Disability Forum and beyond its border.' The Youth Network includes young persons with disabilities from all geographical regions and disability types. Its role is to ensure that the Youth Committee speaks for all of their needs and priorities. The Youth Committee has several responsibilities, including mainstreaming youth into all of the European Disability Forum's policies and documents, raising awareness within the European Disability Forum of youth needs, and representing youth with disabilities at mainstream youth meetings, such as the European Youth Forum. It also helps implement several youth-oriented projects, such as the inclusion of youth with disabilities in higher education. Importantly, the Youth Committee has contributed towards the European Disability Forum's Gender Equality Plan, which importantly included action items directly related to SRHR and GBV, including a campaign on the SRHR and liberty of choice of women and girls with disabilities, including forced sterilisation and coerced abortion, and initiatives on the prevention of violence against women and girls with disabilities.

Disabled People's International North American and Caribbean is a network representing national DPOs across North America and the Caribbean. For its 2011 8th Annual Regional Assembly, Disabled Peoples' International adopted the theme Declaring the Person Inside: Ensuring Our Future through Youth Empowerment and organised workshops on youth and women with disabilities. It also adopted a new strategic plan,

which included the development of a Regional Youth Network and a Regional Women's Network. With the support of the Abilis Fund, it implemented a Youth Empowerment Project, focused on building the capacity of youth with disabilities to represent themselves throughout its member countries.

V. CONCLUSION

This chapter has focused on a strong, vibrant and inclusive civil society as a key ingredient for states to effectively promote the rights of young persons with disabilities, including SRHR and the right to live free from violence. If civil society does not have the freedom and space to flourish and young persons with disabilities are not mainstreamed across civil society and have their own organisations representing their concerns, then states are unable to benefit from the contributions young persons with disabilities can make as advisers on new legislation and policies, as awareness raisers that educate young persons with disabilities and the larger public about their rights, as monitors and evaluators of policy implementation, and as service deliverers. To ensure CSOs representing young persons with disabilities can play these vital roles, states should support a twin-track approach the promote civil rights for all its citizens, simplify the registration and renewal process for CSOs, and facilitate the mainstreaming of young persons with disabilities into mainstream youth-led organisations, those promoting women and girls' empowerment and gender equality, and disability organisations. States should also provide capacity-development assistance to young persons with disabilities, especially young women and adolescent girls, so they can establish their own CSOs. States should also include young persons with disabilities and their representative organisations in advisory boards and other civil society forums regarding laws, policies, and services affecting their rights, including SRHR and the right to live free from violence, at the international regional, national, and local levels.

The final chapter of this report, Chapter 7, provides key recommendations to help all actors foster an environment where the rights of young persons with disabilities, including SRHR and the right to live free from violence, can be realised and are given equal priority. Partnering with civil society will be a recurring theme throughout the recommendations because it is the most effective means by which states can ensure they are addressing barriers and promoting inclusion of young persons with disabilities, especially young women and adolescent girls.

// CHAPTER 7

RECOMMENDATIONS

I. OVERVIEW

States have the responsibility to respect, protect, and fulfil the human rights of all their citizens, including the rights of young persons with disabilities. To fully implement the international commitments outlined in Chapter 3, states should recognise by law the rights of young persons with disabilities to equality and freedom from discrimination, their right to live lives free from violence, and their right to sexual and reproductive health (SRH) on an equal basis with others. States should take prompt and effective action to remove all barriers to the full enjoyment of these rights for young persons with disabilities and ensure to the extent of their ability that all services and programmes available to young people are equally available, accessible, and inclusive of young persons with disabilities. To fulfil these obligations, states should mobilise resources to not only develop laws and policies but also to actively invest in inclusive programmes on the ground that potentially can ensure that young persons with disabilities are able to achieve the full enjoyment of their human rights in their everyday lives and can enable them to become active and engaged participants in societies around the world.

To ensure these norms are translated into reality, commitment and response is required from a broad range of stakeholders. States have a significant role, but other stakeholders do as well. Civil society organisations (CSOs) are critical partners and have been at the forefront of promoting the rights of persons with disabilities. The women's movement has been fighting to end gender-based violence (GBV) through advocacy to ensure the issue receives the attention it deserves from national governments while working for the safety and security of victims and survivors on the ground. Similarly, in the area of sexual and reproductive health and rights (SRHR), civil society has been unwavering in its commitment to ensure that all individuals and couples can realise their rights related to SRH. Most importantly, young persons with disabilities have been organising their own disabled persons' organisations (DPOs) to advocate for the issues that affect them most, including eliminating GBV and promoting SRHR for young persons with disabilities. Other crucial actors include United Nations (UN) agencies, academia, the private sector, and communities, which can champion these issues through their respective policies, programmes, operations, practices, and social norms.

Each of these actors is essential to achieving the full inclusion of young persons with disabilities. United Nations agencies, international organisations and donor agencies, civil society, academia, communities, and the private sector all have an indispensable part to play along with states in advancing the rights of young persons with disabilities. These diverse actors can fulfil this important role by ensuring that young persons with disabilities have the same opportunities to participate in leadership, benefit from capacity building, gain the necessary knowledge and skills, actively participate in public life, and have access to sufficient resources to ensure their full inclusion in society, including in all programmes and initiatives relating to the prevention of and response to GBV and enjoyment of SRHR.

Though the research for this report identified many important recommendations, three are perhaps the most important and applicable to all actors. The first is the following:

Inclusion and participation of young persons with disabilities is critical. Young persons with disabilities and their representative organisations should be full participants in the design and implementation of programmes affecting their lives, from the development of national legislation through to the monitoring

and evaluation of the SRHR-related services and programmes as well as the GBV prevention and response services that those laws mandate.

The recommendations included throughout this chapter emphasise the importance of ensuring that young persons with disabilities be actively included in discussions about laws, policies, and programmes that may affect their lives, and that they be recognised as agents with evolving capacities to act as decision-makers on their own behalf. Young persons with disabilities are experts in the barriers they face in everyday life. States should ensure that young persons with disabilities, especially young women and adolescent girls with disabilities who represent diverse identities and are rooted in different communities and contexts, are empowered to share their own experiences and knowledge and are respected as full partners in efforts to build more equitable and peaceful societies. The needs, rights, and demands of young persons with disabilities, including in relation to eliminating GBV and realising SRHR, should be on the agenda of all CSOs to hold states accountable and to better ensure inclusion and participation of young persons with disabilities in all matters connected to their lives.

A second, overarching recommendation is to:

Translate norms into reality. Equality for young persons with disabilities in realising SRHR and in the prevention of and response to GBV should be a reality in both policy and practice.

For young persons with disabilities to fully enjoy their human rights, including the right to equality and non-discrimination, states should not only eliminate discriminatory laws and regulations and guarantee equality as a matter of law but also should pay attention to the distinct needs of young persons with disabilities within laws, policies, and programmes. Substantive equality recognises that even policies and practices that meet the needs of most rights holders may nevertheless fail to address the specific needs of marginalised groups like young persons with disabilities. Policymakers should keep those most marginalised in mind when designing interventions to truly ensure that no one is left behind.

The third is to:

End Stigma and Discrimination. Efforts should be undertaken to ensure stigma and discrimination against young persons with disabilities are addressed through awareness raising, training, and other initiatives that include all actors in society, from young persons with disabilities and their families to policymakers, service providers, and the broader public.

Young persons with disabilities are too often denied access to their rights and services because of stigma and prejudice that assumes that they are less capable than their peers without disabilities are. These negative beliefs can shape social interactions in the home, the development of laws and policies, and the access to services and protections. To remove barriers and ensure equality and inclusion for young persons with disabilities, states, often in partnership with CSOs, have a responsibility to address stigma and promote positive attitudes toward young persons with disabilities that recognise their equal rights.

The recommendations provided by this study are outlined in the Principal Recommendations text box and summarised by topic below. Detailed recommendations for both state and other actors regarding the prevention of and response to GBV, access to and enjoyment of SRHR, and the promotion of participation of young persons with disabilities through civil society follow.

PRINCIPAL RECOMMENDATIONS

- **Young persons with disabilities and their representative organisations should be full participants in the design and implementation of programmes affecting their lives**, from the development of national legislation to the monitoring and evaluation of the SRHR-related services and programmes as well as the GBV prevention and response services that those laws mandate. States and CSOs should take measures to build the skills and capacity of young persons with disabilities and to ensure that they have opportunities to participate in public decision-making forums.
- **Equality for young people with disabilities in realising SRHR and in the prevention and response to GBV must be both formal and substantive.** States should not only eliminate discriminatory laws and regulations and guarantee equality as a matter of law but also should pay attention to the distinct needs of young persons with disabilities within laws, policies, and programmes. Policymakers and others implementing programmes should keep those facing intersecting and multiple forms of discrimination in mind when designing interventions to truly ensure that no one is left behind.
- **Ending stigma and discrimination against young persons with disabilities is critical to their full inclusion.** Awareness raising, training, and other initiatives that include all actors in society, from young persons with disabilities and their families to policymakers, service providers, the media, civil society, and the broader public, can reshape social interactions in the home and the development of laws and policies and remove barriers to access to services.
- Policymakers should take into account the **compounding nature of discrimination** on the basis of disability, gender, and age, among other social categories, and **address the unique situation of persons with disabilities challenged by conflict and natural disasters, poverty, rurality, institutionalisation, and other multipliers of inequality**.
- The elimination of GBV and a realisation of SRHR for young persons with disabilities require a **comprehensive and integrated approach** that involves **all sectors of government, at all appropriate levels**, including health and social services, education, justice and law enforcement, and overall development planning.
- **Consistent monitoring and evaluation** of interventions aimed at advancing the rights of young persons with disabilities are necessary to ensure such interventions are meeting their objectives, are inclusive of young people with disabilities in all their diversity, and are responding to their needs.
- The **collection of data that are disaggregated on the basis of age, sex, and disability**, among other factors, should meet the requirements of the Sustainable Development Goals (SDGs). Such data should be **collected in a youth-, disability-, and gender- inclusive and**

accessible manner that ensures that young persons with disabilities are included and made visible in data collected. All **data should be publicly available and accessible to persons with disabilities** to ensure that policymakers, researchers, and CSOs can use the data to clearly identify inequalities and gaps across groups.

- **States and international organisations and funders should take disability into account in national, organisational, foreign assistance, and programmatic budgets,** ensuring there are sufficient resources to guarantee that all programme activities related to SRHR and GBV prevention and response can be made accessible and fully inclusive of young persons with disabilities.

INTERNATIONAL STANDARDS

States should ensure that all their practices are based on international standards. A clear, global standard has been developed that promotes young persons with disabilities' SRHR and their right to live free from violence based on internationally agreed-upon human rights conventions and programmes of action. The most important and relevant conventions include the Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). Together, they make clear that young persons with disabilities, including young women and adolescent girls, have the same SRHR and right to live free from violence as all other persons have. Furthermore, states are provided with specific standards through the International Conference on Population and Development (ICPD) Programme of Action regarding the core services they should provide to ensure citizens are able to realise SRHR and live free from violence. The steps for achieving these rights were first outlined and agreed to in the ICPD Programme of Action in 1994 and have been reinforced and expanded on since.

COMPREHENSIVE, INTEGRATED, AND TWIN-TRACK APPROACHES

All actors should recognise that no one policy or programme activity alone is sufficient to achieve the rights of young persons with disabilities. Policy and programmatic responses should adopt a systems approach that brings together of a range of structures, functions, and capacities across sectors to respond to and prevent discrimination and violations of the rights of young persons with disabilities in any given context. The system should be organised around a common goal with attention paid to coordinating the actions of different actors, organisations, and subsystems so that each is mutually reinforcing. For example, that means that not only do laws and policies have to change, but also service providers and other actors should be trained in disability inclusion and the rights of young persons with disabilities. It also means that not only do steps to reduce barriers specific to realising SRHR and accessing GBV prevention and response services need to be taken, but also indirect barriers, such as disability inclusion in basic education and creating new economic opportunities for young persons with disabilities, need to be broken down.

All actors should also be guided by a twin-track approach to laws, policies, and programmes related to SRHR and GBV prevention and response. This approach includes both ensuring young persons with disabilities are mainstreamed into laws, policies, and programme activities by ensuring they are inclusive of young persons with disabilities and, when appropriate, developing and implementing new laws, policies, and programmes that provide specific supports to young persons with disabilities. The vast majority of existing laws, policies, and programmes can and should be made disability, gender, and youth inclusive. Many of the inequalities faced by young persons with disabilities today are the result of practices that segregated young persons with disabilities from the services used by their peers without disabilities; therefore, it is always preferential and, in fact, a legal obligation under the CRPD, that states ensure all laws, policies, and programmes are disability inclusive. However, long histories of marginalisation and very specific circumstances sometimes make it appropriate for states to also develop targeted practices that provide the supports necessary to ensure that young persons with disabilities have equal access to and enjoyment of SRHR and GBV prevention and response services. A targeted approach may include very specific laws and policies that clearly outline the rights of young persons with disabilities and the state's responsibilities for addressing them. A targeted approach may also include special programmes, such as awareness-raising programmes that specifically target the attitudes and beliefs of parents of children and young persons with disabilities or the implementation of social support clubs that provide space for young persons with disabilities to openly discuss disability and SRHR and GBV in contexts in which they would otherwise not be willing to discuss those matters with peers without disabilities.

Finally, a comprehensive approach means that all policy and programmatic responses should effectively address issues that are both directly and indirectly related to SRHR and GBV prevention and response, including the barriers young persons with disabilities experience when exercising their rights and being included in laws, policies, and programmes related to SRHR and GBV prevention and response on an equal basis with others. This includes education, transportation, employment, and so forth. A narrow focus on SRHR and GBV prevention and response will always be insufficient if the larger life circumstances and specific forms of discrimination are not addressed. For example, a clinic providing SRH services may be accessible and inclusive, but inaccessible transportation or the inability of young persons to pay bus fare or taxi fees will prevent such young people from accessing that clinic on an equal basis with others. Policies and programmes related to SRHR and GBV prevention and response should be coordinated with all policies and programmes contributing toward the full complement of human rights that young persons with disabilities have.

CONTEXT AND IDENTITY SPECIFIC

For policymakers, programme implementers, and service providers to develop context and identity specific actions, they should take an integrated approach that addresses compounding forms of discrimination on the basis of disability, gender, and age along with diverse, intersecting identities, such as race, ethnicity, religion, and sexual orientation and gender identity, and so forth. Young persons with disabilities may also be refugees or immigrants, HIV-positive, or living in the context of poverty. Each of these intersecting identities may multiply the discrimination that women and girls with disabilities or young persons with disabilities face in comparison with

their peers without disabilities and others. It is also essential that policymakers, programme implementers, and service providers recognise that certain groups of young persons with disabilities are more excluded than others are and respond appropriately. For example, young persons with intellectual disabilities are often at even higher risk of violence than are young persons with disabilities from different disability groups. A related risk is associated with young persons with disabilities living in institutions. Young persons with disabilities, though often universally discriminated against, are not a homogenous group. States, in collaboration with civil society, should develop policies and programmes that ensure that all identities represented among young persons with disabilities and young persons with disabilities living in all contexts are protected and that their rights are promoted.

Certain contexts and circumstances should be recognised as increasing the vulnerability of young persons with disabilities to rights violations. These include contexts of humanitarian crises, such as conflict, post-conflict, and natural disasters; poverty; rural environments; high prevalence of HIV/AIDS; and so forth. Laws, policies, and programmes should be context specific in their design to be responsive to the lived experiences of young persons with disabilities and to fully address the realities that young persons with disabilities face when seeking to access and exercise their SRHR and to live free of violence. One important reality is cultural specificity. It is insufficient for policymakers, programme implementers, and service providers to simply transplant laws, policies, and programmes developed in different contexts and to implement them without modification and cultural translation. Similarly, national policies should be implemented in ways that address local and circumstantial differences. For example, awareness-raising programmes addressing disability stigma related to the sexuality of young persons with disabilities will be ineffective if they are based on programmes developed for other countries and therefore do not address the specific discriminatory beliefs and practices not conducive to human rights present at the local level. Therefore, programmes should be context specific and should address the barriers within local communities and consider the local culture. Similarly, programmes should be responsive to the socio-economic differences across countries, communities, and individuals. For example, service models may need to be adapted for rural environments or in humanitarian situations to ensure their accessibility in environments substantively different from urban communities or stable populations and so forth.

CAPACITY DEVELOPMENT AND AWARENESS RAISING

It is essential that all policymakers, programme implementers, and service providers are aware of the rights of persons with disabilities and are trained in disability inclusion. It is also essential that young persons with disabilities and their caregivers are aware of the rights of young persons with disabilities, including access to SRH and GBV prevention and response. Policymakers cannot develop new laws and policies, and programme implementers and service providers cannot provide services ensuring the rights of young persons with disabilities if they are unaware of or do not understand that young persons with disabilities have equal rights and that they can be included and accommodated in services. Young persons with disabilities, who are the most important stakeholders in the policymaking and service-delivery process, cannot provide advice on how states can best ensure that they can access and exercise SRHR and live a life free of violence if they are not aware of their rights.

Equally important, parents and other caregivers of young persons with disabilities should be aware of young persons' rights, including in relation to SRH and GBV prevention and response, to ensure they are supportive of young persons with disabilities participating in stakeholder and advisory activities and access their rights on an equal basis with others.

PARTICIPATION AND INCLUSION OF CIVIL SOCIETY

The participation of civil society is critical for ensuring that states and other actors develop laws, policies, and programmes that address the specific barriers young persons with disabilities experience in their daily lives. It is also an important guiding principle for ensuring that policymakers, programme implementers, and service providers continue to be responsive to young persons with disabilities, including through ongoing monitoring and evaluation of SRHR and GBV prevention and response initiatives from the perspective of young persons with disabilities. The issues concerning young persons with disabilities should also be mainstreamed across the work of relevant civil society, including within mainstream youth, women's rights, and disability organisations. These organisations should also support leadership development and technical assistance for young persons with disabilities so that they can establish their own CSOs. Doing so will ensure a vibrant voice for young persons with disabilities and a strong partner for policymakers, programme implementers, and service providers in the development of programmes and services related to SRHR and GBV prevention and response. Policymakers, programme implementers, and service providers should ensure that not only are there CSOs representing young persons with disabilities but also that there is representation from all groups, such as young women and adolescent girls with disabilities, young persons with disabilities representing different identities, and young persons with disabilities representing the diversity of disabilities. This guiding practice advances the principle of 'Nothing About Us, Without Us' and benefits from capturing the insight, experience, and energy that young persons with disabilities offer. To achieve these benefits, policymakers, programme implementers, and service providers should institutionalise a role for young persons with disabilities as advisors on law, policy, and programme activities and include these young people on national advisory boards and other civil society forums at the international, regional, national, and local levels, ensuring that all initiatives related to SRHR and GBV prevention and response are responsive to these young people's advice and monitored from their perspective. Civil society working across different sectors, including DPOs, should ensure they are gender responsive both in terms of ensuring women and girls are represented in their staff and leadership and in ensuring programmes are addressing gender issues, including in relation to eliminating GBV and fostering women's and girls' empowerment.

MONITORING AND EVALUATION

All laws, policies, and programmes related to SRHR and GBV prevention and response should be monitored and evaluated from the perspectives of young persons with disabilities. Young persons with disabilities and their representative organisations can be included in a variety of ways. They should first be mainstreamed and included on advisory boards and civil society forums from the national through to the local level. Their perspectives should also specifically be sought out through qualitative and quantitative means such as interviews, focus groups, civil society forums, and surveys that

specifically target young persons with disabilities. In each of these activities, CSOs representing young persons with disabilities could be supported as partners in contributing to monitoring and evaluation activities. Young persons with disabilities should also be supported and included in the development of civil society or 'shadow' reports on States Parties to the CRPD, CEDAW, and CRC.

DATA COLLECTION AND RESEARCH

Data on disability, gender, and youth should be collected in an inclusive manner that allows researchers to disaggregate statistics in order to clearly identify the gaps in programmes and services related to SRHR and GBV prevention and response. Disaggregation of data is required by the SDGs and is essential to ensure that young persons with disabilities are made visible and recognised as rights holders. Achieving SRHR and the right to live free from violence for young persons with disabilities depends on the ability of states to render inequalities visible. All data collected should be publicly available and broadly disseminated in disability-inclusive formats. Publicly available data on SRHR and GBV are also essential for CSOs representing young persons with disabilities, especially young women and adolescent girls with disabilities, to hold states accountable. In the past, data collection on young persons with disabilities has been inconsistent and often ignored SRHR and GBV issues entirely for young persons with disabilities. Today, however, new data collection tools have been developed that enable researchers to gather the nuanced information they need and allows for cross-national comparisons. The Washington Group on Disability Statistics, for example, has developed new survey instruments that include young persons with disabilities and provide the information necessary for states to develop policy responses.

In certain situations, it may be appropriate for research to be conducted and data collected on specific issues disproportionately effecting young persons with disabilities or on specific identities of young persons with disabilities. For example, it may be important to specifically collect data on the incidence of GBV across young persons with disabilities who have intellectual disabilities or to specifically collect data on issues such as forced sterilisation of young persons with disabilities living in institutions.

DISABILITY-INCLUSIVE BUDGETING

Disability inclusion should be integrated into all budgeting processes, ensuring there is a sufficient amount of funds earmarked for programmes and initiatives related to SRHR and GBV prevention and response that are fully inclusive of young persons with disabilities. In addition to mainstreaming disability inclusion into all programmes and initiatives related to SRHR and GBV prevention and response, policymakers, programme implementers, and service providers should also budget for targeted approaches for when they are appropriate and necessary for ensuring young persons with disabilities can access and exercise SRHR and GBV prevention and response services. For states, this budgeting approach should be mandated from the national level through to the local level. Programme implementers and service providers should also require disability-inclusive budgeting practices for all programming. In both cases, each budget should contain clear line items that address disability-related access and inclusion, and, when appropriate, include targeted activities. A number of states and international disability NGOs have developed guidelines for mainstreaming disability inclusion into programme activities. For example, USAID and Mobility International have published *Building an Inclusive*

Development Community: A Manual on Including Persons with Disabilities in International Development Programmes, which recommends that every budget allocate 5 to 7 per cent for operational costs and 1 to 3 per cent for administrative costs to ensure that all aspects of programmes are accessible.

II. ENDING GENDER-BASED VIOLENCE AGAINST YOUNG PERSONS WITH DISABILITIES

Eliminating GBV, including violence against young persons with disabilities, requires comprehensive and long-term strategies that focus on prevention of violence and on appropriate and supportive responses to it. Such strategies may begin but should not end with the adoption and implementation of strong and comprehensive legal and policy frameworks that recognise and prohibit all forms of violence against all women and girls, including explicitly women and girls with disabilities. Strategies should also include the commitment of sufficient resources to ensure adequate support for implementing programmes and a recognition that prevention and responses to violence should be integrated within multiple policy frameworks, including health and education programmes, justice and policing policies, and national development plans, among others. To ensure that young women and girls with disabilities are provided the same protections from violence afforded their peers without disabilities, laws, policies, and programmes addressing violence against women and girls should explicitly recognise the multiple forms of discrimination to which young women and girls with disabilities, along with other excluded groups, are routinely subjected. Further, these laws, policies, and programmes should outline clear strategies to target those forms of violence while providing support to young women and girls with disabilities at risk of violence or who have been victims of it. The UN Essential Services Package for Women and Girls Subject to Violence is a gold standard for setting up multi-sectoral services[782] – and is being rolled out in more than 30 countries around the world. All efforts under the Essential Services Package should be adapted to respond to the rights and needs of women and girls with disabilities. In addition, the new UNFPA-Women Enabled International (WEI) Guidelines[783] provide guidance in this regard.

Legislation protecting the rights of young persons with disabilities to live free from violence is a necessary element of any strategy to eradicate GBV. In one study of the effect of domestic violence laws, researchers concluded that women who live in countries with laws that prohibit domestic violence have 7 per cent lower odds of experiencing violence than do women who live in countries without such laws.[784] To be inclusive of young persons with disabilities, laws should be reviewed for provisions that may appear on their face to apply equally to all but that in fact have discriminatory effects. To ensure substantive equality, new laws should be drafted that target the particular vulnerabilities of young persons with disabilities.

In addition, legislation should reflect a focus on prevention, emphasising the elimination of discriminatory social norms and behavioural attitudes, including not only those that discriminate on the basis of gender but also on disability and youth. Changing social norms that perpetuate myths about disability and that encourage disability stigma and gender stereotyping and the denial of sexuality of women with disabilities should be a top priority of preventive legislation.[785]

Passing laws is necessary but not sufficient to prevent or respond to GBV however. Ensuring an appropriate, multi-sectoral, and comprehensive and coordinated institutional infrastructure that can implement such laws is critical.[786] Such systems include coordinated health-care services including psycho-social services, shelters, specialised and appropriately trained police and law enforcement officers, appropriately trained judicial staff and officers with knowledge of laws aimed at eliminating GBV, and evidence-based comprehensive, adequately resourced counselling programmes for perpetrators.

Moreover, legal reforms are most likely to be effectively operationalised when a state makes clear efforts to guide implementation through national action plans, regulations, protocols and training for those responsible for the law's implementation. Training implementing authorities and officials is essential not only to ensure they have appropriate knowledge of the law and its requirements but also to combat discriminatory attitudes they may hold that are contrary to the law's intent and may impede its implementation.[787] Effective coordination across sectors is also critical for effective GBV prevention and response.[788] All GBV prevention and response efforts should be aligned with the standards of the UN Essential Services Package for Women and Girls Subject to Violence.

In addition, caregivers and family members should be included in programmes addressing GBV and should be recognised as potential protectors of young persons with disabilities as well as possible violators of their rights.[789] Particularly in programmes targeting forcible sterilisation or coerced contraception, efforts should be made to ensure that caregivers have appropriate information and support.

For programmes and policies to be effective, they should be sustainably financed. States need to ensure through transparent budgets that sufficient funds are dedicated to implementation of relevant laws and should monitor implementation to confirm that allocated funds are being spent as intended.[790] Implementing authorities, including service providers, should also be held accountable for meeting the standards set by policies and regulations.

Civil society organisations, especially women's rights organisations and DPOs, are essential partners in implementing a comprehensive approach to eliminate GBV. Research shows that CSOs can and should be actively involved in service and information delivery, education, and training for implementing authorities and should be beneficiaries of programmes and policies and support for survivors of violence, among other activities.[791] In an Oxfam study on the implementation of laws prohibiting violence against women, the authors highlighted the Dominican Republic for its inclusion of CSOs, noting, 'All the civil society representatives interviewed unanimously emphasised that a successful practice in the implementation of Law 24-97 has been the creation of intersectoral and inter-institutional networks that, with civil society, organise power dynamics at the local level and with the state, and support the system of care. Everyone agrees that this has been possible because women's organisations and the feminist movement have established themselves as permanent interlocutors with the state, sometimes being human resources within the government sector itself who are sensitive to the topic of VAW [violence against women].'[792] Furthermore evidence demonstrates that having autonomous women's rights organisations is the critical factor for policy change and ensuring that

global norms can have an influence on domestic policymaking—pointing to the importance of ongoing activism and a vibrant civil society.[793] Civil society organisations also play a critical role in holding duty bearers accountable to their agreed commitments and obligations.

Finally, all initiatives to prevent and respond to violence should make the safety of young persons with disabilities a priority, taking into account their impairments and the accessibility of their environments as along with the accessibility of all services and shelters.

ENSURING THE RIGHTS OF YOUNG PERSONS WITH DISABILITIES TO LIVE FREE FROM VIOLENCE

RECOMMENDATIONS FOR STATES, IN PARTNERSHIP WITH CIVIL SOCIETY AND PERSONS WITH DISABILITIES

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
International standards	▪ Adopt the CRPD, CEDAW, CRC, and other international and regional instruments prohibiting GBV.	▪ Ensure that all state reports to treaty bodies on the subject of GBV include discussion of actions taken to guarantee the rights of young persons with disabilities to protection from violence.
Assess existing GBV prevention and response laws, policies, and programmes	▪ Review all laws and regulations pertaining to GBV prevention and response to ensure that they are inclusive of women and girls and men and boys with disabilities, in particular by recognising the specific forms of violence to which women and girls and men and boys with disabilities may be subjected. ▪ Repeal any laws or policies that discriminate against young persons with disabilities, including within family law or any other law, and any legislation that permits sterilisation, contraception, abortion, or any other surgical procedure to be performed on a girl or young woman without her free and informed consent, or that permits the forced institutionalisation or involuntary confinement of young persons with disabilities. ▪ Include young persons with disabilities in all existing advisory councils and civil society forums regarding GBV prevention and response.	▪ Where necessary, adopt new legislation that bans GBV against young women and girls and men and boys with disabilities, in all its potential forms. ▪ Ensure that information about existing and future laws, policies, programmes, and complaint mechanisms related to GBV prevention and response is available in accessible formats and distributed widely, including to DPOs, service providers, and caregivers for young persons with disabilities. All complaint mechanisms should be private and ensure that they do not put those making complaints at risk of further violence. ▪ Where necessary, adopt legislation to ensure that law enforcement, health care, educational services, and social support services are accessible to young persons with disabilities, including by recognising the legal capacity of people with disabilities to assert claims against perpetrators. ▪ Develop specific advisory activities for young persons with disabilities, including young women and girls and young men and boys with disabilities, to assess and advise on laws, policies, and programmes related GBV prevention and response.
Preventing GBV	▪ Review existing laws and policies to ensure that they do not discriminate on the basis of gender or disability and do not contribute to or reinforce the subordination of women and girls in any way. ▪ Develop legislation and policies that promote gender equality and challenge discriminatory norms and stereotypes. ▪ Ensure the effective implementation of existing laws that prohibit discrimination and GBV and end impunity of perpetrators. ▪ Ensure that all prevention efforts at national and local levels including campaigns, community mobilisation, and group education include young persons with disabilities in their messaging and as part of their development.	▪ Recognise the exclusion and vulnerability that young persons with disabilities face in regard to sexual abuse and violence in particular contexts, including institutional and conflict settings and humanitarian crises, and take active steps to prevent violence before it happens. ▪ Develop awareness-raising campaigns regarding the human rights of young persons with disabilities as active members of communities and challenging myths about disability that increase vulnerability to violence. ▪ Develop targeted programmes for young persons with disabilities that share information about healthy relationships and the nature of GBV. ▪ Ensure that all prevention efforts including communications are provided in accessible formats and specifically raise awareness about the disproportionate risk of violence young persons with disabilities face.

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Context and identity specific	▪ Policymakers should recognise the compounding nature of discrimination on the basis of disability, gender, and age, among other identities, and address context-specific factors including conflict and natural disasters, poverty, rurality, institutionalisation, and other multipliers of inequality.	▪ All states' practices should be based on international standards and be context-specific to address the lived experiences of young persons with disabilities in particular socioeconomic conditions and cultural realities. ▪ Develop approaches for addressing the specific barriers young persons with disabilities face when exercising and accessing SRHR and GBV prevention and response services, particularly those facing greatest barriers that compound the discrimination experienced by young persons with disabilities.
Awareness raising	▪ Ensure all existing GBV awareness-raising and public education campaigns are accessible to and inclusive of young persons with disabilities, including through the use of multiple formats.	▪ Develop targeted, accessible, and inclusive GBV awareness-raising and public education campaigns for young persons with disabilities and the parents and caregivers of young persons with disabilities.
Disability inclusion training for policymakers, programme implementers, and service providers	▪ Develop mandatory disability awareness and disability inclusion trainings for all policymakers, programme implementers, and service providers, including law enforcement, judicial personnel, and court staff that are involved in preventing and responding to GBV. ▪ Include young persons with disabilities in training design and implementation.	▪ Train a significant number of SRH service providers and GBV prevention and response service providers, youth leaders within DPOs, youth leaders, including young women and adolescent girls, within youth organisations, on how to provide reasonable accommodations (i.e. sign language interpretation).
Participation and inclusion of civil society	▪ Ensure that women's, youth, and human rights organisations and others seeking to eradicate GBV are included in the formation of policies and programmes. ▪ Ensure such organisations have access to relevant information and data to enable them to monitor compliance with state commitments at the international, regional, and national level.	▪ Include DPOs in the formulation of policies and programmes designed to prevent or respond to GBV.
Ensure access and inclusion in essential services and actions for survivors of violence	▪ Ensure the implementation of the UN Essential Services Package, including that all health, justice and policing, and social services for survivors of violence are available, accessible, acceptable, of quality level, emphasise safety, implement informed consent and confidentiality, collect data and implement information management, use effective communication, and link with other sectors and agencies through referral and coordination.	▪ Engage young persons with disabilities by: - Directly educating and distributing information about their rights and services available to young persons with disabilities experiencing violence. - Develop policies, protections, and supports for young persons with disabilities with intellectual disabilities to enable them to secure justice against perpetrators in legal proceedings. - Ensure that young persons with disabilities are informed of their rights and the mechanisms for complaints.
Inclusion in monitoring and evaluation	▪ Provide disability access and accommodations at all public hearings and other events and activities evaluating law, policies, and programmes. ▪ Ensure all survey and evaluation instruments are inclusive and youth, disability, and gender sensitive. ▪ Include young persons with disabilities and their representative organisations on advisory boards of organisations working to eliminate GBV, from the national to the local level.	▪ Facilitate forums, workshops, focus groups, and other events and activities evaluating law, policies, and programmes for young persons with disabilities.
Data collection and research	▪ Ensure that data on the prevalence of GBV are collected, using terminology consistent across all sectors. ▪ Ensure all GBV data collection instruments including those collecting GBV prevalence and incidence data are inclusive and youth, disability, and gender sensitive.	▪ Ensure that data collection instruments are available in accessible formats and distributed widely, including through DPOs and service providers for young persons with disabilities to maximise their ability to participate on the same basis as their peers without disabilities do.
Disability-inclusive budgeting	▪ Mainstream the inclusion of young persons with disabilities in budgets for all programmes related to GBV prevention and response.	▪ Include a separate budget line item for targeted GBV prevention and response when appropriate for ensuring equal access and inclusion of young persons with disabilities.

III. REALISING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR YOUNG PERSONS WITH DISABILITIES

The actualisation of SRHR for young persons with disabilities involves localising international standards so that all laws, policies, and programme activities reflect global norms of positive state practice but respond to and address the specific barriers that young persons with disabilities face in local context. This is a process whereby both local contexts and international standards change, requiring a continual monitoring, evaluation, and response to inequalities in the protection and promotion of SRHR.

There are a number of international standards ensuring the rights of young persons with disabilities, including young women and adolescent girls, to SRH. These include the ICPD Programme of Action, CRPD, CEDAW, and CRC.

It should be noted here that all services should follow the AAAQ Framework and be inclusive of young persons with disabilities for states to meet their obligations under the CRPD, CEDAW, and other international standard-setting agreements.

To identify whether or not states are meeting their obligations, states should assess SRHR from the perspective of young persons with disabilities. In practice, this means that young persons with disabilities and their representative organisations should be included in all existing advisory councils and civil society forums working to promote access to and exercise of SRHR. That means those spaces should be disability inclusive, ensuring access and accommodations to promote the full participation of young persons with disabilities. It also means that states should establish specific advisory opportunities for young persons with disabilities to assess and advise on SRHR and specifically include young women and adolescent girls with disabilities. These activities can include implementing a civil society forum whereby young persons with disabilities are convened to discuss SRHR, supporting CSOs representing young persons with disabilities to implement a study on inclusion and SRHR and to submit their findings and recommendations to relevant state authorities or to develop advisory councils and other bodies ensuring that the experiences of young persons with disabilities are known to the state and that young persons with disabilities are represented in all subsequent initiatives to address identified inequalities.

All relevant SRHR-related legislation and policy should be reviewed from the perspective of young persons with disabilities. New or existing SRHR legislation should include mainstreaming language that specifically refers to young persons, women and girls, and persons with disabilities as excluded groups that shall not be discriminated against in regard to SRHR. Secondly, specific legislation should be developed that clearly spells out the obligations of the state to implement SRHR practices inclusive of young persons with disabilities. This could be accomplished through the inclusion of specific articles in national disability rights legislation on SRHR or through stand-alone legislation specifically developed to ensure the rights of young persons with disabilities to SRHR. Other elements of legislation should be examined in relation to the inclusion of young persons with disabilities in SRHR. This should include the repeal of any laws that allow forced or coerced sterilisation, abortion, or other SRH treatments or procedures. Legal capacity legislation should be reviewed and, if necessary, repealed and replaced, to ensure that persons with intellectual disabilities are recognised as having legal capacity to make

decisions free of coercion in relation to their SRHR and that states provide supported decision-making accommodations. It is particularly important that supported decision-making accommodations are distinct and independent from legal guardianship to ensure that young persons with disabilities themselves are decision-makers. Once necessary law is in place, states should ensure awareness-raising activities that educate the broad public and specifically young persons with disabilities and their parents and caregivers about their SRHR and how these rights can be enjoyed and exercised. Awareness-raising measures include ensuring all mainstream SRHR awareness-raising activities are disability inclusive and that targeted activities are developed as appropriate.

In addition to awareness-raising activities, states should implement mandatory disability-inclusion capacity development and training for all SRHR policymakers, programme implementers, and service providers. These trainings should be comprehensive and periodic to ensure that all relevant personnel involved in developing SRHR related policies, services, education, and programmes thoroughly understand their obligations under the law for non-discrimination of young persons with disabilities, especially young women and adolescent girls with disabilities, and understand basic accommodations that can be provided to ensure inclusion in SRH services. Young persons with disabilities and their representative organisations should be included in the development and implementation of disability inclusion trainings. Targeted trainings should also be implemented to ensure a core group of SRH service providers are broadly available and on-site with in-depth training in specific accommodations in the provision of SRH services, including training in sign language interpretation.

Young persons with disabilities should be included in all comprehensive sexuality education (CSE) curricula and programmes. In addition to the core recommendations laid out in UNESCO's *International Technical Guidance on Sexuality Education,* states should assess CSE programmes from the perspective of young persons with disabilities and address any barriers. For example, the Technical Guidance recommends that CSE take place in a safe and healthy learning environment and that interactive learning methods are integrated through the CSE. From the perspective of young persons with disabilities, CSE programmes should then include from the very beginning disability awareness training to ensure that instructors and peer participants without disabilities are aware of the rights of young persons with disabilities, including in relation to SRHR, and that any beliefs and practices not conducive to human rights have been addressed before the CSE programming begins. Furthermore, learning environments should be assessed from the perspective of accessibility and disability inclusion, and all learning materials should be available in multiple formats, instructors trained in disability-inclusive pedagogies, and accommodations provided. When appropriate, targeted CSE programmes for young persons with disabilities, especially young women and adolescent girls with disabilities, should be implemented with specific CSE-related outreach to parents and caregivers of young persons with disabilities.

SRHR services should be inclusive of young persons with disabilities by ensuring they are both youth friendly and disability inclusive. This requires the active integration of what have heretofore been separate policies. All efforts should also be aligned with the WHO Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities,[794] which outlines what is expected in order to respect children's rights including ensuring child, adolescent, and family-friendly health facilities and services; evidence-based clinical care; availability of child

and adolescent-specific appropriate equipment; and appropriately trained, competent staff. The WHO and UNAIDS's overall Global Standards for Quality Health-Care Services for Adolescents[795] also provides a standardised framework to assist policymakers and health service planners in improving the quality of health-care services so that adolescents find it easier to obtain the health services that they need to promote, protect, and improve their health and well-being.

PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PERSONS WITH DISABILITIES

RECOMMENDATIONS FOR STATES, IN PARTNERSHIP WITH CIVIL SOCIETY AND PERSONS WITH DISABILITIES

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
International standards	▪ Adopt the CRPD, CEDAW, CRC, ICPD Programme of Action, and other international SRHR standards.	▪ Ensure that all state reports to treaty bodies on the subject of SRHR include discussion of actions taken to guarantee the rights of young persons with disabilities.
Reforming national laws and policies	▪ Review all laws and policies relating to SRHR to confirm they are inclusive of young persons with disabilities and advance both formal and substantive equality in the realisation of their rights. ▪ Repeal any laws or policies that discriminate against young persons with disabilities, including within education and the provision of health-care services, and any legislation that permits sterilisation, contraception, abortion, or any other surgical procedure to be performed on a young person with a disability without his/her free and informed consent. ▪ Develop legislation, policies and programmes that: - protect rights related to SRH; - include language that prohibits discrimination on the basis of disability, gender, and youth regarding access to SRH services; and - hold service providers accountable for the denial of SRHR. ▪ Include young persons with disabilities in all existing advisory councils and civil society forums regarding SRHR.	▪ Ensure that information about existing and future laws, policies, programmes, and complaint mechanisms related to SRHR, including the denial of SRHR, is available in accessible formats and distributed widely, including to DPOs and service providers and caregivers for young persons with disabilities. All complaint mechanisms should be private and ensure that they do not put those making complaints at risk of retaliation. ▪ Where necessary, adopt legislation and policies that: - ensure health care, educational, and social support services are accessible to young persons with disabilities and ensure that SRH providers recognise the right of young persons with disabilities to make free and informed decisions about their SRH; - recognise and address barriers to the realisation of SRHR for young persons with disabilities, including attitudinal barriers; - prohibit practices such as forced or coerced sterilisation that deny the SRHR of young persons with disabilities; - guarantee the access to and inclusion of young persons with disabilities to CSE and SRH services and programmes on an equal basis with others; - recognise and address the exclusion of young persons with disabilities in humanitarian crises, conflict settings, and fragile contexts, and take active steps to include young persons with disabilities in all programmes to address SRH needs; and - protect the right of young persons with disabilities to equal recognition as persons before the law and require the recognition of their legal capacity on an equal basis. ▪ Develop advisory activities especially for young persons with disabilities to assess and advise on SRHR, including proposed legislation or programmes. ▪ Ensure all such advisory activities are open to and inclusive of young women and adolescent girls with disabilities and empower them to participate in activities advancing SRHR.

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Context and identity specific	▪ Policymakers should recognise the compounding nature of discrimination on the basis of disability, gender, and age, among other identities and should address context-specific factors, including conflict and natural disasters, poverty, rurality, institutionalisation, and other multipliers of inequality.	▪ Ensure all policies and programmes advancing SRHR recognise and address the lived experiences of young persons with disabilities in differing socioeconomic conditions, rural as well as urban settings, fragile contexts and distinct cultural realities, including recognising the particular forms of exclusion and discrimination young persons with disabilities face when exercising their SRHR. ▪ Develop awareness-raising campaigns regarding the human rights of young persons with disabilities as active members of communities and challenging myths about disability that increase vulnerability to discrimination and the denial of SRHR. ▪ Develop programmes designed particularly for young persons with disabilities, including young persons with intellectual disabilities, that share SRH-related information including information on healthy, positive sexual relationships and family planning. ▪ Ensure that all information about SRHR, including information about the use of contraception, the prevention and treatment of STIs, and maternal health and wellbeing is provided in age-appropriate and accessible formats and is widely available to DPOs, youth organisations, and women's organisations.
Awareness raising	▪ Ensure all existing SRHR awareness-raising and public education campaigns are accessible to and inclusive of young persons with disabilities, including using multiple formats.	▪ Develop targeted, accessible, and inclusive SRHR awareness-raising and public education campaigns for young persons with disabilities and the parents and caregivers of young persons with disabilities. ▪ Ensure that young persons with disabilities and their parents and caregivers are informed of their SRHR and the mechanisms for complaints if rights are violated, and are empowered to advocate for greater inclusion.
Disability inclusion training for policymakers, programme implementers, and service providers	▪ Develop mandatory disability awareness and disability inclusion trainings for all policymakers, programme implementers, and service providers involved in advancing SRHR to: - raise awareness of the SRHR of young persons with disabilities; and - increase recognition of the barriers young persons with disabilities face in realising SRHR. ▪ Include young persons with disabilities in training design and implementation.	▪ Train a significant number of SRH service providers available throughout the SRHR system in the provision of specific accommodations (i.e. sign language interpretation) and train youth leaders within DPOs and youth organisation leaders, including young women and adolescent girls within youth organisations, in the provision of reasonable accommodations (i.e. sign language interpretation).
Participation and inclusion of civil society	▪ Ensure that women's, youth, and human rights organisations and others promoting access to SRH services, education, and information and enjoyment of reproductive rights are included in the formation of policies and programmes. ▪ Ensure such organisations have access to relevant information and data to enable them to monitor compliance with state commitments at the international, regional, and national level.	▪ Include DPOs in the formation of policies and programmes designed to promote access to and enjoyment of SRHR.
Implement CSE	▪ Engage policymakers working on national education and health care policies to follow minimum standards for the provision of CSE in schools and health-care facilities. ▪ Adopt national programmes and strategies to guarantee all young people have access to CSE and that accurate, age-appropriate information about SRHR is widely available to all young people. ▪ Ensure CSE curricula and programmes are inclusive of young persons with disabilities by providing information in accessible formats.	▪ Design and implement CSE programmes that are accessible to young persons with disabilities, including young persons with intellectual disabilities. ▪ Implement CSE programmes designed specifically for parents and caregivers of young persons with disabilities in locations and at times that are accessible.

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Guarantee inclusive SRH services	▪ Ensure all health-care services are youth friendly and disability inclusive by adopting regulations and programmes that: - promote capacity building among health-care service providers; - improve accessibility of health-care service facilities and ensure facilities are properly equipped to meet the needs of persons with disabilities; and - hold health-care service providers accountable to meet inclusive SRHR policy objectives.	▪ Promote inclusion of young persons with disabilities by: - educating young persons with disabilities about their right to inclusive SRH services; - providing accessible information about how and where to find SRH services; - ensuring all programmes promoting SRH services including those related to family planning and the prevention and treatment of STIs are accessible to young persons with disabilities; - developing supported decision-making policies, protections, and supports for young persons with disabilities, including young persons with intellectual disabilities, to enable them to exercise their rights to make decisions about their SRH; and - working to ensure young persons with disabilities can exercise their reproductive rights without fear of interference or coercion.
Inclusion in monitoring and evaluation	▪ Provide disability access and accommodations at all public hearings and other events and activities evaluating law, policies, and programmes. ▪ Ensure all survey and evaluation instruments are inclusive and youth and disability and are gender sensitive. ▪ Ensure young persons with disabilities and their representative organisations are included on SRHR advisory boards from the national to the local level.	▪ Facilitate forums, workshops, focus groups, and other events and activities evaluating law, policies, and programmes for young persons with disabilities.
Data collection and research	▪ Ensure all SRHR data collection instruments are inclusive and youth, disability, and gender sensitive.	▪ Collect data and conduct research on specific barriers to SRHR faced by young persons with disabilities, including data collection and research on barriers faced by young persons with disabilities, particularly those facing greatest barriers and discrimination.
Disability-inclusive budgeting	▪ Mainstream the inclusion of young persons with disabilities in all SRHR-related budgets.	▪ Include a separate budget line item for targeted SRHR-related programmes, services, education, and initiatives for ensuring equal access and inclusion of young persons with disabilities.

IV. ENSURING INCLUSION OF YOUNG PERSONS WITH DISABILITIES

RECOMMENDATIONS FOR STATES

The development and implementation of all government-led good practices require the participation of young persons with disabilities and their representative organisations. Civil society organisations representing young persons with disabilities have a right to participate in public affairs, especially all laws, policies, and programme activities directly affecting their members. As such, a strong and vibrant civil society that is inclusive of young persons with disabilities, especially young women and adolescent girls with disabilities, is a prerequisite for effective initiatives related to SRHR and GBV prevention and response. Governments have a duel duty to support the development of CSOs representing young persons with disabilities but also to protect civil society's freedom from the state by ensuring a space wherein CSOs can act as an independent voice and hold states accountable. States have the convening

power to bring together different movements, including those promoting rights of persons with disabilities, those promoting gender equality and women's and girls' empowerment, and youth-led organisations – and should do so to encourage cross-movement building.

States should develop a comprehensive legal framework that protects the basic civil and political rights of association, assembly, and speech. They should also ensure that there are no legal barriers to young persons with disabilities participating in civil society and that civil society is a protected and inclusive space that ensures young persons with disabilities can access the public sphere on an equal basis with others. For example, public forums in which CSOs express their views should be accessible, and CSOs should not be allowed to discriminate against young persons with disabilities and exclude them from membership. Legal protection and inclusion includes the ability of young persons with disabilities to establish and maintain their own organisations. Many states require that CSOs legally register and renew their registrations periodically. These processes should be disability accessible and inclusive, including providing registration information in multiple formats and ensuring all registration offices are accessible, provide reasonable accommodation, and be available throughout the country. Required documentation and registration fees should not be financially burdensome, nor should the registration, review, and certification process be time consuming. States should also implement positive measures, when appropriate, that assist young persons with disabilities in organising their own CSOs in environments where heretofore there has not been significant inclusion of young persons with disabilities in civil society. That may include states that facilitate leadership and organisation development workshops that convene young persons with disabilities, especially young women and adolescent girls with disabilities, and provide assistance in identifying needs, developing mission statements, programme activities, and strategic plans, and assemble by-laws and other required documentation for registration. These activities may include facilitating connections between young persons with disabilities and mainstream youth, disability, women's rights, and other CSOs and networks undertaking work related to SRHR and GBV prevention and response.

States should develop mechanisms for ensuring that CSOs representing young persons with disabilities are actively included in the policymaking and programme implementation process. This should include CSOs being actively involved in identifying the barriers that young persons with disabilities, especially young women and adolescent girls, experience when seeking to exercise and access SRHR and GBV prevention and response services through to developing laws, policies, and programme activities addressing those barriers. Civil society organisations representing young persons with disabilities should be integrated into all advisory mechanisms that represent their diverse and intersectional identities. That means that they should be included in advisory boards and civil society forums addressing youth, disability, and gender issues. For example, young persons with disabilities should not only be represented on the national disability council, but also on the national youth and national gender equality councils. This same mainstreaming of representation should take place at the local level, such as participation on municipal advisory councils and civil society forums. In this way, each aspect of their identity and each multiplier of discrimination on the basis of age, disability, and gender are recognised in public affairs. Advisory boards and civil society forums specifically dealing with SRHR and GBV prevention and response should also

include representation from young persons with disabilities. All such forums should be disability inclusive by ensuring access and accommodation and all information are available in multiple formats. States should also periodically facilitate civil society forums specifically for young persons with disabilities to discuss their issues and concerns and advise on laws, policies, and programme activities to redress inequalities. Civil society organisations representing young persons with disabilities should also be supported by states to attend international, regional, and national forums, including forums reviewing the CRPD, CEDAW, and CRC.

States should support CSOs representing young persons with disabilities in activities that disseminate information regarding the rights of young persons with disabilities, including their exercise of and access to SRHR and GBV prevention and response. For those CSOs involved in SRHR-related programmes and initiatives and those related to raising awareness and eliminating GBV, states should ensure that state-supported civil society campaigns are accessible and disability-inclusive. States should also support the awareness-raising and rights education activities of DPOs representing young persons with disabilities that include awareness raising as a part of their programme activities. This should include support for awareness-raising campaigns that specifically target young persons with disabilities and their parents and caregivers to educate them about the rights of young persons with disabilities, especially young women and girls, including their rights in connection with sexuality and reproduction and right to live free of violence. States should advocate that all CSOs providing services related to SRHR and GBV prevention and response be accessible and inclusive of young persons with disabilities. This is particularly important in contexts where CSOs provide significant levels of services related to SRHR and GBV prevention and response, such as international NGOs providing access to family planning or HIV/AIDS-related prevention and treatment services in low-income countries. When appropriate, states should also support CSOs representing young persons with disabilities in cases in which they are providing targeted SRHR and GBV prevention and response services to their members and other young persons with disabilities.

Civil society represents the most important tool for holding states accountable, ensuring that they are responsive to their citizens and protect and promote their human rights. A positive state practice for monitoring and evaluation is for states to actively include civil society in the review of laws, policies, and programme implementation. States should include and support young persons with disabilities and their representative organisations in ongoing monitoring processes relevant to SRHR and GBV prevention and response. This should include supporting CSOs representing young persons with disabilities, especially young women and adolescent girls with disabilities, in the preparation of civil society or 'shadow' reports for the CRPD, CEDAW, and CRC and other international instruments relevant to addressing SRHR and eliminating GBV. States Parties under the CRPD have a positive legal obligation to include persons with disabilities in the monitoring of the states' implementation of disability rights. States should ensure that the CSOs included in that monitoring process are inclusive of young persons, including young women and girls.

Lastly, under the CRPD, States Parties providing international cooperation support should not only ensure that their international development

activities are disability inclusive but also that they work with CSOs representing persons with disabilities. In so doing, states should implement policies and practices that ensure that their international development activities not only include persons with disabilities and their representative DPOs but also specifically include young persons with disabilities, especially young women and adolescent girls with disabilities. They should also promote the inclusion of young persons with disabilities within other CSOs focused on promoting rights of young persons, women and girls, gender equality, and SRHR, for example.

PROMOTING THE PARTICIPATION OF YOUNG PERSONS WITH DISABILITIES THROUGH CIVIL SOCIETY

RECOMMENDATIONS FOR STATES, IN PARTNERSHIP WITH CIVIL SOCIETY AND PERSONS WITH DISABILITIES

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Ensuring civil and political rights	▪ Develop legislation that: - Protects the rights to association, assembly, and speech.	▪ Develop legislation that: - Specifically protects the rights of young persons with disabilities to association, assembly, and speech.
Registration and renewal for CSOs	▪ Simplify the process and ensure it is accessible: - All information and required forms should be provided in multiple formats. - Registration offices should be accessible and available at multiple sites throughout the country. - Documentation required should be minimal and non-burdensome. - Registration fees should be at a low or no cost. - Review periods should be as short as possible.	▪ Target young persons with disabilities by: - Facilitating targeted workshops on registration and renewal processes for young persons with disabilities. - Provide ongoing assistance to young persons with disabilities throughout the process. - Waive registration fees for young persons with disabilities and other groups facing multiple and intersecting forms of discrimination.
Active involvement and advice in policymaking and programme implementation	▪ Include young persons with disabilities on government advisory boards, especially those addressing youth, disability, and gender. ▪ Ensure and advocate for disability access and accommodations at all civil society forums.	▪ Ensure civil society, specifically young persons with disabilities, can meaningfully participate in policymaking and programme development including the ability to discuss their issues and concerns. ▪ Support young persons with disabilities representing themselves in international, regional, national, and local forums. ▪ Support young women and adolescent girls with disabilities to represent themselves and their organisations in international, regional, national, and local forums.
Raising awareness on SRHR and GBV prevention and response	▪ CSOs should be supported in awareness-raising campaigns, including those aimed at demand creation for SRHR and prevention of and response to GBV, that are accessible and disability inclusive.	▪ Young persons with disabilities should be supported in developing their own awareness-raising campaigns related to SRHR and GBV prevention and response that target young persons with disabilities, their families, and others.
Inclusion in monitoring and evaluation	▪ Provide disability access and accommodations at all public hearings and other events and activities evaluating law, policies, and programmes. ▪ Ensure all survey and evaluation instruments are inclusive and youth, disability, and gender sensitive.	▪ Facilitate forums, workshops, focus groups, and other events and activities evaluating law, policies, and programmes for young persons with disabilities. ▪ Advocate with CSOs to ensure representation of young persons with disabilities when developing civil society 'shadow' reports to the CRPD, CEDAW, and CRC.

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Service provision	▪ Advocate that all CSOs providing services related to SRHR and GBV prevention and response be accessible and inclusive of young persons with disabilities.	▪ Support CSOs representing young persons implementing services related to SRHR and GBV prevention and response when appropriate.
International development	▪ States providing support to international cooperation should ensure that all development activities are disability inclusive, including those activities provided by civil society partners as well.	▪ States providing international cooperation support should support the development of CSOs representing young persons with disabilities, including organisations specifically representing young women and adolescent girls with disabilities. ▪ States providing international cooperation support should support the development of cross-movement building, by supporting different networks of civil society, in all their diversity, to collaborate and collectively address intersectionality.

RECOMMENDATIONS FOR UN AGENCIES, CIVIL SOCIETY, ACADEMIA, COMMUNITIES, AND THE PRIVATE SECTOR

Everyone has an important and necessary role to play to ensure that young persons with disabilities are active participants in society and are able to enjoy their rights on an equal basis with others in their daily lives. Not only do states need to recognise young persons with disabilities as vital citizens deserving of the same rights, opportunities, and protections as young persons without disabilities, but also families, peers, community leaders, teachers and researchers, employers and co-workers, and all other community members should recognise that they have a responsibility to actively promote the inclusion of young persons with disabilities. Many actors play a role in advancing SRHR and in promoting GBV prevention and services. United Nations agencies, civil society, academia, and private sector actors, in partnership with states, should ensure that young persons with disabilities are included in all policies, programmes, services, and other activities, especially in those related to SRHR and GBV prevention and response.

PROMOTING THE RIGHTS OF YOUNG PERSONS WITH DISABILITIES
RECOMMENDATIONS FOR UN AGENCIES, CIVIL SOCIETY, ACADEMIA, COMMUNITIES, AND THE PRIVATE SECTOR

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
International standards	▪ United Nations agencies, civil society, and the private sector should coordinate with states to meet and advance the international standards. ▪ United Nations agencies, civil society, and the private sector should assess their activities and states' activities from the perspective of international standards.	▪ United Nations agencies, civil society, and the private sector should utilise a rights-based approach that actively includes young persons with disabilities in all programme activities.

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Comprehensive and integrated approaches	▪ Policy and programmatic responses should adopt a comprehensive and integrated approach that involves all within organisations, corporations, community associations, and academia, to ensure inclusion of persons with disabilities, at all appropriate levels. ▪ United Nations agencies, civil society, academia, and the private sector should review all organisational policies and programmes for inclusion of young persons with disabilities.	▪ United Nations agencies, civil society, and private sector should support a twin-track approach to ensuring the rights of young persons with disabilities by mainstreaming disability, youth, and gender into all activities related to SRHR and GBV prevention and response and, targeted programmes addressing the most significant barriers that young persons with disabilities face when exercising and accessing SRHR and GBV prevention and response services. ▪ Disabled persons' organisations should support more youth- and gender-responsive activities, including young women and girls with disabilities in leadership and in activities promoting SRHR and GBV prevention and response services. ▪ United Nations agencies, civil society, academia, and the private sector should ensure that all policies and practices related to prevention and redress of sexual harassment, exploitation, and abuse are not discriminatory toward young persons with disabilities.
Context and identity specific	▪ United Nations agencies, civil society, academia, and the private sector should recognise the compounding nature of discrimination on the basis of disability, gender, and age, among other identities, and address context-specific factors, including conflict and natural disasters, poverty, rurality, institutionalisation, and other multipliers of inequality.	▪ All practices by UN agencies, civil society, and the private sector should be based on international standards and be context specific to address the lived experiences of young persons with disabilities in specific socio-economic conditions and cultural realities. ▪ United Nations agencies, civil society, academia, and the private sector should, develop approaches for addressing the specific barriers young persons with disabilities face when exercising and accessing SRHR and GBV prevention and response services, particularly those facing the greatest barriers that compound the discrimination experienced by young persons with disabilities. ▪ United Nations agencies, civil society, academia, and the private sector should work to address stigma and discrimination, taking into consideration the compounding nature of multiple and intersecting forms of discrimination against young persons with disabilities.
Awareness raising	▪ United Nations agencies, civil society, academia, and the private sector should train all organisational leaders, programme implementers, and service providers regarding disability inclusion and about unconscious bias to address stigma and discrimination. ▪ Communities can advocate with local policymakers to ensure local services for SRHR and GBV prevention and response are accessible for persons with disabilities.	▪ UN agencies, civil society, academia, and the private sector, should support awareness raising campaigns to address stigma and discrimination and ensure all efforts are accessible and inclusive in all respects. ▪ Communities should work to promote positive attitudes and beliefs towards young persons with disabilities including in relation to their SRHR and right to live free of violence. ▪ Communities should challenge violence against and bullying of young persons with disabilities. ▪ Private sector should promote diversity and inclusion in working environments for young persons with disabilities. ▪ Academia should conduct research on young persons with disabilities in relation to SRHR and GBV prevention and response, in consultation and partnership with DPOs.

TOPIC	MAINSTREAMING APPROACHES	TARGETED APPROACHES
Participation	▪ United Nations agencies, civil society, academia, and the private sector, should develop capacity through training of organisational and company leaders, programme implementers, and service providers regarding disability inclusion. ▪ Communities should advocate for and promote the inclusion and participation of young persons with disabilities in their communities. ▪ United Nations agencies, civil society, academia, and the private sector should advocate for young persons with disabilities to be on government advisory boards, in particular, those addressing youth, disability, and gender. ▪ Civil society should ensure and advocate for disability access and accommodations at all civil society forums.	▪ United Nations agencies, civil society, academia, and private sector, should ensure that young persons with disabilities and their representative CSOs participate in the development of organisational policies and programmatic responses related to SRHR and GBV prevention and response. ▪ Networks of various movements should collaborate more closely including those working on disability, youth issues, gender, etc for cross movement building and more effectively addressing intersectionality.
Monitoring and evaluation	▪ United Nations agencies, civil society, academia, and the private sector should ensure that all organisational and corporate policies and programmatic activities are monitored and evaluated from the perspective of young persons with disabilities.	▪ United Nations agencies and civil society should facilitate forums, workshops, focus groups, and other events and stakeholder activities evaluating organisational policies and programme activities for young persons with disabilities. ▪ United Nations agencies should support CSOs representing young persons with disabilities in developing civil society 'shadow' reports to the CRPD, CEDAW, and CRC. ▪ CSOs should ensure participation of young persons with disabilities in developing civil society 'shadow' reports to the CRPD, CEDAW, and CRC.
Data collection, analysis, and use, and research	▪ United Nations agencies and civil society should advocate for and support the collection, analysis, and use of qualitative and quantitative data and research on young persons with disabilities.	▪ United Nations agencies, civil society, and academia should also collect data in a disability-, gender-, and youth- inclusive manner that allows researchers to clearly identify gaps and address inequalities across groups.
Disability-inclusive budgeting	▪ United Nations agencies and civil society should advocate for and support the use of disability-inclusive budgeting.	▪ United Nations agencies, civil society, and the private sector should integrate disability inclusion in all budgeting processes, ensuring there is a significant amount of money to guarantee that all policies, programmes, and services related to SRHR and GBV prevention and response are fully inclusive of young persons with disabilities. ▪ Communities should ensure that any participatory-based budgeting at the local level includes the participation of persons with disabilities, including young persons with disabilities.

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346 Committee on the Rights of the Child, General Comment No. 13 (2011). *The Right of the Child to Freedom from all Forms of Violence*, CRC/C/GC/13.

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350 Committee on the Rights of the Child (2016). *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence, CRC/C/GC/20*.*

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352 CBM (n.d.). *The 3Ps for inclusion of women with disabilities: The Personal, The Political, The Policy.* Retrieved from https://www.cbm.org/article/downloads/54741/The_Personal__The_Political__The_Policy.pdf.

353 Committee on the Elimination of All Forms of Discrimination against Women (2017). *General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19.* CEDAW/C/GC/35; See also CEDAW Committee comments on the intersectionality of discrimination in General Recommendation No. 33, paras. 8 and 9 (CEDAW/C/GC/33); No. 15 on women and AIDS (A/45/38); No. 21 on equality in marriage and family relations (a/49/38); No. 24 on women and health (a/54/38/Rev.1, chap. 1); No. 26 on women migrant workers (CEDAW/C/2009/WP.1/R); No. 27 on older women and protection of their human rights (CEDAW/C/GC/27); No. 30 on women in conflict prevention, conflict, and post-conflict situations (CEDAW/C/GC/30); No. 31 on harmful practices (CEDAW/C/GC/31-CRC/C/GC/18); No. 32 on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women (CEDAW/C/GC/32); and No. 34 on the rights of rural women (CEDAW/C/GC/34). See also communications with reporting States Parties including those referenced in General Recommendation No. 35, note 12 and, most recently, Concluding Observations on the combined seventh and eighth periodic reports of Nigeria (CEDAW/C/NGA/CO/7-8).

354 United Nations (2017). *Report of the Special Rapporteur on the rights of persons with disabilities, Sexual and reproductive health and rights of girls and young women with disabilities*, A/72/133.

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358 The failure to register a child with a disability at birth can make him/her more vulnerable to violence and abuse and deny him/her access to resources such as public health facilities or public schools.

359 Note that that persons of all genders can be subjected to gender-based violence, however, exploring the situation of members of these various communities is beyond the scope of this study.

360 Lisa Jones, et al., Prevalence and Risk of Violence against Children with Disabilities: A Systematic Review and Meta-Analysis of Observational Studies, Lancet 2012, 899-907.

361 For example, The ICCPR recognises the right to physical integrity and security of the person (Arts. 7, 9 and 10), the Committee on Economic, Social, and Cultural Rights has acknowledged gender-based violence is a prohibited form of discrimination, the Convention against Torture and Other Cruel, Unhuman or Degrading Treatment or Punishment prohibits the intentional infliction of severe pain or suffering against any person 'with the acquiescence of a public official' [see Copelon, R. (2009). *End Torture, End Domestic Violence*, On the Issues Magazine for an analysis of the link between torture and gender-based violence], and the Rome Statute of the International Criminal Court has classified rape and sexual violence as grave crimes against humanity. See also UN General Assembly Resolutions 65/228, 'Strengthening Crime Prevention and Criminal Justice Responses to Violence Against Women' (March 2011), 64/137, and 65/187; and Human Rights Council Resolution 14/12 which collectively call upon states to exercise due diligence to prevent and investigate acts of violence against women and girls and punish perpetrators.

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363 Committee on the Elimination of Discrimination against Women (2017). *General recommendation no. 35 on gender-based violence against women, updating general recommendation no. 19.* CEDAW/C/GC/35. Para. 2.

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386 Claudina Velazquez Paiz et al. (Guatemala), Inter-Am. Comm. H.R. Report No. 53/13, Case 11,157 (2011).

387 United Nations ECLAC (2014). *Montevideo Consensus on Population and Development: First Session of the Regional Conference on Population and Development in Latin America and the Caribbean. Full integration of population dynamics into rights-based sustainable development with equality: key to the Cairo Programme of Action beyond 2014.*

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391 The regional instruments listed here represent only a portion of those most relevant to the scope of this study; there are several more. In her comprehensive analysis of legal regimes governing women's and human rights in Africa, Fareda Banda identified more than 25 potentially relevant regional and sub-regional initiatives. See Banda, F. (2005). *Women, Law and Human Rights: An African Perspective.*

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435 Gonzalez et al. ('Cotton Field') v. Mexico, Preliminary Objection, Merits, Reparations and Costs, Judgment of November 16, 2009, Inter-Am. Ct. H.R. (Ser. C) No. 205, paras. 100, 286, 293.

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513 LICA (Colombian League of Autism) is a non-profit organisation that works for the rights and improvement of the quality of life of people with autism and their families. LICA works with people with autism spectrum disorder (ASD), their families, professionals, organisations, and all those who identify with the needs of the population with ASD.

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TEXT ALTERNATIVES FOR INFOGRAPHICS

Full-text versions of each infographic presented in this summary brief are available below.

DISABILITY VS. INCLUSION

Put simply, disability can be defined as the relationship between a person's impairment and their environment. **When inclusive and comprehensively accessible environments are provided, an impairment on its own would not lead to disability. CBM has developed two equations to simplify this complex relationship.** The first equation reads 'impairment plus barrier equals disability'. The graphic argues that the following second equation is better than the first equation and reads 'impairment plus accessible environment equals inclusion'.

Source: CBM International (2017). *Accountability Inclusive Development Toolkit.*

POTENTIAL CAUSES OF VIOLENCE AGAINST CHILDREN WITH DISABILITIES

This infographic was taken from a European Union Agency for Fundamental Rights report where the causes of violence against children with disabilities were identified by respondents which included professionals, key stakeholders from disabled persons' organisations, parent organisations and other nongovernmental organisations, and policymakers in 13 European Union Member States: Austria, Bulgaria, Croatia, the Czech Republic, Denmark, Italy, Lithuania, the Netherlands, Poland, Portugal, Slovenia, Sweden, and the United Kingdom.

The potential causes of violence against children with disabilities as gathered by respondents are presented below (in no particular order):

1. Overextended and untrained care personnel.
2. Over-burdening of parents and lack of support.
3. Lack of knowledge about disability.
4. Societal attitudes based on prejudice and fear of 'otherness'.
5. Isolation and segregation from the community.
6. Risk factors relating to perpetrators seeing children with disabilities as 'easy targets'.

Source: European Union Agency for Fundamental Rights (2015). *Violence against children with disabilities: legislation, policies, and programmes in the EU.*

REGIONAL RATES OF INTIMATE PARTNER VIOLENCE AROUND THE WORLD

This infographic presents a map of the world which utilises World Bank Group regions. Data for Northern and Western European countries and Greenland are shaded in grey denoting that information was not available.

- North America has a 21 per cent rate of intimate partner violence.
- Australia and New Zealand has a 28 per cent rate of intimate partner violence.
- Europe and Central Asia has a 29 per cent rate of intimate partner violence.
- East Asia and the Pacific has a 30 per cent rate of intimate partner violence.
- Latin America and the Caribbean has a 33 per cent rate of intimate partner violence.
- The Middle East and North Africa has a 40 per cent rate of intimate partner violence.
- Sub-Saharan Africa has a 40 per cent rate of intimate partner violence.

- South Asia has a 43 per cent rate of intimate partner violence.

Source: Preliminary analysis of the World Health Organisation global prevalence database (2013) as presented in Voice and Agency: Empowering Women and Girls for Shared Prosperity (2014) by Klugman et al.

NUMBER AND SHARE OF GIRLS AGES 10 TO 17 NOT PROTECTED AGAINST CHILD MARRIAGE IN 112 COUNTRIES

This infographic presents the percentage of girls ages 10 to 17 who are not protected against child marriage. The countries are split up by income group and the source study included 22 low-income countries, 35 lower middle-income countries, 3 upper middle-income countries, and 22 higher income countries. The estimates are based on the number of girls aged 10-17 who are below the minimum age of marriage in their country. Three definitions of the age for marriage in each country are used: Number one is the legal age for marriage without consent from parents or judicial bodies; number two is the minimum age with parental consent; number three is the minimum age with the authorisation of judicial bodies.

The infographic compares changes between 2015 and 2017, with data only existing for 2017 in some cases. The infographic demonstrates that a significant portion of girls are not protected against child marriage, either legally, nor in terms of parental or judicial consent. The figures range from two per cent to thirty-eight per cent, depending on the year, income group of country, or type of protection.

The infographic uses data on laws for the minimum age for marriage collected by the Women, Business and the Law program at the World Bank. The following four tables detail the data presented in the infographic.

Table One: Share of girls not protected against child marriage (percentage) by minimum age of marriage without consent from parents or judicial bodies.

YEAR	INCOME GROUPS (OF COUNTRIES)			
	Low	Lower middle	Upper middle	High
2015	2.0	10.0	5.7	1.1
2017	2.0	10.0	5.7	1.1

Table Two: Share of girls not protected against child marriage (percentage) due to minimum age exceptions with parental consent.

YEAR	INCOME GROUPS (OF COUNTRIES)			
	Low	Lower middle	Upper middle	High
2015	12.2	21.1	22.5	18.0
2017	8.1	22.5	15.9	17.7

Table Three: Share of girls not protected against child marriage (percentage) due to minimum age exceptions with judicial consent.

YEAR	INCOME GROUPS (OF COUNTRIES)			
	Low	Lower middle	Upper middle	High
2017	16.8	35.1	33.7	26.3

Table Four: Share of girls not protected against child marriage (percentage) due to minimum age exceptions either by parental or judicial consent.

YEAR	INCOME GROUPS (OF COUNTRIES)			
	Low	Lower middle	Upper middle	High
2017	20.3	38.1	36.3	35.5

Source: Wodon, Q., Tavares, P., Fiala, O., Le Nestour, A., and Wise, L. (2017). *Ending Child Marriage: Legal Age for Marriage, Illegal Child Marriages, and the Need for Interventions.*

LINK BETWEEN DISABILITY AND POVERTY: HOW DISABILITY CAN EXACERBATE CONDITIONS THAT LEAD TO INCREASED LEVELS OF POVERTY FOR VULNERABLE POPULATIONS

This infographic visualises the link between disability and poverty by presenting the following cycle which neither has a beginning nor end:

Disability may increase the chances of experiencing social and cultural exclusion and stigma as well as denial of opportunities for economic, social and human development. This in turn may cause poverty which may lead to deficits in economic, social, and cultural rights. Poverty may increase the chances of reduced participation in decision making and denial of civil and political rights which in turn can cause increased vulnerability to poverty and ill-health. The cycle continues back to disability through to poverty and back to vulnerability to poverty and ill-health.

Source: DFID (2000). *Disability, poverty, and development.*

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND OPTIONAL PROTOCOL: SIGNATURES AND RATIFICATIONS

This infographic lists all countries that have signed the Convention on the Rights of Persons with Disabilities, countries that have ratified the Convention, countries that have signed the Optional Protocol, countries that have ratified the Optional Protocol, and countries that have not signed the Convention or Optional Protocol.

In summary, 162 countries have signed the Convention, 178 countries have ratified the Convention, 94 countries have signed the Optional Protocol, 93 countries have ratified the Optional Protocol, and 11 countries have not signed.

Information on which country has signed or ratified the Convention or Optional Protocol is accessible at the Database of the United Nations Office of Legal Affairs at untreaty.un.org/ola. This infographic includes data as of 19 February 2018.

LINKS BETWEEN THE SUSTAINABLE DEVELOPMENT GOALS AND ARTICLES OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

This graphic is taken from CBM International and displays the interconnectedness of the Sustainable Development Goals and articles of the Convention on the Rights of Persons with Disabilities (CRPD). The following paragraphs summarise the link between the Sustainable Development Goals and the CRPD per each applicable Sustainable Development Goal:

Goal 1: NO POVERTY: End poverty in all its forms everywhere: This goal is underpinned by the right to life (Article 10); control over one's own resources by guaranteeing equal recognition before the law (Article 12); and an adequate standard of living and social protection (Article 28). Articles 5, 6, 7, 9, 11, 31 and 32 are also applicable.

Goal 2: ZERO HUNGER: End hunger, achieve food security and improved nutrition and promote sustainable agriculture: This goal is underpinned by the right to adequate food, including food security, safeguards, and an adequate standard of living (Article 28); control over land, property and inheritance can be guaranteed by equal recognition before the law (Article 12). Articles 5, 6, 7, 9, 31 and 32 also apply.

Goal 3: GOOD HEALTH AND WELL-BEING: Ensure healthy lives and promote well-being for all at all ages: This goal is underpinned by the right to life (Article 10); access to sexual and

reproductive health services is recognised by the right to enjoyment of the highest attainable standard of health without discrimination on the basis of disability (Article 25); and family planning, information, and education is ensured by respect for home and the family (Article 23). Articles 6, 7, 9, 11, 31 and 32 also apply.

Goal 4: QUALITY EDUCATION: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all: This goal is underpinned by Article 24 of the CRPD which promotes an inclusive education system at all levels on the basis of equal opportunity and freedom from exclusion; Article 27 which states that persons with disabilities must have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training; and Article 16 which states that safe, non-violent learning environments can be enabled by protection from exploitation, violence and abuse outside the home. Articles 5, 6, 7, 9, 31 and 32 also apply.

Goal 5: GENDER EQUALITY: Achieve gender equality and empower all women and girls: This goal is underpinned by Article 6 of the CRPD which recognises that women and girls with disabilities are subjected to multiple discrimination; Article 16 which states the elimination of harmful practices requires effective women- and child-focused legislation and policies; Article 28 which covers the provision of social protection policies; Article 29 which relates to the right to participation in political and public life; Article 25 which recognises the right to the same range and quality and standard of free or affordable sexual and reproductive health; Article 23 which ensures the right to reproductive and family planning is through respect for home and family; Article 12 on the right to equal recognition before the law which acknowledges women's right to ownership over land, property and inheritance; Article 21 regarding the right to accessible information and communications for women and girls; and Article 8 on awareness-raising which discusses the promotion of gender equality for women and girls with disabilities. Articles 5, 7, 9 and 31 are also applicable.

Goal 6: CLEAN WATER AND SANITATION: Ensure availability and sustainable management of water and sanitation for all: Article 28 of the CRPD recognises the right to the continuous improvement of living conditions, access to clean water and the promotion of the right to an adequate standard of living for persons with disabilities. Articles 5, 6, 7, 9, 11, 31 and 32 also apply.

Goal 7: AFFORDABLE CLEAN ENERGY: Ensure access to affordable, reliable, sustainable and modern energy for all: Universal access, especially in developing countries and the requirement to measure progress on this goal in relation to persons with disabilities are covered by Articles 9, 31 and 32.

Goal 8: DECENT WORK AND ECONOMIC GROWTH: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all: Article 27 recognises the right of persons with disabilities to work on an equal basis with others and to gain a living by work freely chosen, and to receive equal remuneration for work of equal value and to have safe working conditions; Article 12 states that equal access to banking, insurance, and financial services can be enabled by upholding the right to equal recognition before the law; and Article 16 covers rights related to freedom from exploitation, violence and abuse such as forced labour, modern slavery and human trafficking. Articles 5, 6, 9 and 31 also apply.

Goal 9: INDUSTRY, INNOVATION AND INFRASTRUCTURE: Build resilient infrastructure, promote inclusive and sustainable industrialisation: Article 12 on equal recognition before the law covers access to financial services including affordable credit; Article 20, if implemented, can guarantee personal mobility with the greatest possible independence for persons with disabilities; Article 21 covers freedom to access information on an equal basis with others and through all forms of communication; and Article 27 covers the promotion of opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business. Articles 5, 6, 7, 9, 31 and 32 are also applicable.

Goal 10: REDUCED INEQUALITIES: Reduce inequality within and among countries: Ensuring enhanced representation and voice of persons with disabilities in decision-making is covered by Article 4; promoting the positive perceptions and greater social awareness towards persons with disabilities to foster inclusion is part of Article 8; facilitating safe migration and mobility can protect persons with disabilities from exploitation is covered under Article 16; ensuring access to social protection and poverty reduction programmes is contained in Article 28. In addition, Articles 5, 6, 7, 9, 11, 31 and 32 are applicable.

Goal 11: SUSTAINABLE CITIES AND COMMUNITIES: Make cities and human settlements inclusive, safe, resilient and sustainable: the right of persons to an adequate standard of living for themselves and their family, including adequate housing must be realised as per Article 28; persons with disabilities must be afforded personal mobility in the manner and at the time of their choice and at affordable cost (Article 20); safe cities and settlements must ensure protection from violence (Article 16); the environment and public transport must be accessible on an equal basis with others in urban and rural areas (Article 9); and participatory planning and management must be respected (Article 4). Articles 5, 6, 7, 11, 31 and 32 also apply.

Goal 13: CLIMATE ACTION: Take urgent action to combat climate change and its impacts: persons with disabilities who are subject to the occurrence of natural disasters and other situations of risk must be included in all protection and safety mechanisms (Article 11); and climate-related planning and management must be inclusive of and accessible to persons with disabilities (Article 32). Articles 5, 6, 7, 9 and 31 also apply.

Goal 16: PEACE, JUSTICE AND STRONG INSTITUTIONS: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels: death rates must be reduced by effective enjoyment of the right to life (Article 10); freedom from violence, exploitation and abuse must be upheld (Article 16); as must freedom from torture cruel, inhuman or degrading treatment or punishment (Article 15); access to justice on an equal basis with others, including through the provision of procedural and age-appropriate accommodations must be in place (Article 13); inclusive decision-making that closely consults with and actively involves persons with disabilities through their representative organisations (Article 4); supported decision-making regimes should be available (Article 12); the right to a legal identity is covered by Article 18; persons with disabilities must enjoy all human rights and fundamental freedoms (Article 1) and are not deprived of their liberty unlawfully (Article 14). In addition, Articles 5, 6, 7, 9, 31 and 32 also apply.

Goal 17: PARTNERSHIPS FOR THE GOALS: Strengthen the means of implementation and revitalise the global partnership for sustainable development: enhancing the use of enabling technology, in particular information and communication technology can be achieved for persons with disabilities by implementing Article 21 to ensure accessibility; collection of high quality, timely and reliable data disaggregated by disability relates directly to Article 31 on statistics and data collection. Articles 9 and 32 regarding partnerships with organisations of persons with disabilities and facilitating access to technology transfer, are also applicable.

Source: CBM International (2016). *CRPD and SDG infographic.* Retrieved from https://www.cbm.org/New-resources-on-Agenda-2030-and-the-CRPD-501728.php.

THE ACCEPTABILITY, AVAILABILITY, ACCESSIBILITY, AND QUALITY FRAMEWORK AND GENDER-BASED VIOLENCE RESPONSE SERVICES FOR YOUNG PERSONS WITH DISABILITIES

Acceptability: Facilities, goods, and services must be respectful of medical ethics and culturally appropriate.

Availability: Facilities, goods, and services must be available in sufficient quantity and continuous supply.

Accessibility: Facilities, goods, and services must be accessible to everyone (physical, economical, information, non-discrimination).

Quality: Facilities, goods, and services must be of good quality.

Source: Adapted from the Committee on Economic, Social, and Cultural Rights (2000). *General Comment 14, The right to the highest attainable standard of health.* U.N. Doc. E/C.12/2000/4.

CUMULATIVE NUMBER OF COUNTRIES WITH LEGISLATION AGAINST DOMESTIC VIOLENCE, 1976 THROUGH 2016

This infographic is a chart which shows the increase in amount of countries with legislation against domestic violence.

In 1976, the number of countries with legislation against domestic violence was zero. By 1994, the number was around 10 countries. Two years later, it had increased to nearly 20. Thirty countries included legislation against domestic violence by 2000. Since 2000, the number of countries continued to increase with 70 countries having legislation against domestic violence by the end of the decade, 2010. Between 2013 and 2016, the number of countries with legislation against domestic violence increased from about 75 to over 140.

Source: World Bank (2015). *Women Business and the Law: Getting to Equal and the Women and Business and the Law database* (updated 2016).

NUMBER OF COUNTRIES WITH OR WITHOUT SELECT GENDER EQUALITY PROVISIONS

The total number of countries included is 189 and the information was last updated in August 2016.

140 countries have domestic violence legislation while 49 countries do not.

144 countries have legislation that specifically addresses sexual harassment while 45 countries do not.

There is an equal minimum age of marriage for men and women in 167 countries. 18 countries do not have an equal minimum age of marriage for men and women, and four countries had no information.

149 countries have laws that prohibit or invalidate child or early marriages. 39 countries do not have laws that prohibit or invalidate child or early marriages, and there was one country with no information.

103 countries have penalties in the law for authorising or knowingly entering into child or early marriage. 85 countries do not have such penalties or laws. One country had no information.

In 76 countries, the legislation explicitly criminalises marital rape. The legislation in the remaining 113 countries do not explicitly criminalise marital rape.

In 13 countries, perpetrators are exempt from facing criminal charges for rape if they marry the victim. The remaining 176 countries do not exempt perpetrators from facing criminal charges for rape if they marry the victim.

Source: Source: World Bank (2016). Women, Business and the Law Project (last updated August 2016). Available at: wbl.worldbank.org.

THE ACCEPTABILITY, AVAILABILITY, ACCESSIBILITY, AND QUALITY FRAMEWORK SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PERSONS WITH DISABILITIES

Acceptability: All facilities, goods, information, and services related to sexual and reproductive health must be respectful of the culture of individuals, minorities, peoples, and communities, and sensitive to gender, age, disability, sexual diversity and life cycles requirements.

Availability: An adequate number of functioning health care facilities, services, goods, and programmes should be available to provide the population with the fullest possible range of sexual and reproductive health services.

Accessibility: Health facilities, goods, information, and services related to sexual and reproductive health services should be accessible to all individuals and groups without discrimination and free from barriers. Accessibility includes physical accessibility, affordability, and information accessibility.

Quality: Facilities, goods, information, and services related to sexual and reproductive health must be of good quality, meaning they are evidence-based and medically appropriate and up-to-date.

Source: Committee on Economic, Social, and Cultural Rights (2016). General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights).

NINE ESSENTIAL COMPONENTS OF COMPREHENSIVE SEXUALITY EDUCATION PROGRAMMES MODIFIED FOR YOUNG PERSONS WITH DISABILITIES

Component One: A basis in the core universal values of human rights, including the rights of persons with disabilities.

Comprehensive sexuality education may be used not only to promote sexual and reproductive health and rights, but also to promote gender equality and the human rights of all people. Comprehensive sexuality education may introduce school-aged children, adolescents, and young persons both with and without disabilities to the ideas of disability equality and the human rights of persons with disabilities at the same time as they are learning about the importance of respect for their own and other's sexuality, gender equality, and human rights.

Component Two: Gender equality

For comprehensive sexuality education to be effective and meet international standards, it must also promote gender equality. As disability often exacerbates gender inequalities, a disability

perspective when examining key subtopics regarding gender is particularly important for the comprehensive sexuality education participants to receive and understand.

Component Three: Thorough and scientifically accurate information

Comprehensive and accurate information is essential for young people to fully enjoy their sexual and reproductive health and rights. Many misconceptions about sexuality and disability exist, including harmful social beliefs that lead to stigmatisation and social isolation. Comprehensive sexuality education should address false beliefs, such as the belief that persons with disabilities are nonsexual, within the appropriate cultural contexts.

Component Four: A safe, healthy, and disability-inclusive learning environment

For someone to fully participate in comprehensive sexuality education, they must have an accessible, safe, and healthy learning environment. Persons with disabilities, especially young persons with disabilities, are often targeted for bullying, discrimination, and even violence by both teachers and their peers. Therefore, it is particularly important that comprehensive sexuality education educators have strong disability inclusion policies that make it clear that any form of discrimination will not be tolerated. This should include disability awareness training for all participants and stakeholders and monitoring policies that ensure participants with disabilities have the ability to file confidential reports of discrimination and abuse.

Component Five: Linking to sexual and reproductive health services and other initiatives that address gender, disability, equality, empowerment, and access to educational, social, and economic assets for young people.

Comprehensive sexuality education programmes should be linked to complementary initiatives that support sexual and reproductive health and rights specifically and larger social factors that affect sexual and reproductive health and rights of young persons with disabilities. When linking to these initiatives, comprehensive sexuality education programmes should ensure that they are disability inclusive so that young persons with disabilities are able to participate on an equal basis. Complementary initiatives could include programmes to create young-friendly sexual health service policies, disability-accessible sexual health care facilities, awareness-raising campaigns aimed at changing harmful gender norms, and the inclusion of sexual and reproductive health and rights in disability laws and policies.

Component Six: Participatory teaching methods for personalisation of information and strengthened skills in communication, decision making and critical thinking

Comprehensive sexuality education participants need to learn the skills necessary to deeply think about their sexual decisions and be able to effectively communicate them with others. Comprehensive sexuality education programmes should be attentive to the fact that many young persons with disabilities may have grown up in overprotective households and may not have developed the same level of autonomous decision-making and self-advocacy skills as their peers. Therefore, comprehensive sexuality education programmes may want to develop targeted lessons to ensure that young persons with disabilities are able to fully develop these skills as well as interactive lessons that include both participants with and without disabilities.

Component Seven: Strengthening youth advocacy and civic engagement

Comprehensive sexuality education programmes should involve young persons both with and without disabilities in the design of programmes and facilitate the participation of young people in positive social change activities, including awareness raising and advocacy regarding sexual and reproductive health and rights. Including young persons with disabilities in the design of programme activities will help ensure a disability perspective is included in the curriculum and that all advocacy and civic engagement activities are disability inclusive. Comprehensive sexuality education programmes should also ensure that any civil society partners have disability inclusion policies and that disabled persons' organisations, especially those representing young persons, are full participants in advising and evaluating comprehensive sexuality education policies and programming.

Component 8: Cultural relevance in tackling human rights violations and gender and disability inequality

As attitudes and beliefs regarding gender and disabilities are often deeply embedded in socio-cultural norms, all comprehensive sexuality education programmes should be developed in a culturally sensitive manner, adhering to the international standards. They should explicitly address myths and misconceptions regarding gender, disability, and other axes of discrimination that exist in the local context. Involvement of stakeholders and others familiar with the local context is key to designing programmes that promote human rights, gender equality, and disability equality in a culturally sensitive manner to ensure that these concepts are understood, accepted, and resonate.

Component 9: Reaching across formal and informal sectors and across age groupings

Successful comprehensive sexuality education porgrammes use age-appropriate information to engage youth of all ages in a variety of settings, including both in-school and out-of-school young people. Comprehensive sexuality education programmes should also develop strategies to specifically identify and invite young persons with disabilities who are socially isolated and may not be aware of or comfortable attending comprehensive sexuality education without specific encouragement and interventions, including awareness raising of their parents and the other participants in comprehensive sexuality education.

BARRIERS FACED BY YOUNG PERSONS WITH DISABILITIES IN THEIR PARTICIPATION IN CIVIL SOCIETY

Societal barriers: Social attitudes and cultural beliefs amplify other barriers.

Systemic barriers: Failure of mainstream civil society organisations to include young persons with disabilities as members or represent their interests; exclusion of cross-disability disabled persons' organisations from mainstream civil society organisations.

Individual barriers: Overprotective parents or spousal control; exclusion from vocational training; non-enforcement of non-discrimination policies in the job market.

Collective barriers: Bans on the freedom of association (a basic political and civil right).

All four of these barriers (societal, systemic, individual, and collective barriers) to participation in civil society represent violations of the human rights of young persons with disabilities.

ANNEXES

// ANNEX 1

GLOSSARY OF KEY TERMS

COMPREHENSIVE SEXUALITY EDUCATION	In their revised edition of the *International technical guidance on sexuality education: An evidence-based* approach, the United Nations Educational, Scientific, and Cultural Organisation (UNESCO) defines comprehensive sexuality education (CSE) as a 'rights-based and gender-focused approach to sexuality education, whether in school or out of school, that aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.'
EMPOWERMENT	Empowerment, as defined by UNESCO, is about people -both women and men- taking control over their lives: setting their own agendas, gaining skills, building self-confidence, solving problems and developing self-reliance. No one can empower another: only the individual can empower herself or himself to make choices or to speak out. However, institutions including international cooperation agencies can support processes that can nurture self-empowerment of individuals or groups.
GENDER	UNFPA defines gender as the economic, social, and cultural attributes and opportunities associated with being male or female. In most societies, being a man or a woman is not simply a matter of different biological and physical characteristics. Men and women face different expectations about how they should dress, behave, or work. Relations between men and women, whether in the family, the workplace, or the public sphere, also reflect understandings of the talents, characteristics, and behaviour appropriate to women and to men. Gender thus differs from sex in that it is social and cultural in nature rather than biological. Gender attributes and characteristics, encompassing, inter alia, the roles that men and women play, and the expectations placed upon them, vary widely among societies and change over time.
GENDER-BASED VIOLENCE	The Inter-Agency Standing Committee defines gender-based violence (GBV) as an umbrella term for any harmful act that is committed against a person's will, and that is based on socially ascribed (i.e. gender) differences between men and women. It includes acts that result in physical, sexual, or psychological harm or suffering, as well as threats of such acts, coercion, or deprivation of liberty. It is important to note that both men and women may experience GBV, although women and girls are overwhelmingly the victims of violence by men, with intimate partner violence and non-partner sexual violence among the most pervasive forms of GBV.
GENDER EQUALITY	Gender equality, as defined by UNESCO, means that women and men have equal conditions for realising their full human rights and for contributing to, and benefiting from, economic, social, cultural, and political development. Gender equality is therefore the equal valuing by society of the similarities and the differences of men and women, and the roles they play. It is based on women and men being full partners in their home, their community, and their society.
INTIMATE PARTNER VIOLENCE	Intimate partner violence, as defined by the WHO, refers to 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.' Examples include acts of **physical violence** such as slapping, hitting, kicking and beating); **sexual** violence, including forced sexual intercourse and other forms of sexual coercion; **emotional (psychological) abuse**, such as insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, or threats to take away children; and **controlling behaviours**, including isolating a person from family and friends, monitoring their movements, and restricting access to financial resources, employment, education or medical care.

REPRODUCTIVE HEALTH	The International Conference on Population and Development (ICPD) Programme of Action states that 'reproductive health … implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. … Reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.'
REPRODUCTIVE RIGHTS	The ICPD Programme of Action states that '…reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents, and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community.'
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS	Sexual and reproductive health and rights (SRHR) is an umbrella term that refers to reproductive and sexual health, services, and rights within the areas of sexuality and reproduction. In the ICPD Programme of Action, reproductive health is defined as 'a state of complete physical, mental and social well-being…in all matters relating to the reproductive system and to its functions and processes.' It includes sexual health, including the ability to have a 'safe and satisfying sex life and… the capability to reproduce and the freedom to decide if, when and how often to do so.' The latter criterion incorporates the right to be informed about and have access to safe, effective, affordable and acceptable methods of family planning and the regulation of fertility, as well as access to appropriate health-care services. Reproductive rights include the basic right of individuals and couples to attain the highest standard of sexual and reproductive health, which necessitates their right to make decisions regarding their own reproduction, including the ability to decide the number, spacing and timing of their children, free from coercion, discrimination, and violence.
SEXUAL HEALTH	According to the current working definition as set by the World Health Organisation (WHO), sexual health is: '…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'
SEXUALITY	According to the current working definition as set by the WHO, sexuality is: '…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.'
SEXUAL VIOLENCE	The World Health Organisation defines sexual violence as: 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work'
TWIN-TRACK APPROACH	The Convention on the Rights of Persons with Disabilities requires States Parties to incorporate disability-sensitive measures into mainstream service delivery, and to provide disability-specific services that are necessary to support the inclusion and participation of persons with disabilities. This is often referred to as the twin-track approach to disability.

VIOLENCE AGAINST WOMEN AND GIRLS	The United Nations defines violence against women (including girls) as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women [including girls], including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.'
YOUNG PERSONS WITH DISABILITIES	For the purposes of this study, the term young persons with disabilities include persons with disabilities between the ages of 10 and 24.

LIST OF ACRONYMS

AAAQ Framework	Availability, accessibility, acceptability, and quality framework
ACJM	Youth Coalition Mozambican Association
AECID	Spanish Agency for International Development Cooperation
AMODEFA	Mozambican Association for Family Development (Associação Moçambicana para Desenvolvimento da Família)
APF	Asia Pacific Forum
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Agency for International Development
CARICOM	Caribbean Community
CEDAW	Convention on the Elimination of all Forms of Violence against Women
CERMI	Spanish Committee of Representatives of People with Disabilities (Comité Español de Representantes de Personas con Discapacidad)
CESCR	UN Committee on Economic, Social, and Cultural Rights
CNIG	National Council for Gender Equality (Ecuador)
CONADIS	National Council for Disability Equality (Ecuador)
COVAW	Coalition on Violence against Women (Kenya)
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organisation
DAWN	DisAbled Women's Network (Canada)
DFID	Department for International Development (United Kingdom)
DPO	Disabled persons' organisation
EU	European Union
FGM	Female genital mutilation
GBV	Gender-based violence
GREVIO	Group of Experts on Action against Violence against Women and Domestic Violence
HIV/AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
ICCPR	Convention on Civil and Political Rights
ICESCR	Convention on Economic, Social and Cultural Rights

ICPD	International Conference on Population and Development
ICT	Information and communication technology
IDA	International Disability Alliance
iiDi	Inter-American Institute on Disability Inclusive Development (Instituto Interamericano sobre Discapacidad y Desarollo Inclusivo)
IRC	International Rescue Committee
Irish Aid	Government of Ireland's agency for international development
KAIH	Kenyan Association for the Intellectually Handicapped
LGBTQI	Lesbian, gay, bisexual, transgender, queer or questioning, and intersex
MENA	Middle East and North Africa
NGO	Nongovernmental organisation
NHRI	National human rights institution
NTPP	National Teenage Pregnancy Partnership (South Africa)
ODA	Overseas development assistance
OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
RBC	Rwanda Biomedical Centre
RHTC	Reproductive Health Training Centre (Moldova)
RIADIS	The Latin American Network of Nongovernmental Organisations of Persons with Disabilities and their Families (Red LatinAmericana de organizaciones no gubernamentales de personas con discapacidad y sus familias)
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UDHR	Universal Declaration of Human Rights
UKAid	See DFID
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme of HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crimes
UPHLS	Umbrella Organisations of Persons with Disabilities in the Fight against HIV/AIDS and for Health Promotion (Rwanda)
USAID	United States Agency for International Development
VALID	The Victorian Advocacy League for People with Intellectual Disabilities (Australia)
VAWG	Violence against women and girls
WEI	Women Enabled International
WHO	World Health Organisation
WRC	Women's Refugee Commission

ANNEX 2

LIST OF RESOURCES

This annex presents resources including databases, guides, and toolkits identified over the course of the study. While the research team has not independently evaluated each resource, this list provides options for future exploration within the areas of sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) prevention and response among young persons with disabilities.

Action Canada for Sexual Health and Rights

- *A Handbook for Health-care Providers Working With Clients From Diverse Communities.* Retrieved from: www.srhweek.ca/wp-content/uploads/2017/02/SRH2017-Handbook-EN.pdf

Banteay Srei (Cambodian Disabled People's Organisation), CBM Australia, the International Women's Development Agency, and Monash University

- *Challenging Discrimination against Women with Disabilities: A Community Toolkit*. Retrieved from: www.banteaysrei.info/wp-content/uploads/2013/03/A-Community-Training-Toolkit-EN.pdf

Baxley, DiAnn and Zendell, Anna

- *Sexuality Across the Lifespan: Sexuality Education for Children and Adolescents with Developmental Disabilities. An Instructional Manual for Educators of Individuals with Developmental Disabilities (First Edition 2005/Revised 2011).* Retrieved from: www.fddc.org/sites/default/files/file/publications/Sexuality%20Guide-Educators-English.pdf

CBM

- *Disability Inclusive Development Toolkit* Retrieved from: www.cbm.org/article/downloads/54741/CBM-DID-TOOLKIT-accessible.pdf

Gender-based Violence Information Management System (GBVIMS)

- Accessible at: www.gbvims.com

Illinois Imagines Project

- *Our Rights, Right Now: Women with Disabilities and Sexual Violence Education Guide.* Retrieved from: www.icasa.org/docs/illinois%20imagines/mini%20module%204%20education%20guide.pdf

Inter-Agency Standing Committee

- *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery.* Retrieved from: www.interagencystandingcommittee.org/system/files/2015-iasc-gender-based-violence-guidelines_lo-res.pdf

Inter-American Institute for Disability and Inclusive Development (Instituto Interamericano sobre Discapacidad y Desarollo Inclusivo, iiDi) and United Nations Population Fund (UNFPA)

- Decímelo a mí! (SRH information in sign language, developed by young deaf people from Argentina, Costa Rica, and Uruguay). Retrieved from: www.decimeloami.com

International Disability Alliance

- *Toolkit for Engagement of Organisations of Persons with Disabilities (DPO) in the Voluntary National Review Process.*
  Retrieved from: www.internationaldisability alliance.org/toolkitvnr

Pacific Disability Forum

- *Toolkit on Eliminating Violence against Women and Girls with Disabilities in Fiji.*
  Retrieved from: www.pacificdisability.org/getattachment/Resources/PDF-Resources/Toolkit-on-Eliminating-Violence-Against-Women-And-Girls-With-Disabilities-In-Fiji1.pdf.aspx

Plan International

- *Protect us! Inclusion of Children with Disabilities in Child Protection.*
  Retrieved from: www.plan-international.org/publications/protect-us

Programa de Educación Sexual (ANEP-CODICEN), Instituto Interamericano sobre Discapacidad y Desarrollo Inclusivo (iiDi), UNFPA, UNICEF

- *Es Parte de la Vida: Material de Apoyo sobre Sexual y Discapacidad para Compartir en Familia* (Spanish Only. English translation: *It's Part of Life: Support material on sex education and disability to share as a family*).
  Retrieved from: www.unfpa.org.uy/userfiles/informacion/items/972_pdf.pdf

Source: International online resource centre on disability and inclusion (Managed by Humanity & Inclusion)

- *Disability and Sexuality.*
  Retrieved from: www.asksource.info/topics/social-inclusion/disability-and-sexuality
- *HIV and AIDS and Disability.*
  Retrieved from: www.asksource.info/topics/health-and-functional-rehabilitation/hiv-and-aids-and-disability

United Nations Department of Economic and Social Affairs, Division for Inclusive Social Development

- *Toolkit on Disability for Africa*
  Retrieved from: www.un.org/development/desa/technical-cooperation/2016/11/18/toolkit-on-disability-for-africa/

United Nations Economic, Social, and Cultural Organisation (UNESCO)

- *International Technical Guidance on Sexuality Education: An evidence-informed approach.*
  Retrieved from: www.unfpa.org/publications/international-technical-guidance-sexuality-education

United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

- *Global Database on Violence against Women.*
  Accessible at: www.evaw-global-database.unwomen.org/en/countries

- *Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines* (in partnership with UNFPA, WHO, United Nations Development Programme, and the United Nations Office on Drugs and Crimes).
  Retrieved from: www.unfpa.org/essential-services-package-women-and-girls-subject-violence

United Nations Human Rights Office of the High Commissioner

- *Special Rapporteur on the Rights of Persons with Disabilities.*

Accessible at: www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/SRDisabilitiesIndex.aspx

- *Committee on the Rights of Persons with Disabilities.*
  Accessible at: www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx

United Nations Population Fund (UNFPA)

- *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies.*
  Retrieved from: www.unfpa.org/featured-publication/gbvie-standards

- *Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions.*
  Retrieved from: www.unfpa.org/publications/reproductive-rights-are-human-rights

- *UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender.*
  Retrieved from: www.unfpa.org/publications/unfpa-operational-guidance-comprehensive-sexuality-education

- *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.*
  Retrieved from: www.unfpa.org/publications/adolescent-sexual-and-reproductive-health-toolkit-humanitarian-settings

Washington Group on Disability Statistics

- Accessible at: www.washingtongroup-disability.com

Women Enabled International

- *accountABILITY Toolkit.*
  Retrieved from: www.womenenabled.org/atk.html

- *Enabling a Global Human Rights Movement for Women and Girls with Disabilities: Global Disabled Women's Rights Advocacy Report.*
  Retrieved from: www.womenenabled.org/mapping.html

Women's Refugee Commission

- *Disability Inclusion in Child Protection and Gender-Based Violence Programmes.*
  Retrieved from: womensrefugeecommission.org/gbv/resources/1620-disability-inclusion-in-child-protection-and-gender-based-violence-programs

- *Gender-based Violence against Children and Youth with Disabilities Toolkit: A Toolkit for Child Protection Actors.*
  Retrieved from: www.womensrefugeecommission.org/populations/disabilities/research-and-resources/1289-youth-disabilities-toolkit

- *Gender-based Violence against Children and Youth with Disabilities Toolkit: A Toolkit for Child Protection Actors (2016), Child- and Youth-led Participatory Assessment on Gender-based Violence and Disability.*
  Retrieved from: www.womensrefugeecommission.org/disabilities/resources/1322-gbv-youth-disabilities-toolkit-participatory-assess

- *I See That It Is Possible: Building Capacity for Disability Inclusion in Gender-based Violence (GBV) Programming in Humanitarian Settings.*
  Retrieved from: www.womensrefugeecommission.org/populations/disabilities/research-and-resources/945-building-capacity-for-disability-inclusion-in-gender-

based-violence-gbv-programming-in-humanitarian-settings-overview

- *'I See That It Is Possible' Gender-based Violence Disability Toolkit: Disability Inclusion in Gender-based Violence (GBV) Programming.* Retrieved from: www.womensrefugee commission.org/gbv/resources/1173-gbv-disability-toolkit-all-in-one-book

- *Strengthening the Role of Women with Disabilities in Humanitarian Action: A Facilitator's Guide.* Retrieved from: www.womensrefugee commission.org/populations/disabilities/research-and-resources/1443-humanitarian-facilitators-guide

Women with Disabilities Australia

- *Human Rights Toolkit for Women and Girls with Disability, First Edition.* Retrieved from: www.wwda.org.au/wp-content/uploads/2016/10/WWDA-Human-Rights-Toolkit-Final.pdf

World Bank

- *Gender Data Portal*. Accessible at: datatopics.worldbank.org/gender

World Health Organisation (WHO)

- *Guidance Note on Disability and Emergency Risk Management for Health.* Retrieved from: www.apps.who.int/iris/bitstream/handle/10665/90369/9789241506243_eng.pdf?sequence=1

World Health Organisation (WHO) and UNFPA

- *Promoting Sexual and Reproductive Health for Persons with Disabilities: WHO/UNFPA Guidance Note.* Retrieved from: www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf

- *Ensuring Human Rights within Contraceptive Service Delivery: Implementation Guide.* Retrieved from: www.apps.who.int/iris/bitstream/handle/10665/158866/9789241549103_eng.pdf?sequence=1

// ANNEX 3

A MODEL FOR UTILISING THE TWIN-TRACK APPROACH IN DESIGNING COMPREHENSIVE SEXUALITY EDUCATION PER UNESCO'S *INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION*[1]

Component 1: A basis in the core universal values of human rights

The Technical Guidance recommends that comprehensive sexuality education (CSE) is used not only to promote sexual and reproductive health and rights (SRHR), but to also be used as a strategic vehicle for promoting gender equality and the human rights of women and girls. As such, CSE also provides a strategic vehicle for promoting disability equality and the human rights of young persons with disabilities. Whereas there has been significant progress in recent years promoting the rights of persons with disabilities, the SRHR of persons with disabilities have often lagged behind and received less attention. For example, many States Parties to the Convention on the Rights of Persons with Disabilities (CRPD) as well as nongovernmental organisations (NGOs) and disabled persons' organisations (DPOs) have implemented awareness-raising campaigns informing both persons with and without disabilities regarding the human rights of persons with disabilities. Many of these campaigns, however, highlight issues such as disability-based discrimination in the workplace or inaccessible public transportation to a greater extent than SRHR.[2] Comprehensive sexuality education, however, provides an opportunity to build off of the messages of disability equality and rights campaigns by explicitly highlighting that persons with disabilities have the same SRHR as persons without disabilities. The advantage of CSE as a platform is that it introduces school-aged children, adolescents, and young persons with and without disabilities to the ideas of disability equality and the human rights of persons with disabilities at a young age and at the same time as they are learning about the importance of respect for their own and other's sexuality, gender equality, and human rights.

Component 2: Gender equality

In order for CSE to be effective and meet international standards, it also needs to promote gender equality within its curriculum so that participants understand the role gender norms play in determining access to and enjoyment of SRHR. The integration of gender equality into CSE also provides an important opportunity for the intersection of gender and disability to be included within the curriculum. Disability often exacerbates gender inequalities, making it particularly important that recipients of CSE understand how gender applies to persons with disabilities. As such, CSE programmes could provide a disability perspective when examining key subtopics regarding gender such as masculine/feminine gender norms, how boys and girls are socialised differently, the impact of gender norms on their lives, and so forth. Including a disability perspective on gender

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1 UNESCO. 2018. International Technical Guidance on Sexuality Education: An evidence-informed approach. Retrieved from: https://www.unfpa.org/publications/international-technical-guidance-sexuality-education.

2 The Council of Europe's disability rights awareness campaign is a notable exception by highlighting sexual and reproductive healht as one of its key pillars along with other issue areas. Source: Dekoninck, K. (2017). *Awareness Raising on the Rights of Persons with Disabilities: Contribution on the Council of Europe Strategy on the Rights of Persons with Disabilities*. Retrieved from https://rm.coe.int/final-study-awareness-raising/168072b421.

also provides an opportunity to highlight topics such as safe sex and HIV risk and prevention. Incorporating a disability and gender lens within CSE also emphasises that all persons with disabilities, irrespective of their gender identity or sexual orientation, should be able to access and enjoy the same SRHR as individuals without disabilities. Comprehensive sexuality education can also expose young women and young men to gender-transformative programming. For example, CSE may include lessons around challenging harmful masculinities that may socialise young men to believe that 'acting like a man' means not having or expressing emotions, acting 'tough', and being physically strong or controlling.

Component 3: Thorough and scientifically accurate information

Comprehensive and accurate information is essential for young people to fully enjoy their SRHR. Both issues regarding disability and sexuality are susceptible to misinformation. Misconceptions and misinformation, including beliefs and practices not conducive to human rights, can lead to the stigmitisation and social isolation of persons with disabilities. Therefore, it is particularly important that only accurate, age-appropriate information is provided in a culturally sensitive manner, and misconceptions are corrected when discussing sexuality and disability.

Component 4: A safe and healthy learning environment

For someone to fully participate in CSE, they must have a safe and healthy learning environment. Persons with disabilities, especially young persons with disabilities, are often targeted for bullying, discrimination, and even violence by both teachers and their peers. Therefore, it is particularly important that CSE providers have strong disability inclusion policies that make it clear that any form of discrimination or harassment of participants with disabilities will not be tolerated. This should include disability-awareness training for all teachers, staff, and students. Comprehensive sexuality education providers should also have monitoring policies in place, including the ability of participants with disabilities to file confidential reports of discrimination and abuse. It is also important that the CSE takes place in a safe facility and that participants can safely access the learning space from their homes. Safety and the health of the learning environment should also extend to the home, where participants in CSE may be returning with information and coursework. Therefore, CSE programmes should also provide awareness raising to parents and other caregivers and family members of young persons with disabilities to ensure that they are able to attend CSE courses outside of the home and be able to return home with information and lessons without fear of discrimination or harassment.

Component 5: Linking to sexual and reproductive health services and other initiatives that address gender, disability, equality, empowerment, and access to education, social, and economic assets for young people

Comprehensive sexuality education programmes should be linked to complementary programmes and initiatives that support SRHR specifically and larger social factors that affect the exercise and enjoyment of SRHR (e.g. initiatives focused on creating youth-friendly sexual and reproductive health policies, awareness-raising campaigns aimed at changing gender norms not conducive to human rights, or advocacy for more responsive laws and policies). When linking with complementary programmes and initiatives, CSE programmes should ensure that

these complementary programmes are disability inclusive and encourage young persons with disabilities to participate on an equal basis with others. Similarly, CSE programmes should be linked to complementary programmes and initiatives that specifically promote the rights of persons with disabilities, including accessible sexual and reproductive health facilities, the inclusion of SRHR in disability laws and policies, and so forth.

Component 6: Participatory teaching methods for personalisation of information and strengthened skills in communication, decisionmaking, and critical thinking

Diverse and interactive teaching methods are important for any subject matter but are particularly important for CSE. The topic of sexuality can be deeply personal, but also embedded in relationships. Thus, participants in CSE need to learn the skills necessary to deeply think about their sexual decisions and be able to effectively communicate them with others. Comprehensive sexuality education programmes should be attentive to the fact that many young persons with disabilities have grown up in overprotective households and may not have developed the same level of autonomous decision-making and self-advocacy skills as their peers. Therefore, CSE programmes may want to develop targeted lessons to ensure that young persons with disabilities are able to fully develop these skills. Interactive lessons that include both participants with and without disabilities are also particularly beneficial in addressing disability stigma by facilitating positive interactions between people with and without disabilities. For young persons with disabilities with specific impairments that effect their ability to communicate with others, practicing communication is particularly important, including advocating for necessary accommodations to be made for their communication needs.

Component 7: Strengthening youth advocacy and civic engagement

Comprehensive sexuality education programmes should involve young persons in the design of programmes and facilitate the participation of young people in positive social change initiatives, including awareness raising and advocacy regarding SRHR. Young persons with disabilities are often excluded from participatory development initiatives and civil society. Therefore, it is particularly important that young persons with disabilities are included in programme design to ensure a disability perspective is included in the curriculum and that all advocacy and civic engagement initiatives are disability inclusive. This could include lessons on how to plan for accessibility during public events or in volunteer activities. Comprehensive sexuality education programmes should also ensure that any civil society partners, such as youth organisations, have disability inclusion policies and that DPOs, especially those representing young persons, are full participants on CSE advisory boards and other forums for direct participation in the planning and evaluation of CSE policies and programming.

Component 8: Cultural relevance in tackling human rights violations and gender inequality

As attitudes and beliefs regarding gender and disabilities are often deeply embedded in socio-cultural norms, all CSE programmes should be developed in a culturally sensitive manner, adhering to the international standards. They should explicitly address myths and misconceptions regarding gender, disability, and other axes of discrimination that exist in the local context. Involvement of stakeholders and others

familiar with the local context is key to designing programmes that promote human rights, gender equality, and disability equality in a culturally sensitive manner to ensure that these concepts are understood, accepted, and resonate.

Component 9: Reaching across formal and informal sectors and across age groupings

Successful CSE programmes engage participants across age groups and in a variety of settings in order to engage both in school and out-of-school young people. It is important that not only older adolescents and youth have access to CSE, as younger adolescents and children benefit from age-appropriate CSE. This is particularly important as children, particularly children with disabilities, are at risk of sexual abuse. As with all marginalised or excluded groups, young persons with disabilities are less likely to be enrolled in schools, thus it is important that CSE is not only taught in schools, including special education classrooms and special education schools, but in community-based settings where young persons who are not enrolled in formal schooling can be engaged. In both school and out-of-school settings, particular attention should be paid to ensuring that the facilities used are physically accessible to all and that information is presented in multiple accessible formats. Comprehensive sexuality education programmes should also develop strategies to specifically identify and invite young persons with disabilities who are socially isolated and may not be aware of or comfortable attending CSE without specific encouragement and interventions, including awareness-raising of their parents and the other participants in CSE.

One strategy for ensuring access to and inclusion in CSE for young persons with disabilities is to provide CSE through mobile technologies and the internet. Many CSE providers have developed websites or text messaging services to reach marginalised and excluded populations, such as youth that are out-of-school. The internet and mobile technologies are also useful for reinforcing CSE messages and allowing users to anonymously ask questions or request specific information from CSE professionals or trained volunteers through the use of chat rooms, messaging, and other forums. The anonymity that these services provide is a particularly powerful tool for encouraging young persons to ask questions they may not be comfortable asking in front of their peers or in a face-to-face situation with a health-care provider. The use of e-learning and text messaging services have been highlighted as a way for young people to access and enjoy SRHR and have their SRHR-related questions answered in contexts where local cultural norms present barriers to the implementation of CSE in schools or broad public awareness campaigns, such as radio announcements or posters, providing information regarding condom use or family planning.[3]

3 UNESCO (2015*). Emerging evidence, lessons and practice in comprehensive sexuality education: A global review*. Retrieved from: https://www.unfpa.org/sites/default/files/pub-pdf/CSE_Global_Review_2015.pdf.

ANNEX 4

STATISTICAL ANNEX

TABLE 1. DEMOGRAPHIC INDICATORS

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Afghanistan	34,656	17,744	5,233	4.0	2.1	28	16	7	52	49	33	37	50	64	4.6
Albania	2,926	659	177	-0.4	0.0	8	6	7	32	25	12	67	72	78	1.7
Algeria	40,606	13,495	4,699	1.7	1.3	17	6	5	47	32	23	50	67	76	2.8
Andorra	77	13	3	1.3	0.1	–	–	–	–	–	–	–	–	–	–
Angola	28,813	15,416	5,277	3.3	3.1	27	23	9	53	53	42	37	42	62	5.7
Anguilla	15	4	1	2.2	0.5	–	–	–	–	–	–	–	–	–	–
Antigua and Barbuda	101	30	8	1.6	0.9	7	7	6	31	19	16	66	71	76	2.1
Argentina	43,847	13,076	3,736	1.1	0.8	9	8	8	23	22	17	66	72	77	2.3
Armenia	2,925	685	202	-0.7	0.0	6	8	10	23	22	13	70	68	75	1.6
Australia	24,126	5,433	1,551	1.3	1.1	9	7	7	20	15	13	71	77	83	1.8
Austria	8,712	1,489	412	0.5	0.2	13	11	10	16	11	10	70	76	82	1.5
Azerbaijan	9,725	2,653	891	1.1	0.7	9	9	7	32	29	18	63	65	72	2.1
Bahamas	391	97	28	1.6	0.8	6	5	6	26	24	14	66	71	76	1.8
Bahrain	1,425	334	107	4.1	2.5	7	3	2	38	29	15	63	72	77	2.0
Bangladesh	162,952	56,869	15,236	1.6	0.9	19	10	5	48	35	19	48	58	72	2.1
Barbados	285	66	17	0.3	0.1	10	10	11	22	16	12	66	71	76	1.8
Belarus	9,480	1,821	579	-0.3	-0.2	9	11	13	16	14	12	71	71	73	1.7
Belgium	11,358	2,309	643	0.5	0.4	12	11	10	14	12	11	71	76	81	1.8
Belize	367	141	40	2.6	1.8	8	5	5	42	36	23	66	71	70	2.5
Benin	10,872	5,379	1,775	3.0	2.6	24	15	9	47	46	37	42	54	61	5.0

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Bhutan	798	259	70	1.5	1.0	24	13	6	49	39	18	40	53	70	2.1
Bolivia (Plurinational State of)	10,888	4,150	1,189	1.8	1.4	20	13	7	42	35	23	46	55	69	2.9
Bosnia and Herzegovina	3,517	628	157	-0.9	-0.2	7	8	11	24	15	9	66	71	77	1.4
Botswana	2,250	840	259	1.9	1.6	13	8	7	46	34	24	55	62	67	2.7
Brazil	207,653	56,235	14,919	1.3	0.6	10	7	6	35	25	14	59	65	76	1.7
British Virgin Islands	31	9	3	2.4	1.0	-	-	-	-	-	-	-	-	-	-
Brunei Darussalam	423	120	34	1.9	1.0	6	4	4	37	29	16	67	73	77	1.9
Bulgaria	7,131	1,183	324	-0.8	-0.7	9	12	15	16	12	9	71	71	75	1.6
Burkina Faso	18,646	9,724	3,221	2.9	2.7	25	17	9	47	47	39	39	49	60	5.4
Burundi	10,524	5,372	1,901	2.6	2.9	21	18	11	47	50	42	44	48	57	5.7
Cabo Verde	540	200	55	1.8	1.2	14	8	6	42	40	21	54	65	73	2.3
Cambodia	15,762	5,854	1,761	2.2	1.3	20	13	6	43	42	23	42	54	69	2.6
Cameroon	23,439	11,578	3,804	2.7	2.4	19	15	10	45	45	36	46	52	58	4.7
Canada	36,290	6,999	1,929	1.0	0.8	7	7	7	17	14	11	73	77	82	1.6
Central African Republic	4,595	2,326	730	1.7	2.1	23	17	14	43	41	36	42	49	52	4.9
Chad	14,453	7,854	2,666	3.4	2.8	23	19	13	47	51	43	41	47	53	5.9
Chile	17,910	4,462	1,184	1.2	0.7	10	6	6	30	22	13	62	74	80	1.8
China	1,403,500	295,112	85,866	0.7	0.2	11	7	7	36	22	12	59	69	76	1.6
Colombia	48,653	14,055	3,712	1.3	0.6	9	6	6	38	26	15	61	68	74	1.9
Comoros	796	369	119	2.5	2.1	19	12	7	46	43	33	46	57	64	4.3
Congo	5,126	2,489	824	2.9	2.5	14	12	7	43	38	35	53	56	65	4.7
Cook Islands	17	6	2	-0.2	0.2	-	-	-	-	-	-	-	-	-	-
Costa Rica	4,857	1,296	346	1.7	0.8	7	4	5	33	27	14	66	76	80	1.8

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Côte d'Ivoire	23,696	11,689	3,861	2.5	2.4	21	14	12	52	43	37	44	52	54	4.9
Croatia	4,213	756	196	-0.5	-0.6	11	11	13	15	11	9	68	72	78	1.5
Cuba	11,476	2,260	636	0.3	0.0	7	7	8	29	17	11	70	75	80	1.7
Cyprus	1,170	241	66	1.6	0.7	7	7	7	19	19	11	73	77	81	1.3
Czechia	10,611	1,881	534	0.1	-0.1	12	12	11	16	12	10	70	72	79	1.5
Democratic People's Republic of Korea	25,369	6,452	1,726	0.9	0.4	10	6	9	37	21	14	60	70	72	1.9
Democratic Republic of the Congo	78,736	41,553	14,494	3.2	3.0	20	17	10	47	46	42	44	49	60	6.1
Denmark	5,712	1,157	285	0.4	0.4	10	12	9	15	12	10	73	75	81	1.7
Djibouti	942	356	102	1.8	1.3	15	11	8	45	40	23	49	57	62	2.8
Dominica	74	22	6	0.1	0.4	–	–	–	–	–	–	–	–	–	–
Dominican Republic	10,649	3,750	1,060	1.5	0.9	11	6	6	42	30	20	58	68	74	2.4
Ecuador	16,385	5,606	1,611	1.8	1.3	12	6	5	41	30	20	58	69	76	2.5
Egypt	95,689	36,997	12,876	2.0	1.6	16	8	6	42	34	26	52	65	71	3.3
El Salvador	6,345	2,153	577	0.7	0.5	13	8	7	43	31	19	55	64	74	2.1
Equatorial Guinea	1,221	521	182	4.0	3.0	26	18	10	42	42	34	40	48	58	4.7
Eritrea	4,955	2,397	744	1.8	2.2	21	16	7	47	42	32	43	50	65	4.1
Estonia	1,312	247	68	-0.7	-0.3	11	13	12	15	14	11	70	69	78	1.6
Ethiopia	102,403	49,500	15,177	2.9	2.2	21	18	7	48	48	32	43	47	65	4.2
Fiji	899	303	87	0.8	0.5	8	6	7	34	29	19	60	66	70	2.5
Finland	5,503	1,078	297	0.4	0.3	10	10	10	14	13	11	70	75	81	1.8
France	64,721	14,080	3,842	0.5	0.3	11	9	9	17	13	12	72	77	83	2.0
Gabon	1,980	822	274	2.8	1.9	20	11	8	37	37	30	47	61	66	3.8
Gambia	2,039	1,065	360	3.1	2.8	26	14	8	50	47	39	38	52	61	5.4
Georgia	3,925	875	271	-1.2	-0.3	9	9	13	20	17	13	67	70	73	2.0

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Germany	81,915	13,103	3,557	0.1	0.0	12	12	11	14	10	9	71	75	81	1.5
Ghana	28,207	12,689	4,085	2.5	2.0	16	11	8	47	39	31	49	57	63	4.0
Greece	11,184	1,937	474	0.3	-0.3	10	9	11	18	11	8	71	77	81	1.3
Grenada	107	34	10	0.4	0.3	9	9	7	28	28	19	64	69	74	2.1
Guatemala	16,582	7,047	2,023	2.2	1.8	14	9	5	45	39	25	53	62	73	3.0
Guinea	12,396	6,082	1,983	2.8	2.5	27	17	9	45	47	36	37	50	60	4.9
Guinea-Bissau	1,816	872	291	2.2	2.3	22	17	11	43	46	37	42	49	57	4.6
Guyana	773	277	76	0.2	0.5	9	8	8	36	28	21	62	63	67	2.5
Haiti	10,847	4,296	1,233	1.6	1.0	18	13	9	39	37	24	47	55	63	2.9
Holy See	1	0	0	0.2	0.0	-	-	-	-	-	-	-	-	-	-
Honduras	9,113	3,541	951	2.3	1.4	15	7	5	48	39	22	53	67	74	2.5
Hungary	9,753	1,694	436	-0.2	-0.4	11	14	13	15	12	9	69	69	76	1.4
Iceland	332	80	22	1.0	0.7	7	7	6	21	17	13	74	78	83	1.9
India	1,324,171	448,314	119,998	1.6	1.0	17	11	7	39	32	19	48	58	69	2.3
Indonesia	261,115	85,965	24,822	1.4	0.9	13	8	7	40	26	19	55	63	69	2.4
Iran (Islamic Republic of)	80,277	22,149	6,823	1.4	0.7	16	7	5	42	33	17	51	64	76	1.7
Iraq	37,203	17,460	5,738	2.9	2.6	12	7	5	46	38	33	58	66	70	4.4
Ireland	4,726	1,197	344	1.1	0.7	11	9	6	22	14	14	71	75	81	2.0
Israel	8,192	2,672	841	2.3	1.4	7	6	5	26	22	20	72	77	83	3.0
Italy	59,430	9,761	2,482	0.2	-0.2	10	10	10	17	10	8	72	77	83	1.5
Jamaica	2,881	820	205	0.7	0.1	8	7	7	35	25	17	68	72	76	2.0
Japan	127,749	20,051	5,343	0.1	-0.4	7	7	11	19	10	8	72	79	84	1.5
Jordan	9,456	3,959	1,227	3.8	1.2	10	5	4	51	35	26	60	70	74	3.4
Kazakhstan	17,988	5,566	1,997	0.3	0.9	9	9	9	26	23	21	63	67	70	2.6
Kenya	48,462	23,094	7,023	2.8	2.3	15	10	6	51	42	31	52	58	67	3.9
Kiribati	114	47	14	1.8	1.5	13	10	7	35	37	28	54	60	66	3.7
Kuwait	4,053	989	316	2.5	1.3	6	3	3	48	23	16	66	72	75	2.0

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Kyrgyzstan	5,956	2,167	760	1.2	1.2	11	8	6	32	32	25	60	66	71	3.0
Lao People's Democratic Republic	6,758	2,674	766	1.8	1.2	18	14	7	43	43	24	46	54	67	2.7
Latvia	1,971	350	97	-1.2	-0.9	11	13	15	14	14	10	70	69	75	1.5
Lebanon	6,007	1,743	483	3.1	-0.8	8	7	5	32	25	15	66	70	80	1.7
Lesotho	2,204	932	286	1.2	1.2	17	10	13	43	35	28	49	59	54	3.1
Liberia	4,614	2,249	715	3.0	2.4	24	18	8	49	45	34	39	47	63	4.6
Libya	6,293	2,111	627	1.3	1.1	13	5	5	51	29	20	56	69	72	2.3
Liechtenstein	38	7	2	1.0	0.6	–	–	–	–	–	–	–	–	–	–
Lithuania	2,908	519	152	-0.9	-0.5	9	11	14	17	15	11	71	71	75	1.7
Luxembourg	576	115	32	1.6	1.1	12	10	7	13	12	11	70	75	82	1.6
Madagascar	24,895	11,988	3,769	2.9	2.6	21	15	6	48	44	33	45	51	66	4.2
Malawi	18,092	9,265	2,908	2.5	2.7	25	19	7	54	49	37	41	47	63	4.6
Malaysia	31,187	9,350	2,612	2.1	1.2	7	5	5	34	28	17	64	71	75	2.0
Maldives	428	117	39	2.5	1.3	21	9	3	50	41	18	44	61	77	2.1
Mali	17,995	9,806	3,332	2.9	2.9	32	20	10	50	49	43	32	46	58	6.1
Malta	429	75	21	0.6	0.2	9	8	9	16	15	10	71	76	81	1.5
Marshall Islands	53	19	5	0.4	0.3	–	–	–	–	–	–	–	–	–	–
Mauritania	4,301	1,996	655	2.9	2.5	16	11	8	46	41	34	49	58	63	4.7
Mauritius	1,262	295	68	0.7	0.1	7	6	8	29	21	11	63	69	75	1.4
Mexico	127,540	41,600	11,581	1.5	1.0	10	5	5	44	29	18	61	71	77	2.2
Micronesia (Federated States of)	105	43	12	0.3	0.8	9	7	6	41	34	24	62	66	69	3.1
Monaco	38	7	2	1.0	0.5	–	–	–	–	–	–	–	–	–	–
Mongolia	3,027	1,017	368	1.3	1.2	15	10	6	44	32	24	55	60	69	2.8
Montenegro	629	139	36	0.1	0.0	7	7	10	22	16	11	70	75	77	1.7
Montserrat	5	2	0	-2.8	0.3	–	–	–	–	–	–	–	–	–	–

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Morocco	35,277	11,491	3,508	1.3	1.1	14	7	5	43	29	20	53	65	76	2.5
Mozambique	28,829	14,929	4,950	3.0	2.8	25	21	10	48	46	39	39	43	58	5.2
Myanmar	52,885	17,485	4,538	1.0	0.8	15	10	8	39	27	18	51	59	67	2.2
Namibia	2,480	1,076	344	2.2	1.9	15	9	7	43	38	29	52	62	64	3.4
Nauru	11	4	1	0.8	0.1	–	–	–	–	–	–	–	–	–	–
Nepal	28,983	11,190	2,756	1.7	1.0	23	13	6	43	39	20	41	54	70	2.1
Netherlands	16,987	3,425	894	0.5	0.3	8	9	9	18	13	11	74	77	82	1.7
New Zealand	4,661	1,109	304	1.2	0.8	8	8	7	22	17	13	71	75	82	2.0
Nicaragua	6,150	2,174	597	1.5	1.0	13	7	5	46	36	20	54	64	75	2.2
Niger	20,673	11,752	4,218	3.6	3.8	28	23	10	57	56	48	36	44	60	7.2
Nigeria	185,990	93,965	31,802	2.6	2.5	23	19	12	46	44	39	41	46	53	5.5
Niue	2	1	0	-1.4	0.2	–	–	–	–	–	–	–	–	–	–
Norway	5,255	1,130	306	0.8	0.9	10	11	8	17	14	12	74	77	82	1.8
Oman	4,425	1,118	401	3.4	2.1	16	5	3	48	38	19	50	67	77	2.7
Pakistan	193,203	79,005	24,963	2.2	1.7	15	11	7	43	40	28	53	60	66	3.5
Palau	22	8	2	1.4	1.0	–	–	–	–	–	–	–	–	–	–
Panama	4,034	1,324	388	1.9	1.4	8	5	5	38	26	20	66	73	78	2.5
Papua New Guinea	8,085	3,449	1,033	2.4	1.9	16	9	7	41	35	28	49	59	66	3.7
Paraguay	6,725	2,404	672	1.8	1.1	7	6	6	37	34	21	65	68	73	2.5
Peru	31,774	10,454	3,033	1.4	1.1	14	7	6	42	30	19	53	66	75	2.4
Philippines	103,320	39,204	11,530	2.0	1.4	9	7	7	39	33	23	61	65	69	2.9
Poland	38,224	6,785	1,819	0.0	-0.3	8	10	10	17	15	9	70	71	78	1.3
Portugal	10,372	1,764	431	0.2	-0.3	11	10	11	21	11	8	67	74	81	1.2
Qatar	2,570	417	130	6.5	1.6	5	2	2	36	22	10	68	75	78	1.9
Republic of Korea	50,792	8,678	2,226	0.6	0.3	9	6	6	30	15	9	61	72	82	1.3
Republic of Moldova	4,060	768	218	-0.3	-0.4	10	10	11	20	19	10	65	68	72	1.2

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Romania	19,778	3,667	944	-0.7	-0.5	10	11	13	21	14	10	68	70	75	1.5
Russian Federation	143,965	28,642	9,561	-0.1	-0.2	9	12	13	15	14	13	69	68	71	1.8
Rwanda	11,918	5,593	1,740	1.9	2.1	20	32	6	50	47	31	44	34	67	3.9
Saint Kitts and Nevis	55	16	5	1.1	0.7	–	–	–	–	–	–	–	–	–	–
Saint Lucia	178	43	11	1.0	0.3	9	6	8	39	28	12	63	71	75	1.5
Saint Vincent and the Grenadines	110	32	8	0.1	0.2	9	7	7	40	25	16	65	70	73	1.9
Samoa	195	85	23	0.7	0.6	11	7	5	41	33	25	55	65	75	4.0
San Marino	33	6	1	1.2	0.3	–	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	200	100	31	2.2	2.1	13	10	7	41	40	34	56	62	67	4.5
Saudi Arabia	32,276	9,641	2,966	2.6	1.4	15	5	4	47	36	20	53	69	75	2.5
Senegal	15,412	7,616	2,544	2.7	2.6	25	11	6	50	43	36	39	57	67	4.8
Serbia	8,820	1,780	469	-0.3	-0.4	9	10	13	19	15	11	68	71	75	1.6
Seychelles	94	24	8	1.1	0.3	9	7	8	35	23	16	66	71	74	2.3
Sierra Leone	7,396	3,638	1,141	2.1	2.0	30	26	13	49	47	35	35	37	52	4.5
Singapore	5,622	1,062	265	2.4	0.9	5	4	5	23	18	9	68	76	83	1.2
Slovakia	5,444	996	281	0.1	-0.1	9	10	10	18	15	10	70	71	77	1.4
Slovenia	2,078	363	107	0.1	-0.1	10	10	10	17	11	10	69	73	81	1.6
Solomon Islands	599	275	83	2.5	1.8	13	11	5	45	40	29	54	57	71	3.9
Somalia	14,318	7,642	2,617	2.5	2.9	23	20	11	47	48	43	41	45	56	6.3
South Africa	56,015	19,428	5,705	1.5	1.0	12	8	10	38	29	21	56	62	63	2.5
South Sudan	12,231	5,944	1,925	2.9	2.5	28	21	11	51	47	36	36	44	57	4.9
Spain	46,348	8,135	2,065	0.6	0.0	9	8	9	20	10	9	72	77	83	1.4
Sri Lanka	20,798	6,020	1,602	0.7	0.2	8	6	7	31	21	15	64	70	75	2.0

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
State of Palestine	4,791	2,231	712	3.2	2.4	13	5	3	50	46	32	56	68	73	4.0
Sudan	39,579	18,971	5,940	2.6	2.3	15	12	7	47	42	33	52	56	64	4.5
Suriname	558	179	50	1.2	0.7	9	7	7	37	28	18	63	67	71	2.4
Swaziland	1,343	592	180	1.7	1.5	18	9	10	49	43	29	48	60	58	3.1
Sweden	9,838	2,006	584	0.5	0.6	10	11	9	14	14	12	74	78	82	1.9
Switzerland	8,402	1,499	434	0.9	0.7	9	9	8	16	12	10	73	78	83	1.5
Syrian Arab Republic	18,430	8,231	2,100	1.5	2.6	11	5	6	46	36	21	59	71	70	2.9
Tajikistan	8,735	3,581	1,183	1.9	1.8	12	10	5	42	41	29	60	63	71	3.4
Thailand	68,864	14,961	3,768	0.8	0.1	10	6	8	38	19	10	59	70	75	1.5
The former Yugoslav Republic of Macedonia	2,081	425	118	0.2	0.0	7	8	10	25	18	11	66	71	76	1.5
Timor-Leste	1,269	650	206	2.0	2.1	23	16	6	43	43	35	40	48	69	5.5
Togo	7,606	3,668	1,176	2.7	2.3	19	12	9	48	42	34	47	56	60	4.5
Tokelau	1	0	0	-0.9	0.8	–	–	–	–	–	–	–	–	–	–
Tonga	107	46	13	0.5	0.9	7	6	6	36	31	24	65	70	73	3.6
Trinidad and Tobago	1,365	335	95	0.4	0.0	7	8	10	27	21	14	65	68	71	1.8
Tunisia	11,403	3,205	1,052	1.3	0.8	16	6	6	41	26	18	51	69	76	2.2
Turkey	79,512	24,162	6,775	1.5	0.8	15	8	6	40	26	16	52	64	76	2.1
Turkmenistan	5,663	2,021	709	1.7	1.3	12	9	7	38	35	25	58	63	68	2.9
Turks and Caicos Islands	35	10	3	4.3	1.2	–	–	–	–	–	–	–	–	–	–
Tuvalu	11	4	1	0.8	1.0	–	–	–	–	–	–	–	–	–	–
Uganda	41,488	22,807	7,699	3.3	3.1	17	18	9	49	50	42	49	46	60	5.6
Ukraine	44,439	7,948	2,334	-0.6	-0.5	9	13	15	15	13	11	71	70	72	1.5

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
United Arab Emirates	9,270	1,498	464	6.2	1.3	7	3	2	37	26	10	62	72	77	1.7
United Kingdom	65,789	13,785	4,000	0.5	0.5	12	11	9	15	14	12	72	76	82	1.9
United Republic of Tanzania	55,572	28,698	9,655	3.0	2.9	18	15	7	48	44	38	47	50	66	5.0
United States	322,180	73,928	19,607	0.9	0.7	10	9	8	16	16	13	71	75	79	1.9
Uruguay	3,444	884	240	0.4	0.3	10	10	9	21	18	14	69	73	77	2.0
Uzbekistan	31,447	10,386	3,184	1.7	1.1	10	8	6	37	35	21	62	66	71	2.3
Vanuatu	270	114	34	2.4	1.9	14	8	5	42	36	26	52	63	72	3.3
Venezuela (Bolivarian Republic of)	31,568	10,493	2,974	1.8	1.1	7	5	6	37	29	19	65	70	75	2.3
Viet Nam	94,569	25,780	7,761	1.3	0.8	12	6	6	36	29	17	60	71	76	2.0
Yemen	27,584	12,957	4,075	3.2	2.1	25	11	6	53	52	32	41	58	65	4.0
Zambia	16,591	8,647	2,820	2.8	2.9	17	18	8	50	45	38	49	45	62	5.0
Zimbabwe	16,150	7,726	2,539	1.8	2.1	13	10	8	47	37	33	55	58	61	3.8
SUMMARY															
East Asia and Pacific	2,291,492	545,358	156,758	0.9	0.4	11	7	7	35	22	14	60	69	75	1.8
Europe and Central Asia	908,161	191,748	55,778	0.3	0.2	10	11	10	18	15	12	69	72	77	1.8
Eastern Europe and Central Asia	416,914	100,514	31,087	0.2	0.2	10	11	11	21	18	15	66	68	73	1.9
Western Europe	491,247	91,234	24,691	0.3	0.1	11	10	10	16	12	10	71	75	81	1.6
Latin America and Caribbean	633,773	193,378	53,227	1.4	0.8	10	7	6	37	27	17	60	68	76	2.1

COUNTRIES AND AREAS	POPULATION (THOUSANDS) 2016			POPULATION ANNUAL GROWTH RATE (%)		CRUDE DEATH RATE			CRUDE BIRTH RATE			LIFE EXPECTANCY			TOTAL FERTILITY RATE
	Total	Under 18	Under 5	1990-2016	2016-2030[a]	1970	1990	2016	1970	1990	2016	1970	1990	2016	2016
Middle East and North Africa	435,225	152,698	49,143	2.1	1.5	15	7	5	44	34	23	53	66	74	2.8
North America	358,469	80,927	21,535	0.9	0.7	9	9	8	16	16	12	71	75	80	1.8
South Asia	1,765,989	619,518	169,895	1.7	1.0	17	11	7	40	33	20	48	58	69	2.5
Sub-Saharan Africa	1,034,153	511,533	167,977	2.7	2.5	21	16	9	47	44	36	45	50	60	4.8
Eastern and Southern Africa	542,206	261,901	83,757	2.6	2.4	19	16	8	47	43	34	47	51	63	4.4
West and Central Africa	491,947	249,631	84,220	2.8	2.6	23	17	11	47	45	39	42	49	57	5.4
Least developed countries	979,388	454,924	142,971	2.5	2.2	21	15	8	47	42	32	44	52	64	4.1
World	7,427,263	2,295,160	674,314	1.3	1.0	13	9	8	33	26	19	59	65	72	2.4

For a complete list of countries and areas in the regions, subregions and country categories, see data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
α Based on medium-fertility variant projections.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005-2006 data from India. Estimates from data years prior to 2000 are not displayed.
y Data differ from the standard definition or refer to only part of a country. If they fall within the noted reference period, such data are included in the calculation of regional and global averages.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.

Definitions of the indicators:
Crude death rate – Annual number of deaths per 1,000 population.
Crude birth rate – Annual number of births per 1,000 population.
Life expectancy– Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.
Total fertility rate – Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Main data sources:
Population – United Nations Population Division. Growth rates calculated by UNICEF based on data from United Nations Population Division.
Crude death and birth rates – United Nations Population Division.
Life expectancy – United Nations Population Division.
Total fertility rate – United Nations Population Division.

TABLE 2. DEMOGRAPHIC INDICATORS (CON'T)

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Afghanistan	27	5.5	3.6	62		32		66		11		62		38		48		28	
Albania	58	1.5	1.4	99		99		105		66		91		90		90	x	92	x
Algeria	71	3.0	1.7	96	x	92	x	117		43		–		–		82		85	
Andorra	85	1.1	0.2	100		100		87		98		–		–		–		–	
Angola	45	5.3	4.2	85		71		55		13		–		–		32		31	
Anguilla	100	2.2	0.5	–		–		178	x	82		–		–		–		–	
Antigua and Barbuda	23	0.0	0.3	–		–		194		73		78		82		–		–	
Argentina	92	1.2	0.8	99		99		151		70		–		–		75		77	
Armenia	63	-0.9	0.1	100		100		115		62		–		–		97		98	
Australia	90	1.5	1.2	–		–		110		88		–		–		–		–	
Austria	66	0.5	0.6	–		–		166		84		–		–		–		–	
Azerbaijan	55	1.2	1.2	100		100		106		78		85		82		–		–	
Bahamas	83	1.8	1.1	–		–		92		80		–		–		–		–	
Bahrain	89	4.0	1.3	99	x	98	x	217		98		90		88		–		–	
Bangladesh	35	3.8	2.7	91		94		78		18		61		75		51		60	
Barbados	31	0.3	0.7	–		–		115		80		80		87		89		89	
Belarus	77	0.2	-0.2	100	x	100	x	124		71		–		–		94		97	
Belgium	98	0.5	0.3	–		–		111		87		85		87		–		–	
Belize	44	2.2	2.0	–		–		64		45		70		73		–		–	
Benin	44	4.1	3.4	64		41		80		12		49		41		40		34	
Bhutan	39	4.8	2.3	90		84		89		42		57		67		52		54	
Bolivia (Plurinational State of)	69	2.8	1.9	99		99		91		40		64		66		–		–	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Bosnia and Herzegovina	40	-0.6	0.6	100		100		89		69		-		-		94		96	
Botswana	58	2.8	1.4	92	x	96	x	159		39		46		57		-		-	
Brazil	86	1.8	0.8	98		99		119		60		76		80		-		-	
British Virgin Islands	47	3.0	1.4	-		-		199	x	38	x	-		-		-		-	
Brunei Darussalam	78	2.6	1.3	99		100		121		75		-		-		-		-	
Bulgaria	74	-0.4	-0.5	98		98		127		60		81		78		-		-	
Burkina Faso	31	5.9	4.7	57		44		84		14		27		26		19		17	
Burundi	12	5.3	5.1	85		75		48		5		21		25		12		11	
Cabo Verde	66	3.0	1.5	98		99		122		48		66		75		-		-	
Cambodia	21	3.3	2.7	88	x	86	x	125		26		44		49		47		54	
Cameroon	55	3.9	3.2	85	x	76	x	68		25		44		40		51		49	
Canada	82	1.3	1.0	-		-		84		90		-		-		-		-	
Central African Republic	40	2.3	2.8	49	x	27	x	25		4		16		9		17		13	
Chad	23	3.6	4.0	41		22		44		5		-		-		16		11	
Chile	90	1.5	0.8	99		99		127		66		75		82		-		-	
China	57	3.7	1.6	100	x	100	x	97		53		-		-		-		-	
Colombia	77	2.0	1.3	98		99		117		58		72		78		74		81	
Comoros	28	2.6	2.8	74		70		58		8		38		42		45		52	
Congo	66	3.4	3.0	86		77		113		8		-		-		65		61	
Cook Islands	75	1.7	0.7	-		-		56	x	54		90		91		-		-	
Costa Rica	78	3.6	1.6	99		99		159		66		74		76		71		73	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Côte d'Ivoire	55	3.5	3.1	59		47		126		27		39		28		26		20	
Croatia	59	-0.1	0.2	100		100		104		73		91		92		-		-	
Cuba	77	0.4	-0.1	100		100		35		39		91		95		-		-	
Cyprus	67	1.6	0.8	100		100		134		76		94		95		-		-	
Czechia	73	0.1	0.3	-		-		115		76		-		-		-		-	
Democratic People's Republic of Korea	61	1.0	0.8	100	x	100	x	14		0	x	57		57		-		-	
Democratic Republic of the Congo	43	4.2	3.6	91		80		39		6		-		-		39		31	
Denmark	88	0.5	0.6	-		-		123		97		89		94		-		-	
Djibouti	77	1.8	1.3	-		-		38		13		44		37		-		-	
Dominica	70	0.5	0.7	-		-		107		67		-		-		-		-	
Dominican Republic	80	2.9	1.5	97		98		81		61		48		58		58		72	
Ecuador	64	2.4	1.7	99		99		84		54		74		78		-		-	
Egypt	43	1.6	1.8	94		90		114		39		83		88		84		86	
El Salvador	67	1.9	1.0	97		98		141		29		67		72		69		73	
Equatorial Guinea	40	3.6	3.0	98	x	97	x	66		24		22		24		-		-	
Eritrea	23	4.3	4.4	91	x	83	x	7		1		20		19		63	y	55	y
Estonia	67	-1.0	-0.3	100		100		149		87		-		-		-		-	
Ethiopia	20	4.6	4.3	63	x	47	x	51		15		35		33		21		26	
Fiji	54	1.8	0.9	-		-		103		47		87		91		-		-	
Finland	84	0.6	0.4	-		-		134		88		96		97		-		-	
France	80	0.8	0.7	-		-		103		86		-		-		-		-	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Gabon	87	3.4	2.2	87		89		144		48		–		–		51		59	
Gambia	60	4.8	3.6	66		56		140		19		35		41		32		32	
Georgia	54	-1.0	-0.1	100		100		129		50		93		91		99	y	99	y
Germany	76	0.2	0.0	–		–		115		90		–		–		–		–	
Ghana	55	4.0	2.7	88	x	83	x	139		35		50		50		33		35	
Greece	78	0.7	0.2	99		99		113		69		95		94		–		–	
Grenada	36	0.7	0.4	–		–		111		56		79		82		–		–	
Guatemala	52	3.3	3.0	95		93		115		35		47		46		54		50	
Guinea	38	4.0	3.5	57		37		85		10		35		24		32		26	
Guinea-Bissau	50	4.5	3.2	71		50		70		4		–		–		10		9	
Guyana	29	0.3	1.1	96		97		66		36		77		75		92		95	
Haiti	60	4.4	2.2	74	x	70	x	61		12		–		–		19		26	
Holy See	100	0.2	0.0	–		–		–		–		–		–		–		–	
Honduras	55	3.4	2.5	95		97		91		30		43		50		48		57	
Hungary	72	0.1	0.2	–		–		119		79		90		89		–		–	
Iceland	94	1.3	0.9	–		–		118		98		96		98		–		–	
India	33	2.5	2.2	90		82		87		30		64		69		–		–	
Indonesia	54	3.6	1.9	100		100		149		25		74		79		85	y	89	y
Iran (Islamic Republic of)	74	2.4	1.4	98		98		100		53		90		92		–		–	
Iraq	70	2.8	2.6	57		49		82		21		–		–		51		47	
Ireland	64	1.6	1.3	–		–		104		82		–		–		–		–	
Israel	92	2.3	1.4	–		–		132		80		–		–		–		–	
Italy	69	0.4	0.3	100		100		140		61		–		–		–		–	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Jamaica	55	1.1	0.9	–		–		116		45		68		78		92		92	
Japan	94	0.9	-0.1	–		–		130		92		–		–		–		–	
Jordan	84	3.8	1.5	99		99		196		62		82		83		92		94	
Kazakhstan	53	0.0	1.0	100	x	100	x	150		77		–		–		99		100	
Kenya	26	4.5	4.0	87		86		81		26		–		–		38		46	
Kiribati	44	2.5	1.9	–		–		51		14		68		88		–		–	
Kuwait	98	2.2	2.0	99		99		147		78		81		88		–		–	
Kyrgyzstan	36	0.9	2.0	100	x	100	x	131		35		88		87		98		98	
Lao People's Democratic Republic	40	5.6	3.3	77		67		55		22		55		57		40		44	
Latvia	67	-1.2	-0.5	100		100		131		80		–		–		–		–	
Lebanon	88	2.6	0.3	99	x	99	x	96		76		67		67		–		–	
Lesotho	28	3.8	2.6	80		94		107		27		22		39		20		37	
Liberia	50	2.6	3.2	63	x	37	x	83		7		7		6		14		15	
Libya	79	1.7	1.4	–		–		120		20		–		–		–		–	
Liechtenstein	14	0.4	1.1	–		–		116		98		90		84		–		–	
Lithuania	67	-0.9	-0.2	100		100		141		74		97		96		–		–	
Luxembourg	90	1.8	1.2	–		–		148		97		83		87		–		–	
Madagascar	36	4.6	4.2	78		75		42		5		28		31		22	x	25	x
Malawi	16	3.8	4.2	72		73		40		10		29		30		25		31	
Malaysia	75	3.7	1.8	98	x	98	x	141		79		85		89		–		–	
Maldives	47	4.3	2.6	99		99		223		59		70		67		64	x	78	x
Mali	41	5.0	4.7	61		39		120		11		33		28		34		26	
Malta	96	0.8	0.2	98		99		125		77		96		96		–		–	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Marshall Islands	73	0.9	0.9	98		99		29	x	30		58		64		-		-	
Mauritania	60	4.2	2.9	66	x	48	x	87		18		22		21		21		20	
Mauritius	40	0.3	0.3	98		99		144		53		82		86		-		-	
Mexico	80	1.9	1.2	99		99		88		60		79		82		86		89	
Micronesia (Federated States of)	22	-0.2	1.6	-		-		22		33		49		56		-		-	
Monaco	100	1.0	0.9	-		-		86		95		-		-		-		-	
Mongolia	73	2.1	1.7	98	x	99	x	114		22		-		-		91		95	
Montenegro	64	1.2	0.2	99		99		167		70		93		93		93		96	
Montserrat	9	-4.0	1.0	-		-		97	x	55	x	-		-		-		-	
Morocco	61	2.1	1.6	95		88		121		58		62		63		-		-	
Mozambique	33	3.8	3.5	80	x	57	x	66		18		17		19		15		17	
Myanmar	35	2.3	2.0	85		84		89		25		53		52		67		71	
Namibia	48	4.2	3.1	93		95		109		31		41		55		54		67	
Nauru	100	0.4	0.5	-		-		97		54	x	66		71		-		-	
Nepal	19	4.7	2.9	90		80		112		20		55		53		42		46	
Netherlands	91	1.6	0.5	-		-		130		90		-		-		-		-	
New Zealand	86	1.3	0.9	-		-		125		88		97		98		-		-	
Nicaragua	59	2.1	1.7	85	x	89	x	122		25		-		-		-		-	
Niger	19	4.5	5.7	35		15		49		4		23		16		21		17	
Nigeria	49	4.5	3.9	76	x	58	x	82		26		-		-		50		49	
Niue	43	-1.1	0.2	-		-		38	x	80	x	-		-		-		-	
Norway	81	1.2	1.1	-		-		110		97		99		99		-		-	
Oman	78	4.0	1.4	99		99		159		70		81		86		-		-	
Pakistan	39	3.0	2.6	80		66		71		16		58		48		36		34	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Palau	88	2.2	1.3	98		99		91	x	–		33		38		–		–	
Panama	67	2.7	1.8	98	x	97	x	172		54		71		74		78		86	
Papua New Guinea	13	1.9	2.8	69	x	64	x	49		10		17		14		–		–	
Paraguay	60	2.8	1.9	98		99		105		51		58		63		–		–	
Peru	79	1.9	1.4	99		99		117		45		71		72		85		87	
Philippines	44	1.6	1.8	97		99		109		56		58		70		–		–	
Poland	61	0.0	0.1	–		–		146		73		93		94		–		–	
Portugal	64	1.4	0.6	99		99		109		70		–		–		–		–	
Qatar	99	6.5	1.0	98		100		147		94		76		83		–		–	
Republic of Korea	83	1.0	0.5	–		–		123		93		98		97		–		–	
Republic of Moldova	45	-1.1	-0.2	99		100		111		71		83		82		96		97	
Romania	55	-0.2	0.1	99		99		106		60		84		83		90	y	90	y
Russian Federation	74	-0.1	-0.2	100	x	100	x	163		76		97		98		–		–	
Rwanda	30	8.7	4.7	81		83		70		20		19		24		25		34	
Saint Kitts and Nevis	32	0.9	1.5	–		–		137		77		80		82		–		–	
Saint Lucia	19	-0.6	1.1	–		–		95		47		74		75		95		90	
Saint Vincent and the Grenadines	51	0.9	0.7	–		–		103		56		88		89		–		–	
Samoa	19	0.3	0.5	99		99		69		29		66		68		–		–	
San Marino	94	1.2	0.3	–		–		114		50	x	91		94		–		–	
Sao Tome and Principe	66	3.8	2.6	97		96		85		28		50		60		46		57	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Saudi Arabia	83	2.7	1.3	99		99		158		74		76		70		-		-	
Senegal	44	3.2	3.5	61		51		99		26		39		42		27		30	
Serbia	56	0.2	-0.2	100		100		121		67		97		97		97		96	
Seychelles	54	1.5	0.9	99	x	99	x	161		57		-		-		-		-	
Sierra Leone	40	2.5	2.7	65		51		98		12		31		29		36		36	
Singapore	100	2.5	1.0	100		100		147		81		-		-		-		-	
Slovakia	53	-0.1	0.1	-		-		128		80		-		-		-		-	
Slovenia	50	0.1	0.3	-		-		115		75		95		97		-		-	
Solomon Islands	23	4.5	3.4	-		-		70		11		23		25		-		-	
Somalia	40	3.4	4.0	-		-		58		2		-		-		-		-	
South Africa	65	2.3	1.2	99		99		142		54		-		-		-		-	
South Sudan	19	4.4	3.8	44	x	30	x	25	x	16	x	1		1		6		3	
Spain	80	1.0	0.4	100		100		110		81		-		-		-		-	
Sri Lanka	18	0.8	1.4	98	x	99	x	118		32		96		96		-		-	
State of Palestine	75	3.5	2.6	99		99		77		61		83		87		92		97	
Sudan	34	3.4	3.1	69	x	63	x	69		28		-		-		31		32	
Suriname	66	1.2	0.7	98		97		146		45		50		61		46		61	
Swaziland	21	1.3	1.6	92	x	95	x	76		29		20		31		33		48	
Sweden	86	0.6	0.8	-		-		127		92		-		-		-		-	
Switzerland	74	0.9	1.1	-		-		136		89		87		87		-		-	
Syrian Arab Republic	58	3.0	2.6	95	x	90	x	54		32		53		52		-		-	
Tajikistan	27	1.3	2.7	100	x	100	x	107		20		98		95		86		84	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15-24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990-2016	2016-2030[a]	2011-2016*				2016				2011-2016*				2010-2016*			
Thailand	52	2.8	1.5	98		98		173		48		79		79		83		86	
The former Yugoslav Republic of Macedonia	57	0.1	0.3	-		98	x	101		72		78		76		86		85	
Timor-Leste	33	3.6	3.4	80	x	79	x	125		25		39		48		30		34	
Togo	40	3.9	3.4	90		78		75		11		-		-		45		40	
Tokelau	0	0	0	-		-		0	x	1	x	-		-		-		-	
Tonga	24	0.6	1.5	99		100		75		40		78		84		-		-	
Trinidad and Tobago	8	0.3	-0.4	-		-		161		73		-		-		-		-	
Tunisia	67	1.8	1.1	97		96		126		51		80		85		76		85	
Turkey	74	2.2	1.3	100		99		97		58		88		86		-		-	
Turkmenistan	50	1.9	1.7	-		-		158		18		-		-		98		98	
Turks and Caicos Islands	93	5.1	1.3	-		-		100	x	0		-		-		-		-	
Tuvalu	61	1.9	1.5	-		-		76		46		73		77		-		-	
Uganda	16	4.8	5.1	86		82		55		22		-		-		15		20	
Ukraine	70	-0.4	-0.4	100		100		133		52		91		91		98		98	
United Arab Emirates	86	6.8	1.9	94	x	97	x	204		91		76		83		-		-	
United Kingdom	83	0.7	0.7	-		-		122		95		96		96		-		-	
United Republic of Tanzania	32	4.9	4.6	87		85		74		13		-		-		25		31	
United States	82	1.3	0.9	-		-		127		76		87		90		-		-	
Uruguay	95	0.7	0.4	99		99		149		66		68		73		75		77	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15–24 YEARS) LITERACY RATE (%)				NUMBER PER 100 POPULATION				LOWER SECONDARY SCHOOL PARTICIPATION							
												NET ENROLMENT RATIO (%)				NET ATTENDANCE RATIO (%)			
	2016	1990–2016	2016–2030[a]	2011–2016*				2016				2011–2016*				2010–2016*			
Uzbekistan	36	1.1	1.7	100		100		77		47		94		92		–		–	
Vanuatu	26	3.7	3.0	–		–		71		24		42		48		–		–	
Venezuela (Bolivarian Republic of)	89	2.0	1.2	98		99		87		60		69		74		–		–	
Viet Nam	34	3.2	2.2	97	x	97	x	128		47		93		95		89		92	
Yemen	35	5.1	3.4	–		–		67		25		47		34		43		34	
Zambia	41	2.9	4.3	91	x	87	x	75		26		31		30		46		51	
Zimbabwe	32	1.9	2.3	88		93		83		23		33		41		48		63	
SUMMARY																			
East Asia and Pacific	57	3.0	1.5	99		97		109		52		71	**	76	**	81	**	84	**
Europe and Central Asia	71	0.5	0.4	–		–		125		74		93		92		–		–	
Eastern Europe and Central Asia	64	0.3	0.4	100		99		129		64		93		92		–		–	
Western Europe	76	0.6	0.4	–		–		122		83		–		–		–		–	
Latin America and Caribbean	80	1.9	1.1	98		99		109		56		74		77		76		79	
Middle East and North Africa	63	2.6	1.8	91		88		112		48		74		74		72		72	
North America	83	1.3	0.9	–		–		123		78		87		–		–		–	
South Asia	33	2.7	2.3	88		80		85		26		63		66		43		44	
Sub-Saharan Africa	37	4.0	3.6	79		72		75		20		32		31		32		32	

COUNTRIES AND AREAS	URBANISED POPULATION (%)	AVERAGE ANNUAL GROWTH RATE OF URBAN POPULATION (%)		YOUTH (15–24 YEARS) LITERACY RATE (%)		NUMBER PER 100 POPULATION		LOWER SECONDARY SCHOOL PARTICIPATION					
								NET ENROLMENT RATIO (%)		NET ATTENDANCE RATIO (%)			
	2016	1990–2016	2016–2030[a]	2011–2016*		2016		2011–2016*		2010–2016*			
Eastern and Southern Africa	31	3.7	3.5	87		85		71	21	29	30	24	29
West and Central Africa	45	4.2	3.7	69		55		80	19	–	–	39	36
Least developed countries	31	4.0	3.6	80		73		68	16	41	41	33	35
World	54	2.2	1.6	92		85		101	46	66 **	68 **	53 **	54 **

For a complete list of countries and areas in the regions, subregions and country categories, see data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
α Based on medium-fertility variant projections.
- Data not available.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005-2006 data from India. Estimates from data years prior to 2000 are not displayed.
y Data differ from the standard definition or refer to only part of a country. If they fall within the noted reference period, such data are included in the calculation of regional and global averages.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.

Definitions of the indicators:
Urbanised population – Percentage of population living in urban areas as defined according to the national definition used in the most recent population census.
Youth literacy rate – Number of literate persons aged 15–24 years, expressed as a percentage of the total population in that group.
Lower secondary school net enrolment ratio – Number of children enrolled in lower secondary school who are of official lower secondary school age, expressed as a percentage of the total number of children of official lower secondary school age. Lower secondary net enrolment ratio does not include lower-secondary-school-aged children enrolled in tertiary education owing to challenges in age reporting and recording at that level.
Lower secondary school net attendance ratio – Number of children attending lower secondary or tertiary school who are of official lower secondary school age, expressed as a percentage of the total number of children of official lower secondary school age. Because of the inclusion of lower-secondary-school-aged children attending tertiary school, this indicator can also be referred to as a lower secondary adjusted net attendance ratio.
All data refer to official International Standard Classifications of Education (ISCED) for the primary and lower secondary education levels and thus may not directly correspond to a country-specific school system.

Main data sources:
Population – United Nations Population Division. Growth rates calculated by UNICEF based on data from United Nations Population Division.
Youth literacy – UNESCO Institute for Statistics (UIS).
Lower secondary enrolment and rate of out-of-school children – UIS. Estimates based on administrative data from national Education Management Information Systems (EMIS) with UN population estimates.
Lower secondary school attendance – Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national household surveys.

TABLE 3. ADOLESCENTS

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Afghanistan	8,587	25	3		17		20		90	x	71	y	78	y
Albania	446	15	1	x	8	x	3	x	18		37	x	24	x
Algeria	5,942	15	-		3		1		12		-		55	y
Andorra	-	-	-		-		-		5		-		-	
Angola	6,486	23	2		18		38		191		24		25	
Anguilla	-	-	-		-		-		46	x	-		-	
Antigua and Barbuda	17	17	-		-		-		67	x	-		-	
Argentina	7,020	16	-		-		12		70		-		2	
Armenia	356	12	0		5		1		23		25		9	
Australia	2,897	12	-		-		-		14		-		-	
Austria	873	10	-		-		-		8		-		-	
Azerbaijan	1,358	14	-		9		4		47		-		24	
Bahamas	55	14	-		-		-		40	x	-		-	
Bahrain	158	11	-		-		-		15		-		-	
Bangladesh	32,575	20	-		44		36		83		-		29	y
Barbados	37	13	-		1		7		49	x	-		5	
Belarus	904	10	1		7		3	x	22		3		3	
Belgium	1,253	11	-		-		-		8		-		-	
Belize	78	21	11		21		17		64		8		6	
Benin	2,440	22	1		16		19		98		19		31	
Bhutan	148	19	-		15		15	x	28		-		70	
Bolivia (Plurinational State of)	2,216	20	4	x	13	x	20	x	89	x	-		17	x

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Bosnia and Herzegovina	410	12	0		1		–		11		5		1	
Botswana	431	19	–		–		–		39		–		–	
Brazil	33,760	16	1		4		–		65		–		–	
British Virgin Islands	–	–	–		–		–		27	x	–		–	
Brunei Darussalam	70	16	–		–		–		17	x	–		–	
Bulgaria	620	9	–		2	y	5		43		–		–	
Burkina Faso	4,306	23	2		32		28	x	136	x	40		39	
Burundi	2,243	21	1		9		11	x	65	x	56		74	
Cabo Verde	114	21	2	x	8	x	22	x	92	x	24	x	23	x
Cambodia	3,052	19	3		16		7		57		26	y	46	y
Cameroon	5,206	22	1		20		28		128	x	45		37	
Canada	3,968	11	–		–		–		13		–		–	
Central African Republic	1,117	24	11		55		45	x	229		83		79	
Chad	3,433	24	3		38		51		203		54		69	
Chile	2,591	14	–		–		–		50		–		–	
China	159,642	11	1		2		–		6		–		–	
Colombia	8,139	17	–		13		20		85	x	–		–	
Comoros	173	22	8		16		17		71		29		43	
Congo	1,083	21	2		16		26		147		76	y	73	y
Cook Islands	–	–	–		–		–		56		–		–	
Costa Rica	759	16	2		10		13		67		–		3	
Côte d'Ivoire	5,409	23	1		21		31		125		51		51	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Croatia	447	11	–		–		–		12		–		–	
Cuba	1,336	12	7		16		6		50		5	y	4	y
Cyprus	143	12	–		–		–		4		–		–	
Czechia	936	9	–		–		–		11		–		–	
Democratic People's Republic of Korea	3,839	15	–		–		–		1	x	–		–	
Democratic Republic of the Congo	17,401	22	1		21		27		135		69		75	
Denmark	690	12	–		–		–		2		–		–	
Djibouti	196	21	1		3		–		21		–		–	
Dominica	–	–	–		–		–		47	x	–		–	
Dominican Republic	2,007	19	–		28		21		90		–		3	
Ecuador	3,005	18	–		16	x	–		100	x	–		–	
Egypt	17,041	18	–		14		7		56		–		46	y
El Salvador	1,289	20	–		16		18		63		–		10	
Equatorial Guinea	217	18	5		22		42		177	x	56		57	
Eritrea	1,085	22	1		17		19	x	–		60		51	
Estonia	122	9	–		–		–		16		–		–	
Ethiopia	24,772	24	1		17		22		71		33		60	
Fiji	157	17	–		–		–		28	x	–		–	
Finland	594	11	–		–		–		7		–		–	
France	7,723	12	–		–		–		9		–		–	
Gabon	379	19	1		14		28		115		47		58	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Gambia	467	23	0		24		19		88		42		58	
Georgia	450	11	–		11		6	x	40		–		5	x
Germany	7,795	10	–		–		–		8		–		–	
Ghana	6,009	21	1		6		17		65		20		35	
Greece	1,108	10	–		–		–		9		–		–	
Grenada	19	17	–		–		–		53	x	–		–	
Guatemala	3,787	23	6		20		20		92		12		14	
Guinea	2,786	22	1		33		40		154		63		89	
Guinea-Bissau	395	22	0		11		28		137		37		40	
Guyana	165	21	13		13		16		97	x	14		10	
Haiti	2,285	21	2		12		13		65		22		24	
Holy See	–	–	–		–		–		–		–		–	
Honduras	1,990	22	5		23		22		99		18		15	
Hungary	996	10	–		–		–		20		–		–	
Iceland	43	13	–		–		–		7		–		–	
India	250,086	19	5	x	30	x	22	x	39		47	x	45	x
Indonesia	46,188	18	–		9	y	7		47		48	y	45	
Iran (Islamic Republic of)	10,928	14	–		16	x	5	x	35		–		–	
Iraq	8,019	22	–		21		12		68	x	–		50	
Ireland	583	12	–		–		–		9		–		–	
Israel	1,296	16	–		–		–		10		–		–	
Italy	5,592	9	–		–		–		6		–		–	
Jamaica	520	18	–		3		15		72	x	–		8	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Japan	11,650	9	-		-		-		4		-		-	
Jordan	1,918	20	-		6		4		27		-		84	y
Kazakhstan	2,269	13	-		6		2		31	x	-		8	
Kenya	11,065	23	1		12		23		101		37		45	
Kiribati	23	20	5	x	16	x	9	x	49		65	x	77	x
Kuwait	450	11	-		-		-		8		-		-	
Kyrgyzstan	991	17	-		14		4		42		-		22	
Lao People's Democratic Republic	1,432	21	9		25		18		94		50		56	
Latvia	181	9	-		-		-		15		-		-	
Lebanon	1,061	18	-		3	x	-		18	x	-		22	x,y
Lesotho	495	22	1		18		14		94		49		48	
Liberia	1,041	23	2		14		37		147		29		45	
Libya	1,093	17	-		-		-		4	x	-		-	
Liechtenstein	-	-	-		-		-		2		-		-	
Lithuania	307	11	-		-		-		14		-		-	
Luxembourg	65	11	-		-		-		6		-		-	
Madagascar	5,740	23	7		28		36		147	x	44		47	
Malawi	4,262	24	3		24		31		143		24		21	
Malaysia	5,513	18	5		6		-		13		-		-	
Maldives	59	14	-		5	x	1	x	14		-		41	x,y
Mali	4,135	23	2		40		37		178		54		68	
Malta	44	10	-		-		-		16		-		-	
Marshall Islands	-	-	5	x	21	x	21	x	85		71	x	47	x

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Mauritania	917	21	1		28		22		71		-		36	
Mauritius	189	15	-		-		-		31		-		-	
Mexico	23,416	18	6		15		21		84		-		6	
Micronesia (Federated States of)	25	24	-		-		-		33		-		-	
Monaco	-	-	-		-		-		-		-		-	
Mongolia	448	15	1		5		3		40		9		14	
Montenegro	81	13	0		2		3		12		5		2	
Montserrat	-	-	-		-		-		36		-		-	
Morocco	5,982	17	1		11		8	x	32	x	-		64	x
Mozambique	6,649	23	8		37		40		166		20		24	
Myanmar	10,042	19	5		13		5		17	x	57		53	
Namibia	539	22	1		5		15		78		30		28	
Nauru	-	-	9	x	18	x	22	x	106		-		-	
Nepal	6,625	23	-		25		16		87	x	-		35	
Netherlands	2,021	12	-		-		-		5		-		-	
New Zealand	616	13	-		-		-		22		-		-	
Nicaragua	1,207	20	-		24	x	28	x	92		-		19	x,y
Niger	4,704	23	3		61		48		210		41		54	
Nigeria	41,050	22	1		29		29		123		27		33	
Niue	-	-	-		-		-		16		-		-	
Norway	633	12	-		-		-		6		-		-	
Oman	480	11	-		3		2		12		-		10	
Pakistan	38,907	20	2		14		8		48		33	y,p	53	y

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Palau	-	-	-		-		-		27		-		-	
Panama	696	17	-		14		-		89		-		9	
Papua New Guinea	1,728	21	3	x	15	x	14	x	65	x	-		-	
Paraguay	1,342	20	-		11	x	-		63	x	-		-	
Peru	5,606	18	-		11		16		68		-		-	
Philippines	20,667	20	-		10		8		59		-		14	
Poland	3,814	10	-		-		-		14		-		-	
Portugal	1,080	10	-		-		-		12		-		-	
Qatar	200	8	1		4		-		16		22		6	y
Republic of Korea	5,686	11	-		-		-		2		-		-	
Republic of Moldova	444	11	1		10		4		25		14		13	
Romania	2,132	11	-		-		-		36		-		-	
Russian Federation	13,260	9	-		-		-		27		-		-	
Rwanda	2,607	22	0		3		6		41	x	24		45	
Saint Kitts and Nevis	-	-	-		-		-		75	x	-		-	
Saint Lucia	29	16	-		4		-		50	x	-		15	
Saint Vincent and the Grenadines	19	17	-		-		-		70		-		-	
Samoa	43	22	1		8		6		39		28		34	
San Marino	-	-	-		-		-		1		-		-	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Sao Tome and Principe	46	23	1		15		27		110	x	19		24	
Saudi Arabia	4,818	15	-		-		-		7	x	-		-	
Senegal	3,380	22	0		21		18		80		36		57	
Serbia	1,063	12	-		4		1		22		-		2	
Seychelles	12	12	-		-		-		62		-		-	
Sierra Leone	1,704	23	1		19		36		131		32		55	
Singapore	665	12	-		-		-		3		-		-	
Slovakia	553	10	-		-		-		21		-		-	
Slovenia	186	9	-		-		-		5		-		-	
Solomon Islands	134	22	2		11		15		62	x	60		78	
Somalia	3,333	23	-		25	x	-		123	x	-		75	x,y
South Africa	10,319	18	2	x	4	x	15	x	54	x	-		-	
South Sudan	2,767	23	-		40		28	x	158	x	-		72	
Spain	4,386	9	-		-		-		9		-		-	
Sri Lanka	3,284	16	-		9	x	4	x	24	x	-		54	x,y
State of Palestine	1,083	23	-		9		22		67		-		-	
Sudan	9,060	23	-		21		22		102		-		36	
Suriname	99	18	-		12		-		66	x	-		19	
Swaziland	302	23	0		4		17		89		29		32	
Sweden	1,025	10	-		-		-		3		-		-	
Switzerland	833	10	-		-		-		3		-		-	
Syrian Arab Republic	4,586	25	-		10	x	9	x	75	x	-		-	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Tajikistan	1,710	20	-		13		2		47		-		47	
Thailand	9,207	13	7		14		9		60		9		9	
The former Yugoslav Republic of Macedonia	253	12	-		4		2		19		-		14	
Timor-Leste	314	25	0		8		9	x	54	x	72		81	
Togo	1,665	22	1		13		15		77		19		26	
Tokelau	-	-	-		-		-		30		-		-	
Tonga	24	23	4		5		2		30		29		27	
Trinidad and Tobago	177	13	-		6	x	-		36	x	-		10	x
Tunisia	1,618	14	-		1		1		7		-		27	
Turkey	13,335	17	-		7		6		29		-		10	
Turkmenistan	954	17	-		6		1		21	x	-		17	
Turks and Caicos Islands	-	-	-		-		-		29	x	-		-	
Tuvalu	-	-	2	x	8	x	3	x	42	x	83	x	69	x
Uganda	9,920	24	2		20		33		140		52		62	
Ukraine	4,059	9	0		7		4		27		2		2	
United Arab Emirates	682	7	-		-		-		34		-		-	
United Kingdom	7,309	11	-		-		-		21		-		-	
United Republic of Tanzania	12,505	23	2		23		22		128	x	50		59	
United States	42,010	13	-		-		-		27		-		-	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Uruguay	508	15	–		7		–		60		–		3	
Uzbekistan	5,360	17	–		5	x	2	x	26	x	63	x	63	x
Vanuatu	54	20	4		11		13		78		63		56	
Venezuela (Bolivarian Republic of)	5,655	18	–		16		24		101		–		–	
Viet Nam	13,605	14	–		10		5		36		–		28	
Yemen	6,297	23	–		17		17		67		–		49	
Zambia	3,956	24	1		17		31		145		41		49	
Zimbabwe	3,557	22	1		20		22		120		49		54	
SUMMARY														
East Asia and Pacific	297,721	13	2		6		7	**	21		43	**	34	**
Europe and Central Asia	101,795	11	–		–		–		19		–		–	
Eastern Europe and Central Asia	50,903	12	–		7		4		29		–		12	
Western Europe	50,892	10	–		–		–		11		–		–	
Latin America and Caribbean	109,829	17	3		11		19		74		–		–	
Middle East and North Africa	73,653	17	–		13		8		41		–		49	
North America	45,978	13	–		–		–		25		–		–	
South Asia	340,270	19	–		–		20	‡	44		–		–	
Sub-Saharan Africa	232,069	22	2		23		28		122		39		49	

COUNTRIES AND AREAS	ADOLESCENT POPULATION		ADOLESCENTS CURRENTLY MARRIED/ IN UNION (%) 2010-16*				BIRTHS BY AGE 18 (%)		ADOLESCENT BIRTH RATE		JUSTIFICATION OF WIFE-BEATING AMONG ADOLESCENTS (%) 2010-16*			
	AGED 10-19 (THOUSANDS)	PROPORTION OF TOTAL POPULATION (%)	Male		Female						Male		Female	
	2016	2016					2011-2016*		2009-2014*					
Eastern and Southern Africa	122,663	23	2		20		26		113		38		49	
West and Central Africa	109,406	22	1		27		29		130		41		48	
Least developed countries	217,756	22	2		26		27		112		45		50	
World	1,201,315	16	–		16		18	‡**	50		–		35	**

For a complete list of countries and areas in the regions, subregions and country categories, see data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
p Based on small denominators (typically 25–49 unweighted cases).
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the claculation of regional and global averages. Data from years prior to 2000 are not displayed
y Data differ from the standard definition or refer to only part of a country. If they fall within the noted reference period, such data are included in the calculation of regional and global averages.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.
‡ Excludes India.
Italicised data are from different sources than the data presented for the same indicators in other tables of the report.

Definitions of the indicators:
Adolescents currently married/ in union – Percentage of boys and girls aged 15–19 who are currently married or in union. This indicator is meant to provide a snapshot of the current marital status of boys and girls in this age group. However, it is worth noting that those not married at the time of the survey are still exposed to the risk of marrying before they exit adolescence.
Births by age 18 – Percentage of women aged 20–24 who gave birth before age 18. This standardised indicator from population-based surveys captures levels of fertility among adolescents up to the age of 18. Note that the data are based on the answers of women aged 20–24, whose risk of giving birth before the age of 18 is behind them.
Adolescent birth rate – Number of births per 1,000 adolescent girls aged 15–19.
Justification of wife-beating among adolescents – The percentage of boys and girls aged 15–19 who consider a husband to be justified in hitting or beating his wife for at least one of the specified reasons: if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations.

Main data sources:
Adolescent population – United Nations Population Division.
Adolescents currently married/ in union – Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), other national surveys and censuses.
Births by age 18 – DHS, MICS and other national surveys.
Adolescent birth rate – United Nations Population Division.
Justification of wife-beating among adolescents – DHS, MICS and other national surveys.

TABLE 4. ADOLESCENTS (CON'T)

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Afghanistan	70	y	52	y	67	43	4		1		2		1		2.1	
Albania	97	x	99	x	101	89	21	x	36	x	51	x	26	x	2.0	x
Algeria	–		–		132	63	–		7		11		7		1.7	
Andorra	–		–		–	–	–		–		–		–		–	
Angola	84		77		36	21	29		31		42		9		4.4	
Anguilla	–		–		–	–	–		–		–		–		–	
Antigua and Barbuda	–		–		117	82	55	x	40	x	–		–		–	
Argentina	–		–		128	85	–		36		–		–		–	
Armenia	88		92		88	90	9		15		25		14		1.7	
Australia	–		–		112	186	–		–		–		–		–	
Austria	–		–		100	100	–		–		–		–		–	
Azerbaijan	–		98		91	–	2	x	3	x	7	x	2	x	3.3	x
Bahamas	–		–		–	–	–		–		–		–		–	
Bahrain	–		–		101	103	–		–		–		–		–	
Bangladesh	–		54	y	83	48	–		12		14		8		1.8	
Barbados	–		98		107	113	–		66		67		69		1.0	
Belarus	–		–		102	119	53		51		56		57		1.0	
Belgium	–		–		185	158	–		–		–		–		–	
Belize	92		92		91	60	–		39		55		33		1.7	
Benin	68		57		70	38	29		22		25		18		1.3	
Bhutan	–		–		96	69	–		22	x,p	32	x	15	x	2.1	x
Bolivia (Plurinational State of)	100	x	97	x	96	81	24	x	20	x	32	x	9	x	3.5	x
Bosnia and Herzegovina	100		100		–	–	41		42		50		47		1.1	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Botswana	-		-		91	-	-		-		-		-		-	
Brazil	-		-		106	91	-		-		-		-		-	
British Virgin Islands	-		-		111	80	-		-		-		-		-	
Brunei Darussalam	-		-		105	93	-		-		-		-		-	
Bulgaria	-		-		90	108	-		-		-		-		-	
Burkina Faso	61		55		47	13	31	x	29	x	46	x	24	x	1.9	x
Burundi	83		69		54	25	50		46		61		51		1.2	
Cabo Verde	88	x	88	x	115	73	-		-		-		-		-	
Cambodia	77		74		63	-	42		33		55		33		1.7	
Cameroon	80		64		68	43	30		26		37		18		2.1	
Canada	-		-		100	119	-		-		-		-		-	
Central African Republic	-		-		23	9	26	x	17	x	19	x	16	x	1.2	x
Chad	30		23		26	18	12		10		25		6		4.0	
Chile	-		-		103	100	-		-		-		-		-	
China	-		-		99	90	-		-		-		-		-	
Colombia	-		-		106	82	-		21	x	26	x	17	x	1.5	x
Comoros	79		67		66	52	21		18		24		17		1.4	
Congo	56		68		65	38	25	p	16		16		10		1.5	
Cook Islands	-		-		96	73	-		-		-		-		-	
Costa Rica	-		-		133	109	-		29		37		27		1.4	
Côte d'Ivoire	73		62		55	28	21		15		22		8		2.7	
Croatia	-		-		104	93	-		-		-		-		-	
Cuba	-		-		101	100	48		59		61		63		1.0	
Cyprus	-		-		100	100	-		-		-		-		-	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Czechia	–		–		101	110	–		–		–		–		–	
Democratic People's Republic of Korea	–		–		92	95	–		7	x	11	x	4	x	2.8	x
Democratic Republic of the Congo	49		38		56	37	20		17		24		15		1.6	
Denmark	–		–		117	144	–		–		–		–		–	
Djibouti	–		–		53	41	–		16	x	18	x	9	x	2.0	x
Dominica	–		–		115	81	39	x	49	x	–		–		–	
Dominican Republic	–		98		86	74	39		–		49		38		1.3	
Ecuador	–		–		116	96	–		–		–		–		–	
Egypt	100		100		99	73	5		3		5		4		1.5	
El Salvador	–		98		99	61	25		28		37		22		1.7	
Equatorial Guinea	91		91		39	–	12		17		27		9		2.9	
Eritrea	70		54		39	23	32	x	22	x	32	x	20	x	1.7	x
Estonia	–		–		112	118	–		–		–		–		–	
Ethiopia	38		31		43	18	32		24		38		19		2.0	
Fiji	–		–		103	76	–		–		–		–		–	
Finland	–		–		102	194	–		–		–		–		–	
France	–		–		108	115	–		–		–		–		–	
Gabon	95		94		–	–	35		29		32		15		2.2	
Gambia	82		70		64	–	27		22		32		18		1.8	
Georgia	–		–		114	95	–		–		–		–		–	
Germany	–		–		101	105	–		–		–		–		–	
Ghana	81		67		89	39	25		18		23		17		1.4	
Greece	–		–		101	111	–		–		–		–		–	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Grenada	–		–		100	98	67	x	59	x	–		–		–	
Guatemala	95		90		72	55	18		20		30		16		1.9	
Guinea	55		53		44	31	29		20		32		16		2.0	
Guinea-Bissau	96		89		–	–	19		20		26		18		1.4	
Guyana	95		96		93	83	33		48		64		47		1.4	
Haiti	85		80		–	–	25		32		41		29		1.4	
Holy See	–		–		–	–	–		–		–		–		–	
Honduras	98		94		74	66	33		29		42		23		1.9	
Hungary	–		–		100	110	–		–		–		–		–	
Iceland	–		–		97	133	–		–		–		–		–	
India	88	x	72	x	88	64	35	x	19	x	33	x	14	x	2.4	x
Indonesia	88	y,p	91		95	76	4	p	9		14		9		1.6	
Iran (Islamic Republic of)	–		–		99	85	–		–		–		–		–	
Iraq	–		–		–	–	–		3		4		1		3.7	
Ireland	–		–		111	154	–		–		–		–		–	
Israel	–		–		104	101	–		–		–		–		–	
Italy	–		–		106	101	–		–		–		–		–	
Jamaica	–		–		86	76	34		39		–		–		–	
Japan	–		–		102	101	–		–		–		–		–	
Jordan	–		100	y	87	74	–		6		8		11		0.7	
Kazakhstan	–		96		114	103	30		–		31		21		1.5	
Kenya	84		75		97	–	58		52		63		52		1.2	
Kiribati	58	x	57	x	105	–	46	x	41	x	45	x	43	x	1.1	x
Kuwait	–		–		99	85	–		–		–		–		–	
Kyrgyzstan	–		100		97	81	18		–		18		21		0.9	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Lao People's Democratic Republic	92		93		76	43	25		23		39		18		2.2	
Latvia	-		-		116	123	-		-		-		-		-	
Lebanon	-		-		68	55	-		-		-		-		-	
Lesotho	60		66		63	40	30		35		44		35		1.3	
Liberia	59		47		44	29	19		35		40		27		1.5	
Libya	-		-		-	-	-		-		-		-		-	
Liechtenstein	-		-		98	139	-		-		-		-		-	
Lithuania	-		-		106	114	-		-		-		-		-	
Luxembourg	-		-		114	94	-		-		-		-		-	
Madagascar	62		59		50	22	24		21		44		18		2.5	
Malawi	50		35		53	22	43		39		47		40		1.2	
Malaysia	-		-		89	69	-		-		-		-		-	
Maldives	-		100	x	97	-	-		22	x	43	x	32	x	1.4	x
Mali	83		75		52	29	27		21		32		16		2.0	
Malta	-		-		102	90	-		-		-		-		-	
Marshall Islands	86	x	85	x	81	67	35	x	27	x	33	x	12	x	2.7	x
Mauritania	55	x	44	x	37	21	10		-		9		4		2.7	
Mauritius	-		-		111	84	-		-		-		-		-	
Mexico	-		96		116	65	-		28		33		25		1.3	
Micronesia (Federated States of)	-		-		81	-	-		-		-		-		-	
Monaco	-		-		-	-	-		-		-		-		-	
Mongolia	98		98		93	90	17		18		36	x	21	x	1.7	x
Montenegro	-		-		95	86	35		42		47		49		1.0	
Montserrat	-		-		-	-	-		-		-		-		-	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Morocco	–		90	x	97	55	–		–		–		–		–	
Mozambique	73		57		39	21	28		28		39		25		1.6	
Myanmar	75		76		59	34	14		13		28		11		2.5	
Namibia	65	y	69		92	–	51		56		67		55		1.2	
Nauru	89	x	86	x	77	94	8	x	8	x	–		–		–	
Nepal	–		77		93	50	24		18		25		14		1.7	
Netherlands	–		–		136	134	–		–		–		–		–	
New Zealand	–		–		103	134	–		–		–		–		–	
Nicaragua	–		95	x	–	–	–		–		–		–		–	
Niger	35		44		27	10	21		12		31		9		3.3	
Nigeria	54		50		52	60	29		22		30		20		1.4	
Niue	–		–		119	95	–		–		–		–		–	
Norway	–		–		100	125	–		–		–		–		–	
Oman	–		–		113	96	–		–		–		–		–	
Pakistan	59	y,p	49	y	57	35	5	p	1		–		–		–	
Palau	–		–		78	119	–		–		–		–		–	
Panama	–		96		94	57	–		–		–		–		–	
Papua New Guinea	–		–		73	22	–		–		–		–		–	
Paraguay	–		–		84	69	–		–		–		–		–	
Peru	–		90		100	90	–		21	x	27	x	8	x	3.3	x
Philippines	–		90		92	77	–		19	x	23	x	17	x	1.4	x
Poland	–		–		101	115	–		–		–		–		–	
Portugal	–		–		119	119	–		–		–		–		–	
Qatar	98		98		100	82	23		10		–		–		–	
Republic of Korea	–		–		103	95	–		–		–		–		–	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Republic of Moldova	96		96		87	85	26		35		41		32		1.3	
Romania	-		-		93	92	-		-		-		-		-	
Russian Federation	-		-		101	114	-		-		-		-		-	
Rwanda	78		71		42	31	60		62		74		62		1.2	
Saint Kitts and Nevis	-		-		93	86	55	x	54	x	-		-		-	
Saint Lucia	-		99		87	82	-		58		57		63		0.9	
Saint Vincent and the Grenadines	-		-		120	86	-		-		-		-		-	
Samoa	99		97		102	78	5	x	2	x	5	x	2	x	2.4	x
San Marino	-		-		94	95	-		-		-		-		-	
Sao Tome and Principe	97		97		110	61	42		41		43		40		1.1	
Saudi Arabia	-		-		108	108	-		-		-		-		-	
Senegal	69		76		59	36	28		26		-		-		-	
Serbia	99		100		102	91	43	x	53	x	63	x	41	x	1.5	x
Seychelles	-		-		112	59	-		-		-		-		-	
Sierra Leone	55		49		61	28	29		28		38		22		1.7	
Singapore	-		-		-	-	-		-		-		-		-	
Slovakia	-		-		98	86	-		-		-		-		-	
Slovenia	-		-		100	118	-		-		-		-		-	
Solomon Islands	37		28		78	29	26	x	29	x	34	x	28	x	1.2	x
Somalia	-		-		-	-	-		3	x	7	x	2	x	4.1	x
South Africa	-		-		97	88	-		-		-		-		-	
South Sudan	-		-		18	5	-		8	x	16	x	7	x	2.3	x
Spain	-		-		124	136	-		-		-		-		-	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
Sri Lanka	-		88	x,y	99	99	-		-		-		-		-	
State of Palestine	-		-		88	66	-		5		8	x	6	x	1.3	x
Sudan	-		-		54	35	10		-		12		7		1.9	
Suriname	-		99		101	54	-		40	x	45	x	33	x	1.4	x
Swaziland	89		86		75	52	44		45		56		47		1.2	
Sweden	-		-		115	164	-		-		-		-		-	
Switzerland	-		-		106	98	-		-		-		-		-	
Syrian Arab Republic	-		-		61	32	-		6	x	7	x	7	x	1.0	x
Tajikistan	-		89		98	68	9		-		11		8		1.4	
Thailand	-		-		128	130	45		47		55		56		1.0	
The former Yugoslav Republic of Macedonia	-		-		83	76	-		23	x	33	x	18	x	1.8	x
Timor-Leste	61		62		87	65	15	x	11	x	14	x	12	x	1.2	x
Togo	67		63		68	36	28		23		28		19		1.5	
Tokelau	-		-		206	-	-		-		-		-		-	
Tonga	92		95		103	56	13		10		11		13		0.8	
Trinidad and Tobago	-		-		-	-	-		49	x	-		-		-	
Tunisia	-		98		103	78	-		15		22		13		1.7	
Turkey	-		-		99	106	-		-		-		-		-	
Turkmenistan	-		100		73	120	-		19		7	x	4	x	2.0	x
Turks and Caicos Islands	-		-		-	-	-		-		-		-		-	
Tuvalu	89	x	95	x	99	56	57	x	31	x	38	x	41	x	0.9	x
Uganda	88		82		-	-	40		41		55		42		1.3	
Ukraine	97		96		102	93	37		43		52		45		1.1	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
United Arab Emirates	-		-		92	-	-		-		-		-		-	
United Kingdom	-		-		113	138	-		-		-		-		-	
United Republic of Tanzania	61		57		43	9	42		37		52		36		1.5	
United States	-		-		102	93	-		-		-		-		-	
Uruguay	-		-		110	81	-		36		34		-		-	
Uzbekistan	-		-		97	95	-		27	x	33	x	30	x	1.1	x
Vanuatu	58		58		70	34	-		14	x	23	x	13	x	1.8	x
Venezuela (Bolivarian Republic of)	-		-		97	79	-		-		-		-		-	
Viet Nam	-		97		97	-	-		51		54		47		1.1	
Yemen	-		85		58	39	-		2	x	4	x	1	x	6.7	x
Zambia	75		69		63	-	42		39		50		34		1.5	
Zimbabwe	57		53		68	37	41		41		56		41		1.4	
SUMMARY																
East Asia and Pacific	-		89	**	96	87	13	**	22	**	29	**	23	**	1.3	**
Europe and Central Asia	-		-		104	112	-		-		-		-		-	
Eastern Europe and Central Asia	-		-		100	102	-		-		-		-		-	
Western Europe	-		-		109	119	-		-		-		-		-	
Latin America and Caribbean	-		-		107	81	-		-		-		-		-	
Middle East and North Africa	-		-		96	70	-		-		-		-		-	

COUNTRIES AND AREAS	USE OF MASS MEDIA AMONG ADOLESCENTS (%) 2010-16*				LOWER SECONDARY SCHOOL GROSS ENROLMENT RATIO	UPPER SECONDARY SCHOOL GROSS ENROLMENT RATIO	COMPREHENSIVE KNOWLEDGE OF HIV AMONG ADOLESCENTS (%) 2011-16*				COMPREHENSIVE KNOWLEDGE OF HIV/AIDS (%) FEMALES 15-24 2011-16*					
	Male		Female		2011-2016*		Male		Female		Urban		Rural		Ratio of urban to rural	
North America	–		–		102	96	–		–		–		–		–	
South Asia	–		–		83	59	8	‡	6	‡	13	‡	7	‡	1.8	‡
Sub-Saharan Africa	61		54		53	37	31		27		37		23		1.6	
Eastern and Southern Africa	64		56		52	31	36		35		45		30		1.5	
West and Central Africa	58		52		54	42	26		20		28		17		1.7	
Least developed countries	62		57		55	33	27		23		31		18		1.7	
World	–		–		86	70	–		21	**‡	30	‡**	20	‡**	1.5	‡**

For a complete list of countries and areas in the regions, subregions and country categories, see data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available
p Based on small denominators (typically 25–49 unweighted cases).
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the claculation of regional and global averages. Data from years prior to 2000 are not displayed
y Data differ from the standard definition or refer to only part of a country. If they fall within the noted reference period, such data are included in the calculation of regional and global averages.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.
‡ Excludes India.
Italicised data are from different sources than the data presented for the same indicators in other tables of the report.

Definitions of the indicators:
Use of mass media among adolescents – The percentage of boys and girls aged 15–19 who make use of at least one of the following types of information media at least once a week: newspaper, magazine, television or radio.
Lower secondary school gross enrolment ratio – Number of children enrolled in lower secondary school, regardless of age, expressed as a percentage of the total number of children of official lower secondary school age.
Upper secondary school gross enrolment ratio – Number of children enrolled in upper secondary school, regardless of age, expressed as a percentage of the total number of children of official upper secondary school age.
Comprehensive knowledge of HIV among adolescents – Percentage of young men and women aged 15–19 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission and who know that a healthy-looking person can be HIV-positive.

Main data sources:
Use of mass media among adolescents – DHS, MICS and other national surveys.
Gross enrolment ratio – UNESCO Institute for Statistics (UIS).
Comprehensive knowledge of HIV among adolescents – AIDS Indicator Surveys (AIS), DHS, MICS and other national household surveys.

TABLE 5. WOMEN

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011-2016*		2011-2016*		2011-2016*	
Afghanistan	104	39		69	56	42	
Albania	105	98		97	94	13	x
Algeria	103	82	x	94	104	77	
Andorra	-	100		-	-	-	
Angola	110	67		64	65	24	
Anguilla	-	-		-	-	-	
Antigua and Barbuda	107	101	x	94	102	-	
Argentina	110	100		100	107	-	
Armenia	109	100		100	101	40	
Australia	105	-		100	95	-	
Austria	106	-		99	95	-	
Azerbaijan	109	100		98	-	22	x
Bahamas	108	-		-	-	-	
Bahrain	103	95	x	101	100	-	
Bangladesh	105	92		108	113	73	
Barbados	107	-		101	103	70	
Belarus	116	100	x	100	99	74	
Belgium	106	-		100	114	-	
Belize	108	-		95	102	66	
Benin	105	49		92	70	25	
Bhutan	101	73		107	107	85	x
Bolivia (Plurinational State of)	108	92		97	98	43	x
Bosnia and Herzegovina	107	96		-	-	22	
Botswana	109	102	x	97	-	82	x
Brazil	110	101		97	105	90	
British Virgin Islands	-	-		-	-	-	

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011–2016*		2011–2016*		2011–2016*	
Brunei Darussalam	104	97		100	100	–	
Bulgaria	110	99		99	97	–	
Burkina Faso	102	59		96	92	44	
Burundi	107	78		101	91	33	
Cabo Verde	106	89		95	112	73	x
Cambodia	106	80	x	99	–	56	
Cameroon	104	83	x	90	86	40	
Canada	105	–		101	100	–	
Central African Republic	107	48	x	74	51	29	
Chad	105	45		77	46	18	
Chile	107	100		97	101	–	
China	104	95	x	100	103	97	x
Colombia	110	100		97	107	84	x
Comoros	105	75		93	107	28	
Congo	105	84		107	87	39	
Cook Islands	–	–		94	108	–	
Costa Rica	106	100		99	104	89	
Côte d'Ivoire	106	73		89	72	31	
Croatia	109	99		100	105	–	
Cuba	105	100		95	105	88	
Cyprus	106	99		100	99	–	
Czechia	108	–		100	101	86	x
Democratic People's Republic of Korea	110	–		–	101	90	
Democratic Republic of the Congo	105	75		91	62	16	
Denmark	105	–		98	104	–	
Djibouti	105	–		91	82	–	

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011-2016*		2011-2016*		2011-2016*	
Dominica	-	-		98	99	-	
Dominican Republic	109	101		91	110	84	
Ecuador	107	98		106	104	81	
Egypt	106	81		100	99	80	
El Salvador	113	96		96	101	82	
Equatorial Guinea	105	86	x	98	-	21	
Eritrea	107	73	x	86	85	20	x
Estonia	113	100		100	99	-	
Ethiopia	106	59	x	91	96	59	
Fiji	109	-		99	111	-	
Finland	107	-		100	109	-	
France	108	-		99	101	96	x
Gabon	105	94		97	-	34	
Gambia	104	65		105	-	24	
Georgia	112	100		102	100	53	x
Germany	106	-		99	94	-	
Ghana	103	83	x	102	97	41	
Greece	107	98		99	94	-	
Grenada	107	-		96	100	-	
Guatemala	109	88		96	93	66	
Guinea	102	50		85	66	16	
Guinea-Bissau	106	50		-	-	38	
Guyana	107	99		97	99	53	
Haiti	107	84	x	-	-	45	
Holy See	-	-		-	-	-	
Honduras	107	100		99	119	76	
Hungary	110	-		99	100	-	
Iceland	104	-		99	104	-	
India	105	75		112	101	72	

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011–2016*		2011–2016*		2011–2016*	
Indonesia	106	96		97	100	79	
Iran (Islamic Republic of)	103	89		105	99	69	
Iraq	107	72		–	–	59	
Ireland	105	–		101	103	–	
Israel	104	–		101	101	–	
Italy	106	99		99	98	–	
Jamaica	107	116	x	–	107	83	x
Japan	108	–		100	100	–	
Jordan	105	99		101	106	58	
Kazakhstan	115	100	x	102	103	80	
Kenya	108	88		99	–	75	
Kiribati	110	–		103	–	36	x
Kuwait	103	98		101	116	–	
Kyrgyzstan	112	99	x	99	102	62	
Lao People's Democratic Republic	105	74		96	93	61	
Latvia	114	100		99	99	–	
Lebanon	105	93	x	91	99	–	
Lesotho	109	125		97	136	76	
Liberia	103	44	x	90	78	37	
Libya	108	–		–	–	30	x
Liechtenstein	–	–		98	78	–	
Lithuania	115	100		100	96	–	
Luxembourg	106	–		100	102	–	
Madagascar	105	91		100	98	50	x
Malawi	109	79		102	90	75	
Malaysia	106	95	x	100	108	–	
Maldives	103	100		–	–	43	x
Mali	102	49		91	81	48	

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011-2016*		2011-2016*		2011-2016*	
Malta	104	103		102	107	-	
Marshall Islands	-	100		100	110	81	x
Mauritania	105	62	x	105	93	30	
Mauritius	110	96		102	105	41	
Mexico	107	98		100	107	81	
Micronesia (Federated States of)	103	-		100	-	-	
Monaco	-	-		-	-	-	
Mongolia	113	100	x	98	102	68	
Montenegro	106	98		98	100	34	
Montserrat	-	-		-	-	-	
Morocco	103	74		95	85	75	
Mozambique	108	54	x	92	92	28	
Myanmar	107	90		97	103	75	
Namibia	109	99		97	-	75	
Nauru	-	-		92	102	43	x
Nepal	105	68		108	107	56	
Netherlands	105	-		99	101	-	
New Zealand	104	-		100	106	-	
Nicaragua	108	100	x	-	-	90	
Niger	103	38		86	71	35	
Nigeria	103	68	x	98	93	33	
Niue	-	-		82	110	-	
Norway	105	-		100	97	-	
Oman	106	89		103	107	19	x
Pakistan	103	64		85	79	47	
Palau	-	100		111	99	-	
Panama	108	99	x	97	107	76	
Papua New Guinea	108	80	x	91	76	41	x

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011–2016*		2011–2016*		2011–2016*	
Paraguay	106	98		97	107	84	x
Peru	107	94		100	100	63	
Philippines	110	101		100	110	52	
Poland	111	–		100	96	–	
Portugal	108	96		96	97	–	
Qatar	103	100		101	126	69	
Republic of Korea	108	–		99	99	–	
Republic of Moldova	113	100		99	101	60	
Romania	110	99		98	99	47	x
Russian Federation	117	100	x	101	98	72	
Rwanda	107	89		101	109	66	
Saint Kitts and Nevis	–	–		102	105	–	
Saint Lucia	107	–		–	99	72	
Saint Vincent and the Grenadines	106	–		98	97	–	
Samoa	109	100		100	111	39	
San Marino	–	–		99	103	–	
Sao Tome and Principe	107	90		94	113	50	
Saudi Arabia	104	95		103	76	–	
Senegal	106	64		112	98	44	
Serbia	108	99		100	101	25	
Seychelles	113	101	x	103	107	–	
Sierra Leone	102	60		101	86	38	
Singapore	105	97		–	–	–	
Slovakia	110	–		99	101	–	
Slovenia	107	–		100	100	–	
Solomon Islands	104	–		99	94	60	x

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011-2016*		2011-2016*		2011-2016*	
Somalia	106	-		-	-	-	
South Africa	112	98		95	127	81	x
South Sudan	104	55	x	71	54	6	x
Spain	107	99		101	100	-	
Sri Lanka	109	97	x	98	105	69	x
State of Palestine	105	97		100	110	65	
Sudan	105	-		90	95	30	
Suriname	109	96		98	127	73	x
Swaziland	112	98	x	92	99	81	
Sweden	104	-		104	114	-	
Switzerland	105	-		100	97	-	
Syrian Arab Republic	120	84	x	97	100	53	x
Tajikistan	109	100	x	99	90	51	
Thailand	111	96		94	94	89	
The former Yugoslav Republic of Macedonia	105	96	x	99	97	22	
Timor-Leste	105	83	x	99	107	38	x
Togo	103	66		95	-	32	
Tokelau	-	-		-	93	-	
Tonga	109	100		99	109	48	
Trinidad and Tobago	110	-		-	-	55	x
Tunisia	106	84		97	105	73	
Turkey	109	94		99	97	60	
Turkmenistan	111	-		98	96	76	
Turks and Caicos Islands	-	-		-	-	-	
Tuvalu	-	-		101	128	41	x
Uganda	108	78		102	91	48	

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011–2016*		2011–2016*		2011–2016*	
Ukraine	115	100		102	98	68	
United Arab Emirates	103	102	x	99	–	–	
United Kingdom	105	–		100	104	–	
United Republic of Tanzania	106	88		103	91	53	
United States	106	–		100	102	83	x
Uruguay	110	101		98	111	–	
Uzbekistan	108	100		96	98	–	
Vanuatu	106	–		98	106	51	
Venezuela (Bolivarian Republic of)	112	100		97	108	–	
Viet Nam	113	95	x	99	–	70	
Yemen	105	–		84	69	47	
Zambia	108	88	x	101	–	64	
Zimbabwe	106	99		98	98	85	
SUMMARY							
East Asia and Pacific	106	–		99	102	89	
Europe and Central Asia	109	–		100	99	75	
Eastern Europe and Central Asia	113	98		100	98	68	
Western Europe	107	–		100	100	82	
Latin America and Caribbean	109	99		98	105	83	
Middle East and North Africa	105	84		98	95	71	
North America	106	–		100	102	86	
South Asia	104	75		107	99	71	

COUNTRIES AND AREAS	LIFE EXPECTANCY: FEMALES AS A % OF MALES	ADULT LITERACY RATE: FEMALES AS A % OF MALES		ENROLMENT RATIOS: FEMALES AS A % OF MALES		DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (%)	
				PRIMARY GER	SECONDARY GER		
	2016	2011–2016*		2011–2016*		2011–2016*	
Sub-Saharan Africa	106	78		95	87	50	
Eastern and Southern Africa	107	88		94	94	61	
West and Central Africa	104	–		95	81	35	
Least developed countries	105	77		94	89	58	
World	106	85		100	98	78	

For a complete list of countries and areas in the regions, subregions and country categories, visit data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages. Estimates from data years prior to 2000 are not displayed.
+ Data collection method for this indicator varies across surveys and may affect comparability of the coverage estimates. For detailed explanation see General Note on the Data within The State of the World's Children 2017 report.
† The maternal mortality data in the column headed 'reported' refer to data reported by national authorities. The data in the column headed 'adjusted' refer to the 2015 United Nations inter–agency maternal mortality estimates. Periodically, the United Nations Maternal Mortality Estimation Inter–agency Group (WHO, UNICEF, UNFPA The World Bank and the United Nations Population Division) produces internationally comparable sets of maternal mortality data that account for the well–documented problems of under–reporting and misclassification of maternal deaths, including also estimates for countries with no data. Please note that owing to an evolving methodology, these values are not comparable with previously reported maternal mortality ratio 'adjusted' values. Comparable time series on maternal mortality ratios for the years 1990, 1995, 2000, 2005 and 2015 are available at < http://data.unicef.org/maternal–health/maternal–mortality.html>.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.
‡ Excludes India.

Definitions of the indicators:
Life expectancy – Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.
Adult literacy rate – Percentage of the population aged 15 years and over who can both read and write with understanding a short, simple statement on his/her everyday life.
Primary gross enrolment ratio (GER) – Total enrolment in primary school, regardless of age, expressed as a percentage of the official primary-school-aged population.
Secondary gross enrolment ratio (GER) – Total enrolment in secondary school, regardless of age, expressed as a percentage of the official secondary-school-aged population.
Survival rate to last grade of primary – Percentage of children entering the first grade of primary school who eventually reach the last grade (administrative data).
Demand for family planning satisfied with modern methods – Percentage of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.

Main data sources:
Life expectancy – United Nations Population Division.
Adult literacy – UNESCO Institute for Statistics (UIS).
Primary and secondary school enrolment – UIS.
Survival rate to last grade of primary – UIS.
Demand for family planning satisfied with modern methods – SDG Global Database based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Reproductive Health Surveys, other national surveys, National Health Information Systems (HIS).

TABLE 6. WOMEN (CON'T)

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†			
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015	
Afghanistan	59		18		51		48		3		9		40		1,300		396	52
Albania	97	x	67	x	99	x	97	x	19	x	1	x	83	x	6		29	1,900
Algeria	93		67		97		97		16		–		–		–		140	240
Andorra	–		–		–		–		–		–		–		–		–	–
Angola	82		61		50		46		4		21		23		–		477	32
Anguilla	–		–		–		–		–		–		–		–		–	–
Antigua and Barbuda	100	x	100		100		–		–		–		–		0	x	–	–
Argentina	98		90		100		99		29		–		–		39		52	790
Armenia	100		96		100		99		18		98		97		17		25	2,300
Australia	98	x	92	x	–		99		31	x	–		–		–		6	8,700
Austria	–		–		99		99		24	x	–		–		–		4	18,200
Azerbaijan	92		66		100		93		20		3	x	83		14		25	1,600
Bahamas	98	x	85		98		–		–		–		–		37		80	660
Bahrain	100	x	100		100		98	x	–		–		–		17	x	15	3,000
Bangladesh	64		31		42		37		23		32		36		180		176	240
Barbados	93		88		99		100		21		98		97		52		27	2,100
Belarus	100		100		100		100		25		100		100		0		4	13,800
Belgium	–		–		–		–		18	x	–		–		–		7	8,000
Belize	97		93		97		96		34		96		96		45		28	1,300
Benin	83		59		77		87		5		80		78		350		405	51
Bhutan	98		85		86	x	74		12	x	30	x	41	x	86		148	310
Bolivia (Plurinational State of)	90		75		85	x	71		27		76	x	77	x	310	x	206	160

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†			
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015	
Bosnia and Herzegovina	87		84		100		100		14		–		–		0		11	6,800
Botswana	94	x	73	x	99	x	100		–		–		–		130		129	270
Brazil	97		91		99		99		56		–		–		55		44	1,200
British Virgin Islands	–		–		–		–		–		–		–		–		–	–
Brunei Darussalam	99	x	93		100		100	x	–		–		–		–		23	2,300
Bulgaria	–		–		100		94		36		–		–		6		11	6,200
Burkina Faso	93		47		80		82		4		33		74		330		371	48
Burundi	99		49		85		84		4	x	8	x	49		500	x	712	23
Cabo Verde	98	x	72	x	92		76	x	11	x	–		–		10		42	900
Cambodia	95		76		89		83		6		79		90		170		161	210
Cameroon	83		59		65		61		2		69		65		780		596	35
Canada	100	x	99	x	100	x	98		26	x	–		–		11		7	8,800
Central African Republic	68	x	38	x	40	x	53	x	5	x	–		–		540	x	882	27
Chad	55		31		20		22		1		5		16		860		856	18
Chile	–		–		100		100		50		–		–		14		22	2,600
China	97		69		100		100		41		–		–		20		27	2,400
Colombia	97		90		99		99		46		7	x	1		54		64	800
Comoros	92		49		82	x	76		10		14		49		170		335	66
Congo	93		79		94		92		5		86		80		440		442	45
Cook Islands	100	x	–		100	x	100	x	–		–		–		0		–	–
Costa Rica	98		90		99		99		22		–		–		28		25	2,100
Côte d'Ivoire	91		44		59	x	57		3		34		70		610		645	32

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†				
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED		LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015		
Croatia	–		92		100		–		21		–		–		3		8		7,900
Cuba	99		98		99		100		40		98		99		42		39		1,800
Cyprus	99	x	–		–		97		–		–		–		–		7		9,400
Czechia	–		–		100	x	100		20	x	–		–		1		4		14,800
Democratic People's Republic of Korea	100	x	94	x	100	x	95	x	13	x	–		–		77	x	82		660
Democratic Republic of the Congo	88		48		80		80		5		8		44		850		693		24
Denmark	–		–		–		–		21	x	–		–		–		6		9,500
Djibouti	88		23		87	x	87		11		–		–		380		229		140
Dominica	100	x	–		100		–		–		–		–		110		–		–
Dominican Republic	98		93		98		98		58		95		95		110		92		400
Ecuador	84	x	58	x	96		93		46		–		–		46		64		580
Egypt	90		83		92		87		52		14		82		49		33		810
El Salvador	96		90		98		98		32		97		94		42		54		890
Equatorial Guinea	91		67		68	x	67		7		–		–		310		342		61
Eritrea	89	x	57	x	34	x	34	x	3	x	–		5	x	490	x	501		43
Estonia	–		97		100	x	99		–		–		–		7		9		6,300
Ethiopia	62		32		28		26		2		0		17		410		353		64
Fiji	100	x	94		100		99		–		–		–		59		30		1,200
Finland	100	x	–		–		100		16	x	–		–		–		3		21,700
France	100	x	99	x	–		98		21	x	–		–		–		8		6,100
Gabon	95		78		89	x	90		10		25		60		320		291		85

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†			
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015	
Gambia	86		78		57		63		2		6		76		430		706	24
Georgia	98	x	88		100		100		41		–		–		32		36	1,500
Germany	100	x	99		–		99		29	x	–		–		–		6	11,700
Ghana	91		87		71		73		13		23		81		450	x	319	74
Greece	–		–		–		–		–		–		–		–		3	23,700
Grenada	100	x	–		99		–		–		–		–		23		27	1,500
Guatemala	91		86		66		65		26		8		78		140		88	330
Guinea	85		57		45	x	40		2		25		37		720		679	29
Guinea-Bissau	92		65		45		44		4		55		48		900		549	38
Guyana	91		87		86		93		17		95		93		86	x	229	170
Haiti	90		67		49		36		6		19		32		380		359	90
Holy See	–		–		–		–		–		–		–		–		–	–
Honduras	97		89		83	x	83		19		81		85		73	x	129	300
Hungary	–		–		99	x	–		31	x	–		–		15		17	4,400
Iceland	–		–		–		–		17	x	–		–		–		3	14,600
India	74	x	51		81		79		17		24		62		170		174	220
Indonesia	95		84		93		80		12		48		80		360		126	320
Iran (Islamic Republic of)	97	x	94	x	96	x	95	x	46	x	–		–		25	x	25	2,000
Iraq	78		50		91	x	77		22		–		–		35		50	420
Ireland	100	x	–		100	x	100		25	x	–		–		–		8	6,100
Israel	–		–		–		–		–		–		–		–		5	6,200
Italy	99	x	68	x	–		100		40	x	–		–		–		4	19,700
Jamaica	98		86		99	x	99		21		–		–		80		89	520
Japan	–		–		–		100		–		–		–		–		5	13,400

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†			
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015	
Jordan	99		95		100	x	99		28		75		82		19	x	58	490
Kazakhstan	99		95		99		99		15		99		98		13		12	3,000
Kenya	94		58		62		61		9		36		53		360		510	42
Kiribati	88	x	71	x	98	x	66	x	10	x	–		–		33		90	300
Kuwait	100	x	–		99	x	99		–		–		–		2		4	10,300
Kyrgyzstan	98		95		98		98		7		99		98		36		76	390
Lao People's Democratic Republic	54		37		40	x	38		4		41		40		210		197	150
Latvia	92	x	–		100	x	98		–		–		–		24		18	3,500
Lebanon	96	x	–		98	x	100	x	–		–		–		–		15	3,700
Lesotho	95		74		78		77		10		18		62		1,000		487	61
Liberia	96		78		61		56		4		35		71		1,100		725	28
Libya	93	x	–		–		100		–		–		–		–		9	4,200
Liechtenstein	–		–		–		–		–		–		–		–		–	–
Lithuania	100	x	–		100	x	–		–		–		–		7		10	6,300
Luxembourg	–		97		100	x	100	x	29	x	–		–		–		10	6,500
Madagascar	82		51		44		38		2		13	x	46	x	480		353	60
Malawi	95		51		90		91		6		60		42		440		634	29
Malaysia	97		–		99		99		–		–		–		24		40	1,200
Maldives	99	x	85	x	96	x	95	x	32	x	1	x	70	x	110		68	600
Mali	48		38		44		65		2		63		58		460	x	587	27
Malta	100	x	–		–		100		–		–		–		–		9	8,300
Marshall Islands	81	x	77	x	90	x	85	x	9	x	–		–		110		–	–
Mauritania	85		63		64		69		5		58		57		630		602	36
Mauritius	–		–		100		98	x	–		–		–		22	x	53	1,300

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†			
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015	
Mexico	99		94		98		97		41		95		95		35		38	1,100
Micronesia (Federated States of)	80	x	–		100	x	87	x	11	x	–		–		160		100	310
Monaco	–		–		–		–		–		–		–		–		–	–
Mongolia	99		90		98		98		23		99		95		26		44	800
Montenegro	92		87		99		99		20		99		95		0	x	7	8,300
Montserrat	–		–		–		–		–		–		–		–		–	–
Morocco	77		55		74	x	73		16		–		1	x	110	x	121	320
Mozambique	91		51		54	x	55		4		–		5	x	410		489	40
Myanmar	81		59		60		37		17		36		71		230		178	260
Namibia	97		63		88		87		14		20		69		390		265	100
Nauru	95	x	40	x	97	x	99	x	8	x	–		–		0		–	–
Nepal	84		69		58		57		9		58		57		280	x	258	150
Netherlands	–		–		–		–		14	x	–		–		–		7	8,700
New Zealand	–		–		–		97		23	x	–		–		–		11	4,500
Nicaragua	95		88		88	x	71		30		–		3	x	51		150	270
Niger	83		38		40		59		1		13		37		520		553	23
Nigeria	61		51		35		36		2		14		40		550		814	22
Niue	100	x	–		100	x	–		–		–		–		0		–	–
Norway	–		–		–		99		16	x	–		–		–		5	11,500
Oman	99		94		99		99		19		98		95		18		17	1,900
Pakistan	73		37		55		48		14		43		60		280	x	178	140
Palau	90	x	81	x	100		100	x	–		–		–		0	x	–	–
Panama	93		88		94		91		28		93		92		81		94	420
Papua New Guinea	79	x	55	x	53	x	43		–		–		–		730	x	215	120

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†				
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED		LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015		
Paraguay	96	x	83		96	x	97		49		–		–		82		132		270
Peru	97		96		92		91		32		96		93		93	x	68		570
Philippines	95		84		73		61		9		53		72		220		114		280
Poland	–		–		100	x	100		21	x	–		–		2		3		22,100
Portugal	100	x	–		100	x	99		31	x	–		–		–		10		8,200
Qatar	91		85		100		99		20		–		–		11		13		3,500
Republic of Korea	–		97		–		100		32	x	–		–		–		11		7,200
Republic of Moldova	99		95		100		99		16		–		87	x	30		23		3,200
Romania	76		76	x	95		95		34		–		–		14		31		2,300
Russian Federation	–		–		100	x	99		13		–		–		11		25		2,300
Rwanda	99		44		91		91		13		19		43		210		290		85
Saint Kitts and Nevis	100	x	–		100		–		–		–		–		310		–		–
Saint Lucia	97		90		99	x	100		19		100		90		34		48		1,100
Saint Vincent and the Grenadines	100	x	100	x	99		–		–		–		–		45		45		1,100
Samoa	93		73		83		82		5		–		63		29	x	51		500
San Marino	–		–		–		–		–		–		–		–		–		–
Sao Tome and Principe	98		84		93		91		6		91		87		160	x	156		140
Saudi Arabia	97	x	–		98		–		–		–		–		14		12		3,100
Senegal	95		47		53		75		5		50		74		430		315		61
Serbia	98		94		98		98		29		–		–		12		17		3,900
Seychelles	–		–		99	x	–		–		–		–		57	x	–		–

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†			
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015	
Sierra Leone	97		76		60		54		3		39		73		1,200		1,360	17
Singapore	–		–		–		100		–		–		–		–		10	8,200
Slovakia	97	x	–		99	x	–		24	x	–		–		0		6	12,100
Slovenia	100	x	–		100	x	100		–		–		–		0		9	7,000
Solomon Islands	89		69		86		85		6		16		69		150	x	114	220
Somalia	26	x	6	x	9	x	9	x	–		–		–		1,000	x	732	22
South Africa	94		76		97		96		26		–		84		580		138	300
South Sudan	62		17	x	19	x	12	x	1	x	–		–		2,100	x	789	26
Spain	–		–		–		–		26	x	–		–		–		5	14,700
Sri Lanka	99	x	93	x	99	x	100		32		–		–		32		30	1,600
State of Palestine	99		96		100		99		20		94		91		–		45	490
Sudan	79		51		78		28		9		28		27		220	x	311	72
Suriname	91	x	67	x	90	x	92	x	19	x	–		–		130		155	270
Swaziland	99		76		88		88		12		90		88		590	x	389	76
Sweden	100	x	–		–		–		–		–		–		–		4	12,900
Switzerland	–		–		–		–		30	x	–		–		–		5	12,400
Syrian Arab Republic	88	x	64	x	96	x	78	x	26	x	–		–		65	x	68	440
Tajikistan	79		53		98		77		4		54		81		29		32	790
Thailand	98		91		99		99		33		–		–		12	x	20	3,600
The former Yugoslav Republic of Macedonia	99		94		100		100		25		–		–		4		8	8,500
Timor-Leste	84	x	55	x	29	x	21	x	2	x	2	x	24	x	570	x	215	82
Togo	73		57		45		73		7		35		71		400		368	58

COUNTRIES AND AREAS	ANTENATAL CARE (%)				DELIVERY CARE (%)						POSTNATAL HEALTH CHECK (%)+				MATERNAL MORTALITY RATIO†				
	AT LEAST ONE VISIT		AT LEAST FOUR VISITS		SKILLED BIRTH ATTENDANT		INSTITUTIONAL DELIVERY		C-SECTION		FOR NEWBORNS		FOR MOTHERS		REPORTED		ADJUSTED		LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011-2016*				2013-2016*		2011-2016*		2011-2016*		2011-2016*				2011-2016*		2015		
Tokelau	–		–		–		–		–		–		–		–		–		–
Tonga	99		70		96	x	98		17		–		–		36	x	124		230
Trinidad and Tobago	96	x	100		100		97	x	–		–		–		84		63		860
Tunisia	98		85		74	x	99		27		98		92		–		62		710
Turkey	97		89		97		97		48		72		88		29	x	16		3,000
Turkmenistan	100		96		100		100		6		100		100		7	x	42		940
Turks and Caicos Islands	–		–		–		–		–		–		–		–		–		–
Tuvalu	97	x	67	x	93	x	93	x	7	x	–		–		0	x	–		–
Uganda	97		60		57	x	73		5		11		54		340		343		47
Ukraine	99		87		99	x	99		12		99		96		14		24		2,600
United Arab Emirates	100	x	–		100	x	100		–		–		–		0	x	6		7,900
United Kingdom	–		–		–		–		26	x	–		–		–		9		5,800
United Republic of Tanzania	91		51		64		63		6		42		34		560		398		45
United States	–		97		99		–		31	x	–		–		28		14		3,800
Uruguay	97		77		100		100		30		–		–		17		15		3,300
Uzbekistan	99		–		100		100		14		–		–		19		36		1,000
Vanuatu	76		52		89		89		12		–		–		86	x	78		360
Venezuela (Bolivarian Republic of)	98		84		100		99		52		–		–		69		95		420
Viet Nam	96		74		94		94		28		89		90		67		54		870
Yemen	60		25		45		30		5		11		20		150		385		60

COUNTRIES AND AREAS	ANTENATAL CARE (%)		DELIVERY CARE (%)			POSTNATAL HEALTH CHECK (%)+		MATERNAL MORTALITY RATIO†		
	AT LEAST ONE VISIT	AT LEAST FOUR VISITS	SKILLED BIRTH ATTENDANT	INSTITUTIONAL DELIVERY	C-SECTION	FOR NEWBORNS	FOR MOTHERS	REPORTED	ADJUSTED	LIFETIME RISK OF MATERNAL DEATH (1 IN:)
	2011–2016*		2013–2016*	2011–2016*	2011–2016*	2011–2016*		2011–2016*	2015	
Zambia	96	56	63	67	4	16	63	400	224	79
Zimbabwe	93	76	78	77	6	73	57	650	443	52
SUMMARY										
East Asia and Pacific	96	74	95	90	31	56 **	79 **	–	59	930
Europe and Central Asia	–	–	–	98	22	–	–	–	16	3400
Eastern Europe and Central Asia	96	87	99	97	22	–	–	–	25	2000
Western Europe	–	–	–	99	–	–	–	–	7	9600
Latin America and Caribbean	97	90	96	94	43	–	–	–	68	670
Middle East and North Africa	84	66	86	80	30	–	–	–	81	400
North America	–	97	99	–	–	–	–	–	13	4100
South Asia	69 ‡	46	73	70	17	28	59	–	182	200
Sub-Saharan Africa	80	52	56	56	5	24	46	–	546	36
Eastern and Southern Africa	85	52	60	57	7	24	40	–	409	52
West and Central Africa	75	52	52	56	3	24	50	–	679	27
Least developed countries	79	46	56	54	7	25	42	–	436	52
World	86 ‡	62	78	75	20	34 **	59 **	–	216	180

For a complete list of countries and areas in the regions, subregions and country categories, visit data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages. Estimates from data years prior to 2000 are not displayed.
+ Data collection method for this indicator varies across surveys and may affect comparability of the coverage estimates. For detailed explanation see General Note on the Data within The State of the World's Children 2017 report.
† The maternal mortality data in the column headed 'reported' refer to data reported by national authorities. The data in the column headed 'adjusted' refer to the 2015 United Nations inter–agency maternal mortality estimates. Periodically, the United Nations Maternal Mortality Estimation Inter–agency Group (WHO, UNICEF, UNFPA The World Bank and the United Nations Population Division) produces internationally comparable sets of maternal mortality data that account for the well–documented problems of under–reporting and misclassification of maternal deaths, including also estimates for countries with no data. Please note that owing to an evolving methodology, these values are not comparable with previously reported maternal mortality ratio 'adjusted' values. Comparable time series on maternal mortality ratios for the years 1990, 1995, 2000, 2005 and 2015 are available at < http://data.unicef.org/maternal–health/maternal–mortality.html>.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.
‡ Excludes India.

Definitions of the indicators:
Life expectancy – Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.
Adult literacy rate – Percentage of the population aged 15 years and over who can both read and write with understanding a short, simple statement on his/her everyday life.
Primary gross enrolment ratio (GER) – Total enrolment in primary school, regardless of age, expressed as a percentage of the official primary-school-aged population.
Secondary gross enrolment ratio (GER) – Total enrolment in secondary school, regardless of age, expressed as a percentage of the official secondary-school-aged population.
Survival rate to last grade of primary – Percentage of children entering the first grade of primary school who eventually reach the last grade (administrative data).
Demand for family planning satisfied with modern methods – Percentage of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.
Antenatal care – Percentage of women (aged 15–49) attended at least once during pregnancy by skilled health personnel (doctor, nurse or midwife) and the percentage attended by any provider at least four times.
Skilled birth attendant – Percentage of births attended by skilled heath personnel (doctor, nurse or midwife).
Institutional delivery – Percentage of women (aged 15–49) who gave birth in a health facility.
C-section – Percentage of births delivered by Caesarean section. NB: C-section rates between 5 per cent and 15 per cent expected with adequate levels of emergency obstetric care.
Post-natal health check for newborn – Percentage of last live births in the last 2 years who received a health check within 2 days after delivery. NB: For MICS, health check refers to a health check while in facility or at home following delivery or a postnatal visit.
Post-natal health check for mother – Percentage of women age 15–49 years who received a health check within 2 days after delivery of their most recent live birth in the last 2 years. NB: For MICS, health check refers to a health check while in facility or at home following delivery or a postnatal visit.
Maternal mortality ratio – Number of deaths of women from pregnancy-related causes per 100,000 live births during the same time period. The 'reported' column shows country-reported figures that are not adjusted for under-reporting and misclassification. For the 'adjusted' column, see note below (†). Maternal mortality ratio values have been rounded according to the following scheme: Reported: <100, no rounding; 100–999, rounded to nearest 10; and >1,000, rounded to nearest 100. Adjusted: <1000, rounded to nearest 1; and ≥1,000, rounded to nearest 10.
Lifetime risk of maternal death – Lifetime risk of maternal death takes into account both the probability of becoming pregnant and the probability of dying as a result of that pregnancy, accumulated across a woman's reproductive years. Lifetime risk values have been rounded according to the following scheme: <1000, rounded to nearest 1; and ≥1,000, rounded to nearest 10.

Main data sources:
Life expectancy – United Nations Population Division.
Adult literacy – UNESCO Institute for Statistics (UIS).
Primary and secondary school enrolment – UIS.
Survival rate to last grade of primary – UIS.
Demand for family planning satisfied with modern methods – SDG Global Database based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Reproductive Health Surveys, other national surveys, National Health Information Systems (HIS).
Antenatal care – DHS, MICS and other nationally representative sources.
Skilled birth attendant – Joint UNICEF/WHO SBA database, November 2017 update, based on DHS, MICS and other nationally representative sources.
Institutional delivery – DHS, MICS and other nationally representative sources.
C-section – DHS, MICS and other nationally representative sources.
Post-natal health check for newborn and mother – DHS and MICS.
Maternal mortality ratio (reported) – Nationally representative sources, including household surveys and vital registration.Maternal mortality ratio (adjusted) – United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division).
Lifetime risk of maternal death – United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division).

TABLE 7. ATTITUDES TOWARDS DOMESTIC VIOLENCE

COUNTRIES AND AREAS	ATTITUDES TOWARDS DOMESTIC VIOLENCE	
	Men	Women
Belize (2015)	5.4	5.2
Kazakhstan (2015)	-	15.1
Mali (2015)		72.6
Mauritania (2015)	21.2	26.6
Nigeria (2016-17)	21.5	33.7
Pakistan (Gilgit-Baltistan) (2016-17)	-	78.1
Paraguay (2016)	-	6.0
Senegal (Dakar) (2015-2016)	-	23.2
Thailand (2015-16)	8.7	8.6
Turkmenistan (2015)	-	26.3

Source: Publicly available Multi-cluster Indicator Surveys from 2015 onwards, as of 4 February 2018.

Notes: – Data not available.

Definitions of the indicators: Attitudes towards domestic violence: Percentage of people age 15-49 years who state that a husband is justified in hitting or beating his wife in at least one of the following circumstances: 1) she goes out without telling him, 2) she neglects the children, 3) she argues with him, 4) she refuses sex with him, 5) she burns the food.

TABLE 8. CONTRACEPTION AND UNMET NEED

COUNTRIES AND AREAS	CONTRACEPTIVE PREVALENCE RATE	UNMET NEED
Belize (2015)	51.4	22.2
Kazakhstan (2015)	55.7	9.8
Mali (2015)	15.6	15.8
Mauritania (2015)	17.8	33.6
Nigeria (2016-17)	13.4	27.6
Pakistan (Gilgit-Baltistan) (2016-17)	38.1	23.8
Paraguay (2016)	68.4	12.1
Senegal (Dakar) (2015-16)	33.3	23.3
Thailand (2015-16)	78.4	6.2
Turkmenistan (2015)	50.2	12.1

Source: Publicly available Multi-cluster Indicator Surveys from 2015 onwards, as of 4 February 2018.

Notes: – Data not available.

Definitions of the indicators: *Contraceptive prevalence rate:* Percentage of women aged 15-49 years currently married or in a union who are using (or whos partner is using) a (modern or traditional) contraceptive method. *Unmet need:* Percentage of women 15-49 years who are currently married or in union who are fecund and want to space their births or limit the number of children they have and who are not currently using contraception.

TABLE 9. HIV/AIDS

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Afghanistan	0.03	0.01	0.02	7,500	<500	<500	<1,000	<100	<100	<500	<100	<100
Albania	0.08	0.04	0.16	1,700	-	-	<500	-	<100	<100	-	-
Algeria	0.02	0.01	0.05	13,000	<500	<500	<1,000	<100	<200	<200	<100	<100
Andorra	-	-	-	-	-	-	-	-	-	-	-	-
Angola	0.94	0.76	0.81	280,000	23,000	13,000	25,000	3,600	2,400	11,000	2,100	<500
Anguilla	-	-	-	-	-	-	-	-	-	-	-	-
Antigua and Barbuda	-	-	-	-	-	-	-	-	-	-	-	-
Argentina	0.13	0.02	0.28	120,000	1,200	3,700	5,500	<100	<1,000	2,400	<100	<100
Armenia	0.09	<0.01	0.18	3,300	-	-	<500	-	<100	<200	-	-
Australia	0.05	<0.01	0.02	25,000	<100	<100	1,100	<100	<100	<500	<100	<100
Austria	-	-	-	-	-	-	-	-	-	-	-	-
Azerbaijan	0.10	0.01	0.05	9,200	<200	<100	<1,000	<100	<100	<500	<100	<100
Bahamas	-	-	-	8,200	-	-	-	-	-	-	-	-
Bahrain	0.04	0.02	0.02	<500	-	-	<100	-	<100	<100	-	-
Bangladesh	0.01	<0.01	<0.01	12,000	<500	<500	1,500	<100	<100	1,000	<100	<100
Barbados	0.58	0.08	0.33	2,600	-	-	<200	-	<100	<100	-	-
Belarus	0.20	0.01	0.13	19,000	<100	<200	1,800	<100	<100	<200	<100	<100
Belgium	-	-	-	-	-	-	-	-	-	-	-	-
Belize	0.75	0.46	1.48	4,300	<200	<500	<500	<100	<100	<200	<100	<100
Benin	0.34	0.25	0.58	67,000	6,300	5,100	3,600	<500	<1,000	2,400	<500	<200
Bhutan	-	-	-	-	-	-	-	-	-	-	-	-
Bolivia (Plurinational State of)	0.10	0.01	0.21	19,000	<500	<1,000	1,100	<100	<500	<1,000	<100	<100

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Bosnia and Herzegovina	-	-	-	-	-	-	-	-	-	-	-	-
Botswana	5.52	2.30	7.18	360,000	12,000	17,000	10,000	<1,000	1,400	3,900	<500	<500
Brazil	0.24	0.04	0.48	830,000	11,000	30,000	48,000	<1,000	8,200	14,000	<1,000	<500
British Virgin Islands	-	-	-	-	-	-	-	-	-	-	-	-
Brunei Darussalam	-	-	-	-	-	-	-	-	-	-	-	-
Bulgaria	-	-	-	3,500	-	-	<500	-	-	<200	-	-
Burkina Faso	0.19	0.18	0.47	95,000	10,000	12,000	3,400	<1,000	<1,000	3,100	<500	<500
Burundi	0.20	0.20	0.15	84,000	12,000	8,100	2,200	<500	<200	2,900	<1,000	<500
Cabo Verde	-	-	-	2,800	<200	<200	<200	<100	-	<100	<100	<100
Cambodia	0.04	0.05	0.08	71,000	4,200	3,300	<1,000	<100	<200	1,800	<100	<100
Cameroon	1.39	1.09	2.41	560,000	46,000	40,000	32,000	4,000	5,900	29,000	3,200	1,400
Canada	-	-	-	-	-	-	-	-	-	-	-	-
Central African Republic	1.80	0.80	1.51	130,000	9,200	8,700	8,700	<1,000	<1,000	7,300	<1,000	<500
Chad	0.34	0.38	0.38	110,000	11,000	7,600	4,800	<1,000	<1,000	2,800	<1,000	<500
Chile	0.28	0.08	0.59	61,000	<500	2,200	5,000	<100	<1,000	-	-	-
China	-	-	-	-	-	-	-	-	-	-	-	-
Colombia	0.12	0.01	0.22	120,000	<1,000	3,500	5,600	<100	<1,000	2,800	<100	<100
Comoros	0.01	0.01	0.02	<200	-	-	<100	-	<100	<100	-	-
Congo	1.65	1.39	1.38	91,000	6,000	4,100	7,600	1,100	<1,000	3,800	<1,000	<200
Cook Islands	-	-	-	-	-	-	-	-	-	-	-	-
Costa Rica	0.19	0.02	0.36	13,000	<100	<500	<1,000	<100	<200	<500	<100	<100
Côte d'Ivoire	0.86	0.87	0.60	460,000	36,000	25,000	20,000	3,300	1,500	25,000	2,600	1,100

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Croatia	0.02	<0.01	0.05	1,500	–	–	<100	–	<100	<100	–	–
Cuba	0.29	0.05	0.68	25,000	<200	1,100	3,300	<100	<500	<200	<100	<100
Cyprus	–	–	–	–	–	–	–	–	–	–	–	–
Czechia	0.04	<0.01	0.08	3,400	–	–	<500	–	<100	<100	–	–
Democratic People's Republic of Korea	–	–	–	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	0.17	0.21	0.24	370,000	48,000	32,000	13,000	2,900	2,100	19,000	2,800	1,400
Denmark	–	–	–	–	–	–	–	–	–	–	–	–
Djibouti	0.58	0.68	0.40	8,600	<1,000	<1,000	<500	<100	<100	<1,000	<100	<100
Dominica	–	–	–	–	–	–	–	–	–	–	–	–
Dominican Republic	0.24	0.07	0.52	67,000	1,700	3,100	2,500	<100	<500	2,200	<100	<100
Ecuador	–	–	–	33,000	<500	1,400	1,900	<100	–	<1,000	<100	<100
Egypt	0.02	<0.01	0.04	11,000	<500	<1,000	1,600	<100	<500	<500	<100	<100
El Salvador	0.16	0.09	0.31	24,000	<500	<1,000	<1,000	<100	<200	<1,000	<100	<100
Equatorial Guinea	2.71	1.35	2.36	35,000	2,400	1,300	2,300	<200	<200	<1,000	<200	<100
Eritrea	0.15	0.22	0.11	15,000	1,500	1,300	<1,000	<200	<100	<1,000	<200	<100
Estonia	–	–	–	–	–	–	–	–	–	–	–	–
Ethiopia	0.33	0.26	0.23	710,000	62,000	67,000	30,000	3,800	2,700	20,000	2,900	2,500
Fiji	–	–	–	<1,000	–	–	<200	–	–	<100	–	–
Finland	–	–	–	–	–	–	–	–	–	–	–	–
France	0.09	0.01	0.25	180,000	<500	2,800	6,000	<100	<1,000	<1,000	<100	<100
Gabon	0.92	0.95	1.57	48,000	3,700	2,900	1,700	<500	<500	1,500	<500	<100
Gambia	0.65	0.47	0.23	20,000	1,600	<1,000	1,300	<200	<100	1,100	<200	<100

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Georgia	0.28	0.06	0.15	12,000	<100	<100	1,100	<100	<100	<500	<100	<100
Germany	-	-	-	-	-	-	-	-	-	-	-	-
Ghana	0.78	0.79	0.83	290,000	32,000	23,000	20,000	3,000	2,200	15,000	2,500	1,100
Greece	-	-	-	-	-	-	-	-	-	-	-	-
Grenada	-	-	-	-	-	-	-	-	-	-	-	-
Guatemala	0.18	0.15	0.35	46,000	1,800	2,300	2,900	<500	<1,000	1,600	<200	<100
Guinea	0.67	0.68	1.08	120,000	10,000	8,700	8,300	1,300	1,400	5,800	<1,000	<500
Guinea-Bissau	0.72	0.72	0.56	36,000	4,200	2,100	1,300	<500	<200	2,000	<500	<200
Guyana	0.77	0.32	1.62	8,500	<500	<1,000	<1,000	<100	<200	<200	<100	<100
Haiti	0.77	0.50	0.59	150,000	7,200	6,200	7,900	<1,000	<1,000	4,600	<500	<200
Holy See	-	-	-	-	-	-	-	-	-	-	-	-
Honduras	0.11	0.05	0.21	21,000	<1,000	1,300	<1,000	<100	<200	<1,000	<100	<100
Hungary	-	-	-	-	-	-	-	-	-	-	-	-
Iceland	-	-	-	-	-	-	-	-	-	-	-	-
India	0.06	-	-	2,100,000	130,000	130,000	80,000	9,100	16,000	62,000	7,000	3,100
Indonesia	0.19	0.13	0.29	620,000	14,000	17,000	48,000	3,200	6,300	38,000	1,900	<500
Iran (Islamic Republic of)	0.06	0.01	0.03	66,000	1,000	<1,000	5,000	<100	<200	4,000	<100	<100
Iraq	-	-	-	-	-	-	-	-	-	-	-	-
Ireland	0.06	<0.01	0.03	6,200	<100	<100	<500	<100	<100	-	-	-
Israel	-	-	-	-	-	-	-	-	-	-	-	-
Italy	0.06	0.02	0.04	130,000	<1,000	<500	3,600	<100	<200	-	-	-
Jamaica	-	-	-	30,000	<500	1,300	1,700	<100	-	1,300	<100	<100
Japan	-	-	-	-	-	-	-	-	-	-	-	-
Jordan	<0.01	<0.01	0.01	<500	-	-	<100	-	<100	<100	-	-
Kazakhstan	0.16	0.03	0.08	26,000	<500	<500	2,900	<100	<100	<1,000	<100	<100

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Kenya	1.46	0.87	2.69	1,600,000	120,000	140,000	62,000	6,100	14,000	36,000	4,800	3,300
Kiribati	-	-	-	-	-	-	-	-	-	-	-	-
Kuwait	0.02	0.01	0.03	<500	-	-	<100	-	<100	<100	-	-
Kyrgyzstan	0.13	0.02	0.07	8,500	<200	<200	<1,000	<100	<100	<500	<100	<100
Lao People's Democratic Republic	0.10	0.10	0.10	11,000	<1,000	<500	<1,000	<100	<100	<500	<100	<100
Latvia	0.23	0.02	0.63	6,600	<100	<200	<500	<100	<100	<500	<100	<100
Lebanon	0.02	0.02	0.05	2,200	-	-	<200	-	<100	<100	-	-
Lesotho	12.68	7.57	13.73	330,000	-	-	21,000	-	2,900	9,900	-	-
Liberia	0.66	0.47	1.49	43,000	4,200	5,000	2,900	<500	<1,000	2,800	<500	<500
Libya	-	-	-	-	-	-	-	-	-	-	-	-
Liechtenstein	-	-	-	-	-	-	-	-	-	-	-	-
Lithuania	0.09	<0.01	0.05	2,900	-	-	<500	-	<100	<200	-	-
Luxembourg	0.18	0.03	0.40	-	-	-	<200	<100	<100	<100	<100	<100
Madagascar	0.18	0.09	0.37	31,000	1,900	3,200	4,300	<500	<1,000	1,600	<500	<100
Malawi	2.29	1.61	2.58	1,000,000	110,000	90,000	36,000	4,300	4,800	24,000	4,100	3,200
Malaysia	0.19	0.01	0.07	97,000	<500	<1,000	5,700	<100	<200	7,000	<100	<100
Maldives	-	-	-	-	-	-	-	-	-	-	-	-
Mali	0.33	0.51	0.62	110,000	14,000	9,900	5,900	1,600	1,200	6,100	<1,000	<500
Malta	-	-	-	<500	-	-	<100	-	-	<100	-	-
Marshall Islands	-	-	-	-	-	-	-	-	-	-	-	-
Mauritania	-	-	-	11,000	<1,000	<1,000	<500	<100	-	<1,000	<100	<100
Mauritius	-	-	-	-	-	-	-	-	-	-	-	-
Mexico	0.10	0.02	0.19	220,000	2,500	7,200	12,000	<500	2,200	4,200	<200	<100

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Micronesia (Federated States of)	-	-	-	-	-	-	-	-	-	-	-	-
Monaco	-	-	-	-	-	-	-	-	-	-	-	-
Mongolia	0.01	<0.01	0.02	<500	-	-	<100	-	<100	<100	-	-
Montenegro	0.11	0.05	0.30	<500	-	-	<100	-	<100	<100	-	-
Montserrat	-	-	-	-	-	-	-	-	-	-	-	-
Morocco	0.03	0.01	0.06	22,000	<500	<1,000	<1,000	<100	<200	<1,000	<100	<100
Mozambique	3.63	2.77	3.03	1,800,000	200,000	120,000	83,000	13,000	9,000	62,000	9,200	4,400
Myanmar	0.22	0.12	0.49	230,000	9,300	11,000	11,000	<1,000	2,300	7,800	<500	<200
Namibia	4.37	1.32	5.31	230,000	15,000	13,000	9,600	<500	1,300	4,300	<500	<500
Nauru	-	-	-	-	-	-	-	-	-	-	-	-
Nepal	0.03	0.02	0.02	32,000	1,200	<1,000	<1,000	<100	<100	1,700	<100	<100
Netherlands	0.03	<0.01	0.07	23,000	<100	<500	<500	<100	<100	<200	<100	<100
New Zealand	-	-	-	-	-	-	-	-	-	-	-	-
Nicaragua	0.06	0.01	0.13	8,900	<200	<500	<500	<100	<100	<500	<100	<100
Niger	0.09	0.13	0.18	48,000	5,800	4,400	1,800	<1,000	<500	3,400	<500	<500
Nigeria	1.23	1.19	2.18	3,200,000	270,000	240,000	220,000	37,000	40,000	160,000	24,000	7,900
Niue	-	-	-	-	-	-	-	-	-	-	-	-
Norway	-	-	-	-	-	-	-	-	-	-	-	-
Oman	-	-	-	-	-	-	-	-	-	-	-	-
Pakistan	0.10	0.04	0.05	130,000	3,300	2,300	19,000	<1,000	<1,000	5,500	<500	<100
Palau	-	-	-	-	-	-	-	-	-	-	-	-
Panama	0.34	0.08	0.70	21,000	-	-	1,300	-	<500	<1,000	-	-
Papua New Guinea	0.37	0.42	0.27	46,000	3,400	2,000	2,800	<500	<500	1,100	<500	<100
Paraguay	0.20	0.05	0.38	19,000	<500	<1,000	1,300	<100	<500	<1,000	<100	<100

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Peru	-	-	-	70,000	1,300	2,400	2,700	<100	-	2,200	<100	<100
Philippines	0.11	0.01	0.25	56,000	<500	5,200	10,000	<200	2,400	<1,000	<100	<100
Poland	-	-	-	-	-	-	-	-	-	-	-	-
Portugal	-	-	-	-	-	-	-	-	-	-	-	-
Qatar	0.02	0.03	0.04	<100	-	-	<100	-	<100	<100	-	-
Republic of Korea	-	-	-	-	-	-	-	-	-	-	-	-
Republic of Moldova	0.38	0.06	0.19	15,000	<200	<200	1,600	<100	<100	<500	<100	<100
Romania	0.04	<0.01	0.10	16,000	<100	<500	<1,000	<100	<200	<200	<100	<100
Russian Federation	-	-	-	-	-	-	-	-	-	-	-	-
Rwanda	0.70	0.50	0.85	220,000	16,000	16,000	7,500	<1,000	<1,000	3,300	<1,000	<500
Saint Kitts and Nevis	-	-	-	-	-	-	-	-	-	-	-	-
Saint Lucia	-	-	-	-	-	-	-	-	-	-	-	-
Saint Vincent and the Grenadines	-	-	-	-	-	-	-	-	-	-	-	-
Samoa	-	-	-	-	-	-	-	-	-	-	-	-
San Marino	-	-	-	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	-	-	-	-	-	-	-	-	-	-	-	-
Saudi Arabia	0.02	0.01	0.01	8,200	<500	<200	<500	<100	<100	<500	<100	<100
Senegal	0.08	0.16	0.12	41,000	4,800	2,900	1,100	<500	<200	1,900	<500	<200
Serbia	0.03	0.01	0.06	2,700	-	-	<500	-	<100	<100	-	-
Seychelles	-	-	-	-	-	-	-	-	-	-	-	-
Sierra Leone	-	-	-	67,000	4,400	5,000	5,300	<500	-	2,800	<500	<200
Singapore	-	-	-	-	-	-	-	-	-	-	-	-

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Slovakia	0.02	<0.01	0.04	<1,000	–	–	<200	–	<100	<100	–	–
Slovenia	0.03	<0.01	0.06	<1,000	–	–	<100	–	<100	<100	–	–
Solomon Islands	–	–	–	–	–	–	–	–	–	–	–	–
Somalia	0.17	0.18	0.13	24,000	2,500	1,400	1,800	<500	<200	1,700	<500	<100
South Africa	5.58	2.19	10.51	7,100,000	320,000	370,000	270,000	12,000	50,000	110,000	9,300	6,200
South Sudan	1.35	1.25	1.08	200,000	18,000	10,000	16,000	2,400	1,500	13,000	1,700	<500
Spain	0.09	<0.01	0.21	140,000	<100	1,200	3,900	<100	<500	–	–	–
Sri Lanka	0.03	<0.01	0.06	4,000	–	–	<1,000	–	<100	<200	–	–
State of Palestine	–	–	–	–	–	–	–	–	–	–	–	–
Sudan	0.13	0.10	0.26	56,000	3,000	3,800	5,000	<1,000	1,100	3,000	<500	<100
Suriname	0.62	0.17	1.35	4,900	<200	<500	<500	<100	<100	<200	<100	<100
Swaziland	9.37	4.50	11.91	220,000	15,000	15,000	8,800	<1,000	1,400	3,900	<1,000	<500
Sweden	0.06	<0.01	0.14	11,000	<100	<200	<1,000	<100	<100	<100	<100	<100
Switzerland	–	–	–	–	–	–	–	–	–	–	–	–
Syrian Arab Republic	–	–	–	–	–	–	–	–	–	–	–	–
Tajikistan	0.15	0.02	0.07	14,000	<500	<500	1,300	<100	<100	<1,000	<100	<100
Thailand	0.10	0.01	0.23	450,000	4,100	9,700	6,400	<100	<1,000	16,000	<100	<100
The former Yugoslav Republic of Macedonia	0.02	<0.01	0.03	<500	–	–	<100	–	<100	<100	–	–
Timor-Leste	–	–	–	–	–	–	–	–	–	–	–	–
Togo	0.59	0.65	0.49	100,000	12,000	7,600	4,100	<1,000	<500	5,100	<1,000	<500
Tokelau	–	–	–	–	–	–	–	–	–	–	–	–
Tonga	–	–	–	–	–	–	–	–	–	–	–	–

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
Trinidad and Tobago	0.29	0.05	0.60	11,000	<100	<500	<500	<100	<100	<500	<100	<100
Tunisia	0.03	0.01	0.06	2,900	-	-	<500	-	<100	<100	-	-
Turkey	-	-	-	-	-	-	-	-	-	-	-	-
Turkmenistan	-	-	-	-	-	-	-	-	-	-	-	-
Turks and Caicos Islands	-	-	-	-	-	-	-	-	-	-	-	-
Tuvalu	-	-	-	-	-	-	-	-	-	-	-	-
Uganda	1.50	0.69	2.55	1,400,000	130,000	120,000	52,000	4,600	10,000	28,000	5,800	3,800
Ukraine	0.38	0.17	0.57	240,000	4,000	5,100	17,000	<500	1,200	8,500	<200	<100
United Arab Emirates	-	-	-	-	-	-	-	-	-	-	-	-
United Kingdom	-	-	-	-	-	-	-	-	-	-	-	-
United Republic of Tanzania	1.19	1.28	1.04	1,400,000	110,000	98,000	55,000	10,000	5,500	33,000	6,500	3,200
United States	-	-	-	-	-	-	-	-	-	-	-	-
Uruguay	-	-	-	12,000	<100	<500	<1,000	<100	-	<500	<100	<100
Uzbekistan	-	-	-	-	-	-	-	-	-	-	-	-
Vanuatu	-	-	-	-	-	-	-	-	-	-	-	-
Venezuela (Bolivarian Republic of)	0.21	0.10	0.44	120,000	2,500	4,400	6,500	<500	1,200	2,500	<200	<100
Viet Nam	0.12	0.04	0.06	250,000	5,800	3,200	11,000	<500	<500	8,000	<200	<100
Yemen	0.04	0.02	0.08	9,900	<500	<1,000	1,100	<100	<500	<500	<100	<100
Zambia	4.08	3.28	6.46	1,200,000	94,000	95,000	59,000	8,900	11,000	21,000	5,700	2,300
Zimbabwe	3.03	1.36	3.50	1,300,000	-	-	40,000	-	5,800	30,000	-	-

COUNTRIES AND AREAS	HIV INCIDENCE PER 1,000 UNINFECTED POPULATION 2016			EPIDEMIOLOGY								
				PEOPLE LIVING WITH HIV 2016			NEW HIV INFECTIONS 2016			AIDS-RELATED DEATHS 2016		
	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19	All ages	Children <5	Adolescents 15–19	All ages	Children <15	Adolescents 10–19
SUMMARY												
East Asia and Pacific	0.07	0.03	0.11	2,800,000	48,000	60,000	160,000	5,100	15,000	100,000	3,000	<1,000
Europe and Central Asia	0.25	0.02	0.19	2,400,000	-	-	220,000	-	9900	49,000	-	-
Eastern Europe and Central Asia	0.47	0.03	0.28	1,600,000	-	-	190,000	-	7200	41,000	-	-
Western Europe	0.06	0.01	0.11	840,000	-	-	29,000	-	2700	8,400	-	-
Latin America and Caribbean	0.19	0.05	0.36	2,100,000	34,000	77,000	120,000	2,600	19,000	45,000	2,000	<1,000
Middle East and North Africa	0.03	0.01	0.04	150,000	3,000	4,000	11,000	<500	1,100	6,300	<200	<100
North America	-	0.01	0.24	-	-	-	-	-	-	-	-	-
South Asia	0.06	0.02	0.03	2,300,000	140,000	130,000	100,000	10,000	18,000	71,000	7,600	3,100
Sub-Saharan Africa	1.23	0.87	1.83	25,700,000	1,900,000	1,700,000	1,200,000	140,000	190,000	730,000	100,000	50,000
Eastern and Southern Africa	1.68	1.01	2.34	19,600,000	1,400,000	1,300,000	800,000	79,000	130,000	420,000	59,000	34,000
West and Central Africa	0.78	0.74	1.25	6,100,000	540,000	450,000	360,000	60,000	62,000	300,000	43,000	16,000
Least developed countries	0.54	0.46	0.70	10,800,000	980,000	800,000	490,000	69,000	68,000	320,000	52,000	27,000
World	0.26	0.29	0.55	36,700,000	2,100,000	2,100,000	1,800,000	160,000	260,000	1,000,000	120,000	55,000

For a complete list of countries and areas in the regions, subregions and country categories, visit data.unicef.org/regionalclassifications. It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages. Estimates from years prior to 2006 are not displayed.
p Based on small denominators (typically 25–49 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.
* Data refer to the most recent year available during the period specified in the column heading.

Definitions of the indicators:
HIV incidence per 1,000 uninfected population – Estimated number of new HIV infections per 1,000 uninfected population, 2016. Data reported for children (aged <5), adolescents (aged 15–19) and all ages.
People living with HIV – Estimated number of people living with HIV, 2016. Data reported for children (aged 0–14), adolescents (aged 10–19) and all ages.
New HIV infections – Estimated number of new HIV infections, 2016. Data reported for children (aged <5), adolescents (aged 15–19) and all ages.
AIDS-related deaths – Estimated number of AIDS-related deaths, 2016. Data reported for children (aged 0–14), adolescents (aged 10–19) and all ages.

Main data sources:
HIV incidence per 1,000 uninfected population – UNAIDS 2017 estimates, July 2017.
People living with HIV – UNAIDS 2017 estimates, July 2017.
New HIV infections – UNAIDS 2017 estimates, July 2017.
AIDS-related deaths – UNAIDS 2017 estimates, July 2017.

TABLE 10. HIV/AIDS (CON'T)

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011–2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011–2016*			
		All ages	Children <15	Adolescents 10–19	Male		Female		Male		Female	
Afghanistan	5	7	17	16	–		–		<0.1		1	
Albania	–	30	–	–	–		–		0	x	0	x
Algeria	49	76	>95	77	–		–		–		1	
Andorra	–	–	–	–	–		–		–		–	
Angola	44	22	14	–	39		31		4		16	
Anguilla	–	–	–	–	–		–		–		–	
Antigua and Barbuda	–	–	–	–	100	x	54	x	–		–	
Argentina	91	64	>95	–	–		–		–		–	
Armenia	–	36	–	–	–		–		0		1	
Australia	>95	90	93	–	–		–		–		–	
Austria	–	–	–	–	–		–		–		–	
Azerbaijan	75	30	76	36	–		–		–		–	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Bahamas	-	28	-	-	-		-		-		-	
Bahrain	-	42	-	-	-		-		-		-	
Bangladesh	17	16	39	23	-		-		-		-	
Barbados	-	46	-	-	-		-		-		10	
Belarus	92	45	>95	-	-		-		15		15	
Belgium	-	-	-	-	-		-		-		-	
Belize	35	32	64	-	-		-		-		14	
Benin	>95	57	32	-	43		38		6		7	
Bhutan	-	-	-	-	-		-		-		3	x
Bolivia (Plurinational State of)	68	25	43	40	43	x	-		1	x	-	
Bosnia and Herzegovina	-	-	-	-	-		-		<0.1		<0.1	
Botswana	>95	83	60	77	-		-		-		-	
Brazil	89	60	37	32	-		-		-		-	
British Virgin Islands	-	-	-	-	-		-		-		-	
Brunei Darussalam	-	-	-	-	-		-		-		-	
Bulgaria	-	26	-	-	-		-		-		-	
Burkina Faso	83	60	24	-	76	x,p	57	x,p	4	x	8	x
Burundi	84	61	25	-	-		-		8		13	
Cabo Verde	>95	57	65	40	-		-		-		-	
Cambodia	75	80	87	-	-		-		3		7	
Cameroon	74	37	18	-	70		52		7		15	
Canada	-	-	-	-	-		-		-		-	
Central African Republic	81	24	18	25	50	x	28	x	7	x	15	x
Chad	63	39	14	-	-		54		2		5	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Chile	38	53	35	7	–		–		–		–	
China	–	–	–	–	–		–		–		–	
Colombia	>95	–	–	–	–		45	x	–		8	x
Comoros	–	35	–	–	51	p	–		3		2	
Congo	16	23	25	–	56		46		4		8	
Cook Islands	–	–	–	–	–		–		–		–	
Costa Rica	65	49	80	–	–		59	p	–		9	
Côte d'Ivoire	73	41	25	–	70		32		5		10	
Croatia	–	70	–	–	–		–		–		–	
Cuba	63	70	24	9	–		79	p	16		19	
Cyprus	–	–	–	–	–		–		–		–	
Czechia	–	52	–	–	–		–		–		–	
Democratic People's Republic of Korea	–	–	–	–	–		–		–		–	
Democratic Republic of the Congo	70	42	30	–	17		12		1		5	
Denmark	–	–	–	–	–		–		–		–	
Djibouti	35	26	9	10	–		–		–		–	
Dominica	–	–	–	–	74	x	86	x	–		–	
Dominican Republic	83	46	45	30	–		40		–		11	
Ecuador	>95	52	>95	–	–		–		–		–	
Egypt	18	27	38	–	–		–		–		–	
El Salvador	44	48	50	–	–		31	p	8		8	
Equatorial Guinea	90	43	16	–	31		17		7		27	
Eritrea	37	59	34	–	–		–		–		–	
Estonia	–	–	–	–	–		–		–		–	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Ethiopia	69	59	35	-	57	p	-		9		12	
Fiji	-	32	-	-	-		-		-		-	
Finland	-	-	-	-	-		-		-		-	
France	>95	78	>95	-	-		-		-		-	
Gabon	76	63	39	61	77		58		6		20	
Gambia	69	30	33	-	-		-		2		6	
Georgia	46	32	50	62	-		-		-		2	x
Germany	-	-	-	-	-		-		-		-	
Ghana	56	34	15	-	-		22	p	1		5	
Greece	-	-	-	-	-		-		-		-	
Grenada	-	-	-	-	80	x	92	x	-		-	
Guatemala	19	36	42	25	66		38		2		5	
Guinea	43	35	18	-	46	p	30		1		3	
Guinea-Bissau	85	33	15	-	60		41		2		5	
Guyana	66	58	69	-	83	p	-		10		16	
Haiti	71	55	49	53	58		42		4		9	
Holy See	-	-	-	-	-		-		-		-	
Honduras	54	51	69	60	73		39		3		10	
Hungary	-	-	-	-	-		-		-		-	
Iceland	-	-	-	-	-		-		-		-	
India	41	49	33	-	39	x	-		0	x	1	x
Indonesia	14	13	21	-	-		-		-		-	
Iran (Islamic Republic of)	51	14	28	19	-		-		-		-	
Iraq	-	-	-	-	-		-		-		0	
Ireland	>95	77	>95	-	-		-		-		-	
Israel	-	-	-	-	-		-		-		-	
Italy	58	80	94	-	-		-		-		-	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Jamaica	>95	35	>95	-	75		56	p	20		35	
Japan	-	-	-	-	-		-		-		-	
Jordan	-	55	-	-	-		-		-		-	
Kazakhstan	87	31	89	>95	94	p	-		-		11	
Kenya	80	64	65	-	64		26		27		35	
Kiribati	-	-	-	-	29	x	-		-		-	
Kuwait	-	80	-	-	-		-		-		-	
Kyrgyzstan	-	28	88	>95	-		-		-		11	
Lao People's Democratic Republic	50	41	34	-	-		-		1		1	
Latvia	>95	26	93	-	-		-		-		-	
Lebanon	-	51	-	-	-		-		-		-	
Lesotho	66	53	-	-	80		58		25		41	
Liberia	70	19	11	-	22	p	27		4		13	
Libya	-	-	-	-	-		-		-		-	
Liechtenstein	-	-	-	-	-		-		-		-	
Lithuania	-	23	-	-	-		-		-		-	
Luxembourg	56	-	-	-	-		-		-		-	
Madagascar	3	5	2	52	5		6	p	1		2	
Malawi	84	66	49	-	59		44		22		32	
Malaysia	73	37	>95	71	-		-		-		-	
Maldives	-	-	-	-	-		-		-		-	
Mali	35	35	21	7	47		26		1		8	
Malta	-	75	-	-	-		-		-		-	
Marshall Islands	-	-	-	-	-		-		-		-	
Mauritania	34	23	23	15	-		-		-		-	
Mauritius	-	-	-	-	-		-		-		-	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Mexico	58	60	74	28	-		36	p	-		7	
Micronesia (Federated States of)	-	-	-	-	-		-		-		-	
Monaco	-	-	-	-	-		-		-		-	
Mongolia	-	33	-	-	78	p	-		-		-	
Montenegro	-	60	-	-	64	p	-		<0.1		0	
Montserrat	-	-	-	-	-		-		-		-	
Morocco	62	48	>95	-	-		-		-		-	
Mozambique	80	54	38	-	39		43	p	10		25	
Myanmar	87	55	78	-	-		-		2		1	
Namibia	>95	64	66	-	75		61		14		29	
Nauru	-	-	-	-	-		-		-		-	
Nepal	64	40	83	-	-		-		3		3	
Netherlands	>95	80	>95	-	-		-		-		-	
New Zealand	-	-	-	-	-		-		-		-	
Nicaragua	>95	43	71	33	-		-		-		-	
Niger	52	32	17	14	-		-		2		4	
Nigeria	32	30	21	-	46	p	38		2		4	
Niue	-	-	-	-	-		-		-		-	
Norway	-	-	-	-	-		-		-		-	
Oman	-	-	-	-	-		-		-		-	
Pakistan	4	7	10	85	-		-		-		-	
Palau	-	-	-	-	-		-		-		-	
Panama	-	54	-	-	-		-		-		-	
Papua New Guinea	33	52	37	-	-		-		-		-	
Paraguay	71	35	55	25	-		50	x	-		-	
Peru	85	60	73	15	-		20		-		-	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Philippines	12	32	10	3	-		-		-		<0.1	
Poland	-	-	-	-	-		-		-		-	
Portugal	-	-	-	-	-		-		-		-	
Qatar	-	86	-	-	-		-		-		-	
Republic of Korea	-	-	-	-	-		-		-		-	
Republic of Moldova	>95	29	83	55	-		-		6		10	
Romania	>95	68	>95	66	-		-		-		-	
Russian Federation	-	-	-	-	-		-		-		-	
Rwanda	82	80	55	-	-		-		22		27	
Saint Kitts and Nevis	-	-	-	-	54	x	50	x	-		-	
Saint Lucia	-	-	-	-	-		-		-		12	
Saint Vincent and the Grenadines	-	-	-	-	-		-		-		-	
Samoa	-	-	-	-	-		-		1	x	0	x
San Marino	-	-	-	-	-		-		-		-	
Sao Tome and Principe	-	-	-	-	79		-		8		22	
Saudi Arabia	39	60	48	>95	-		-		-		-	
Senegal	55	52	26	31	-		-		6		10	
Serbia	-	62	-	-	63	x	-		1	x	1	x
Seychelles	-	-	-	-	-		-		-		-	
Sierra Leone	87	26	18	-	24		10		3		11	
Singapore	-	-	-	-	-		-		-		-	
Slovakia	-	59	-	-	-		-		-		-	
Slovenia	-	-	-	-	-		-		-		-	
Solomon Islands	-	-	-	-	54	x,p	15	x,p	-		-	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Somalia	7	11	5	-	-		-		-		-	
South Africa	>95	56	55	-	88		-		29		38	
South Sudan	29	10	5	-	-		6	x,p	-		4	x
Spain	>95	77	>95	-	-		-		-		-	
Sri Lanka	-	27	-	-	-		-		-		-	
State of Palestine	-	-	-	-	-		-		-		-	
Sudan	4	10	16	-	-		-		-		-	
Suriname	89	48	81	36	-		86	x,p	-		11	x
Swaziland	95	79	64	91	-		-		30		41	
Sweden	>95	83	>95	-	-		-		-		-	
Switzerland	-	-	-	-	-		-		-		-	
Syrian Arab Republic	-	-	-	-	-		-		-		-	
Tajikistan	85	30	88	90	-		-		-		1	
Thailand	95	69	86	>95	-		-		4		6	
The former Yugoslav Republic of Macedonia	-	48	-	-	-		-		-		-	
Timor-Leste	-	-	-	-	-		-		-		-	
Togo	86	51	26	27	-		-		7		11	
Tokelau	-	-	-	-	-		-		-		-	
Tonga	-	-	-	-	-		-		2		0	
Trinidad and Tobago	95	62	>95	-	-		-		-		-	
Tunisia	-	29	-	-	-		-		-		<0.1	
Turkey	-	-	-	-	-		-		-		-	
Turkmenistan	-	-	-	-	-		-		-		5	
Turks and Caicos Islands	-	-	-	-	-		-		-		-	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011-2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011-2016*			
		All ages	Children <15	Adolescents 10-19	Male		Female		Male		Female	
Tuvalu	-	-	-	-	-		-		-		-	
Uganda	>95	67	47	-	52		26		28		39	
Ukraine	84	37	64	-	90		-		10		7	
United Arab Emirates	-	-	-	-	-		-		-		-	
United Kingdom	-	-	-	-	-		-		-		-	
United Republic of Tanzania	84	62	48	-	45		38		13		21	
United States	-	-	-	-	-		-		-		-	
Uruguay	83	53	>95	-	-		67	p	-		7	
Uzbekistan	-	-	-	-	-		-		-		-	
Vanuatu	-	-	-	-	-		-		-		-	
Venezuela (Bolivarian Republic of)	48	-	-	-	-		-		-		-	
Viet Nam	66	47	84	-	-		-		-		4	
Yemen	8	18	21	-	-		-		-		-	
Zambia	83	65	52	-	38		33		19		33	
Zimbabwe	93	75	-	-	71		-		19		30	
SUMMARY												
East Asia and Pacific	54	48	62	-	-		-		-		-	
Europe and Central Asia	-	46	-	-	-		-		-		-	
Eastern Europe and Central Asia	-	29	-	-	-		-		-		-	
Western Europe	-	77	-	-	-		-		-		-	
Latin America and Caribbean	75	57	53	-	-		-		-		-	

COUNTRIES AND AREAS	INTERVENTION COVERAGE											
	PREGNANT WOMEN RECEIVING ARVS FOR PMTCT (%) 2016*	PEOPLE LIVING WITH HIV RECEIVING ANTIRETROVIRAL THERAPY (ART) (%) 2016*			CONDOM USE AMONG ADOLESCENTS WITH MULTIPLE PARTNERS (%) 2011–2016*				ADOLESCENTS TESTED FOR HIV IN THE LAST 12 MONTHS AND RECEIVED RESULTS (%) 2011–2016*			
		All ages	Children <15	Adolescents 10–19	Male		Female		Male		Female	
Middle East and North Africa	37	33	62	-	-		-		-		-	
North America	-	-	-	-	-		-		-		-	
South Asia	38	46	33	-	-		-		-		-	
Sub-Saharan Africa	78	54	42	-	49		32		10		15	
Eastern and Southern Africa	88	60	51	-	54		-		16		24	
West and Central Africa	49	34	21	-	43		32		3		6	
Least developed countries	81	56	40	-	-		-		8		13	
World	76	53	43	-	-		-		-		-	

For a complete list of countries and areas in the regions, subregions and country categories, visit data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:

– Data not available.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages. Estimates from years prior to 2006 are not displayed.
p Based on small denominators (typically 25–49 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.
* Data refer to the most recent year available during the period specified in the column heading.

Definitions of the indicators:

Pregnant women receiving ARVs for PMTCT – Per cent of the estimated number of pregnant women living with HIV receiving effective regimens (excludes single-dose nevirapine) of antiretroviral medicines (ARVs) for preventing mother-tochild transmission (PMTCT) of HIV, 2016.
People living with HIV receiving ART – Per cent of the estimated number of people living with HIV receiving antiretroviral therapy (ART), 2016. Data reported for children (aged 0–14), adolescents (aged 10–19) and all ages.
Condom use among adolescents with multiple partners – Among adolescent males and females (aged 15–19) who reported having had more than one sexual partner in the last 12 months, the percentage who reported the use of a condom the last time they had sex with any partner, 2011–2016.
Adolescents tested for HIV in the last 12 months and received results – Percentage of adolescent boys and girls (aged 15–19) who were tested for HIV in the last 12 months and received the result of the most recent test, 2011–2016.

Main data sources:

Pregnant women receiving ARVs for PMTCT – UNAIDS 2017 estimates, July 2017.
People living with HIV receiving ART – UNAIDS 2017 estimates, July 2017.
Condom use among adolescents with multiple partners – UNICEF global databases based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS), and other national household surveys.
Adolescents tested for HIV in the last 12 months and received results – UNICEF global databases based on MICS, DHS, AIS, and other national household surveys.

TABLE 11. CHILD PROTECTION

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES									
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Afghanistan	29		34		24		9		35		42		-	-		-	72	y	80	y	74	y	75	y	74	y
Albania	5	y	6	y	4	y	0	x	10	x	99	x	-	-		-	36	x	30	x	77	x,y	81	x,y	73	x,y
Algeria	5	y	6	y	5	y	0		3		100		-	-		-	-		59	y	86	y	88	y	85	y
Andorra	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Angola	23		22		25		8		30		25		-	-		-	20		25		-		-		-	
Anguilla	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Antigua and Barbuda	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Argentina	4	y	5	y	4	y	-		-		100	y	-	-		-	-		2		72	y	74	y	71	y
Armenia	9	y	11	y	6	y	0		5		99		-	-		-	23		10		69		71		67	
Australia	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Austria	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Azerbaijan	7	x,y	8	x,y	5	x,y	2		11		94	x	-	-		-	-		28		77	x,y	80	x,y	74	x,y
Bahamas	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Bahrain	5	x,y	6	x,y	3	x,y	-		-		-		-	-		-	-		-		-		-		-	
Bangladesh	4	y	5	y	4	y	22		59		20		-	-		-	-		28	y	82		83		82	
Barbados	2	y	3	y	1	y	1		11		99		-	-		-	-		3		75	y	78	y	72	y
Belarus	1	y	1	y	2	y	0		3		100	y	-	-		-	4		4		65	y	67	y	62	y
Belgium	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Belize	3	y	5	y	1	y	3		26		96		-	-		-	5		5		65		67		63	
Benin	53		54		51		7		26		85		9	0		3	17		36		91		92		90	
Bhutan	3	y	3	y	3	y	6		26		100		-	-		-	-		68		-		-		-	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Bolivia (Plurinational State of)	26	x,y	28	x,y	24	x,y	3	x	22	x	76	x,y	–	–		–	–		16	x	–		–		–	
Bosnia and Herzegovina	5	x,y	7	x,y	4	x,y	0		4		100	x	–	–		–	6		5		55	y	60	y	50	y
Botswana	9	x,y	11	x,y	7	x,y	–		–		83	y	–	–		–	–		–		–		–		–	
Brazil	7	y	9	y	5	y	11	x	36	x	96		–	–		–	–		–		–		–		–	
British Virgin Islands	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Brunei Darussalam	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Bulgaria	–		–		–		–		–		100	y	–	–		–	–		–		–		–		–	
Burkina Faso	39	y	42	y	36	y	10		52		77		76	13		9	34		44		83	x,y	84	x,y	82	x,y
Burundi	26	y	26	y	27	y	3		20		75		–	–		–	44		73		–		–		–	
Cabo Verde	6	y	–		–		3	x	18	x	91		–	–		–	17	x,y	17	x,y	–		–		–	
Cambodia	19	y	20	y	19	y	2		19		73		–	–		–	27	y	50	y	–		–		–	
Cameroon	47		50		44		10		31		66		1	1	y	7	39		36		85		85		85	
Canada	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Central African Republic	29	y	27	y	30	y	29		68		61		24	1		11	75		80		92	y	92	y	92	y
Chad	52		51		52		30		67		12		38	10		29	51		74		71		72		71	
Chile	7	y	–		–		–		–		99	y	–	–		–	–		–		–		–		–	
China	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Colombia	8	y	10	y	5	y	5		23		99		–	–		–	–		–		–		–		–	
Comoros	22	y	20	y	24	y	10		32		87		–	–		–	17		39		–		–		–	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Congo	23		–		–		6		33		96		–	–		–	40		54		83		–		–	
Cook Islands	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Costa Rica	4	y	4	y	5	y	7		21		100	y	–	–		–	–		4		46	y	52	y	39	y
Côte d'Ivoire	26	y	25	y	28	y	10		33		65		38	10		14	42		48		91	x,y	91	x,y	91	x,y
Croatia	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Cuba	–		–		–		5		26		100		–	–		–	7	y	4	y	36		37		35	
Cyprus	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Czechia	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Democratic People's Republic of Korea	–		–		–		–		–		100	x	–	–		–	–		–		–		–		–	
Democratic Republic of the Congo	38		36		41		10		37		25		–	–		–	61		75		82		82		81	
Denmark	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Djibouti	8	x,y	8	x,y	8	x,y	2	x	5	x	92	x	93	49	y	37	–		–		72	x,y	73	x,y	71	x,y
Dominica	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Dominican Republic	13		17		9		12		36		88		–	–		–	–		2		63		64		61	
Ecuador	5	y	5	y	5	y	4	x	22	x	94		–	–		–	–		–		–		–		–	
Egypt	7		8		6		2		17		99		87	14	y	54	–		36	y	93		93		93	
El Salvador	9	y	13	y	5	y	6		26		99		–	–		–	–		8		52		55		50	
Equatorial Guinea	28	x,y	28	x,y	28	x,y	9		30		54		–	–		–	52		53		–		–		–	
Eritrea	–		–		–		13		41		–		83	33		12	45		51		–		–		–	
Estonia	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Ethiopia	27	y	31	y	24	y	14		40		3		65	16		18	28		63		–		–		–	
Fiji	–		–		–		–		–		–		–	–		–	–		–		72	x,y	–		–	
Finland	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
France	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Gabon	13	y	15	y	12	y	6		22		90		–	–		–	40		50		–		–		–	
Gambia	19	y	21	y	18	y	9		30		72		75	56		65	33		58		90	y	90	y	91	y
Georgia	4	y	6	y	2	y	1		14		100		–	–		–	–		7	x	67	x,y	70	x,y	63	x,y
Germany	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Ghana	22	y	23	y	21	y	5		21		71		4	1		2	13		28		94	y	94	y	94	y
Greece	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Grenada	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Guatemala	26	y	35	y	16	y	6		30		96	y	–	–		–	7		11		–		–		–	
Guinea	28	y	29	y	27	y	21		52		58		97	46		76	66		92		–		–		–	
Guinea-Bissau	51		50		53		6		24		24		45	30		13	29		42		82		83		82	
Guyana	18		20		17		4		30		89		–	–		–	10		10		70		74		65	
Haiti	24	y	25	y	24	y	3		18		80		–	–		–	15		17		85	y	85	y	84	y
Holy See	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Honduras	14	y	21	y	8	y	8		34		94		–	–		–	10		12		–		–		–	
Hungary	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Iceland	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
India	12	x,y	12	x,y	12	x,y	18	x	47	x	72		–	–		–	42	x	47	x	–		–		–	
Indonesia	7	x,y	8	x,y	6	x,y	1		14		73	y	–	49	y	–	18	y	35		–		–		–	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES									
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Iran (Islamic Republic of)	11	y	13	y	10	y	3		17		99	y	-	-		-	-		-		-		-		-	
Iraq	5	y	5	y	4	y	5		24		99		8	3	y	5	-		51		79	y	81	y	77	y
Ireland	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Israel	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Italy	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Jamaica	3	y	4	y	3	y	1		8		100		-	-		-	-		5		85	y	87	y	82	y
Japan	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Jordan	2	y	3	y	0	y	0		8		99		-	-		-	-		70	y	90	y	91	y	89	y
Kazakhstan	2	x,y	2	x,y	2	x,y	0		7		100		-	-		-	-		14		53		55		50	
Kenya	26	x,y	27	x,y	25	x,y	4		23		67		21	3		6	36		42		-		-		-	
Kiribati	-		-		-		3	x	20	x	94	x	-	-		-	60	x	76	x	81	x,y	-		-	
Kuwait	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Kyrgyzstan	26		30		22		1		12		98		-	-		-	-		33		57		60		54	
Lao People's Democratic Republic	10	y	9	y	11	y	9		35		75		-	-		-	49		58		76	y	77	y	74	y
Latvia	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Lebanon	2	x,y	3	x,y	1	x,y	1	x	6	x	100	x	-	-		-	-		10	x,y	82	x,y	82	x,y	82	x,y
Lesotho	23	x,y	25	x,y	21	x,y	1		17		43		-	-		-	40		33		-		-		-	
Liberia	21	x,y	21	x,y	21	x,y	9		36		25	y	50	-		39	24		43		90	x,y	90	x,y	90	x,y
Libya	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Liechtenstein	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Lithuania	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Luxembourg	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Madagascar	23	y	23	y	23	y	12		41		83		-	-		-	46	y	45		-		-		-	
Malawi	39		42		37		9		42		67		-	-		-	13		16		72		73		72	
Malaysia	-		-		-		-		-		-		-	-		-	-		-		71	y	74	y	67	y
Maldives	-		-		-		0	x	4	x	93	x	-	-		-	14	x,y	31	x,y	-		-		-	
Mali	56		59		52		17		52		87		83	76		75	51		73		73		73		73	
Malta	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Marshall Islands	-		-		-		6	x	26	x	96	x	-	-		-	58	x	56	x	-		-		-	
Mauritania	38		-		-		14		34		66		67	53		36	21	y	27	y	80		-		-	
Mauritius	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Mexico	12		16		9		4		26		95		-	-		-	-		5		63		63		63	
Micronesia (Federated States of)	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Monaco	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Mongolia	17		19		15		0		5		99		-	-		-	9	y	10		49		52		46	
Montenegro	13		15		10		1		5		99		-	-		-	5		3		69		73		66	
Montserrat	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Morocco	8	x,y	9	x,y	8	x,y	3	x	16	x	94	y	-	-		-	-		64	x	91	x,y	92	x,y	90	x,y
Mozambique	22	x,y	21	x,y	24	x,y	14		48		48		-	-		-	20		23		-		-		-	
Myanmar	9	y	10	y	9	y	2		16		81		-	-		-	49		51		77	y	80	y	75	y
Namibia	-		-		-		2		7		87	y	-	-		-	22		28		-		-		-	
Nauru	-		-		-		2	x	27	x	83	x	-	-		-	-		-		-		-		-	
Nepal	37		37		38		10		37		58		-	-		-	-		43		82		83		81	
Netherlands	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
New Zealand	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Nicaragua	15	x,y	18	x,y	11	x,y	10	x	41	x	85		–	–		–	–		14	x,y	–		–		–	
Niger	31	y	31	y	30	y	28		76		64		2	2	y	6	27		60		82	y	82	y	81	y
Nigeria	25	y	24	y	25	y	17		43		30	y	25	17		23	25		35		91	y	91	y	90	y
Niue	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Norway	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Oman	–		–		–		–		–		–		–	–		–	–		8		–		–		–	
Pakistan	–		–		–		3		21		34		–	–		–	32	y	42	y	–		–		–	
Palau	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Panama	3	y	4	y	1	y	7		26		96		–	–		–	–		6		45		47		43	
Papua New Guinea	–		–		–		2	x	21	x	–		–	–		–	–		–		–		–		–	
Paraguay	28	y	32	y	24	y	2	x	18	x	85	y	–	–		–	–		–		–		–		–	
Peru	22	y	24	y	19	y	3		22		98	y	–	–		–	–		–		–		–		–	
Philippines	11	y	14	y	8	y	2		15		90		–	–		–	–		13		–		–		–	
Poland	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Portugal	3	x,y	4	x,y	3	x,y	–		–		100	v	–	–		–	–		–		–		–		–	
Qatar	–		–		–		0		4		100	y	–	–		–	16		7		50	y	53	y	46	y
Republic of Korea	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Republic of Moldova	16	x,y	20	x,y	12	x,y	0		12		100		–	–		–	13		11		76	y	77	y	74	y
Romania	1	x,y	1	x,y	1	x,y	–		–		–		–	–		–	–		–		–		–		–	
Russian Federation	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Rwanda	29	y	27	y	30	y	0		7		56		-	-		-	18		41		-		-		-	
Saint Kitts and Nevis	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Saint Lucia	4	y	5	y	3	y	1		8		92		-	-		-	-		7		68	y	71	y	64	y
Saint Vincent and the Grenadines	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Samoa	-		-		-		1		11		59		-	-		-	30		37		-		-		-	
San Marino	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Sao Tome and Principe	26		25		28		8		35		95		-	-		-	14		19		80		80		79	
Saudi Arabia	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Senegal	23		29		17		9		31		68		24	15		19	25		57		-		-		-	
Serbia	10		12		7		0		3		99		-	-		-	-		4		43		44		42	
Seychelles	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Sierra Leone	37	y	38	y	37	y	13		39		77		90	31	y	69	34		63		82	y	81	y	82	y
Singapore	-		-		-		-		-		-		-	-		-	-		-		-		-		-	
Slovakia	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Slovenia	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Solomon Islands	48	y	47	y	49	y	6		21		88		-	-		-	57		77		86	y	86	y	85	y
Somalia	49	x,y	45	x,y	54	x,y	8	x	45	x	3	x	98	46	y	65	-		76	x,y	-		-		-	
South Africa	-		-		-		1	x	6	x	85	y	-	-		-	-		-		-		-		-	
South Sudan	-		-		-		9		52		35		-	-		-	-		79		-		-		-	
Spain	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Sri Lanka	1	y	1	y	1	y	2	x	12	x	97	x	–	–		–	–		53	x,y	–		–		–	
State of Palestine	6	y	7	y	4	y	1		15		99		–	–		–	–		–		92		93		92	
Sudan	25		28		22		12		34		67		87	32		41	–		34		64		65		63	
Suriname	4	y	4	y	4	y	5		19		99		–	–		–	–		13		86	y	87	y	85	y
Swaziland	7	y	8	y	7	y	1		5		54		–	–		–	17		20		88		89		88	
Sweden	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Switzerland	–		–		–		–		–		100	v	–	–		–	–		–		–		–		–	
Syrian Arab Republic	4	x,y	5	x,y	3	x,y	3	x	13	x	96	x	–	–		–	–		–		89	x,y	90	x,y	88	x,y
Tajikistan	10	x,y	9	x,y	11	x,y	0		12		88		–	–		–	–		60		78	x,y	80	x,y	75	x,y
Thailand	8	x,y	8	x,y	8	x,y	4		23		100	y	–	–		–	9		9		75		77		73	
The former Yugoslav Republic of Macedonia	13	y	12	y	13	y	1		7		100		–	–		–	–		15		69	y	71	y	67	y
Timor-Leste	4	x,y	4	x,y	4	x,y	3		19		55		–	–		–	81		86		–		–		–	
Togo	28		29		27		6		22		78		5	0		1	18		29		81		81		80	
Tokelau	–		–		–		–		–		–		–	–		–	–		–		–		–		–	
Tonga	–		–		–		0		6		93		–	–		–	21		29		–		–		–	
Trinidad and Tobago	1	x,y	1	x,y	1	x,y	2	x	8	x	97	x	–	–		–	–		8	x	77	x,y	78	x,y	77	x,y
Tunisia	2	y	3	y	2	y	0		2		99		–	–		–	–		30		93	y	94	y	92	y
Turkey	6	y	8	y	4	y	1		15		99	y	–	–		–	–		13		–		–		–	
Turkmenistan	0		1		0		0		6		100		–	–		–	–		26		37	y	39	y	34	y
Turks and Caicos Islands	–		–		–		–		–		–		–	–		–	–		–		–		–		–	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010-16*						CHILD MARRIAGE (%) 2010-16*				BIRTH REGISTRATION (%)++ 2010-16*		FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*				JUSTIFICATION OF WIFE-BEATING (%) 2010-16*				VIOLENT DISCIPLINE (%)+ 2010-16*					
													PREVALENCE			ATTITUDES										
	Total		Male		Female		Married by 15		Married by 18		Total		Women[a]	Girls[b]		Support for the practice[c]	Male		Female		Total		Male		Female	
Tuvalu	-		-		-		0	x	10	x	50	x	-	-		-	73	x	70	x	-		-		-	
Uganda	16	y	17	y	16	y	10		40		30		1	1		9	44		58		-		-		-	
Ukraine	2	y	3	y	2	y	0		9		100		-	-		-	9		3		61	y	68	y	55	y
United Arab Emirates	-		-		-		-		-		100	y	-	-		-	-		-		-		-		-	
United Kingdom	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
United Republic of Tanzania	29	y	29	y	28	y	5		31		26		10	0		3	40		58		-		-		-	
United States	-		-		-		-		-		100	v	-	-		-	-		-		-		-		-	
Uruguay	8	x,y	8	x,y	8	x,y	1		25		100		-	-		-	-		2		55	y	58	y	51	y
Uzbekistan	-		-		-		0	x	7	x	100	x	-	-		-	61	x	70	x	-		-		-	
Vanuatu	15	y	15	y	16	y	3		21		43	y	-	-		-	60		60		84	y	83	y	84	y
Venezuela (Bolivarian Republic of)	8	x,y	9	x,y	6	x,y	-		-		81	y	-	-		-	-		-		-		-		-	
Viet Nam	16		17		16		1		11		96		-	-		-	-		28		68		72		65	
Yemen	23	x,y	21	x,y	24	x,y	9		32		31		19	16	y	19	-		49		79	y	81	y	77	y
Zambia	41	x,y	42	x,y	40	x,y	6		31		11		-	-		-	32		47		-		-		-	
Zimbabwe	-		-		-		4		32		44		-	-		-	33		39		63		63		62	
SUMMARY																										
East Asia and Pacific	-		-		-		2	**	15	**	84	**	-	-		-	-		29	**	-		-		-	
Europe and Central Asia	-		-		-		-		-		99		-	-		-	-		-		-		-		-	

COUNTRIES AND AREAS	CHILD LABOUR (%)+ 2010–16*			CHILD MARRIAGE (%) 2010–16*		BIRTH REGISTRATION (%)++ 2010–16*	FEMALE GENITAL MUTILATION/ CUTTING (%)+ 2004-16*			JUSTIFICATION OF WIFE-BEATING (%) 2010–16*		VIOLENT DISCIPLINE (%)+ 2010–16*		
							PREVALENCE		ATTITUDES					
	Total	Male	Female	Married by 15	Married by 18	Total	Women[a]	Girls[b]	Support for the practice[c]	Male	Female	Total	Male	Female
Eastern Europe and Central Asia	–		–		–	1	11	99	–	–	–	–	14	–	–	–
Western Europe	–		–		–	–	–	100	–	–	–	–	–	–	–	–
Latin America and Caribbean	11		13		8	–	–	95	–	–	–	–	–	–	–	–
Middle East and North Africa	7		8		6	3	17	92	–	–	–	–	45	87	88	86
North America	–		–		–	–	–	100	–	–	–	–	–	–	–	–
South Asia	–		–		–	–	–	60	–	–	–	–	–	–	–	–
Sub-Saharan Africa	29		30		29	12	38	43	37	15	20	34	48	–	–	–
Eastern and Southern Africa	26		27		24	9	35	41	45	12	17	32	48	–	–	–
West and Central Africa	32		32		32	14	41	45	31	17	23	35	48	86	87	86
Least developed countries	26		26		24	12	40	40	–	–	–	39	49	79	79	78
World	–		–		–	6	** 25	** 71	** –	–	–	–	–	–	–	–

For a complete list of countries and areas in the regions, subregions and country categories, visit data.unicef.org/regionalclassifications.
It is not advisable to compare data from consecutive editions of The State of the World's Children.

Notes:
– Data not available.
v Estimates of 100% were assumed given that civil registration systems in these countries are complete and all vital events (including births) are registered. Source: United Nations, Department of Economic and Social Affairs, Statistics Division, Population and Vital Statistics Report, Series A Vol. LXV, New York, 2013.
x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages.

y Data differ from the standard definition or refer to only part of a country. If they fall within the noted reference period, such data are included in the calculation of regional and global averages.
+ A more detailed explanation of the methodology and the changes in calculating these estimates can be found in the General Note on the Data within The State of the World's Children 2017 report.
++ Changes in the definition of birth registration were made from the second and third rounds of MICS (MICS2 and MICS3) to the fourth round (MICS4). In order to allow for comparability with later rounds, data from MICS2 and MICS3 on birth registration were recalculated according to the MICS4 indicator definition. Therefore, the recalculated data presented here may differ from estimates included in MICS2 and MICS3 national reports.
* Data refer to the most recent year available during the period specified in the column heading.
** Excludes China.
Italicised data are from different sources than the data presented for the same indicators in other tables of the report.

Definitions of the indicators:
Child labour – Percentage of children 5–17 years old involved in child labour at the moment of the survey. A child is considered to be involved in child labour under the following conditions: (a) children 5–11 years old who, during the reference week, did at least one hour of economic activity or at least 28 hours of household chores, (b) children 12–14 years old who, during the reference week, did at least 14 hours of economic activity or at least 28 hours of household chores, (c) children 15–17 years old who, during the reference week, did at least 43 hours of economic activity or household chores, and (d) children aged 5–17 years old in hazardous working conditions.
Child marriage – Percentage of women 20–24 years old who were first married or in union before they were 15 years old and percentage of women 20–24 years old who were first married or in union before they were 18 years old.
Birth registration – Percentage of children under age 5 who were registered at the moment of the survey. The numerator of this indicator includes children reported to have a birth certificate, regardless of whether or not it was seen by the interviewer, and those without a birth certificate whose mother or caregiver says the birth has been registered.
Female genital mutilation/cutting (FGM/C) – (a) Women: percentage of women 15–49 years old who have undergone FGM/C; (b) girls: percentage of girls 0–14 years old who have undergone FGM/C (as reported by their mothers); (c) support for the practice: percentage of women 15–49 years old who have heard about FGM/C and think the practice should continue.
Justification of wife-beating – Percentage of women and men 15–49 years old who consider a husband to be justified in hitting or beating his wife for at least one of the specified reasons, i.e., if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations.
Violent discipline – Percentage of children 1–14 years old who experience any violent discipline (psychological aggression and/or physical punishment).

Main data sources:
Child labour – Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys.
Child marriage – DHS, MICS and other national surveys.
Birth registration – DHS, MICS, other national surveys, censuses and vital registration systems.
Female genital mutilation/cutting – DHS, MICS and other national surveys.
Justification of wife-beating – DHS, MICS and other national surveys.
Violent discipline – DHS, MICS and other national surveys.

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