**POLICY BRIEF ON SDG 3**

**Ensure healthy lives and promote wellbeing for all at all ages Implementation for persons with disabilities**

**The right to the highest attainable standard of physical and mental health is a fundamental human right, indispensable for the exercise of other human rights.[[1]](#endnote-1) Persons with disabilities are more likely to have health needs, but much less likely to receive health services.**

The UN Convention on the Rights of Persons with Disabilities, ratified by 173 countries, defines 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.”* Article 25 of the Convention on the Rights of Persons with Disabilities reinforces the rights of persons with disabilities to enjoy the highest standard of health without discrimination on the basis of disability[[2]](#endnote-2), as well as continuation of services in the event of disasters or other emergencies.

**Disability and Goal 3.**

Goal 3 of the SDGs pertains to health and wellbeing and contains 9 targets. No target will be reached without considering the needs of persons with disabilities. Pertaining to each target: pregnant women with disabilities may have much less access to prenatal, labour and delivery and post-natal services (target 1)[[3]](#endnote-3); infant mortality amongst children with disabilities is higher (target 2) [[4]](#endnote-4); persons with disabilities may have higher rates of HIV (target 3)[[5]](#endnote-5); 80% of all years lived with disability are caused by NCDs (target 4)[[6]](#endnote-6); persons with disabilities may exhibit higher health risk behaviours (target 5)[[7]](#endnote-7); in addition to the estimated 1.25 million road deaths each year, there are 50 million injuries leading to temporary or permanent impairments and disabilities (target 6)[[8]](#endnote-8); Women with disabilities are less likely to access sexual and reproductive health (target 7)[[9]](#endnote-9); persons with disabilities are less likely to access health services or experience discrimination from health care providers (target 8) [[10]](#endnote-10); and persons with disabilities may be more vulnerable to hazardous pollution and contamination (target 9)[[11]](#endnote-11). Despite clear evidence that we are moving towards a society where for the first time global health impacts are more relating to disability than death, this is poorly reflected within the Goal 3 indicators.

**Accelerating Progress to achieve Universal Health Coverage for all persons with disabilities**

Of all the targets, however, Universal health coverage (UHC) is the most powerful tool to address this gap, achieve equity and leave no one behind. If fully implemented, “*all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship*.[[12]](#endnote-12)

**Remove barriers for persons with disabilities to access health services**

Persons with disabilities encounter communication, informational, attitudinal and physical barriers to achieving the highest attainable standard of health, and face additional barriers in accessing healthcare services compared to persons without disabilities.[[13]](#endnote-13) Other barriers include lack of disability awareness among health workers, which can lead to persons with disabilities being denied health care and other health services.

Health systems and all its six building blocks must be strengthened so that quality essential healthcare services are inclusive of and accessible to persons with disabilities. Furthermore, the Committee on Economic, Social and Cultural Rights has recommended that health facilities, goods and services be located within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as persons with disabilities.[[14]](#endnote-14) Health facilities must be gender sensitive, scientifically and medically appropriate, of good quality and respectful of medical ethics, including autonomy and non-discrimination. Ensuring access to healthcare services, including rehabilitation, contributes towards the empowerment of persons with disability fully participating and contributing within society.

**Ensure participation and inclusion of persons with disabilities in health systems development**

The full participation of affected communities in the development, implementation and monitoring of policy has a positive impact on health outcomes and on the realization of their human rights. Ensuring their participation supports the development of responses that are relevant to the context and ensures that policies are effective.[[15]](#endnote-15) The meaningful participation of persons with disabilities during all stages of planning and implementation is envisaged in article 4 (3) of the Convention on the Rights of Persons with Disabilities and recommended by the Committee on Economic, Social and Cultural Rights in its general comment No. 14 (para. 54).

**Eliminate the financial burden and discriminatory practices in health financing**

Of all persons with disabilities, half cannot afford required health care; people with disabilities are also 50% more likely than those without disability to suffer catastrophic health expenditures.[[16]](#endnote-16) Furthermore, a major review by the London School of Hygiene and Tropical Medicine highlighted the significant economic costs of excluding persons with disabilities, and the gains of inclusion.[[17]](#endnote-17) Existing health financing and social protection systems frequently fail to protect persons with disabilities and their families from financial risks associated with using available health services. Public health financing and health insurances must be fully inclusive of persons with disabilities and any discrimination on the basis of disability by private health insurance companies must be prohibited.

**Strengthen rehabilitation services and access to assistive devices**

Disability inclusion and rehabilitation services are broadly overlooked in global health planning and budgets. For example, despite its clear disabling consequences, the Global Polio Eradication Initiative contains no specific budget for meeting the needs of people who have impairments caused by polio.[[18]](#endnote-18) A recent systematic review suggested that rehabilitation services may well be cost effective for many health conditions.[[19]](#endnote-19) Health and Social policies need to ensure continuous access to rehabilitation and the provision of well designed, easily usable and affordable assistive devices in a timely manner.

**Scale up in non-discriminatory mental health services**

Mental health and wellbeing are essential to society as a whole in which ­all people are able to realize their own abilities, enjoy personal freedoms and have the ability to shape and lead, on one’s own terms, a fulfilling life. Achieving mental health and wellbeing for all does not concern only, nor particularly, persons with disabilities.

The quantity and quality of mental health services need to be improved within a legal and policy environment that is conducive to the realization of the human rights of persons with disabilities, including those with mental health conditions, psychosocial disabilities and intellectual disabilities. Involuntary treatment and forced institutionalization must be put to an end, equally any mental health policies which lead to discrimination, stigmatization and exclusion against persons with disabilities.

**Collect data and evidence on access to health by persons with disabilities and their reach by UHC systems**

Data in Health Information Systems need to be increasingly disaggregated by disability. Indicators to measure progress towards Universal Health Coverage need to be able to show the level of access to health services by persons with disabilities (compared to the general population), and the availability of quality rehabilitation services. Further qualitative evidence on accessibility of and inclusion in health systems needs to be created.

1. Committee on Economic Social and Cultural Rights, General Comment No. 14 (2000). The Right to the Highest Attainable Standard of Health (Art. 12), para. 1. [↑](#endnote-ref-1)
2. UN (2006) Convention on the Rights of Persons with Disabilities <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf> [↑](#endnote-ref-2)
3. WHO/UNFPA (2009) Promoting sexual and reproductive health for persons with disabilitieshttps://www.unfpa.org/sites/default/files/pub-pdf/srh\_for\_disabilities.pdf [↑](#endnote-ref-3)
4. UNICEF (2013) Children and Young People with Disabilities: Fact Sheet <http://www.unicef.org/disabilities/files/Factsheet_A5__Web_NEW.pdf> [↑](#endnote-ref-4)
5. De Beaudrap, P. et al (2014) Disability and HIV: a systematic review and a meta-analysis of the risk of HIV infection among adults with disabilities in Sub-Saharan Africa,[*,*](https://www.ncbi.nlm.nih.gov/pubmed/25033274)  26(12):1467-76

   <https://www.ncbi.nlm.nih.gov/pubmed/25033274> [↑](#endnote-ref-5)
6. IHME/Universoty of Washington (2017) GBD Compare: data from 2015 Global Burden of Disease report, available at https://vizhub.healthdata.org/gbd-compare/ [↑](#endnote-ref-6)
7. World Bank/WHO (2011) World Report on Disability <http://www.who.int/disabilities/world_report/2011/report/en/> [↑](#endnote-ref-7)
8. WHO (2015) Global status report on road safety http://www.who.int/violence\_injury\_prevention/road\_safety\_status/2015/en/ [↑](#endnote-ref-8)
9. Women Enabled International. (2016). Women Enabled International Submission to OHCHR: *Protection of the Rights of the Child and 2030 Agenda for Sustainable Development*. [↑](#endnote-ref-9)
10. World Bank/WHO (2011) World Report on Disability <http://www.who.int/disabilities/world_report/2011/report/en/> [↑](#endnote-ref-10)
11. https://www.cbm.org/article/downloads/54741/Disability\_and\_Climate\_Change.pdf [↑](#endnote-ref-11)
12. <http://www.who.int/health_financing/universal_coverage_definition/en/> [↑](#endnote-ref-12)
13. CBM (2015). Dialogues on Sustainable Development: A Disability-inclusive Perspective. [↑](#endnote-ref-13)
14. See general comment No. 14, para. 12 (b). [↑](#endnote-ref-14)
15. See Joint United Nations Programme on HIV/AIDS, “Non-discrimination in HIV responses” (June 2010), paras. 18-22. [↑](#endnote-ref-15)
16. WHO (2014) WHO Global Disability Action Plan 2014-2021 <http://www.who.int/disabilities/actionplan/en/> [↑](#endnote-ref-16)
17. Banks, L, M. and Polack, S. (2014) The Economic Costs of Exclusion and Gains of Inclusion of People with Disabilities <http://disabilitycentre.lshtm.ac.uk/new-report-economic-costs-exclusion-gains-inclusion-people-disabilities/> [↑](#endnote-ref-17)
18. GPEI (2016) FINANCIAL RESOURCE REQUIREMENTS http://polioeradication.org/wp-content/uploads/2016/10/FRR2013-2019\_April2016\_EN\_A4.pdf#page=23 [↑](#endnote-ref-18)
19. Howard-Wilshire et al (2015) Systematic overview of economic evaluations of health-related rehabilitation <https://www.ncbi.nlm.nih.gov/pubmed/26440556> [↑](#endnote-ref-19)