



**Feminists with Disabilities Joint Submission to the
Working Group on discrimination against women and girls:
Women's and girls' sexual and reproductive health and rights in situations of crisis**

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I. Introduction

Women Enabled International (WEI), My Life My Choice (U.K.), CIMUNIDIS (Chile), Shanta Memorial Rehabilitation Centre (India), Women with Disabilities India Network, HYPE Sri Lanka, and Disabled Women in Africa (Malawi) appreciate the opportunity to provide the Working Group on discrimination against women and girls (WGDAG) with information on women and girls' sexual and reproductive health and rights (SRHR) in situations of crisis.

This submission presents an overview of how women, girls, and gender non-conforming persons¹ with disabilities are being affected by the most significant health crisis of our time, the COVID-19 pandemic. Not only is the world still facing the threat of the disease itself, but it is also dealing with the negative impact that the pandemic and the response to the pandemic have had on social, economic, and health matters.

This submission focuses particularly on the barriers women with disabilities face to exercising their SRHR globally, which have been considerably overlooked during this crisis. This includes increased barriers to accessing healthcare services, family planning, safe abortion services, birth control methods, maternal healthcare, and information, as well as an escalation of gender-based violence. Many factors contribute to this, such as States not prioritizing SRHR, isolation due to lockdowns and quarantines, the lack of accessible services and support persons, the risk of COVID-19 infection, and not mainstreaming gender and disability into all COVID-19 related policies. States have also failed to ensure the social determinants of sexual and reproductive health (SRH), both prior to and during this crisis, for women with disabilities, which means that women with disabilities have not been able to meet their basic needs, get the disability-related health and support services they need, as well as non-disability related healthcare, or access employment and education on an equal basis with others.

WEI, in conjunction with the U.N. Population Fund (UNFPA) and 7 women-led organizations of persons with disabilities around the world², have conducted a global human rights study with women, girls, and gender non-conforming persons with disabilities to better understand how the pandemic has impacted their lived experiences. The purpose of this ongoing study, commenced in September 2020, is to address a gap in the global response to COVID-19, in which many actors discussed how to include women or persons with disabilities in the response but few were considering the unique experiences of women with disabilities and others living at the intersection of gender and disability. To this end, the study includes 19 virtual consultations with nearly 150 women, girls, and non-conforming persons with disabilities focused on SRHR and the social determinants of SRHR during the pandemic, including access to information, testing, and treatment related to COVID-19; access to healthcare more broadly; meeting basic needs; freedom from gender-based violence; and employment and education (Virtual Consultations). Furthermore, in March and April 2020, WEI conducted a survey of women, girls, and gender non-conforming persons with disabilities about issues impacting them during the crisis (WEI Survey).

This submission is based on the findings of this work and begins with a summary of those findings, including the forthcoming findings of the Virtual Consultations. This submission will also provide a summary of human rights standards surrounding the guarantee of SRHR for women with disabilities, as well as examples of good practices implemented in some States and will conclude with recommendations that we hope will help inform WGDAW's forthcoming report.

II. The SRHR-related impact of COVID-19 on women, girls and gender non-conforming persons with disabilities

Women with disabilities make up almost one-fifth of the world's population of women,³ and they are just as likely to be sexually active as their peers without disabilities,⁴ despite inaccurate stereotypical views to the contrary. Hence, they have the same SRH needs as any other women. Due to multiple and intersecting forms of discrimination on the basis of gender and disability, however, women with disabilities face unique and pervasive barriers to the full realization of their SRHR, even outside of times of crisis. For instance, students with disabilities are often excluded from sexuality education programs due to assumptions that this information is unnecessary for them. When they receive information about SRH, it is frequently not presented in accessible formats or mediums⁵ or is not inclusive of disability. Accessing SRH care is also more challenging for women with disabilities, as the equipment and facilities in sexual and reproductive healthcare settings may not be accessible (physically, but also in terms of inaccessible communications), and healthcare providers may demonstrate a lack of sensitivity, courtesy, and support for them. Also, women with disabilities may face financial, social, and psychological barriers to accessing adequate reproductive healthcare,⁶ and the stigma around disability often means that healthcare providers and others may perceive them as being asexual or infantilized women who would be unable to make decisions for themselves or who do not need SRH, or as people who cannot be good parents.⁷ This is especially true for women who are denied full legal capacity, either formally or informally, whose decisions are frequently substituted by legal representatives or family members,⁸ including many women with intellectual or psychosocial disabilities.

SRHR for women in general can be heavily impacted by health emergencies. For instance, throughout the Zika crisis, women faced significant barriers to healthcare due to a lack of autonomy over their own SRH, inadequate access to health services⁹ and insufficient financial resources to travel to hospitals.¹⁰ During the COVID-19 pandemic so far, women around the world have also experienced a reduction in SRH services and medications, the cancellation of family planning services, increased barriers to accessing safe abortion, lack of accessibility, and negative changes in prenatal care and labor protocols, as described in greater detail below.

During times of crisis, when all women are facing increased barriers to SRHR, the barriers for women with disabilities are compounded due to both their gender and disability status.¹¹ Indeed, during the COVID-19 crisis, women with disabilities have reported disproportionately increased barriers to accessing a range of SRH information, goods, and services, as outlined below.

Women with disabilities have reported significant barriers to accessing **SRH appointments** during the COVID-19 pandemic. The crisis has affected elective and non-essential healthcare, and, in many countries, SRH has been designated as non-essential. On other occasions, this type of health services has been moved to virtual means, such as telehealth, which are not always accessible to them. Consequently, women with disabilities lacked attention for SRH services in general. For instance:

- For many WEI Survey respondents, online health services have not been an adequate substitute, because they did not have the needed technology, or it was not fully accessible. In many cases, there was no sign language interpretation during the appointments and the information about how to join and online appointment was not provided in easy read formats. Other participants doubted the quality of care or they were afraid their insurance would not cover it.¹²
- A Virtual Consultation participant from **Zambia** reported she had been diagnosed with an ovarian cyst and the surgery would be performed in April. Due to the COVID-19 crisis, however, the gynecological facility was closed and she could not see the doctor anymore, even though she needed medical care.
- A Virtual Consultation participant from **India** affirmed that accessing a gynecologist has been challenging and rarely available, and there is not enough affordable accessible public transport to get to the hospital. In **Sri Lanka**, transportation was only provided to go to the hospital, leaving women with disabilities with no means of transportation to go back home.

- Another Virtual Consultation participant from **India** shared that, when she went to a gynecological appointment, the hospital staff was afraid she would bring in the virus, as it is difficult to sanitize her wheelchair constantly. Due to this attitude, she decided not to continue her treatment for a serious gynecological condition during the pandemic.

Similar barriers were faced by women with disabilities attending **prenatal, labor, and delivery services** during the COVID-19 pandemic. Lack of accessible prenatal, labor and delivery services for pregnant persons with disabilities during this time had a profound impact. On this subject:

- In **Sri Lanka**, a speech impaired young woman reported that she experienced a miscarriage during her third month of pregnancy because she could not access needed prenatal services during the pandemic.
- A pregnant woman with a disability from **Bangladesh** reported that she had to shift doctors several times during the pandemic because they did not pay much attention to her, dispensing with measuring her blood pressure and other procedures.
- In **India**, the commandeering of public health facilities for COVID-19 treatment in some areas has also meant that pregnant persons, particularly those with complications, cannot rely on these facilities for labor and delivery services, leading distressingly in some cases to maternal mortality¹³.
- One WEI survey respondent with chronic illness who was nine weeks pregnant was experiencing nausea and migraines and reported being worried about her health. “I cannot visit my acupuncturist for the nausea. My pregnancy related care is usually on the telephone instead of in person, except for the ultrasounds.”¹⁴.

Indeed, in order to prevent the spread of COVID-19, some hospitals have adopted policies that disallowed any support persons, including partners, from accompanying a pregnant person during labor, delivery, and the postpartum period.¹⁵ These policies did not consider exceptions for pregnant persons with disabilities, even though they may need support persons simply to communicate with healthcare personnel or to get assistance meeting personal hygiene needs.

- In **Sri Lanka**, pregnant women with disabilities could not bring sign language interpreters or other support people to the hospital with them, including during childbirth, due to COVID-19 contamination policies in the country. At the same time, hearing and speech impaired women who were hospitalized for childbirth during the lockdown could not use the phone call interpretation services offered by the hospital, as there were not sufficient trained staff on duty during this time period to support this call service. This meant that these women faced significant barriers to communicating with their healthcare providers during an already difficult and stressful time.
- A woman with a visual impairment in **Malawi** shared that being pregnant during the pandemic was very challenging, hospital protocols for care and appointments had changed, which was disrupting. Also, she felt frightened about COVID-19 when going into the hospital to deliver, including without a support person due to hospital regulations.

Furthermore, women with disabilities reported significant barriers to **accessing contraceptives and family planning information, goods, and services**, which in some contexts have formally or informally been deemed non-essential during the crisis. For example:

- In **Malawi**, Virtual Consultation participants shared that most family planning clinics were closed to prevent the spread of the virus. Women living in rural areas could not access any SRH services because health workers, who visited rural communities to provide this type of care, stopped doing so due to the pandemic.
- In **Sri Lanka**, a Virtual Consultation participant shared that local villages ran out of contraceptives and feminine hygiene products, requiring women to travel to other places to access these goods, which can be particularly complicated for women with disabilities.
- A Virtual Consultation participant with a physical disability from **Panama** reported difficulty accessing emergency contraception: “I tried accessing the day after pill, and four out of five pharmacies asked me for a prescription (...) and I was wondering why they did that. And none of the pharmacies [we] went to were accessible. As a woman with a disability, it is impossible to get a safe emergency contraception method [during the COVID-19 pandemic].”
- A Virtual Consultation participant with multiple sclerosis and learning disabilities from the **United Kingdom** reported that she used to take the pills as a contraceptive method and decided to talk to her doctor about using it again. The doctor was not available to talk when she called and said he would call back but did not, leaving her with no answer.

- A Virtual Consultation participant with a visual disability from **Argentina** further reported that the system for delivering contraceptives had changed: “It seems like there are no campaigns providing free contraception and condoms anymore. It is all about coronavirus.”

Menstrual hygiene has also been a major challenge for women with disabilities during the COVID-19 pandemic, impacting the lives of those who menstruate by restricting mobility, freedom, and choices; reducing participation in school, work, and community life; compromising safety; and causing stress and anxiety.¹⁶ Additionally, women with disabilities face unique challenges with regard to the management of menstrual hygiene, including outside of crisis situations. The absence of appropriate sanitation facilities, including separate, accessible, and sheltered toilets, in addition to the lack of education, resources, and support for menstrual hygiene, compromise their ability to properly manage their hygiene.¹⁷

- A Virtual Consultation participant from **India** reported that there have been difficulties to access sanitary pads and other hygiene products during the lockdown, which has impacted sexual health tremendously.
- In **Sri Lanka**, Virtual Consultation participants reported that sanitary pads were scarce and women with disabilities did not know whom to contact to purchase them.
- A Virtual Consultation participant from **Nepal** shared that “due to the taboo with menstruation, having the period during lockdown increased isolation and discrimination, as they [women with disabilities] cannot talk to family members or enter in the kitchen while having their period. It has affected their mental health and increases depression.”

Moreover, as the barriers to accessing SRH have contributed to increasing unplanned and unwanted pregnancies, in contexts where access to **safe abortion** is restricted, more women may resort to unsafe methods for termination of pregnancy that can endanger their lives. Unsafe abortion is one of the main causes of maternal mortality worldwide, in spite of being almost entirely preventable.¹⁸ Even in jurisdictions where abortion is legal, COVID-19 has led some States to restrict access. In this regard, some States have attempted to limit access to abortion services during the COVID-19 crisis by classifying abortion as a non-essential service (**U.S. states of Texas and Ohio**, among others)¹⁹ or attempting to adopt laws that further restrict access to abortion during the pandemic (**Poland**).²⁰ In **Italy**, some hospitals that had previously provided abortions stopped offering the service and sent women elsewhere for care, making obtaining an abortion arduous.²¹ Furthermore, in **Brazil**, local authorities have suspended access to some sexual and reproductive health services, including contraception, labeling them as nonessential, while the number of hospitals performing legal abortions has significantly decreased.²² The Brazilian government also dismissed officials from the Ministry of Health for signing onto a technical note that requested local authorities to ensure access to sexual and reproductive health services during the pandemic.²³

Women with disabilities may be particularly affected by such restrictions and complications, because, due to societal discrimination, they are more likely to have lower levels of education and less access to employment resulting in lower incomes, and so frequently cannot afford to travel far from their homes for abortion, while women with mobility-related disabilities face additional barriers to travel, as the means of travel are often inaccessible.²⁴

- A WEI Survey respondent with a psychosocial disability from **Chile** noted that the law in her country already limits access to abortion, particularly for women and girls with disabilities who have been placed under guardianship and for those who face conscientious objection from providers, and worries that COVID-19 would intensify those barriers.²⁵
- In a UNFPA report on COVID-19 in **Ethiopia**, a 19-year-old woman with a physical disability explained she had an unplanned pregnancy during the pandemic, and recognized the symptoms too late due to her preoccupation with the economic challenges brought on by COVID-19. “Because of the disease, I was all focused on getting money and did not observe the changes in my body. It was too late when I learned I was pregnant [...] I did not want to get pregnant but it happened.”²⁶

Even though accurate gender and disability data is vital to analyze and recognize the specific lived experience of women with disabilities, it is not common to see quantitative data related to COVID-19 disaggregated by sex or disability. UN Women has found that only 37 percent of COVID-19 cases globally have been disaggregated by both sex and age as of mid-July 2020.²⁷ This has made it challenging to understand how the

pandemic has impacted women with disabilities, as well as to design and implement a gender and disability inclusive response to COVID-19, especially regarding SRHR.

III. Impact of COVID-19 on the social determinants of SRHR for women, girls, and gender non-conforming persons with disabilities

As mentioned above, although this submission is focused on how the pandemic has affected SRHR for persons living at the intersection of gender and disability, many factors have contributed to preventing the fulfillment of their SRHR and must not be overlooked. For instance, limited access to information, unemployment, school closures, or the barriers to access healthcare in general have all created a situation where the fulfillment of SRHR has become more difficult for women with disabilities. Furthermore, the increased risk of gender-based violence has increased the need for accessible SRH and well-trained SRH workers. To better understand how the COVID-19 crisis is affecting SRHR, it is important to broaden the analysis to include other needs and rights—also highly limited during the pandemic—to plan a response that ensures all of them.

A. Access to other needed healthcare

The COVID-19 pandemic has profoundly impacted the capacity of health systems worldwide. The World Health Organization (WHO) has recommended that, despite the demand for COVID-19-related care, it is essential for health systems to maintain preventive and curative services, especially for persons in a situation of vulnerability such as persons with disabilities,²⁸ Nevertheless, this is not what has happened in many States.

The pandemic is affecting routine healthcare services, with patients waiting long hours at crowded clinics for health services, which increases the risk of infection transmission. Cancellation of routine check-ups, including those needed by persons with disabilities specifically because of their disability, has been common due to the deployment of staff away to acute care.²⁹ For instance:

- A WEI Survey respondent from the **Netherlands** affirmed: “I can’t go to physical therapy and that’s why I’m hurrying [hurting] much more”.
- A deaf woman who participated in the Virtual Consultations from **Malawi** highlighted that women with disabilities who need support persons to go to medical appointments have struggled with the lack of transportation during the pandemic, as these professional support persons have difficulty finding public transportation to go to appointments with them.
- Another Virtual Consultation participant from **Malawi** shared that transport doubled in price during the pandemic, which she cannot afford, and she also cannot walk to the hospital.
- Another Virtual Consultation participant from **Chile** said that the doctor, instead of examining her carefully and meticulously as he used to, was quick, which made her feel insecure and doubtful about his protocol. As a result, she decided to postpone her next appointment to months later, hoping she would receive better attention then.
- A Virtual Consultation participant from **Pakistan**, who has heart disease, felt that doctors did not dedicate enough time to the appointments during the pandemic.
- A Virtual Consultation participant from **Indonesia** reported that the barriers faced in accessing medication increased, as the government reduced the dosage of several drugs provided by the public health system, forcing patients to buy the rest of the needed medication.

The existing barriers to accessing other needed healthcare may impede the fulfillment of SRHR for women with disabilities, as it is crucial for the whole health system to work adequately in order to respond to their needs. This includes well-trained health workers, prepared to assist patients with disabilities; an accessible environment, including the availability of sign language interpreters and easy read information about health; and no disability discrimination in access to healthcare for women with disabilities during the pandemic.

B. Gender-based violence

Violence increases during times of emergency, and women with disabilities are likely to face additional risk factors. Social distancing, home isolation, stress, unemployment, shifts in social safety nets, increasing institutionalization and isolation within institutions, lack of mobility, and lack of access to information/services, when combined with a sexist and ableist culture, contribute to increasing gender-based violence.³⁰ Gender-based violence also impacts SRHR and increases the need for SRH care, as individuals

may need this care for emergency treatment or for rehabilitation following violence. Even though data are limited, reports from several countries suggest an increase in violence against women with disabilities since the pandemic began:

- In **Haiti**, 81% of households led by or including persons with disabilities reported fears of increased violence because of local beliefs, traditions, and stigma.³¹ Particularly, communities of older persons, persons with disabilities, and persons living with HIV or AIDS felt they were at a higher risk of violence.³²
- In **Ethiopia**, 22% of persons with disabilities felt unsafe due to prolonged restrictions on movement, and 41% of children with disabilities experienced increased fear and anxiety associated with movement restrictions and difficulties communicating with family and caregivers.³³
- According to a report from Humanity and Inclusion, **Uganda** also reported intensified violence against women and girls with disabilities during the pandemic.³⁴ Personal anecdotes from the **Philippines** shared with the authors of this report identified that persons with disabilities were being emotionally and psychically abused by those living in their household.³⁵

The participants in the Virtual Consultations also observed an increase of cases of violence against women with disabilities during the pandemic. For example:

- A woman with a physical disability from **Nigeria** stated: “during the lockdown in Nigeria, we saw a spike in violence against women with disabilities. [For instance] we had a deaf girl that was gang raped within the same environment. I think there was a lot of increase in violence at home, and, for women and girls with disabilities, it was more because of the lockdown.”
- A participant from **Sri Lanka** mentioned: “there is gender-based violence, several cases but we don't have any official statistics. A 13-year-old girl with an intellectual disability was raped by three men at different times. That was in the newspapers, but, except for that, there is no data on gender-based violence. However, we know it happens frequently because we contacted [women with disabilities] who suffered gender-based violence.”
- A respondent from **Malawi** described that, in her country, as commonly happens worldwide, most deaf girls are raped by family members, who take advantage of hearing impairments because they think the victims would not be able to explain what happened to them, and that “the pandemic makes the situation worst because of the stay at home order and courts won't proceed with the case saying that this is a family matter. Most of the time women and girls with disabilities suffer in silence.”
- A young woman with an intellectual disability in **Bosnia and Herzegovina** was sexually abused by her uncle, who lives very close to her family home. Despite reporting the abuse to the police, the family is concerned that this case will not be brought to justice, because justice system actors do not believe that adults can experience sexual abuse, that the victim's disability should be considered when deciding whether to prosecute, and that persons with intellectual disabilities may not be credible witnesses.
- As reported by Rising Flame in India in a COVID-19 report issued in July 2020, a woman with a physical disability in **India** moved in with her parents after being abused by her husband but was asked to return to her husband's house with her small daughter, since her family could not economically support them anymore, due to the COVID-19 recession.³⁶

Furthermore, because women with disabilities are deprived of professional support persons or social networks due to social distancing and lockdown requirements,³⁷ their family members and intimate partners have become the main support persons. This is problematic for a few reasons. First, these people may also be the main perpetrators of violence against women with disabilities during this time, and women with disabilities experience heightened barriers to escaping such violent situations because their usual support networks have collapsed. Second, family members and intimate partners of women with disabilities may have to necessarily take on a more active caretaking role in supporting women with disabilities, and combined with the heightened stress of the COVID-19 pandemic, may become the perpetrators of disability-related abuse. Respondents to the WEI Survey reported that, due to familial tensions, they feared that family members may not be willing to help them with tasks of daily living or to access needed medications.

- One WEI Survey respondent who wished to remain anonymous shared that, because of an argument with a family member, that family member would no longer deliver her medications.
- Another WEI Survey respondent from the **United States** shared that “my family is emotionally abusive, and I am trapped in a house with them.”
- One WEI Virtual Consultation participant from **Sri Lanka** reported that, outside of situations of crisis, when living in a violent environment, many women with disabilities are able to end cycles of violence

through employment in cities, allowing them to leave their homes. During the pandemic, however, several women with disabilities were forced to return to abusive households due to quarantine measures and/or unemployment.

C. Ability to meet basic needs

Women, girls, and gender non-conforming persons with disabilities are experiencing significant barriers to meeting their basic needs due to COVID-19. Many of them require support for basic tasks of independent living, including preparing and consuming food, personal hygiene, and leaving their homes. Other persons with disabilities may require support to navigate inaccessible environments or to communicate with others, including healthcare providers. For women with disabilities, these support services may be the difference between being able to access needed health services, including SRH services and COVID-19 response services, and suffering alone at home.

According to WEI Survey respondents, lockdowns, shelter-in-place orders, inaccessibility of food supply services and other restrictions on movement during the COVID-19 crisis have had a significant impact on their ability to meet basic needs, achieve an adequate standard of living, and live independently. This is because many respondents had lost their sources of income, their support services were no longer available, accessible transportation was shut down or became inaccessible, and social distancing rules and recommendations made members of the public or family members unable or unwilling to help them. In this regard:

- A woman with a physical disability from **Argentina** reported that, preceding the pandemic, “I had a person who helped me change and bathe every day. With this situation the service is not available and I feel powerless to handle my own hygiene.”
- A woman from the **Netherlands** with muscular dystrophy reported that “I was in the process of getting support from the rehabilitation center for new assistive devices and other necessary solutions for my current physical challenges; this process is now on hold because the rehabilitation center is closed for external patients. In addition, I was in the process of applying for personal assistance for daily activities at home (transfer bed-wheelchair, shower, etc.). This is also on hold because having caregivers coming in and out of the house is too risky - and there are no protection materials or guidelines provided by the government for home care. Until all this is arranged, I cannot return to my full-time job (I’m currently on sick leave).”
- Virtual Consultation participants from **Sri Lanka** also shared that food delivery trucks were inaccessible or restricted to main roads, and that people had to wait in long lines to get food assistance, placing a disproportionate burden on persons with disabilities and female caretakers.

D. Education and Employment

UNICEF has stated that the COVID-19 pandemic is having a disproportionate impact on learners with disabilities, many of them being left behind during the transition to online learning, due to lack of accessibility, supports persons, and biases around disability and gender.³⁸ For instance:

- According to Human Rights Watch, a teacher at a school for girls, including children with disabilities, in the **Central African Republic**, said that he had not been in touch with any of his students since schools closed on March 27, 2020.³⁹
- A WEI Virtual Consultation participant from **Ethiopia** shared that the country had shifted to online classes but most of them are not accessible, and the majority of women and girls with disabilities did not have access to the internet to attend online classes, excluding them from the education system during the pandemic.
- Virtual Consultation participants in many other contexts shared that lack of access to sign language interpretation, the fact that it is hard to lip-read over online platforms, limited resources and technology devices, and the fact that families prioritized education for nondisabled siblings have all played a role in diminishing access to education for women and girls with disabilities.

Regarding employment, the COVID-19 pandemic has led to economic pressures for many households, which may disproportionately affect people with disabilities and their families. For instance, a survey with persons with physical impairments in **Jordan** has found that 58% lived in a household with a single income earner pre-pandemic, of which 78% had lost their jobs due to COVID-19 restrictions.⁴⁰ Women with disabilities face a very unstable employment situation, which is exacerbated during economic crises, as they are more likely to work in the informal sector, lacking job security and financial protections such as unemployment insurance,

paid sick, maternity, and caregiver leave.⁴¹ They may also take longer to rejoin the labor market once restrictions are eased, due to intersectional discrimination, inaccessible environments, and lack of public policies to foster their inclusion through employment. Many companies have not been able to provide accessible means to work remotely, which increased the exclusion of women with disabilities. A WEI Virtual Consultation participant with a visual impairment from **Uruguay** shared that, as her company did not have accessible equipment to work from home, her supervisor suggested her to take a sick leave during the lockdown for being from a risk group, even though she was not.

Education and employment are powerful tools to guarantee access to SRHR, and must not be overlooked during the pandemic. Without good quality and accessible education, students with disabilities cannot receive information and training on their own bodies, health, and rights. Additionally, school closures reduce the chances of teachers to screen gender-based violence, diminishing the opportunity for girls with disabilities to receive proper health and psychological care⁴². Likewise, employment provides the financial resources to access needed healthcare and medications. It also contributes to women's empowerment, which increases their interest in knowledge of SRHR to fulfill their rights.

III. International Human Rights Framework and International Guiding Documents

It is crucial to understand that human rights are interdependent and indivisible in order to properly ensure them, as asserted by the United Nations.⁴³ Particularly, States must bear in mind that, during a humanitarian emergency, human rights law and treaties continue to apply and are complementary and mutually reinforcing with the laws that apply in emergencies.⁴⁴ In this sense, a response to a health or humanitarian crisis implemented with little consideration for accessibility, inclusion, gender mainstreaming, or access to sexual and reproductive healthcare is not a human rights-based response. This response must take into account the full range of rights, including rights at the intersection of gender and disability.

As WGDRAW is likely familiar with a range of SRHR standards including in times of crisis for women broadly, this submission will focus on standards as developed under disability rights law, as they intersect with SRHR standards. The Convention on the Rights of Persons with Disabilities (CRPD) guarantees the right to health, emphasizing the importance of ensuring access to gender-sensitive health services and to provide quality, free or affordable SRH in the community.⁴⁵ Likewise, the CRPD Committee's General Comment No. 3 on women and girls with disabilities highlights that women with disabilities often experience stereotyping related to disability and gender in the context of sexual and reproductive health, and States must respect, protect and fulfill the rights of women with disabilities. To tackle the barriers women with disabilities face to exercise this right, States must guarantee other rights as well, such as access to justice, health, and equal recognition before the law, and ensure that they have the same right to control and decide freely and responsibly on issues related to their sexual and reproductive health as any other person.⁴⁶

Regarding situations of crisis, the CRPD further demands that States take “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.”⁴⁷ This reinforces that persons with disabilities—including women with disabilities—are entitled to the same rights and protections under international humanitarian law and international human rights law as any other person. For instance, the CRPD Committee has urged at least one State to train all civil defense staff in addressing issues of security and protection for persons with disabilities in situations of risk — such as armed violence, humanitarian emergencies, and natural disasters — including a gender and age perspective.⁴⁸

Other guides from U.N human rights experts and agencies help bring together standards on disability rights, SRHR, and humanitarian emergencies. In a 2017 report on SRHR from the Special Rapporteur on the rights of persons with disabilities, the Special Rapporteur underlines that women with disabilities in humanitarian situations are at heightened risk of being subjected to physical or sexual abuse and contracting sexually transmitted infections,⁴⁹ increasing their need for satisfactory SRH care. A 2015 report from the Office of the United Nations High Commissioner for Human Rights (OHCHR) on the rights of persons with disabilities under Article 11 of the CRPD emphasized that States must prevent gender-based violence during humanitarian

crises and guarantee accessible health and rehabilitation services, including reproductive health services for women and girls with disabilities.⁵⁰

Other international guidance on emergency preparedness address disability rights and SRHR, but rarely link the two. This includes, for instance, the Sendai Framework for Disaster Reduction 2015-2030,⁵¹ which addresses both topics but not in tandem and without an intersectional lens. The Inter-Agency Standing Committee (IASC) Operational Guidelines on the Protection of Persons in Situations of Natural Disasters ensures the right to health, including access to SRH, must be respected and protected during natural disasters. Nonetheless, there is no specific reference to women with disabilities in the document, only women and persons with disabilities in general,⁵²

On a more positive note, the IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action does address SRHR. These guidelines note that SRH is usually a low priority for healthcare stakeholders, who frequently provide support during humanitarian emergencies and that proactive efforts, such as mapping and determining the sexual and reproductive health needs of persons with disabilities, are necessary.⁵³ Additionally, the IASC Guidelines provide that disability inclusion must be incorporated into all response services by collaborating with civil society to undertake evidence-based advocacy on SRH issues and campaigns to increase SRH awareness among women with disabilities.⁵⁴

IV. Good practices in ensuring SRHR for women, girls, and gender non-conforming persons with disabilities during the COVID-19 crisis

There have been some positive actions taken by States, civil society organizations, and international organizations to address rights and needs related to SRH during the COVID-19 crisis for women with disabilities, non-governmental organizations have often led the way in ensuring SRHR for persons with disabilities during this crisis. For instance:

- The organization This-Ability Trust in **Kenya** has developed a toll-free system for women with disabilities to find accessible SRH services, available in 8 counties, and produced materials on family planning and online curricula for medical providers, addressing biomedical, cultural, and legal issues, all based on needs identified through a questionnaire. In addition, they are delivering online training on SRHR through an accessible e-learning platform. They are also redistributing sanitary pads and other hygiene products received from UNFPA, reaching approximately 300 women with disabilities, and organizing therapeutic sessions to help women deal with loneliness and isolation.
- My Life, My Choice, a self-advocacy organization for persons with learning disabilities in the **United Kingdom**, has helped facilitate peer-to-peer support to women with disabilities during the pandemic by ensuring the continuity of the women self-advocates group. To this end, they faced significant challenges, as many women had never used computers before and/or lacked the equipment to join virtual meetings. The organization was able to identify a charity that provided free used laptops and to raise the funds to buy more tablets. They also developed Easy-Read materials on how to use Zoom and is providing remote technical support to the women in partnership with another organization. Thanks to that, the 9 members of the group meet up once a week to discuss important topics to them, including related to their health.
- In the **United States**, Planned Parenthood has remained open to offer a variety of sexual and reproductive health services through telemedicine appointments,⁵⁵ which can help substitute in-person services as long as accessible services are also provided.

Several States have also taken proactive measures to ensure that access to SRH is maintained for all persons, particularly women, during the pandemic. For instance, the **United Kingdom** has modified its policies to allow for abortion pills to be taken from home,⁵⁶ whereas midwives in the **Netherlands** have also turned local hotel rooms into delivery centers,⁵⁷ and **France** has continued to allow birth control pills to be delivered without a renewed prescription⁵⁸.

V. Recommendations

Women, girls, and non-conforming persons with disabilities are facing increased and specific barriers to fulfilling SRHR during the COVID-19 crisis. As a Virtual Consultation participant from **Nepal** stated: “in the whole COVID process, I would say that the issue of gender, the issue of intersectionality has almost remained in a vacuum. So it's always in a single linear model and that a single linear model is not working for women

with disabilities and other marginalized groups.” To tackle this issue and implement effective solutions to the problem, there is an immediate need for States to incorporate gender and disability perspectives in the disease outbreak preparedness and responses.

With this in mind, we hope that WGDAW will consider including the following recommendations in its upcoming report:

- Ensure that SRHR is respected, protected, and fulfilled for women with disabilities before a crisis, including by repealing all laws and policies that restrict SRH service provision and/or discriminate against women with disabilities in health provision (such as laws that limit legal capacity), ensuring that health facilities are physically and financially accessible, including through accessible public transportation, and that persons with disabilities have access to information about SRH in accessible formats and free or low-cost communication support.
- Train healthcare providers on the rights and needs of persons with disabilities, as well as the diversity of disability, and how to provide persons with disabilities with rights-based healthcare services.
- Adopt policies and programs that address the gendered and disability impacts of the COVID-19 outbreak, and develop a SRH legal framework, based on an inclusive approach, to provide the legal mechanisms to monitor and respond to the inequitable disability, gender, health, and social effects of COVID-19 and its impact on SRHR. Additionally, ensure accessible mechanisms to report and respond to gender-based violence, and train legal and policy professionals to respond to this issue appropriately.
- Define and promote SRH goods and services—including abortion, contraception, family planning, and maternal and newborn care, and menstrual hygiene products—as essential goods and services during the pandemic, and guarantee they are accessible to women with all types of disabilities.
- Ensure that SRH workers and other healthcare workers providing essential healthcare to persons with disabilities are not redeployed to other healthcare during the crisis, and reestablish health services that have been suspended. Classify disability support providers, including sign language interpreters, as essential workers, as well.
- Guarantee that all adaptation of health services to face the pandemic, such as telehealth, is accessible to all persons with all types of disabilities. In addition, ensure that all the information about SRHR is provided in accessible formats and that persons with disabilities can continue to access communications support, such as sign language interpreters, when receiving SRH care.
- Include women, girls, and gender non-conforming persons with all types of disabilities, as well as their representative organizations, in the response and recovery process, guaranteeing a gender and disability perspective is mainstreamed into all policies developed to respond to the COVID-19 crisis, and that their needs and rights are reflected in laws, policies, and programs to address the crisis, with corresponding budget allocation.
- Ensure that programs established to respond to the COVID-19 crisis are inclusive and address the needs of women with disabilities, including by ensuring that employment assistance is provided to small business owners and entrepreneurs and that food assistance and other programs to help meet basic needs are disability inclusive and accessible.
- Disaggregate data related to the pandemic by sex, gender, age, and type of disability. In addition, guarantee that the data and its impact is analyzed accordingly, conducting intersectional analysis to show how multiple forms of discrimination and inequality may shape SRH access.
- Develop online sexuality education courses, and ensure the availability of both in-person and online instruction in response to school closures. Guarantee those courses are accessible and that students with disabilities have access to technological equipment to attend classes.

For further detailed recommendations on how to ensure human-rights based sexual and reproductive healthcare for women and girls with disabilities, including in crisis situations, please see [the WEI and UN Population Fund \(UNFPA\) publication, *Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights*](#).

- ¹ This submission generally uses the term “women” to refer to all women and girls throughout the lifecycle, unless otherwise noted.
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