

**Response to the U.N. Special Procedures Questionnaire on COVID-19 from  
Members of the Nairobi Principles Working Group:  
*Ensuring Rights at the Intersection of Gender, Disability, and Sexuality during COVID-19*  
June 19, 2020**

Members of the [Nairobi Principles](#) Working Group<sup>1</sup>—a coalition of individuals and civil society organizations from around the world working to advance sexual and reproductive health and rights inclusive of gender and disability—is grateful for the opportunity to provide the below response to “Protecting human rights during and after the COVID-19: Joint questionnaire by Special Procedure mandate holders.” This response provides information on the impact of COVID-19 on health service provision and meeting basic needs for women, girls, non-binary, trans, and gender non-conforming persons with disabilities, as well as gaps in national, regional, and global data on COVID-19 as related to gender and disability. This response further provides suggested recommendations to States, U.N. entities, and healthcare systems about how to address human rights abuses against women, girls, non-binary, trans, and gender non-conforming persons with disabilities during this crisis.

It is important to note that issues identified in this response are ones that many women, girls, non-binary, trans, and gender non-conforming persons with disabilities experience in their everyday lives, often due to stigma, stereotypes, and discrimination at the intersection of gender, disability, and sexuality. The COVID-19 pandemic has amplified these abuses and likely deepened their impact, but it will be important for States to address not only the abuses themselves as they are occurring during the COVID-19 crisis, but also the root causes of these abuses.

**A. COVID-19 and Health Service Provision for Women, Girls, Non-binary, Trans, and Gender Non-conforming Persons with Disabilities**

*1. Rollback of the right to health, including sexual and reproductive health and rights*

Everyone has **the right to the highest attainable standard of physical and mental health.**<sup>2</sup> Although the right to health is considered a right of progressive realization, in that implementation of that right is dependent on a State’s finances and level of development, the U.N. Committee on Economic, Social, and Cultural Rights (ESCR Committee) has found that every State has a core obligation to ensure “minimum essential levels” under this right, including to ensure “the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.”<sup>3</sup> Indeed, the Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifically require that States ensure the right to health for persons with disabilities and for women on an equal basis with others and without discrimination.<sup>4</sup> The ESCR Committee has further found that, in times of emergency, “[p]riority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population,”<sup>5</sup> which includes many women, girls, non-binary, trans, and gender non-conforming persons with disabilities.

Within these core obligations under the right to health:

- States must ensure access to health services that people need specifically because of their gender and/or disability, including sexual and reproductive health services (such as abortion, contraception, maternal health services, reproductive cancer screenings, etc.) and disability-related services (including pain management, physical therapy, rehabilitation, mobility equipment, etc.);<sup>6</sup>
- Governments are responsible for respecting, protecting, and fulfilling the right to health for all, including by ensuring availability of accessible, acceptable, and quality health information, goods, and services.<sup>7</sup> This requires that States ensure that access to healthcare facilities, goods, and services is provided on a non-discriminatory basis, including discrimination based on gender or disability; that available health facilities, goods, and services are distributed equitably; and that States ensure that healthcare facilities and providers are given training on human rights.<sup>8</sup> In particular, under Article 25 of the CRPD, States are obligated to “[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons...” and “[p]revent discriminatory denial of health care or health services or food and fluids on the basis of disability.”<sup>9</sup>

COVID-19 is a healthcare crisis that has been testing States’ implementation of the right to health, particularly for the most marginalized. During the COVID-19 crisis, healthcare has changed in several respects. Many health services have either been cancelled, thereby delaying needed care, or moved to virtual means like telehealth, which are not always accessible or adequate to meet the sometimes-complex needs of people living at the intersection of gender and disability. In other circumstances, some health services have been classified as “essential” while others, including some needed particularly by women and/or persons with disabilities, have been classified as “non-essential,” meaning that these services are not available to people who need them.

Specifically, States have taken measures that impact access to sexual and reproductive healthcare and that can have a disproportionate impact on women, girls, non-binary, trans, and gender non-conforming persons with disabilities. For instance, some States have attempted to limit access to certain sexual and reproductive health services, particularly abortion, during the COVID-19 crisis by classifying abortion as a non-essential service (U.S. states of Texas and Ohio)<sup>10</sup> or attempting to adopt laws that further restrict access to abortion (Poland).<sup>11</sup> In Italy, some hospitals that had previously provided abortions stopped providing the service and sent women elsewhere for care, making obtaining an abortion much more complicated.<sup>12</sup> In parts of India, public health services and service providers have also been commandeered for treatment of COVID-19, private health facilities have closed due to lack of protective gear, public transportation has been shut down, and supply chains for medication abortion have been cut-off-further limiting access to abortion.<sup>13</sup> In Brazil, some local authorities have suspended access to some sexual and reproductive health services, including contraception, labeling them as “non-essential,” while the number of hospitals performing abortions has significantly decreased.<sup>14</sup> The Brazilian government dismissed officials from the Ministry of Health for signing onto a technical note that called on local authorities to ensure access to sexual and reproductive health services during the pandemic.<sup>15</sup>

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. Women with mobility-related disabilities face additional barriers to travel, as the means of travel are often inaccessible, and other women with disabilities are denied legal capacity, further complicating their access.<sup>16</sup>

Furthermore, in order to prevent the spread of COVID-19, some hospitals adopted or considered adopting policies that disallowed any support persons, including partners, from accompanying a pregnant person during labor, delivery, and the postpartum period.<sup>17</sup> These policies did not carve out exceptions for pregnant persons with disabilities and would have had a disproportionate impact on them, as they may need support persons simply to communicate with healthcare personnel or to get assistance meeting personal hygiene needs while hospital staff are overstretched.

In March and April 2020, Women Enabled International (WEI) conducted a [global human rights survey](#) of women, girls, non-binary, trans, and gender non-conforming persons with disabilities on the impact of COVID-19 on their rights (WEI Survey). The majority of WEI Survey respondents reported that COVID-19 had affected their access to their usual health services, medications, and equipment. Many reported that their usual medical appointments and needed procedures, including those related to their gender or disability, were being cancelled or pushed back,<sup>18</sup> with resources in some cases being diverted to the COVID-19 pandemic instead.<sup>19</sup> Women with disabilities also reported that their pain management and physical therapy appointments had been cancelled or delayed, leading to increased pain for some and likely also decrease in bodily function.<sup>20</sup> As a 48-year-old woman from the Netherlands described, “I can't go to physical therapy and that's why I'm hurrying [hurting] much more.”<sup>21</sup>

- A March report from Shanta Memorial Rehabilitation Centre in India found that public health facilities have been frequently repurposed for COVID-19 care, and private health facilities were too expensive and not covered by insurance, leaving them too expensive for many women with disabilities to access essential non-COVID care.<sup>22</sup> When women with disabilities could access health facilities or providers, they were several instances where they were denied medical treatment and healthcare.<sup>23</sup>
- A forthcoming report from Engelli Kadın Derneği on the impact of COVID-19 on women with disabilities in Turkey also found that women with disabilities could not access needed rehabilitation services, medicine, and pharmacies and feared they would lose skills needed for independent movement.<sup>24</sup>

For many WEI Survey respondents, telemedicine services were not an adequate substitute, because they did not have the needed technology, the technology was not fully accessible, they doubted the quality of care, or they were afraid their insurance would not cover it.<sup>25</sup> Those who can access in-person health services may also find them newly inaccessible with providers wearing masks, thereby making it more difficult for them to read lips or facial expressions or to clearly understand the person speaking. Restrictions on public and private transportation as a result of COVID-19, or discomfort with using these services, have also posed significant barriers to many WEI Survey respondents accessing needed health services.<sup>26</sup>

In particular, WEI Survey respondents identified increased barriers to accessing healthcare goods and services they needed specifically because of their gender or gender identity, including sexual and reproductive health services. They reported significant barriers to accessing, for instance, regular sexual and reproductive health check-ups,<sup>27</sup> breast cancer screenings,<sup>28</sup> pregnancy-related services,<sup>29</sup> menopause services,<sup>30</sup> and abortion.<sup>31</sup> Two non-binary individuals identified that their access to hormones has become more difficult.<sup>32</sup> These barriers sometimes caused WEI Survey respondents mental distress or threatened their overall health.

## *2. Healthcare Shortages and Healthcare Rationing*

Additionally and distressingly, as healthcare shortages increase, States and healthcare providers may be placed in a position to make decisions about who does and does not receive care, a process known as “rationing.”<sup>33</sup> This rationing may, due to entrenched discrimination, leave behind the most marginalized, including many women, girls, non-binary, trans, and gender non-conforming persons with disabilities.<sup>34</sup>

The vast majority of WEI Survey respondents identified that healthcare rationing was occurring in their countries, in both formal and informal ways, or that they were afraid that such rationing would occur. Several respondents expressed concern about the inadequate preparedness of the healthcare system in their countries, which could lead to rationing in practice as healthcare providers have to make decisions about to whom to provide care. One respondent remarked that the lack of adequate facilities in public hospitals and the cost of care in private hospitals would in effect ration care,<sup>35</sup> while another respondent identified that the lack of personal protective equipment (PPE) and lack of training for healthcare personnel may also lead to rationing.<sup>36</sup> These concerns were not confined to a particular region but rather spanned the globe, from Brazil to England to Lesotho.

Some respondents identified that their healthcare systems were overloaded in normal times, let alone in a pandemic.<sup>37</sup> Others identified shortages that were already occurring in their healthcare systems in the early days of the pandemic.<sup>38</sup> Some respondents identified particular fears of not being able to access their usual medications, other usual health services, or COVID-19 treatments due to their disability or due to shortages in the healthcare system.<sup>39</sup> Some respondents expressed fear about the shortage of ventilators in particular,<sup>40</sup> including that persons with disabilities might be deprioritized concerning the use of ventilators.<sup>41</sup>

In the United States of America (U.S.), some states put in place medical protocols on rationing that discriminated against persons with disabilities, older persons or those with underlying health conditions.<sup>42</sup> In the United Kingdom (U.K.), it was reported that persons with disabilities may be discriminated against in accessing medical care on the basis of needing personal assistance.<sup>43</sup>

WEI Survey respondents expressed fear about going to the hospital in this context, being aware of likely healthcare system overload and the potential of rationing. Several respondents described that they feared their age, disability, or other status may make them less of a priority in receiving healthcare.<sup>44</sup> Others classified rationing as a form of discrimination or eugenics.<sup>45</sup> Two respondents further expressed distrust of healthcare providers when it came to rationing, likely

resulting from the medical model of disability, which assumes that disability is a condition to be fixed and that persons with disabilities have a lower quality of life.<sup>46</sup>

### Recommendations

- **To States:** Issue specific guidance to healthcare providers on ensuring rights-based care during the COVID-19 crisis that makes clear that discrimination on prohibited grounds, including at the intersection of gender and disability, is not permitted. Continue or initiate efforts to tackle stereotypes and stigma about gender and/or disability, as a means of ensuring they get the community supports and healthcare they need without discriminatory rationing. Ensure that access to disability-accessible public transportation is maintained and at reasonable cost. Classify sexual and reproductive health services as essential services during this crisis, and provide support to women, girls, non-binary, trans, and gender non-conforming persons with disabilities to access these services.
- **To Healthcare Systems:** Involve women, girls, non-binary, trans, and gender non-conforming persons with disabilities in planning for and implementation of new protocols for providing care, including within consultations with bioethics committees and commissions. Provide accessibility supports for virtual or remote medical appointments, including Sign Language interpretation. Prioritize marginalized groups, including women, girls, non-binary, trans, and gender non-conforming persons with disabilities, in the provision of all forms of available care, including mental healthcare and access to needed medications.

### **B. Barriers to Meeting Basic Needs, including Interruptions in Access to Disability-Related Formal and Informal Supports**

All persons have the **right to an adequate standard of living**, which includes the right to have their basic needs met, such as those related to water, hygiene, food, and shelter.<sup>47</sup> Indeed, ensuring that people have access to essential underlying determinants of health (including food, water, shelter, and essential medicines) is also part of the core minimum obligations that States must meet to protect the **right to health**.<sup>48</sup> Women and persons with disabilities also have a **right to social protection** without discrimination, and States must in particular ensure that women and girls with disabilities have access to social protection measures to ensure an adequate standard of living.<sup>49</sup> Persons with disabilities further have a **right to live in the community**, including “access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.”<sup>50</sup> As the CRPD Committee has found, although the right to access support services to live in the community is a right of progressive realization, States cannot implement retrogressive measures with respect to this right unless they are “temporary, necessary and non-discriminatory”<sup>51</sup> while respecting the core obligations of this right, including the right to make decisions for oneself about where and how to live.<sup>52</sup>

Many persons with disabilities 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, girls, non-binary, trans, and gender non-conforming persons with disabilities, these support services may be the difference between being

able to access needed health services, including sexual and reproductive health services and COVID-19 response services, and putting their health at risk at home alone. If a woman with a disability has to instead rely exclusively on a partner or family member to undertake these tasks, that dependence makes them vulnerable to violence and abuse.<sup>53</sup> Outside services provide a network of support for women with disabilities that allow them independence and give them an avenue to leave violent home environments, particularly important in times of increased isolation and heightened stress and anxiety.

Furthermore, women, girls, non-binary, and gender non-conforming persons with disabilities already disproportionately live on the brink of extreme poverty, due to significant barriers to accessing education based on gender and disability discrimination, as well as lower rates of formal employment, reliance on informal sectors of work, and lower rates of pay than men with disabilities or other women.<sup>54</sup> They also have higher costs of living than many others, due to disability-related needs (including assistive devices, healthcare, support services, etc.)<sup>55</sup> and gendered expectations and needs (including related to healthcare, higher costs for hygiene items, items for menstrual hygiene, etc.).<sup>56</sup>

According to WEI Survey respondents, lockdowns, shelter-in-place orders, 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.

Nearly one-third of WEI Survey respondents indicated that the COVID-19 crisis had affected their ability to access needed disability-related support services.<sup>57</sup> This is because these individuals themselves were not permitted to leave their homes, because support services and personal assistants were not able to come to them, because policymakers failed to authorize to grant disability support providers with movement permits,<sup>58</sup> and because service providers could not access their offices.<sup>59</sup> As a result, WEI Survey respondents reported, for instance, a decrease in access to technical assistance, personal assistance, wheelchair replacement and repair, and accessibility services such as Sign Language interpreters,<sup>60</sup> as well as a decrease in access to public transportation.<sup>61</sup>

- The March 2020 report from Shanta Memorial Rehabilitation Centre in India found that, during the first two-to-three weeks of the lockdown, the government neglected to include personal assistants (PAs) in the list of essential services. Even after being added to the list of essential services the process for obtaining mandatory passes for essential works was cumbersome, creating further barriers for persons with disabilities to access their PAs. Some persons with disabilities, particularly women with disabilities, were left to fend for themselves or to become dependent on others, including neighbors.<sup>62</sup>
- A forthcoming report from Engelli Kadın Dernegi on the impact of COVID-19 on women with disabilities in Turkey also found that women with disabilities had lost access to personal assistants and support services, including those related to personal hygiene and health, which has had an impact on both their physical and mental well-being.<sup>63</sup>

WEI and other Survey Respondents further identified that their ability to take care of their own needs or receive informal support from family, friends, and the community had also been jeopardized by the COVID-19 crisis. For instance, orders for new assistive devices and wheelchairs had been delayed due to the crisis, making it difficult for these individuals to leave their homes, transfer from their beds, or do their jobs.<sup>64</sup> A few respondents identified that the stress of COVID-19 with family members or friends meant that requests for assistance were harder to make,<sup>65</sup> while others reported that the support they had received from community members to, for instance, cross the street had been stymied by social distancing rules.<sup>66</sup> For instance, a young blind woman in Argentina described how this lack of assistance made it hard for her to meet her basic needs on her own and has made her more dependent on family: “My family has to do the shopping because I have to cross an avenue to go to any business and nobody comes to help me because they want to avoid contact.”<sup>67</sup>

This decreased access to services and the community has had an impact on meeting even the most basic needs for WEI Survey respondents, including those related to food, sanitation, and hygiene, as well as social and psychological needs.<sup>68</sup>

- As Rosario, a woman with muscular dystrophy in Argentina, explained: “Before, 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.”<sup>69</sup>
- Changes to public transportation were a particular issue for many. Lyness, a person with a physical disability from Malawi, noted: “Our minister of transport announced that the bus fares have been doubled and those who can not afford should walk without considering persons with disabilities.”<sup>70</sup> Other respondents highlighted a decrease in ability to access groceries, including as a result of cuts in public transportation.<sup>71</sup>
- A woman from Nepal emphasized the decreased access to sanitary products and services as a result of the lockdown, including the lack of supports to access these goods.<sup>72</sup>
- A woman from Uganda stated “I fear I may run out of food. I was not prepared for this. The government is distributing food only in the city centre.”<sup>73</sup>
- Lisa from London expressed how inconsiderate people are at this time, which makes meeting needs for people like her more difficult: “[T]he situation showed that people started to fight on their own - pushing each other in the supermarket to get the last milk etc. If you are a vulnerable person who has problems with fighting your way through and standing up for yourself you get treated like a door mat. We are simply forgotten. I decided that I won't hoard food so that other people have a chance as well - the result was that I eat a whole week the few toasts which I had left in the house because the aisles in the supermarkets were empty.”<sup>74</sup>

At least two respondents reported that the decrease in access to services or assistance from the public made them more reliant on intimate partners or other family members to meet basic needs.<sup>75</sup> This dependence could open them up to violence or abuse by these individuals, as it changes the power dynamic between these individuals and exacerbates stress.

Without the ability to meet basic needs including accessing essential services such as food, water, and sanitation, persons with disabilities are more vulnerable to being placed in long-term residential care institutions, in violation of their right to independent living. Women, girls, non-binary, and gender non-conforming persons with disabilities may be especially vulnerable to

institutionalization, as they may lack employment or other means of support to live in the community and may also receive less support from family than men with disabilities.<sup>76</sup> While institutionalized, these individuals are also more vulnerable to violence and abuse as well as to COVID-19.

### Recommendations to States

- Urgently adopt social protection measures—including income supplementation, rent subsidies and eviction moratoriums, food subsidies, and free clean water and hygiene measures, including menstrual hygiene—to fill the gap in income for all persons so that they can meet their basic needs. Ensure those who worked as freelancers, entrepreneurs, or in the informal sector or who received other types of income support are eligible for these measures.
- Undertake particular efforts to reach women, girls, non-binary, trans, and gender non-conforming persons with disabilities with social protection measures, including through campaigns that provide information in a variety of accessible formats, and ensure that social protection goes directly to these individuals rather than to families or partners.
- Classify disability-related support services as essential services during COVID-19 lockdowns, stay-in-place orders, or other restrictions on movement and ensure a streamlined process for obtaining any needed permits for movement for these service providers.

### **C. Gaps in COVID-19 Data related to Gender and Disability**

Much of the quantitative data surrounding COVID-19, its impact, and the reach of assistance programs is not disaggregated by sex, gender, or disability—and even where the data is disaggregated, none of the reviewed datasets were disaggregated so as to recognize the specific lived experience as the intersection of gender and disability. This has made it difficult to understand whether and how the COVID-19 crisis is having a disproportionate impact on women, girls, non-binary, and gender non-conforming persons with disabilities. Without specific efforts to collect data on this group, it may also be difficult to do so during a time like COVID-19, as lockdowns and the need for physical distancing combined with lack of access to technology mean that women with disabilities may be hard to reach during this crisis.

These data gaps begin at the national level – for instance, data reported by the Centers for Disease Control on COVID-19 cases, testing, and deaths in the U.S. are not disaggregated by either sex, gender, or disability, though they are disaggregated by other categories such as age and race/ethnicity.<sup>77</sup> Data on COVID-19 in the U.K., Canada, and South Africa are disaggregated by sex or gender but not by disability.<sup>78</sup> As a result, regional and international data on COVID-19 similarly does not disaggregate by sex, gender, and/or disability. For instance, the World Health Organization’s global dashboard on COVID-19 deaths and cases does not disaggregate,<sup>79</sup> and while UN Women’s data does provide an estimate of cases and deaths for women globally based on confirmed data, this is not disaggregated by disability.<sup>80</sup> Other U.N. reports have attempted to estimate the impact of COVID-19 on women and on persons with disabilities but have had to do so based on pre-COVID-19 data that is disaggregated, while current data is not.<sup>81</sup>

The data that does exist about women and persons with disabilities during COVID-19 paints a bleak picture. A report by UN Women’s Asia-Pacific regional office found that women in Asia and the Pacific are having difficulty accessing medical supplies and hygiene products, and in countries where women are having difficulty accessing medical services, they are having difficulty accessing these services at much higher rates than males.<sup>82</sup> Sub-nationally, the U.S. states of New York and Pennsylvania have disaggregated their COVID-19 data by disability, including intellectual and developmental disability.<sup>83</sup> By disaggregating data based on these categories, they were able to discover that persons with intellectual or developmental disabilities who live in group homes are four times more likely to contract COVID-19, and once contracted two times more likely to die from it.<sup>84</sup> This is essential information for States to be collecting in order to fully address the COVID-19 crisis, including its impact on women, girls, non-binary, trans, and gender non-conforming persons with disabilities.

### Recommendations

- **To States:** Immediately begin disaggregating data related to COVID-19 and its impact (including related to access to healthcare, food, hygiene products, services, and as related to violence) by gender and disability, such that the situation of women, girls, non-binary, trans, and gender non-conforming persons with disabilities can be adequately assessed and addressed.
- **To U.N. Entities:** Request that States provide data on the impact of COVID-19 that is fully disaggregated including by gender and disability, and seek information on the situations of women, girls, non-binary, trans, and gender non-conforming persons with disabilities where disaggregated data is not currently available.
- **To States and U.N. Entities:** Refer to the [Washington Group on Disability and Statistics](#) for questions sets and tools for data collection and disaggregation by disability:

*Thank you for your time and attention to these responses. If you have any questions or would like further information, please contact Amanda McRae, [a.mcrae@womenenabled.org](mailto:a.mcrae@womenenabled.org); Rupsa Mallik, [rmallik@creaworld.org](mailto:rmallik@creaworld.org); and Bahar Turan, [psybahar@gmail.com](mailto:psybahar@gmail.com).*

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<sup>1</sup> Endorsing members of the Nairobi Principles Working Group include ANIS (Brazil), CREA (India), Disability Rights Fund/Disability Rights Advocacy Fund (U.S.), Engelli Kadın Dernegi (Turkey), International Women’s Health Coalition (U.S.), Women Enabled International (U.S.), and Megan Smith (Iceland).

<sup>2</sup> Universal Declaration of Human Rights, adopted Dec. 10, 1948, art. 25, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948) [hereinafter UDHR]; International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Jan. 3, 1976) [hereinafter ICESCR].

<sup>3</sup> ESCR Committee, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, para. 43(a), U.N. Doc. E/C.12/2000/4 (2000). [hereinafter ESCR Committee, *Gen. Comment No. 14*].

<sup>4</sup> See Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW]; Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, art. 25, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611, (entered into force May, 3 2008) [hereinafter CRPD].

<sup>5</sup> ESCR Committee, *Gen. Comment No. 14, supra* note 3, para. 40.

<sup>6</sup> *Id.*, para. 44; CEDAW, *supra* note 4, art. 12; CRPD, *supra* note 4, art. 25; CEDAW Committee, *General Recommendation No. 24: Women and health*, para. 11, U.N. Doc. CEDAW/C/GC/24 (1999).

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- <sup>7</sup> ESCR Committee, *Gen. Comment No. 14, supra* note 3, para. 12.
- <sup>8</sup> *Id.*, paras. 12, 43-44.
- <sup>9</sup> CRPD, *supra* note 4, art. 25.
- <sup>10</sup> Sabrina Tavernise, “Texas and Ohio Include Abortion as Medical Procedure that Must Be Delayed, N.Y. TIMES, Mar. 21, 2020, <https://www.nytimes.com/2020/03/23/us/coronavirus-texas-ohio-abortion.html>.
- <sup>11</sup> Shaun Walker, “Concerns over Polish government tightening abortion laws during Covid-19 crisis,” THE GUARDIAN, Apr. 14, 2020, <https://www.theguardian.com/world/2020/apr/14/concerns-over-polish-government-tightening-abortion-laws-during-covid-19-crisis>.
- <sup>12</sup> Laura Smith-Spark, “Abortion access thrown into jeopardy by coronavirus pandemic,” CNN, Apr. 9, 2020, <https://www.cnn.com/2020/03/27/health/coronavirus-abortion-access-intl/index.html>.
- <sup>13</sup> IPAS, *Compromised Abortion Access due to COVID 19* (2020), <https://www.ipasdevelopmentfoundation.org/publications/compromised-abortion-access-due-to-covid-19-a-model-to-determine-impact-of-covid-19-on-women-s-access-to-abortion.html>.
- <sup>14</sup> See, e.g., Human Rights Watch, “Brazil: Protect Sexual, Reproductive Rights in Pandemic; Officials Who Defended Women’s, Girls Rights Demoted,” June 12, 2020, <https://www.hrw.org/news/2020/06/12/brazil-protect-sexual-reproductive-rights-pandemic>.
- <sup>15</sup> *Id.*
- <sup>16</sup> Inclusion Ireland, “Inclusion Ireland Joins ‘Together for Yes’” 5 (May 2018), <http://www.inclusionireland.ie/sites/default/files/attach/news-item/1680/inclusion-ireland-together-yes.pdf>.
- <sup>17</sup> Christina Caron & Katie Van Syckle, “Some Pregnant Women in New York City Will Have to Deliver Babies Alone,” N.Y. TIMES, Mar. 24, 2020, [https://www.nytimes.com/2020/03/24/parenting/coronavirus-labor-birth.html?fbclid=IwAR030piD\\_a1LrkjAolxM3cKM31TEfUHKShu1mNmd65Lpi0aOw0Jrdvuo7X8](https://www.nytimes.com/2020/03/24/parenting/coronavirus-labor-birth.html?fbclid=IwAR030piD_a1LrkjAolxM3cKM31TEfUHKShu1mNmd65Lpi0aOw0Jrdvuo7X8).
- <sup>18</sup> A non-binary person with depression, age 25, California, U.S.; A woman with psychosocial disabilities, age 48; Rachael, a woman with mobility and movement-related disabilities, age 42, U.S.; Alex, a non-binary autistic person with physical, emotional, and mental disabilities, age 23, Texas, U.S.; Angélica, a woman with a physical disability, age 53, El Salvador; Laura, a woman with a psychosocial disability, age 38, Mexico.
- <sup>19</sup> A woman with psychosocial disabilities, age 48.
- <sup>20</sup> A woman, age 48, the Netherlands; Survey from a person who does not wish to be identified; Rachael, a woman with mobility and movement-related disabilities, age 42, U.S.
- <sup>21</sup> A woman, age 48, the Netherlands
- <sup>22</sup> Shanta Memorial Rehabilitation Centre, *COVID 19 and Impact of Lockdown on Women with Disabilities in India* (2020), [http://www.internationaldisabilityalliance.org/sites/default/files/covid\\_and\\_women\\_with\\_disabilities\\_in\\_india\\_edited\\_1.pdf](http://www.internationaldisabilityalliance.org/sites/default/files/covid_and_women_with_disabilities_in_india_edited_1.pdf).
- <sup>23</sup> *Id.*
- <sup>24</sup> Bahar Turan (Engelli Kadın Derengi), *To be a Disabled Women in Coronavirus in Turkey – English Summary* (June 2020), <http://engellikadin.org.tr/wp-content/uploads/2020/06/To-be-A-Disabled-Woman-in-Coronavirus.pdf/>.
- <sup>25</sup> A woman with physical disability and chronic health condition, age 26, New York, U.S.; Brenda, a woman with post-traumatic stress disorder, age 43, U.S.; Karina, a woman with mental disabilities, age 41, U.S.; Cassandra, a woman with diabetes and a compromised immune system, age 25, U.S.
- <sup>26</sup> Lyness, a woman with physical disabilities, age 54, Malawi; Rachel, a woman with a physical disability, age 61, Malawi; Namugabwe, a person with a psychosocial disability; Gina Rose, a woman with a visual impairment, age 37, the Philippines.
- <sup>27</sup> Cassandra, a woman with diabetes and a compromised immune system, age 25, U.S.; Celeste, a woman with a visual impairment, age 19, Argentina.
- <sup>28</sup> Yolanda, a woman with a physical disability, age 55, Canada.
- <sup>29</sup> A woman with chronic illness, age 34.
- <sup>30</sup> A woman with psychosocial disabilities, age 48.
- <sup>31</sup> Marcela, a woman with a psychosocial disability, age 59, Chile.
- <sup>32</sup> Alex, a non-binary autistic person with physical, emotional, and mental disabilities age 23, Texas, U.S.; Gwen, a non-binary autistic person, age 24, France.
- <sup>33</sup> See, e.g., Jason Horowitz, “Italy’s Health Care System Groans Under Coronavirus — a Warning to the World,” N.Y. TIMES, Mar. 12, 2020, <https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html>.

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<sup>34</sup> See, e.g., Joseph Shapiro, “People with Disabilities Say Rationing Care Policies Violate Civil Rights,” NPR.ORG, Mar. 23, 2020, <https://www.npr.org/2020/03/23/820398531/people-with-disabilities-say-rationing-care-policies-violate-civil-rights/>; Katelyn Burns, “Coronavirus isn’t transphobic. But America’s economic and health systems are,” VOX.COM, Apr. 3, 2020, [https://www.vox.com/identities/2020/4/3/21204305/coronavirus-transgender-economy-health-care](https://www.vox.com/identities/2020/4/3/21204305/coronavirus-transgender-economy-health-care;);

<sup>35</sup> Survey from a person who does not wish to be identified

<sup>36</sup> Janeth, a woman with a permanent medullary lesion, age 45, El Salvador.

<sup>37</sup> Rachel, a woman with a physical disability, age 61, Malawi; a woman with albinism, age 32, Lesotho; A woman with hearing disabilities, age 44, Brazil; Daisy, a non-binary person with ME, age 27, U.K.; Elizabeth, a woman with a psychosocial disability, age 45; Mexico.

<sup>38</sup> Daisy, a non-binary person with ME, age 27, U.K.; A woman with physical disabilities, age 26, U.S.

<sup>39</sup> Tamara a woman with skeletal muscle disorder, age 52, Mexico; A woman in Uganda; A woman with psychosocial disabilities, age 48.

<sup>40</sup> Daisy, a non-binary person with ME, age 27, U.K.

<sup>41</sup> Rosario, a woman with muscular dystrophy, age 23, Argentina.

<sup>42</sup> Amy Silverman, “People With Intellectual Disabilities May Be Denied Lifesaving Care Under These Plans as Coronavirus Spreads,” PROPUBLICA, March 27, 2020, <https://www.propublica.org/article/people-with-intellectual-disabilities-may-be-denied-lifesaving-care-under-these-plans-as-coronavirus-spreads>.

<sup>43</sup> Center for Public Representation, “CPR and Partners File Complaint Regarding Illegal Disability Discrimination in Treatment Rationing During COVID-19 Pandemic,” March 23, 2020, <https://www.centerforpublicrep.org/news/cpr-and-partners-file-complaint-regarding-illegal-disability-discrimination-in-treatment-rationing-during-covid-19-pandemic/>.

<sup>44</sup> Pahola, woman with tetraplegia, age 29, Guatemala; Lili, a woman with a physical disability, age 62, Mexico; Rosario, a woman with muscular dystrophy, age 23, Argentina; Gina Rose, a woman with a visual impairment, age 37, the Philippines; Gwen, a non-binary autistic person, age 24, France; A non-binary autistic person with post-traumatic stress disorder, the Netherlands; Linda, a woman with an intellectual disability, age 41, New York, U.S.; Alex, a non-binary, autistic person with physical, emotional, and mental disabilities, age 23, Texas, U.S.; A woman with physical disabilities, age 26, New York, U.S.; Karina, a woman with mental disabilities, age 41, U.S.

<sup>45</sup> A non-binary autistic person, age 30, U.S.

<sup>46</sup> See, e.g., WOMEN ENABLED INTERNATIONAL, ABORTION AND DISABILITY: TOWARDS AN INTERSECTIONAL HUMAN RIGHTS-BASED APPROACH 7 (2020),

<https://womenenabled.org/pdfs/Women%20Enabled%20International%20Abortion%20and%20Disability%20-%20Towards%20an%20Intersectional%20Human%20Rights-Based%20Approach%20January%202020.pdf>;

Andrea, age 50; Marcela, a woman with a psychosocial disability, age 59, Chile, translated from Spanish {“...Nos preocupa que se hable de un protocolo ético de la mesa social, cuando los servicios públicos solo consultan la familia y ven la ficha clínica de los pacientes, y que esto sea ético pero, que nadie tenga información accesible sobre declaraciones de voluntad anticipada por ejemplo para el acceso de respiradores mecánicos en casos críticos”}.

<sup>47</sup> ICESCR, *supra* note 2, art. 11.

<sup>48</sup> ESCR Committee, *Gen. Comment No. 14*, *supra* note 3, para. 43.

<sup>49</sup> CEDAW, *supra* note 4, art. 13; CRPD, *supra* note 4, art. 28.

<sup>50</sup> CRPD, *supra* note 4, art. 19.

<sup>51</sup> CRPD Committee, *General Comment No. 5 on living independently and being included in the community*, para. 43, U.N. Doc. CRPD/C/GC/5 (2017).

<sup>52</sup> *Id.*, para. 38.

<sup>53</sup> See, e.g., MATTHEW J. BREIDING & BRIAN S. ARMOUR, THE ASSOCIATION BETWEEN DISABILITY AND INTIMATE PARTNER VIOLENCE IN THE UNITED STATES, 25(6) ANN. EPIDEMIOL. 455 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4692458/>

<sup>54</sup> See, e.g., Women Enabled International, *Submission on the Rights of Women with Disabilities in the World of Work to the Working Group on the issue of Discrimination against Women in Law and in Practice* (Aug. 30, 2019), <https://womenenabled.org/pdfs/WEI%20Submission%20Women%20with%20Disabilities%20and%20the%20World%20of%20Work%20August%2030,%202019.pdf>.

<sup>55</sup> For instance, it costs 25% more to live with a disability in the UK than without one, considering additional expenses for support services and health care. PAPWORTH TRUST, DISABILITY IN THE UNITED KINGDOM 2014: FACTS AND FIGURES 14 (2014),

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<http://www.papworthtrust.org.uk/sites/default/files/UK%20Disability%20facts%20and%20figures%20report%202014.pdf>.

<sup>56</sup> See, e.g., Aimee Pichi, “The doubly high cost of being female,” CBSNEWS.COM, Apr. 7, 2018,

<https://www.cbsnews.com/news/the-doubly-high-cost-of-being-female/>.

<sup>57</sup> See, e.g. Pratima, a woman with a physical disability, age 39, Nepal; Nanyunja, a woman with a physical disability, age 30, Uganda; an autistic woman with various psychiatric and learning disabilities, Washington, U.S.; Karina, a woman with mental disabilities, age 41, U.S.; Barbara, a woman with a physical disability, age 71, Indiana, U.S.

<sup>58</sup> A woman with a physical disability, age 43, Serbia.

<sup>59</sup> A woman from Uganda.

<sup>60</sup> See, e.g., Marilene, a woman with a hearing impairment, age 46, Brazil; Rachel, a woman with a physical disability, age 61, Malawi; A Deafblind woman, age 45; a woman with a psychosocial disability, age 39, Ireland; Lyness, a woman with physical disabilities, age 54, Malawi; a woman with paraplegia, age 56; Aver, a woman with a physical disability, age 34, Nigeria; a woman with psychosocial disabilities, age 48; Lisa, an autistic woman, age 30, U.K.; Alex, a non-binary, autistic person with physical, emotional, and mental disabilities, age 23, Texas, U.S., Namugabwe, a person with a psychosocial disability (access to support groups), Line 42, Abia, a woman with a physical disability, age 34, Pakistan; Caroline, a woman with a physical disability, age 48, France; a woman with depression, age 65, Indiana, U.S.; Cassandra, a woman with diabetes and a compromised immune system, age 25, U.S.

<sup>61</sup> Daisy, a non-binary person with ME, age 27, U.K.; Caitlin, an autistic woman, age 22, Australia; Estefania, a blind woman, age 26, Panama; Asia, a woman with a physical disability, age 30, Jordan; A woman with a physical disability, age 43, Serbia (dependent on husband now and restricted to neighbourhood), Joyce, a woman with physical disabilities, age 55, Canada.

<sup>62</sup> Shanta Memorial Rehabilitation Centre, *COVID 19 and Impact of Lockdown on Women with Disabilities in India* (2020),

[http://www.internationaldisabilityalliance.org/sites/default/files/covid\\_and\\_women\\_with\\_disabilities\\_in\\_india\\_-\\_edited\\_1.pdf](http://www.internationaldisabilityalliance.org/sites/default/files/covid_and_women_with_disabilities_in_india_-_edited_1.pdf).

<sup>63</sup> Bahar Turan (Engelli Kadın Derengi), *To be a Disabled Women in Coronavirus in Turkey – English Summary* (June 2020), <http://engellikadin.org.tr/wp-content/uploads/2020/06/To-be-A-Disabled-Woman-in-Coronavirus.pdf/>.

<sup>64</sup> A woman with muscular dystrophy, age 33, the Netherlands; A woman with chronic illness, age 34.

<sup>65</sup> A woman with physical paraplegy, age 56; Barbara, a woman with a physical disability, age 71, Indiana, U.S.; A non-binary person with depression, age 25, U.S.; Rosario, a woman with muscular dystrophy, age 23, Argentina; Celeste, a blind woman, age 19, Argentina.

<sup>66</sup> Andrea, a woman with a visual disability, age 33, Argentina, translated from Spanish (“Si bien se permite la circulación de personas que deban asistir a personas con discapacidad, mi temor es que muchas personas con discapacidad visual llevábamos una vida autónoma, aunque para eso necesitábamos ayuda de otras personas para cruzar las calles. Pero esa ayuda no cumpliría con el distanciamiento social requerido en esta emergencia, por lo que supongo que nuestra vida independiente se verá restringida hasta tanto dure la pandemia”).

<sup>67</sup> translated from Spanish (“Mi familia es quien tiene que hacer las compras porque yo para ir a cualquier negocio tengo que cruzar una avenida y nadie se acerca a ayudar para evitar el contacto”).

<sup>68</sup> A woman with a disability resulting from polio, age 44, Nepal; Pratima, a woman with a physical disability, age 39, Nepal.

<sup>69</sup> Rosario, a woman with muscular dystrophy, age 23, Argentina, translated from Spanish (“Antes tenía una persona que me asistía a cambiarme y bañarme todos los días. Con ésta situación se hace imposible el servicio y me siento impotente frente a mi propia higiene.”).

<sup>70</sup> Lyness, a woman with physical disabilities, age 54, Malawi.

<sup>71</sup> Daisy, a non-binary person with ME, age 27, U.K.; Caitlin, an autistic woman, age 22, Australia; Estefania, a blind woman, age 26, Panama; Asia, a woman with a physical disability, age 30, Jordan; A woman with a physical disability, age 43, Serbia (dependent on husband now and restricted to neighbourhood), Joyce, a woman with physical disability, age 55, Canada.

<sup>72</sup> A woman with a disability resulting from polio, age 44, Nepal.

<sup>73</sup> A woman from Uganda.

<sup>74</sup> Lisa, an autistic woman, age 30, U.K.

<sup>75</sup> A woman with a physical disability, age 43, Serbia (dependent on husband now and restricted to neighbourhood); Celeste, a blind woman, age 19, Argentina, translated from Spanish (“Mi familia es quien tiene que hacer las

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compras porque yo para ir a cualquier negocio tengo que cruzar una avenida y nadie se acerca a ayudar para evitar el contacto”).

<sup>76</sup> See, e.g., U.N. Commission on Human Rights, *Women and adequate housing: Study by the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living*, Miloon Kothari, para. 64, U.N. Doc. E/CN.4/2005/43 (2005), [https://www.un.org/womenwatch/enable/E-CN4-2005-43\\_Housing.pdf](https://www.un.org/womenwatch/enable/E-CN4-2005-43_Housing.pdf).

<sup>77</sup> Centers for Disease Control and Prevention, *Coronavirus Disease 2019: Cases in the U.S.*, <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html> (accessed June 2020).

<sup>78</sup> Government of the United Kingdom, *Coronavirus in the UK*, <https://coronavirus.data.gov.uk/> (accessed June 2020); Government of Canada, *COVID-19 Resources*, <https://resources-covid19canada.hub.arcgis.com/> (accessed June 2020); South African Government, *Minister Zweli Mkhize confirms total of 55 421 cases of Coronavirus COVID-19* (June 10, 2020), <https://www.gov.za/speeches/minister-zweli-mkhize-confirms-total-55-421-cases-coronavirus-covid-19-10-jun-2020-0000>.

<sup>79</sup> World Health Organization, *WHO Coronavirus Disease (COVID-19) Dashboard*, <https://covid19.who.int/> (accessed June 2020).

<sup>80</sup> UN Women, *COVID-19: Emerging gender data and why it matters*, <https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters> (accessed June 2020).

<sup>81</sup> United Nations, *Policy Brief: Impact of COVID-19 on Women* 19 (April 2020), <https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2020/06/report/policy-brief-the-impact-of-covid-19-on-women/policy-brief-the-impact-of-covid-19-on-women-en-1.pdf>; *Policy Brief: A Disability-Inclusive Response to COVID-19* 4 (May 2020), [https://www.un.org/sites/un2.un.org/files/sg\\_policy\\_brief\\_on\\_persons\\_with\\_disabilities\\_final.pdf](https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf).

<sup>82</sup> UN Women, *Surveys show that COVID-19 has gendered effects in Asia and the Pacific*, <https://data.unwomen.org/resources/surveys-show-covid-19-has-gendered-effects-asia-and-pacific>

<sup>83</sup> Joseph Shapiro, “COVID-19 Infections And Deaths Are Higher Among Those With Intellectual Disabilities,” NPR.ORG, June 2, 2020, <https://www.npr.org/2020/06/09/872401607/covid-19-infections-and-deaths-are-higher-among-those-with-intellectual-disabili>.

<sup>84</sup> *Id.*