

THE IMPACT OF COVID-19 ON WOMEN AND GIRLS WITH DISABILITIES

A Global Assessment and Case Studies on Sexual and Reproductive Health and Rights, Gender-Based Violence, and Related Rights



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EXECUTIVE SUMMARY

“When I worked in the disability [sector] in 1993, women with disabilities’ situation was worse, because they had to live inside the house. They had nothing to do. They were uneducated. ... With the pandemic, that same situation is happening to women with disabilities again, because they are losing their jobs, they have to stay all day and night with the family and can’t contribute to the family. It is a really hard time, especially for women with disabilities.”

— Rama, a woman with a physical disability, Nepal

In 2020, the U.N. Population Fund (UNFPA) and Women Enabled International (WEI), alongside the U.N. Partnership for the Rights of Persons with Disabilities and eight local and regional organisations working to advance rights for persons with disabilities, partnered to undertake a global study of the impact of COVID-19 on women and girls with disabilities, particularly as related to their sexual and reproductive health and rights (SRHR) and their right to be free from gender-based violence (GBV). Through virtual consultations with and written survey responses from over 300 women, girls, men, and gender non-conforming persons with disabilities, their advocates, and their support persons from around the world, we have learned that in almost all contexts—Global North and Global South, in places hit hard by COVID-19 and others with a much lower rate of infection—women and girls with disabilities have been left behind. They have struggled to meet their basic needs, to access needed health services including those needed both because of their gender and disability, and have faced disproportionate risks of violence.

In particular, this Impact Assessment identifies that:

- ◆ Barriers to accessing sexual and reproductive health (SRH) information, goods, and services and exercising bodily autonomy for women and girls with disabilities have increased during the COVID-19 pandemic, in ways that are both similar to and distinct from other women’s experiences. For instance, some women and girls with disabilities who require the assistance of sign language interpreters or other assistants to access SRH services were no longer allowed to bring those individuals with them, due to social distancing rules. Lack of accessible and affordable transportation options meant that, when family planning clinics closed in local communities, women and girls with disabilities disproportionately could not travel to other communities to receive SRH services and goods. In two extreme cases, a deaf woman from Fiji and a non-binary autistic person from Chile could not access urgent SRH services and faced potentially dire consequences for their health and lives.
- ◆ Women and girls with disabilities worldwide faced increased risk factors for GBV and compounded barriers to accessing GBV support services, police, and justice mechanisms. As women and girls with disabilities were confined at home with their families and lost their usual systems of support, tensions rose, leading to physical, sexual, emotional, and psychological violence against them. Family and friends who were new to caretaking responsibilities, or who were not receiving respite from those responsibilities, sometimes

withheld needed assistance or weaponized disability to denigrate or undermine women and girls with disabilities. At the same time, GBV support services became even harder to access due to lockdown measures, and police were re-allocated away from investigating GBV and towards enforcing COVID-19 restrictions. Justice mechanisms also moved even more slowly in some contexts, leading to virtual impunity for perpetrators.

- ◆ Women and girls with disabilities—often primarily due to their disability status—were cut off from other needed health services, lost access to employment and education, lost access to disability-related support services, and faced significant barriers to affording and accessing food, clean water, housing, sanitation items, and other basic needs. These other related rights issues impacted the ability of women and girls with disabilities to fully exercise their SRHR, bodily autonomy, and the right to be free from violence.

Gender and disability have not necessarily equally impacted the experiences of women and girls with disabilities during the COVID-19 pandemic. For instance, the barriers that women and girls with disabilities report to meeting basic needs or to accessing employment and education during the COVID-19 pandemic are largely based in disability discrimination and exclusion. On the other hand, many of the new barriers they have experienced to accessing SRH and exercising bodily autonomy are similar to those experienced by other women and girls. However, the situation of women and girls with disabilities before this crisis was significantly worse than for others. Before the pandemic, they were less likely than both men and boys with disabilities and non-disabled women to have access to employment or education; were more likely to live in poverty; faced higher rates of violence, and encountered significant accessibility and attitudinal barriers based on both gender and disability to exercising their SRHR. These pre-existing barriers, combined with the impact of COVID-19 itself, have created a particularly precarious situation for women and girls with disabilities, as distinct from other groups.

In addition to these global findings, this Impact Assessment presents four case studies on the impact of COVID-19 in particular country contexts. These countries—Malawi, the United Kingdom, Chile, and Fiji—were in very different places in ensuring the rights of women and girls with disabilities before the COVID-19 pandemic, had different experiences with the severity of the pandemic, and had different governmental and public health responses. These case studies provide the opportunity to examine how differences in the realization of rights for women and girls with disabilities before the pandemic, as well as differing approaches to the crisis, have impacted women and girls with disabilities from a variety of backgrounds.

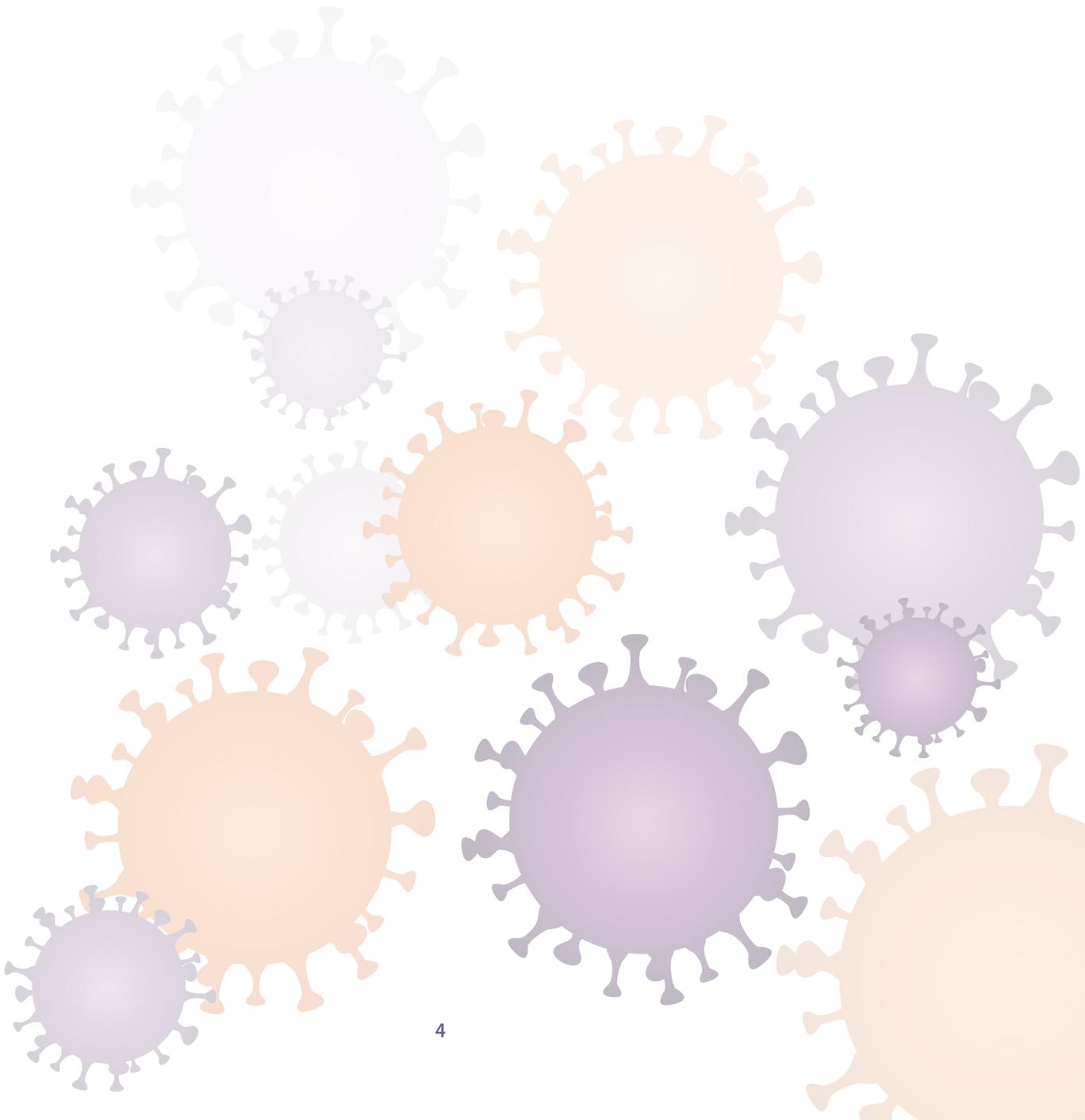
Drawn from this Impact Assessment are three important lessons for States, U.N. agencies, human rights experts, humanitarian responders, public health officials, advocates, and others to take into the recovery from COVID-19 and into preparation for and response to future crises:

- 1. In preparation for and response to crises, States must turn to existing international guidance on disability inclusion, SRHR, freedom from violence, and related rights.** Women and girls with disabilities were almost universally invisible in policies and programmes adopted to address COVID-19, but many of the impacts of COVID-19 on this population were anticipated in pre-existing international guidance on humanitarian response. In the future, this guidance must be incorporated into crisis preparation and response.
- 2. Women and girls with disabilities themselves must be included in the preparation for, response to, and recovery from crises.** The absence of policies and programmes explicitly recognizing the lived experiences of women and girls with disabilities during this crisis has largely been a result of their

exclusion from participation in these processes. Their inclusion in future crisis response is imperative for ensuring that women and girls with disabilities are not left behind.

- 3. States must undertake long-term efforts to ensure the full respect, protection, and fulfilment of SRHR, the right to be free from violence, and related rights for women and girls with disabilities at all times.** The differential impact of the COVID-19 pandemic was often just an exacerbation of pre-existing inequalities experienced by women and girls with disabilities. To ensure that women and girls with disabilities can live with dignity, both during and outside of crises, long-term efforts must be undertaken to implement human rights obligations in all contexts.

This Impact Assessment highlights the lived experiences of women and girls with disabilities as the basis for these findings and these lessons learned. We thank them for their time and willingness to share those experiences, and we hope that we can honour those experiences to ensure a rights-based, gender- and disability-inclusive response and recovery from the COVID-19 crisis and future crises.



INTRODUCTION

On 11 March 2020, the World Health Organization (WHO) declared COVID-19 a pandemic. In the days that followed, as case counts rose, it was clear that the world was in the midst of a global health emergency. Countries and cities closed schools, mandated restrictions on movement and gatherings, changed healthcare protocols, and otherwise braced for a global health, economic, and human rights emergency.

Governments as well as international organisations had learned some lessons from past emergencies about how to respond to such a disaster. For instance, in many contexts, global, national, and local actors had learned that the need for sexual and reproductive health goods and services continues during times of emergency and that the provision of sexual and reproductive healthcare (SRH) needed to remain a priority in this crisis.¹

For many of people experiencing marginalization around the world, however, the lessons from past disasters and emergencies did not translate into rights protections, and they found themselves left behind in the COVID-19 response. Indeed, both women and persons with disabilities have experienced disproportionate impacts on their employment, their health, and their well-being due to the COVID-19 crisis. Those experiencing intersectional discrimination based on gender and disability, such as women and girls with disabilities, have faced even greater barriers to accessing healthcare, including SRH, and higher risks of violence, unemployment, and inability to meet basic needs. As Pratima, a woman with a physical disability and advocate for indigenous persons with disabilities in Nepal, shared with researchers for this Impact Assessment, related to response to the COVID-19 crisis, “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 single linear model is not working for women with disabilities and other marginalized groups.”²

To the extent that global actors and governments had learned the lesson of intersectionality, their responses were not adequate to overcome the ways in which COVID-19 exacerbated the pre-existing barriers to sexual and reproductive health and rights (SRHR), freedom from violence, and fulfilment of the full range of rights for women and girls with disabilities. Indeed, as the U.N. Committee on the Rights of Persons with Disabilities (CRPD Committee)—the expert body monitoring the implementation of disability rights around the world—has found, women and girls with disabilities face unique and disproportionate barriers to exercising their rights, due to their gender and disability, even outside of times of emergency.³ It is therefore not surprising that States were not prepared to adequately consider and address the needs and rights of women and girls with disabilities during the COVID-19 pandemic.

This paper provides an assessment of the impact of COVID-19 on the exercise of rights for and well-being of women and girls with disabilities around the world. It is based on 20 virtual consultations and written survey results from over 300 women, girls, and gender non-conforming persons with disabilities, as well as their advocates, family members, and support persons, in all of the major world regions.

This Impact Assessment has a particular focus on SRHR and freedom from gender-based violence (GBV) for women and girls with disabilities. All persons with disabilities—including women and girls with disabilities—maintain a right to SRH and bodily autonomy and a right to be free from violence, even when facing humanitarian crises. States have agreed to respect, protect, and ensure these rights by ratifying the Convention

on the Rights with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and other human rights treaties, as well as signing on to the Programme of Action of the International Conference on Population and Development (ICPD).⁴ These human rights standards should guide COVID-19 response and recovery, as well as preparation for, response to, and recovery from other crises.

This particular focus on SRHR and GBV is because women and girls with disabilities experience disproportionately high rates of violence, and access to SRH information, goods, and services, as well as the ability to make decisions about one's own body and life, are rights that are disproportionately overlooked for women and girls with disabilities as compared to other groups.⁵ SRHR and GBV did not impact the daily lives of all virtual consultation participants and survey respondents during the pandemic. However, those who were in need of SRH or experienced GBV during the pandemic faced sometimes harrowing barriers to accessing goods and services, including contraception, treatment for reproductive cancers, and healthcare related to pregnancy, childbirth, and the post-partum period, as well as an inability to escape violent situations.

At the same time, many women and girls with disabilities experienced barriers to meeting their other needs and fulfilling their other rights, which in turn impacted their SRHR and risk of GBV. These included a decrease in their ability to independently meet basic needs—such as those related to food, hygiene, housing, and water—due to the loss of income and educational opportunities, barriers to accessing their usual systems of disability-related support, and government protection programmes that were not designed with gender and disability in mind.

These virtual consultations and survey responses also revealed that, although the diversity of disability, age, location, and other factors has made some difference in the impact of COVID-19 on the lives of women and girls with disabilities, there are some experiences that are near-universal and that, with adequate preparation, could have been prevented and addressed. These “Lessons Learned” are presented in a section after the analysis of the virtual consultations and written surveys below. Also following the global results of these virtual consultations and surveys, case studies from four diverse countries—Chile, Fiji, Malawi, and the United Kingdom—highlight how individual country situations and responses impacted the lives of primarily women and girls with disabilities during the COVID-19 crisis.

Brief Methodology of Virtual Consultations and Written Surveys

The results outlined in this Impact Assessment stem from 20 virtual consultations with 173 women, girls, and gender non-conforming persons with disabilities, family members, and advocates for their rights in Latin America, Asia-Pacific, Sub-Saharan Africa, Europe, and Central Asia. The results of this Impact Assessment are also based on 137 responses to written surveys by women, girls, and men with disabilities and their support persons in the Arab region, Mauritania, and the Pacific. These consultations and written surveys were undertaken in the second half of 2020.

Virtual consultations usually included between 5 and 10 individuals and were led by 1 or 2 facilitators from the staff of WEI, the UNFPA, and local, national, and regional partner organisations.⁶ Both virtual consultations and written surveys were focused on several topics, including access to healthcare, particularly SRH information, goods, and services; safety from violence; access to support services and other means to meet basic needs; and access to education, employment, and other income. The standard questionnaire for the virtual consultations and the written surveys is available in [Annex B below](#).

Virtual consultation participants were primarily identified by national and regional civil society partners, with input from WEI and UNFPA. They were identified to try to represent a diversity of socioeconomic backgrounds, ages, ethnicities, geographic locations such as rural and urban communities, gender identities, and impairments or disabilities, with a particular emphasis on ensuring the inclusion of women, girls, and gender non-conforming persons with disabilities who are often underrepresented in global surveys. For instance:

- ◆ Six of the virtual consultations were focused on women and girls with intellectual or learning disabilities in Europe and Central Asia, and women with intellectual disabilities further participated in country or regional consultations as well as written surveys in Africa, the Arab region, the Asia-Pacific region, and Latin America.
- ◆ Deaf and hard-of-hearing persons participated in written surveys in the Arab region and in nine national and regional consultations in Latin America, Sub-Saharan Africa, and Asia-Pacific.
- ◆ Women and gender non-conforming persons with psychosocial disabilities participated in the vast majority of consultations.
- ◆ A consultation with women with disabilities in Nepal included several indigenous women with disabilities, and consultations in Sri Lanka further included ethnic and language minorities.
- ◆ Non-binary persons with disabilities participated in consultations in Africa, Asia-Pacific, and Latin America,
- ◆ Written surveys and some virtual consultations also reached individuals in areas affected by conflict or other humanitarian emergencies.
- ◆ Young women and girls with disabilities were more than half of survey respondents in the Arab region and made up a majority of virtual consultation participants in Eastern Europe and Central Asia.

The surveys and virtual consultations had some limitations. Virtual consultation organizers provided a small stipend (\$25 USD) to cover internet, transportation, or other costs incurred by participants in the consultations, when needed and requested. However, due to the barriers to internet access particularly in rural and remote areas, individuals from those areas are underrepresented in this Impact Assessment. Furthermore, the surveys and virtual consultations did not reach persons, particularly those with intellectual or psychosocial disabilities, living in psychiatric hospitals or long-term residential care institutions and who may have been particularly at risk during the COVID-19 pandemic. Finally, although virtually all consultations included young persons with disabilities, only consultations in Eastern Europe and Central Asia and written surveys in the Arab region reached girls with disabilities and directly documented their lived experiences during the pandemic. We hope that these gaps will be addressed in future research.

For a full summary of the methodology for conducting and analysing results from virtual consultations and written surveys, see [Annex A below](#).

IMPACT OF COVID-19 ON GENDER NON-CONFORMING PERSONS WITH DISABILITIES

During the COVID-19 pandemic and in their daily lives, gender non-conforming persons with disabilities experience intersectional discrimination, marginalization, and stigma that is distinct from the intersectional discrimination experienced by women and girls with disabilities. As such, international human rights standards recognize the right of gender non-conforming persons with disabilities to be free from discrimination on these grounds.⁷

There has been work by several individuals and organisations to document the lived experiences of gender non-conforming persons, including those with disabilities, during the COVID-19 pandemic. In July 2020, the U.N. Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Víctor Madrigal-Borloz, issued a report on the impact of COVID-19 for lesbian, gay, bisexual, transgender (LGBT) and gender-diverse communities. The report outlines that, while several of the risks faced by these individuals overlap with those faced by women and girls with disabilities during the pandemic, COVID-19 has also increased risks of their continued criminalization in some contexts and furthered their “demonization” within their communities, while lack of recognition of their gender identities on identification and other documents could lead to denial of aid or treatment during the pandemic.⁸ Related to gender non-conforming persons with disabilities in particular, the results from a global survey conducted by WEI in March and April 2020 outlined that non-binary and trans persons with disabilities experienced barriers to accessing needed hormones and other medications related to their gender and faced increased risks of violence based on gender from family members with whom they were now living due to the COVID-19 crisis and from whom they had to receive disability-related assistance with meeting daily needs.⁹

Four gender non-conforming persons with disabilities participated in the virtual consultations and surveys conducted by UNFPA, WEI, and local partners related to this Impact Assessment. Similar to the women and girls with disabilities included in this Impact Assessment, these individuals reported significant barriers to accessing urgent SRH services, violence that had gotten little attention from the police, and stigma and harassment from their communities as a result of their disability and/or gender. Their stories and experiences are shared below. However, because the number of gender non-conforming persons who participated in the virtual consultations is small, this Impact Assessment cannot provide a full picture of the lived experiences of gender non-conforming persons with disabilities during the COVID-19 pandemic. We hope that others will continue to document these lived experiences and ensure that gender non-conforming persons with disabilities are included in COVID-19 response and recovery, as well as response and recovery from future crises.

IMPACT OF COVID-19 ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Women with disabilities are almost one-fifth of the world's population of women,¹⁰ and they are just as likely to be sexually active as their peers without disabilities,¹¹ despite inaccurate stereotypical views to the contrary. Hence, they have the same SRH needs, rights, and desires as any other women. Due to multiple and intersecting forms of discrimination on the basis of gender and disability, however, women and girls with disabilities face unique and pervasive barriers to the full realization of their SRHR.

Women and girls with disabilities are deeply affected by restrictions on access to SRH, even though the literature exploring the intersection of disability and SRHR is scarce.¹² Hindering or restraining access to SRHR may affect several aspects of the lives of women with disabilities, such as education, employment, and participation in public life, as it may undermine their health, wellbeing, and self-esteem, leading to isolation, disempowerment, and infantilization. Hence, SRHR may be a prerequisite to fulfilling other human rights and, concurrently, its realization depends on other rights, such as universal accessibility, non-discrimination, freedom from violence, privacy, and information.¹³

This section will explore how the COVID-19 pandemic exacerbated pre-existing barriers to SRHR for women and girls with disabilities, based on the experiences of the participants in this the virtual consultations and written surveys. It also explores how COVID-19-related restrictions imposed further barriers to SRHR for this group.

Access to Sexual and Reproductive Health Information, Goods, and Services Before the COVID-19 Pandemic

Even before the COVID-19 pandemic, accessing SRH care was more challenging for women and girls with disabilities as compared to other persons for several reasons. The equipment and facilities in SRH settings are often not physically accessible or located near the homes of women with disabilities, without accessible and affordable transportation options, and healthcare providers may demonstrate a lack of sensitivity, courtesy, and support for them. Women with disabilities may also face financial, social, and psychological barriers to accessing adequate reproductive healthcare.¹⁴ Discrimination, stigma, stereotypes, and cultural taboos in communities and among healthcare workers about disability, including around the sexuality and ability to parent of persons with disabilities, also pose significant barriers to their access to acceptable and quality SRH information, goods, and services.¹⁵ Lack of confidentiality and privacy is a further major barrier for persons with disabilities in accessing SRH, as healthcare providers may lack training to communicate with them directly and often do not provide access to neutral support persons.¹⁶

Virtual consultation participants and survey respondents reported a range of experiences in accessing SRH information, goods, and services prior to the COVID-19 pandemic. For instance, many respondents shared that they had never or rarely accessed SRH information or services before the pandemic. This was for a variety of reasons, including accessibility barriers, assumptions that they do not need SRH information and services based on stereotypes about their sexuality, and other cultural taboos, including related to disability.¹⁷

Many women and girls with intellectual disabilities in particular reported that they had rarely been provided with information in school or by their families about sexuality and had rarely visited an SRH provider.¹⁸ For instance, in consultations with 23 women, young people, and girls with intellectual disabilities in Eastern Europe and Central Asia, only one reported that she had ever received gynaecological services.¹⁹ In Kosovo, some of the mothers of consultation participants expressed that they were hesitant for their adult daughters to receive information about SRH and bodily autonomy. The mother of an 18-year-old woman with an intellectual disability said that her daughter was too young to inform her about relationships and thought SRH information would be disturbing. Another, the mother of a 26-year-old, responded to the question of whether she might one day talk about SRH with her daughter by stating, “No, it is something very delicate.”²⁰

These stereotypes about sexuality extend beyond direct access to SRH and impact a range of rights for women and girls with disabilities related to their bodies, intimate relationships, and sexuality. For instance, in Sri Lanka, consultation participants reported that they are not encouraged by their families to choose a partner or to get married. One consultation participant reported that persons with disabilities are sometimes abused and raped, but marrying them is considered taboo, and it is also considered taboo for women with disabilities to have children. Another consultation participant reported that it is considered a burden for a man to marry a woman with a disability.²¹

Some people who had accessed SRH information, goods, or services before the pandemic, or had heard stories of other women and girls with disabilities doing so, reported dismissive and sometimes hostile attitudes from healthcare providers, which had made them avoid accessing further care.²² For instance, Martha, an advocate for deaf-blind persons in Malawi, shared that: “There is also attitudinal challenges. Women with disability don’t want to go to the hospital because they see negative attitude. For example, health practitioners say, ‘you are deaf-blind or disabled, how did you become like this [pregnant]?’ Women with disability feel like they can’t have intimate relationships because of the attitude they see from healthcare providers.”²³

“Before the pandemic, I had not been to doctors to treat my SRH very often. . . when I did, I felt a lot of prejudice, as if I were a child.”

— A participant in a virtual consultation from Latin America

Virtual consultation participants and survey respondents also expressed that healthcare providers did not always give persons with disabilities an opportunity to make informed decisions about their SRH, contributing to the negative experiences some of them had in these settings. For instance, Lyness, a woman with a physical disability in Malawi, explained, “Women with disabilities are not given the chance to choose which family planning we want to use. The providers end up choosing for us”²⁴ Gina, a woman with a learning disability in the U.K., reported that although she uses a contraceptive implant to prevent pregnancy, she felt that contraceptive options were not always explained to her in a way she could understand.²⁵

Accessibility barriers and lack of support have played a significant role in preventing virtual consultation participants and survey respondents from accessing SRH. For instance, several virtual consultation participants and survey respondents shared that there was generally a lack of sign language interpretation in SRH facilities, inhibiting communication between patients and providers. This posed a financial barrier to some respondents in accessing services, as they had to bring their own interpreters, and for others, it dissuaded them from seeking SRH services, because they did not want to jeopardise their privacy.²⁶

“Regarding the Deaf community, there is no accessibility in this area [SRH]. . . There are certain things which one does not want to discuss with one’s parents, siblings, or children, including sexual topics. It is complicated. One needs a professional that uses sign language, who can provide this type of counselling.”

— A deaf woman, Ecuador

These pre-existing barriers to exercising SRHR are important to acknowledge as part of the COVID-19 pandemic, as they have led to a lower baseline of SRH, bodily autonomy, and access to health information, goods, and services for women and girls with disabilities leading into the crisis. The next section will explore how these barriers have been exacerbated—and new barriers have emerged—in the wake of this global health emergency.

Barriers to Sexual and Reproductive Health and Rights Exacerbated or Caused by COVID-19

The COVID-19 crisis has created further barriers to SRH information, goods, and services and the exercise of bodily autonomy for all persons, including persons with disabilities. Some of these barriers have resulted from specific COVID-19 restrictions, such as lockdowns or social distancing measures, while others have resulted from fear and stigma, including fear of catching the virus and cultural barriers to accessing information, goods, and services now that women and girls with disabilities are confined in homes with their families. Many of these barriers impact all women and girls but are exacerbated for women and girls with disabilities due to the pre-existing barriers to their exercise of SRHR, described above, as well as the creation of new rules and protocols in healthcare settings that have not always taken disability into consideration. These barriers have largely left women and girls with disabilities without SRH information, goods, and services and the ability to exercise their bodily autonomy during the pandemic.

Impact of Lockdown Measures and Changes to Healthcare Delivery

“I was diagnosed with the ovarian cyst. I was supposed to go for an operation in April. But, after COVID-19 hit Zambia, I couldn’t see the doctor anymore, because the health facility where I saw the gynaecologist was closed after they confirmed the first case of COVID-19. From then after that, I’ve been having some issues with my female reproductive organs, especially [the right side].”

— Soneni, a woman with a physical disability, Zambia, age 35

In some locations, virtual consultation participants and survey respondents reported that SRH-related facilities either partially or fully closed down, were reallocated towards other health services with staff reassigned to address COVID-19, or became more limited in the types of services they provided.²⁷ Overburdened healthcare systems, shortages in SRH goods and commodities, and changes to protocols also limited access to SRH and other healthcare for persons with disabilities, even when those services were technically still available.²⁸

For instance, Jackie, a woman with multiple disabilities in the U.K., reported that she had a specific form of contraception (which she referred to as a “coil”) to stop her from getting pregnant, but at the time of the virtual consultation, she was confused about when the coil needed changing. She had tried asking her doctor, and he said he would call back but, at the time of the virtual consultation, he had not done so.²⁹

These changes to healthcare protocols, services, and staffing have had a negative impact on SRHR for all women and girls, but virtual consultation participants and survey respondents reported some changes that particularly impacted them due to both their gender and disability. For instance, several virtual consultations participants reported fear of going to health clinics or hospitals, because they did not want to catch COVID-19 or be suspected of having COVID-19, a particular concern for persons with disabilities who have been disproportionately impacted by the virus.³⁰

“There are very few hospitals that are non-COVID and many women with disabilities because of many co-morbidities, they need safer environments.”

— Nidhi, a woman with a visual impairment and advocate for women with disabilities, India

These changes impacted many different kinds of SRH service delivery, including for pregnant persons with disabilities who were receiving maternal healthcare. As an example, a woman with a visual impairment in Bangladesh reported that she was not receiving adequate maternal healthcare during her pregnancy, due to the pandemic. She had to change doctors several times because they did not pay enough attention to her. One doctor did not check her blood pressure. She particularly noted how important it is for healthcare providers to talk to persons with disabilities directly and not to their support persons.³¹

Accessibility and Attitudinal Barriers Caused by COVID-19 Restrictions

A number of disability-related accessibility and attitudinal barriers also arose for women and girls with disabilities related to SRH services and goods during the COVID-19 pandemic. The accessibility barriers resulted directly from lockdown and social distancing measures, while attitudinal barriers—including stigma and stereotypes about persons with disabilities that they may carry COVID-19—stemmed from societal misconceptions and pre-existing healthcare provider bias.

Physical Barriers, including Barriers to Accessible and Affordable Transportation

The closing of clinics in local communities and the reallocation of resources towards COVID-19 have had a disproportionate impact on women with disabilities, who often lack sufficient accessible transportation options to access services or goods in other communities or cannot afford such transportation.³² The unavailability of SRH services near the homes of women and girls with disabilities left some SRH-related needs unmet,³³ particularly in rural and remote communities.³⁴ Even interpreters and support persons were affected by the lack of accessible transportation during the pandemic, impacting SRH.

“It was difficult for sign language interpreters to get transportation during COVID to come to the hospital to translate for deaf woman.”

– A deaf woman, South Sudan

LOCKDOWN MEASURES LEADING TO EXTREME HEALTH RISKS FOR WOMEN AND GENDER NON-CONFORMING PERSONS WITH DISABILITIES

In at least two instances, virtual consultation participants reported that the physical inaccessibility of SRH services caused by lockdown measures in their countries led to extreme risks to their health and their lives.

A 20-year-old deaf woman from Gau Island in Fiji recounted her attempt to secure police authorization to travel to the hospital to deliver a baby. Despite being in labour with her water broken, her mother spent hours calling the police to secure the necessary pass to go to the hospital. As a result of this delay, she delivered her baby in the car on the way to the hospital—almost 18 hours after her mother had first contacted the police to try to secure a pass—and fainted during the delivery.³⁵

Tamara, a non-binary person in a remote island in Chile, recounted a harrowing experience during the pandemic, with no access to needed healthcare off the island:

I was bleeding for a month, and I went to the midwife, and they injected me with a 'hormone bomb' ... to stop the bleeding. After a month, I started bleeding again so they gave me another one ... because here there are no gynaecologists and that is the only thing the midwives can do to stop the bleeding until I can travel to Punta Arenas to see what is happening down there, because there must be something that is failing. In my case, I have a history of breast cancer. I have a cyst in my armpit that is under control, and I have to get a mammogram every year. The thing is this week I found a lump on my other breast and, sadly, I can do absolutely nothing about it, because as in this island there are no specialists, they won't take you out [to Punta Arenas] unless you are dying.³⁶

The two experiences described above do not necessarily reflect specific disability-related barriers to SRH in the context of COVID-19. Rather, they illustrate how women and gender non-conforming persons with disabilities are also impacted by a lack of planning broadly for the provision of SRH services for all in times of crisis.

Information and Communications Barriers

Communications accessibility became a major issue for many virtual consultation participants, particularly those from the Deaf community. For those who could access in-person appointments, they were told in some contexts that they could not bring a sign language interpreter, personal assistant, or support person with them, or were no longer provided with that support by the health service providers.³⁷

“If you don’t have a sign language interpreter, the doctors often say that they can’t help you because you don’t have a sign language interpreter. Also, sometimes when you go with an interpreter, they won’t let the person to get in.”

— Sekarani, a deaf person and advocate for deaf women, Malawi

Lack of accessible information about COVID-19 restrictions themselves also caused confusion for at least one woman trying to access SRH services, possibly leading to pregnancy complications. A 35-year-old deaf woman from Fiji reported that the information available to the Deaf community underscored that you cannot leave your home during the COVID-19 pandemic, and despite being pregnant, she was too scared to leave her home even to go to the hospital for maternity care.³⁸ Women with learning disabilities in the U.K. broadly reported that the main information they were receiving about the COVID-19 pandemic and government lockdown rules was coming from a non-governmental organisation who was producing materials in Easy-Read format, because the government itself was not issuing information in formats that were accessible to them.³⁹

Financial Inaccessibility of Sexual and Reproductive Health Services and Commodities

“Because of financial shortage I couldn’t buy my sanitary pads.”

— A young woman with a physical disability, Palestine

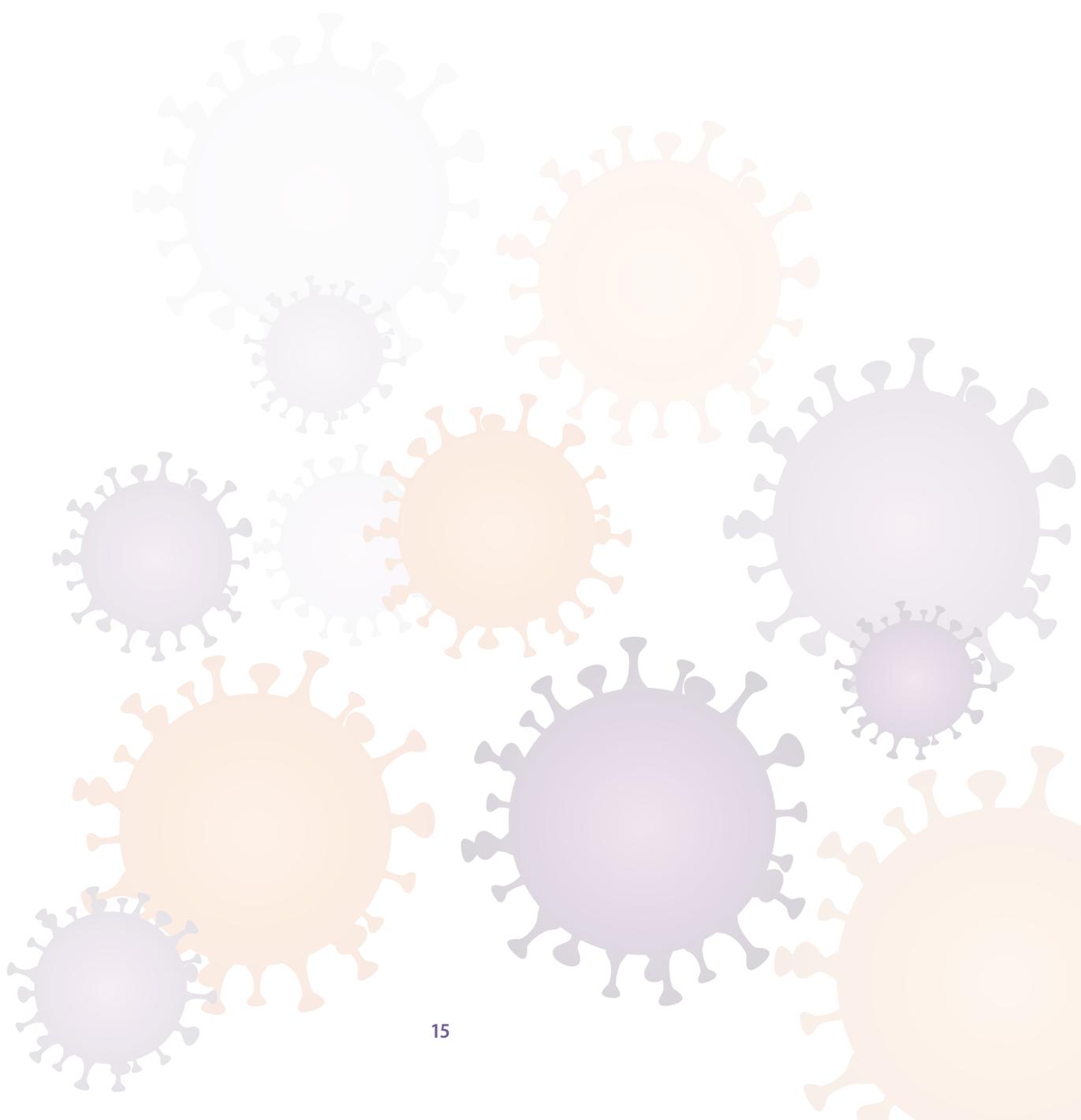
Virtual consultation participants further shared financial accessibility barriers to accessing SRH commodities and services during the COVID-19 pandemic. For instance, Janine, a woman with a visual impairment in the Philippines, asked, “How can women and girls with disability access that online consultation if they don’t have Internet or can’t pay the professional fee of their gynaecologist?”⁴⁰ Programmes to provide free dignity kits, which included menstrual hygiene items, also were suspended in some locations.⁴¹ As will be described in more detail below, many women with disabilities, already in precarious financial situations, lost access to employment or other income during the pandemic. This has meant fewer resources to pay for health goods, commodities, and services.

Barriers to Accessing Support Persons

During the COVID-19 pandemic, the usual disability-related supports that women and girls with disabilities could access within the healthcare system were sometimes reallocated to other roles. A woman with a physical disability from Pakistan reported that she could not access the support of an assistant from her healthcare services during the pandemic because of social distancing rules. As a result, she had to train her own assistant to give her those health-related supports, compromising her privacy. “We have to plan something for the future, so we can ensure that persons with disabilities should get all the relevant health services appropriately and on time.”⁴²

Stigma, Stereotypes, and Discrimination Exacerbated by the COVID-19 Pandemic

Pre-existing stigma, stereotypes, and discrimination against women and girls with disabilities related to their bodily autonomy and SRH also re-emerged during and were exacerbated by the COVID-19 crisis. This included hostile attitudes by SRH providers towards women with disabilities,⁴³ as well as assumptions by healthcare providers that women with disabilities may be infected with COVID-19, leading to negative treatment.⁴⁴ For instance, a woman with a disability in Asia reported that, when she went to the gynaecologist, the hospital staff was scared about her bringing the virus because she uses a wheelchair, which cannot be easily sanitized.⁴⁵



RISKS AND PREVALENCE OF GENDER-BASED VIOLENCE DURING THE COVID-19 PANDEMIC

Gender-Based Violence Before the COVID-19 Pandemic

Before the COVID-19 pandemic, women and girls with disabilities experienced higher rates of GBV than other women and girls, due to factors based on both their gender and disability, as well as other statuses.⁴⁶ Indeed, women and girls with disabilities experience violence from partners and family members at least three times the rate of other women.⁴⁷ Furthermore, persons with disabilities—and women and girls with disabilities in particular—face unique forms of violence, including violence at the hands of caregivers, withholding of medications or assistive devices, forced institutionalization, and forced medical interventions, and women and girls with disabilities also experience forced reproductive health interventions (including forced sterilization, contraception, and abortion) at disproportionate rates.⁴⁸ Institutionalized persons with disabilities are at further risk of violence due to their isolation.⁴⁹

As an advocate for persons with disabilities in Ethiopia shared, misconceptions and stereotypes about the sexuality of women with disabilities, combined with barriers to seeking justice and other support services, put them at greater risk of violence, even during non-emergency times:

There is also a misconception that it is safe to have sex with women with disabilities because they are pure. This misconception led to the increased number of rape cases. The justice system is not also accessible for women and girls with disabilities. Police officers don't have sign language interpreter. There are GBV shelters in Addis Ababa, but they are also not accessible. When I went there to visit and asked why the facility is not accessible for women and girls with disabilities, one of the staff told me that who would rape women with disability.⁵⁰

These factors, as well as significant accessibility barriers for women and girls with disabilities to accessing justice, alert perpetrators of GBV that they can act with impunity.⁵¹ For instance, a deaf person and advocate for deaf women with disabilities in Malawi noted, "Perpetrators take advantage to sexually abuse considering that no police can speak sign language. This could be remedied by having a sign language interpreter at a police station and empowering police to learn sign language."⁵²

Gender-Based Violence During the COVID-19 Pandemic

During lockdowns, shelter in place orders, and other times of mandatory or recommended isolation, women and girls with disabilities are even less able to escape and seek redress for violence, particularly if their usual supports are not available to them, than in non-emergency situations.⁵³ The WHO has recognized that violence typically increases during times of emergency and that women with disabilities are likely to have additional risk factors, making them more vulnerable to abuse.⁵⁴ The United Nations Children's Fund (UNICEF) has also reported that women and girls with disabilities who experience a disruption of essential services, restricted movements, and have primary caregiving responsibilities—all of which are likely to increase during an emergency like the COVID-19 pandemic—are at a higher risk for GBV.⁵⁵

Responses from virtual consultation and survey participants have indicated that women and girls with disabilities had experienced heightened risk factors for violence due to COVID-19, and many of these risk factors were based on intersectional discrimination, stigma, and stereotypes related to their gender, disability, and other factors. They also shared that police, justice mechanisms, and support services had become even less accessible to them during the pandemic, limiting their ability to escape violence, receive protection, and seek redress.

Increased Risk Factors for Violence

Several virtual consultation participants and survey respondents reported that stay-at-home and lockdown orders in their communities were increasing the risk of violence against women and girls with disabilities. Their experiences had some commonality with risks faced by other women, including as a result of tensions within households when everyone was locked in together for long periods.⁵⁶ One participant also reported an increase in child marriage in her community, experienced by girls broadly and including girls with disabilities.⁵⁷

But virtual consultation participants also reported risks that were exacerbated by disability, including because intimate partners or others had to take on new caregiving responsibilities, as well as due to discrimination and other factors.⁵⁸

“Everyone was at home, so there a lot of intolerance. Already, our disabled community is facing a lot of trouble by being a burden on their families. A lot of relations got distorted as well, people living in joint family systems and even otherwise, it gets difficult to sustain for longer time durations.”

– A woman with a disability, Pakistan

Some of these risk factors were specific to certain disability groups. For instance, a deaf woman in Ecuador shared that the lack of ability to effectively communicate with family during lockdowns has had a significant impact on deaf women:

Being at home with our families—who are not deaf—and not being able to communicate always creates a kind of discomfort and stress, and there were arguments, because they can’t understand what we want, and we can’t understand them either. There emerged violence, particularly psychological violence due to the lack of access to information... [being unable to understand each other] and the impotence caused by not knowing what is happening around oneself generates this kind of violence from both sides.⁵⁹

Increased Prevalence of Violence

Virtual consultation participants and survey respondents from around the world reported dozens of instances of violence against women and girls with disabilities during the pandemic, occurring against themselves, against family or friends with disabilities, or against people on whose behalf they advocated. This violence was sexual, psychological, physical, and emotional in nature and impacted women of diverse ages and diverse disability groups.⁶⁰

“One girl [with a disability] who was forced to marry, got pregnant, and because it was a forced marriage, she was being abused. Because of COVID-19, she was trapped and there were fears in that family.”

— **Stella, a woman with a disability and advocate for persons with disabilities,
Malawi**

Himpunan Wanita Disabilities Indonesia (HWDI), an organisation of women with disabilities, conducted a rapid assessment of the needs of women with disabilities during the COVID-19 pandemic. HWDI found that 80 percent of respondents were facing abuse, with 40 percent indicating this abuse was happening daily. This abuse was primarily psychological violence, including by close friends, family, and partners, as well as online violence and some physical and sexual abuse, including rape. In the vast majority of cases, the victims/survivors of violence did not report the crime to the police or other community authorities.⁶¹

The prevalence of violence against persons with intellectual disabilities—already higher than for other persons with disabilities before the pandemic in many contexts⁶²—also increased due to COVID-19 restrictions and tensions caused by everyone being at home together. For instance, in Kosovo, during the COVID-19 lockdown, one young woman with intellectual disabilities was threatened by her father and hit by her brother. Both of her parents, as well as her brother, have intellectual disabilities. Her parents are divorced and, although she had been living with her father, she moved in with her mother after the incident of physical abuse.⁶³ This higher prevalence of violence was also coupled with inadequate access to justice or support services for women and girls with intellectual disabilities.⁶⁴

“In Kenya, we had two sets of things. One is we’ve had a lot of girls especially with disabilities being defiled, raped, and being very severely traumatized. A girl with intellectual disability was gang raped at her own home. She may not be able to know or tell maybe of the people who did that to her. This happened because of this time when we have a lot of people that are just at home.”

– **Jenipher, a self-advocate with intellectual disabilities, Kenya, age 33,
and her support person**

Many other virtual consultation participants and survey respondents reported that they or others were experiencing disability-related violence, including physical violence, psychological and emotional violence such as getting angry when a person needed assistance or weaponizing disability to undermine or discredit a person, as well as the withholding of needed assistance due to disability and involuntary institutionalization.⁶⁵ Even though these forms of violence are primarily based on disability, for women and girls with disabilities there is also a gender component, as they may be less valued than men and boys with disabilities in their households and communities while also facing the same types of power imbalances between genders as do other women, leading to higher risk of certain forms of violence that are based on this power dynamic.⁶⁶

“Sometimes they get angry at home when I need help and they are busy. During COVID I stay a lot at home and sometimes they [family] don’t meet my needs or get angry at me when I need help.”

— A woman with a visual disability, Yemen, age 27

“I stopped talking to my father for a whole month because when I had the anxiety crisis, he said, ‘She can control it, she’s just pretending.’ He then regretted having said that. I think it was what he could do at that moment.”

— Jembell, a woman with a physical disability, Panama, age 29

“Because of the increased pressure within the family, some of my friends and my members [of her organisation] face an increased pressure inside their families. It affects their mental health; they cannot participate in daily life activities. Some of them were even forcibly hospitalized in a mental institution. The increased pressure within the family and the social isolation during the pandemic trigger that [institutionalization].”

— An advocate for persons with psychosocial disabilities, Indonesia

Barriers to Accessing Gender-Based Violence Services and Other Systems of Support

Some virtual consultation participants reported that GBV support services—such as shelters, psychosocial counselling, legal aid, and others—had become unavailable or inaccessible during the pandemic, making it difficult for women and girls with disabilities to report or escape violent situations. For instance, shelters became or continued to be inaccessible to or not inclusive of women with disabilities, while alternative housing arrangements through other kinds of support services simultaneously became unavailable for women and girls with disabilities due to the pandemic.⁶⁷ Several advocates also reported that, for the Deaf community, pre-existing barriers to accessing helplines and other services had continued during the pandemic, rendering deaf women and girls particularly vulnerable to violence.⁶⁸

“So at the beginning [of the crisis], we get cases and when women with disabilities are faced with domestic violence, we ask them ‘do we file a case for you?’ ‘No, if you file a case for us, then where will we go, because I have to stay in my home. There is nowhere to go outside.’ ... Even the shelter resource ... they do not provide acceptance to women with disabilities to get shelter from their shelter home”

- Misti, a woman with a disability and advocate for persons with disabilities, Bangladesh

Furthermore, GBV impacts SRH by elevating the risks of sexually transmitted infections (STIs), reproductive injuries, and unplanned pregnancies, including for women and girls with disabilities.⁶⁹ Timely access to SRH services can help prevent or mitigate some of these harms, while also providing referrals for other services

including those related to mental health.⁷⁰ Because barriers to SRH services and goods have also been compounded for women and girls with disabilities during the COVID-19 pandemic, those who experience GBV during this crisis may not be able to access emergency contraception, STI prophylaxis, or other healthcare to remedy physical and psychological injuries following GBV, compounding the harms they face as a result of GBV.⁷¹

Furthermore, some virtual consultation participants and survey respondents reported negative interactions with or discomfort revealing GBV to SRH service providers during the COVID-19 pandemic. For instance, Janine, a woman with a visual disability and advocate for persons with disabilities in the Philippines, recorded several cases of rape against women with disabilities during the pandemic. In one case, one of the victims/survivors was a deaf woman who was then forced to obtain an abortion, a situation which further traumatized her.⁷²

"I do not feel safe as I was verbally abused from some of my brothers. ... I don't know [about SRH] except what I hear from the reproductive health centre and the government facility near us and they only provide a bag with my needs and I am afraid to tell them about my abuse so that my family doesn't know."⁷³

- A woman with a physical disability, Yemen, age 23

The loss of social networks and broader systems of support for women and girls with disabilities during the pandemic, which will be discussed in more detail below, has made it even more difficult for these women to report and escape violence. As Nidhi, a woman with a visual impairment and advocate for women with disabilities in India, shared, "...domestic violence was a huge issue, and ... the outcome, the important piece was that women with disabilities because they were even more with families and external support was cut out, they were not able to even communicate the violence that they were facing from home."⁷⁴

Barriers to Accessing Police and Justice Mechanisms

Virtual consultation participants, particularly advocates for persons with disabilities, also reported significant gaps in access to justice for GBV during the COVID-19 pandemic. Many of the new barriers virtual consultation participants identified impacted all persons who experienced GBV during the pandemic. However, the situation of women and girls with disabilities during the COVID-19 pandemic is still in some ways unique.

During the COVID-19 pandemic, in many contexts, courts or police were no longer functioning at the same level as previously.⁷⁵ For instance, Maulani, an advocate for women with disabilities in Indonesia, shared that even before the pandemic, justice was difficult to access, and due to the pandemic, "courts have also reduced the number of cases to be put on trial during pandemic and [prioritize] the ongoing over taking of new cases."⁷⁶ In other contexts, women and girls with disabilities reported they did not know how to seek help⁷⁷ or there were taboos around reporting or talking about violence.⁷⁸

In particular, advocates reported problems with getting police involved in investigations during the pandemic, due to limited resources or social distancing rules. Sometimes, the experiences of women and girls with disabilities in reporting violence during the pandemic mirrored that of other women, with police largely unavailable because they have deprioritized investigating other crimes in order to enforce COVID-19 restrictions.⁷⁹ For instance, during the pandemic Hlobisile, a non-binary person with albinism from South Africa,

experienced a house robbery and violent attack, which led her to leave her home to stay with her grandmother and made her fearful for her life. Although Hlobisile reported this incident to police, police to her knowledge had not taken any action on the matter, in part, she felt, due to delays caused by COVID-19.⁸⁰

“And the rape cases, when we go to the police station, they say that now we are very much busy with other duties so we will not file the case for girls and women with disabilities or other victims in society. Some cases police become come forward and they help the families. There is mixed situation in our country.”

— Misti, a woman with a disability and advocate for persons with disabilities, Bangladesh

In some instances, lack of gender and disability sensitivity and training among police impacted the way they dealt with cases of GBV against women and girls with disabilities during the COVID-19 pandemic, in similar ways as before the crisis, including communication barriers⁸¹ and lack of respect for the autonomy and personhood of women and girls with disabilities. For instance, in Bosnia and Herzegovina, a young woman with intellectual disabilities faced sexual abuse by her uncle, who lived close by. The family reported the abuse to the police, but at the time of the consultation there had been little action by the police or prosecutors to investigate the case. From the family’s account, police and prosecutors were not convinced that a young woman with an intellectual disability could fully experience sexual abuse, or that if she could, that she could be a credible witness to that abuse. At the time of the consultation, the case had recently received some significant media attention, which the family hoped would spur police and prosecutors to action.⁸²

Lack of Data on Prevalence of Gender-Based Violence against Women and Girls with Disabilities

The lack of disaggregated data on the situation of women and girls with disabilities generally and particularly as related to violence⁸³ has meant that many advocates are operating with an incomplete understanding of the scope of the issue, particularly during the COVID-19 pandemic. These advocates have a sense from their work that the prevalence of violence has increased due to the factors described above, and they are hearing from more victims/survivors of violence about their experiences. But in some contexts, beyond media reports, there is no official recording of this violence.⁸⁴ This lack of data has meant that GBV against women and girls with disabilities has remained a largely invisible problem, even while U.N. entities and States have recognized the broader “shadow pandemic” of GBV during the COVID-19 crisis.

“In Sri Lanka, there is gender-based violence, several cases, but we don’t have any official statistics. . . . [Some cases are] in the newspapers, but, except for that, there is no data on gender-based violence. However, we know it happens frequently because we contacted [those] who suffered gender-based violence.”

— Manique, a woman with a visual impairment, Sri Lanka

IMPACT OF COVID-19 ON OTHER RIGHTS FOR WOMEN AND GIRLS WITH DISABILITIES

Women and girls with disabilities have faced significant barriers to accessing disability-related and COVID-related healthcare, accessing employment and education, accessing disability-related supports and services, and meeting basic needs during the COVID-19 pandemic. The barriers women and girls with disabilities have experienced in this context are largely centred around disability—including lack of accessible information, accessibility barriers to virtual education, and lack of reasonable accommodations in employment settings. However, their experiences are in many ways still distinct from men and boys with disabilities, as women and girls with disabilities are less likely to be employed, face more discrimination based on gender and disability in education, and experience higher rates of poverty, even outside of crises.⁸⁵ Furthermore, their experiences related to employment, education, broader healthcare, access to support services, and meeting basic needs have also impacted gender-specific rights and needs they have, including those related to SRHR, bodily autonomy, and freedom from violence.

SRHR, bodily autonomy, and freedom from violence, including GBV all rely on the fulfilment of other rights, including for persons with disabilities. Human rights experts have affirmed that it is essential to ensure these related rights in order to fully respect, protect, and fulfil SRHR and the right to be free from violence. For instance, according to the U.N. Committee on Economic, Social, and Cultural Rights (ESCR Committee), the right to the highest attainable standard of health, including SRH, not only includes the right to access needed health information, goods, and services, but also includes the underlying and social determinants of health, such as water, sanitation, education, food, and housing.⁸⁶ The U.N. Committee on Elimination of Discrimination against Women (CEDAW Committee) has further outlined that, as part of their obligation to eliminate and redress GBV against women and girls, States must ensure access to “education, affordable housing, land, child care, training and employment opportunities for women victims/survivors and their family members.”⁸⁷

This section will outline how the COVID-19 pandemic has affected rights related to SRHR and freedom from violence for women and girls with disabilities. This section will focus on access to healthcare broadly, economic well-being, access to education, broader accessibility and access to disability-related supports and services, and the ability to meet basic needs to water, sanitation, food, and housing during the COVID-19 pandemic. The fulfilment of these rights determine whether women and girls with disabilities can access SRH services, make informed decisions about their bodies and lives, and recognize and seek redress for violence when they experience it.⁸⁸

Barriers to Disability-Related Healthcare and COVID-19 Testing and Treatment

In addition to barriers specifically accessing SRH information, goods, and services, virtual consultation participants and survey respondents shared that they were also facing increased barriers to accessing disability-related healthcare, as well as healthcare related to COVID-19. The experiences of women and girls with disabilities in these contexts were not necessarily distinct from those of men and boys with disabilities during the COVID-19 pandemic. However, this lack of access to healthcare caused virtual consultation participants stress, physical pain, and anxiety, and it put their long-term physical and mental health at risk, including their SRH.

Barriers to Disability-Related Health Goods and Services

“Before COVID, she used to go to a clinic for a nurse to change the covering on her wounded leg, but he was moved to the field to support the pandemic efforts, so she does not go now.

She also has to cover the costs of the covering for her leg at her own expenses.”

— Support person for a woman with a physical disability, Palestine, age 31

Virtual consultation participants and survey respondents reported that, at various times during the pandemic, their physical healthcare services were deprioritized, or changes to protocols made them less effective. Many virtual consultation participants and survey respondents reported that their routine sessions with healthcare providers stopped for some period of time during the pandemic, including for chronic conditions and disability-related impairments, due to the closure of clinics or the reallocation of services,⁸⁹ as well as lack of access to public transportation.⁹⁰

For others, protocols in healthcare facilities changed, making them perceive that regular services were less effective or less accessible.⁹¹ For instance, Ninoshka, a woman with a physical disability in Chile, shared:

The doctor changed his protocol. The distance between us was more than one meter. He was on one corner of the office, and I on the opposite one. He didn't examine me as he used to. Given my diagnosis, he has to be careful and meticulous with the physical examination, and he was just going over it. That made me feel insecure, because I did not trust his protocol. He was insecure, too ... so I decided to move my September appointment to October and see what happens.⁹²

Urgent medical needs were sometimes left behind, including in conflict or other humanitarian emergency settings: For instance, the representative of a woman with a visual impairment in Palestine reported:

Her sensory condition in her right eye is a result of the war and the doctors have advised her of an urgent operation to be done abroad but she cannot travel as a result of the pandemic ... She discovered a benign tumour during the lockdown and could not do further investigations because of the pandemic. She was following up with a private doctor at her own expense. She could not investigate further because her financial status was bad.⁹³

Many persons with disabilities lost access to consistent physical therapy, a healthcare service important for many persons, including those with physical disabilities, to maintain mobility and decrease pain.⁹⁴

“I usually go to physiotherapy, but I stopped going for three months. And then June came, and I said to myself, ‘I can't go on like this.’ ... I was in a lot of pain, so my physical therapist and I decided they would come to assist me at home.”

— Irene, a woman with a physical disability, Ecuador, age 28

Many virtual consultation participants and survey respondents also lost access to medications and goods daily living, or those goods and medications became unaffordable or out of stock.⁹⁵ This has compromised their overall health and comfort during the pandemic and led to additional stress during an already stressful time.⁹⁶

“COVID-19 has also affected my access to sanitary and health materials. For example, I used CIC [clean intermittent catheterization], the amount they’re costing now is double the price I used to buy before COVID-19, for some, and the price has even tripled. It’s difficult for me to buy those materials because of the money that I have. It’s not enough for those things.”

— Soneni, a woman with a physical disability, Zambia, age 35

Some virtual consultation participants further reported particular problems with accessing mental health-related medications and services, a particular concern for persons with psychosocial disabilities, compromising their health and well-being.⁹⁷ As an advocate for persons with psychosocial disabilities in Indonesia reported, medication dosages covered by national health insurance had been reduced during the pandemic, meaning that persons with psychosocial disabilities who use medication had to make up the difference with their own funds, while appointments with psychiatrists to adjust medications when health conditions changed had become largely unavailable due to the high demand stemming from the pandemic and the lack of available providers.⁹⁸

Barriers to COVID-19 Information, Testing, and Treatment

Information, testing, and treatment specifically related to the COVID-19 pandemic was difficult for some women and girls with disabilities to access. For instance, virtual consultation participants reported that information provided digitally was not always provided in accessible formats.⁹⁹ This problem was particularly acute for deaf persons and persons with intellectual or developmental disabilities, who often had to rely on NGOs or others to get information about COVID-19.¹⁰⁰

“So around the end of March, there were some rumours and all, but there was not information. . . So many words like lockdown, quarantine, isolation were new for us, and obviously it was very new and difficult to understand for the persons having disabilities including especially deaf people and people with autism and developmental disabilities, because there were not many focused programmes on how to inform them about these issues.”¹⁰¹

— Laxmi, a woman with a disability and advocate for persons with disabilities, Nepal

Misinformation and lack of accessible and culturally appropriate information about COVID-19 also led to confusion and fear among persons with disabilities in some cases. For instance, Pratima, a woman with a physical disability and advocate for indigenous persons with disabilities in Nepal, shared, “So when I went to the rural part, they asked that the word COVID is so similar with the food they get in the forest, so so many people were confused on whether the COVID is related to the food that they receive from the forest.”¹⁰²

Virtual consultation participants also reported barriers to testing for COVID-19, even when they had symptoms, due to disability and other related factors such as cost.¹⁰³ Others reported the measures taken to ensure social distancing during COVID-19 testing had actually led to positive experiences for persons with disabilities.

“So I happened to get the COVID test twice and one of them was negative and one of them was positive. So I didn’t face any kind of issue while getting the examinations for COVID as a person with disabilities because when you go to get tested for the COVID, you get tested in your [vehicle] and in the drive-through facility. You don’t need to get out of the car and go into the lab and stuff like that.”

– Maria, a woman with a disability, Pakistan

Barriers to Accessing Employment and Education

Barriers to Employment

Women with disabilities face disproportionate and unique barriers to their equal participation in employment.¹⁰⁴ The CRPD Committee has outlined, for instance, that women with disabilities encounter discriminatory employer attitudes, lack of workplace accommodations, unequal pay, sexual harassment, and limited avenues for “seek[ing] redress because of discriminatory attitudes dismissing their claims, as well as physical, information, and communication barriers” in the workplace.¹⁰⁵

“Even if I am to go for work, I have to use a public transport, I will need someone to escort me. The public transports are not fit for wheelchair. I have to pay for my personal assistant, and I also pay for myself. So, going to work to and from work is a high cost. When the wheelchair breaks down, I need money to have it fixed or to buy . . . This might be the reason why we are being neglected when it comes to recruitment. Even though we qualify for the job, just because we are persons in a wheelchair or the person who is hearing impaired or a person who is deaf, they know you need a sign language interpreter, they will not pick you for employment.”¹⁰⁶

— Soneni, a woman with physical disability, Zambia, age 35

The COVID-19 pandemic has created instability in employment for many, and this has had a particular impact on women with disabilities. Several virtual consultation participants and survey respondents reported that they had lost job opportunities or been laid off due to the pandemic.¹⁰⁷ Some virtual consultation participants reported financial instability, even if they had been able to maintain their employment, leading to stress and anxiety.¹⁰⁸ For instance, Irene, a young woman with a physical disability in Ecuador, shared, “I work for a government agency, and [due to the COVID-19 pandemic] the payment of salaries was not stable.”¹⁰⁹

Furthermore, women with disabilities are also more likely than men with disabilities and non-disabled women to participate in the informal job market or in otherwise inconsistent employment, meaning that their

livelihoods are more precarious.¹¹⁰ Small businesses, consultancies, and informal employment have been hit particularly hard by the pandemic, which has led to income instability.¹¹¹ For instance, a virtual consultation participant who was the mother of a woman with intellectual disabilities shared that, in her country which had very strict social distancing and lockdown measures, “we opened a coffee shop before the pandemic. As coffee shops in the city are closed, people with disability in our network who worked for the coffee shop are staying at home.”¹¹²

The pandemic has also exacerbated gender and/or disability-related stereotypes and discrimination in the workplace for some women with disabilities, while others experienced a lack of support and reasonable accommodation in the transition to remote work environments.¹¹³ For instance, a virtual consultation participant in Latin America shared:

My supervisor at work, when the pandemic started, since remote work was not accessible to me, suggested I take sick leave for being from a risk group. Afterward, she said it was not necessary, but suggesting something like to me was so surprising... I never thought anyone would think I am from the risk group because of the disability... Regarding my work, I would like to go back to the office, some of my colleagues are doing so once a week. Since my company had to lend me an accessible desktop computer to work from home, they had to come and install it in my house, I cannot do that every week to go to the office once a week, so my colleagues go and I remain here, but I would like to go back to the office. I asked to go back every day, but they said no.¹¹⁴

“They [people with disabilities] are asked to work from home, but the equipment or the assistive devices were not available at home. They were available only at their workplace. So working from home was not easy for them...”

— Manique, a woman with a disability and employment specialist, Sri Lanka

Many organisations of persons with disabilities themselves lost funding to operate during the crisis, risking employment as well as services for persons with disabilities. As Jannatul, a woman with a disability in Bangladesh, shared, “We had to struggle because all of the funding and all of those things are postponed. ... We are hearing every day that so many colleagues even in other organisations, they are leaving their jobs because of the funding crisis. So definitely our income is affected in a big way.”¹¹⁵

Barriers to Education

Women and girls with disabilities also face discrimination in education and training that prevents their access to a full range of employment opportunities on the open labour market. These barriers include lack of birth registration, which makes girls with disabilities invisible in the education system; stereotypes or assumptions about their abilities, which combined with their gender means that families deprioritize their education over other family members; violence and bullying in school; and numerous physical, geographic, attitudinal, financial, information, and communications barriers to participating in school on an equal basis with others.¹¹⁶

“I studied the whole course online because it started during the pandemic. It was hard, I told the professors I have a visual disability, but they forgot it, every time they sent us an assignment, I had to repeat that. . .it is tiring. Most professors did not adapt their assignments to my needs, it was mostly done by my friends reading the assignments to me through WhatsApp audios or helping me record the videos I had to send to the professors.”

— A virtual consultation participant from Latin America

In many contexts, schools moved online for at least the first part of the COVID-19 pandemic. Many consultation participants reported accessibility and other barriers to accessing online school, including lack of access to personal assistants or their usual reasonable accommodations in school¹¹⁷ and lack of internet access or other technology, particularly in rural areas and informal settlements.¹¹⁸ Some advocates expressed fears that the barriers to education and employment at the intersection of gender and disability during the pandemic would mean a loss of opportunity and a setback in rights for a whole generation of women and girls with disabilities.

“Education, there has been disruption technologically, as we are a rural economy. Girls, there are many studies that women have lesser technology and particularly in the space where families had digital connections to have online connection, girls with disabilities were deprioritized over boys with disabilities or non-disabled siblings.”

— Nidhi, a woman with a visual impairment and advocate for women with disabilities, India

Loss of Formal and Informal Disability-Related Support

Due to the COVID-19 pandemic, many persons with disabilities have also lost access to personal assistants and other support services, as well as informal systems of support they may have used to take care of daily needs, including shopping for and cooking food, bathing, toileting, taking care of hygiene needs, and maintaining finances, among other tasks.¹¹⁹ This loss of support has then limited their ability to meet their basic needs and live independently during the COVID-19 crisis.

“I think the cancelling of services for people with disabilities was—and still is—one of the aspects that were most impactful.”

— A woman with a physical disability, Ecuador, age 28

The evaporation of personal assistants and disability-related support services had an immediate impact on some virtual consultation participants. For instance, Lisa, a woman with a learning disability in the U.K., had laryngitis during the first lockdown in that country. At first, her caregivers and doctors thought it could be COVID-19, and her caregiver could not come visit her for a week. She had some meals pre-prepared, but no one came in to help her during that time.¹²⁰

Due to social distancing rules and lockdown measures, some virtual consultation participants lost access to community members, friends, and family during parts of the pandemic, and also found that individuals were no longer willing to help them.¹²¹ For instance, Chantey, a woman with visual and physical impairments in Cambodia, noted that she needs someone to go with her to the store or to places when she needs to buy something to take care of her needs. “But with COVID outbreak everybody’s scared, and no one brings me to the store.”¹²² Loss of access to community, friends, and family, and the informal support that community provided, had a negative impact on the ability of virtual consultation participants to meet basic needs.¹²³

In some cases, family members started taking on the role of caregiver for persons with disabilities in the absence of more formal systems of support, straining relationships and increasing stress. As an advocate in India described, women with disabilities have actually been thrown out of their houses due to these tensions and lack of formal support services, without adequate alternative housing situations.¹²⁴

“Because of the lockdown... we didn’t have caregiver support. And this was a huge problem within the disability community. Members of the family were involved in caregiving, which created a lot of pressure among the family. Women with disabilities largely depend on help, on assistance from others. When we go out, we need support, we need somebody to help us negotiate the world.”

— Jeeja, a woman with a disability, India

Other Barriers to Meeting Basic Needs

Many virtual consultation participants and survey respondents indicated that they or other persons with disabilities they knew were having trouble meeting their basic needs, such as accessing clean water, food, sanitation items, and housing, as well as access to social interaction and human connection. These individuals reported that they could no longer meet basic needs due to loss of income, because goods became scarce or significantly more expensive, because they lacked accessible information about government or other assistance programmes or ineligibility for such programmes, and due to barriers to accessing technology. These factors were frequently impacted by their gender and/or disability.

Many women and girls with disabilities were already experiencing economic hardship before the COVID-19 crisis, as—due to their gender and disability—they were more likely to be unemployed, rely on informal employment, live in poverty, and rely on social assistance programmes.¹²⁵ This put them in a precarious financial situation. For instance, Misti, an advocate for women with disabilities in Bangladesh, shared that some women with disabilities in that country previously had gotten an allowance from the government, but that many had not gotten that allowance since June 2019—about nine months before the beginning of the pandemic—when it suddenly stopped.¹²⁶

Lack of accessible assistance programmes related to basic needs during the COVID-19 pandemic, or inadequacy of such programmes, was particularly problematic for many.¹²⁷ For instance, consultation participants in Sri Lanka reported that they lacked information about when food assistance deliveries would occur in their neighbourhoods. One participant shared that she had not received sufficient food, as she was not made aware of when mobile trucks selling groceries came to her neighbourhood. Another woman with a physical disability

found it difficult to access mobile trucks for food assistance, as she had to cross a paddy field to access the road where such trucks were parked.¹²⁸

For others, difficult economic circumstances caused by the pandemic or by pre-existing barriers to accessing employment and income had resulted in difficulties affording housing, food, or other basic services, with individuals losing access to these in some cases.¹²⁹

“Everything is now more expensive and getting food was hard and my disability became more problematic for me to get my daily survival needs. We are poor and receive a daily income and cannot deal with extra expenses.”

— A girl with a physical disability, Yemen, age 17

Several virtual consultation participants and survey respondents reported particularly significant barriers to accessing clean water, based on financial and physical inaccessibility.¹³⁰

“In South Sudan there’s no pipe to water. It’s mainly transported by trucks. And you just buy it in terms of drums. So, it’s now very expensive. Women with disability are not able to afford [water] because most of them don’t have a job or any source of income like businesses running. The situation has gone very worse compared to before. Because the economy completely depreciated in that everything has gone, the prices of things are high as the inflation is now rocketing.”

— A deaf woman, South Sudan

On the other hand, in Malawi, the COVID-19 crisis has improved access to clean water, as water service providers have become more sympathetic to the inability of some individuals to pay: Ruth, a woman with a visual impairment and advocate for women with disabilities in Malawi, shared: “Due to COVID-19, maybe you can pay half of it [the water bill], then we can give you the water. Otherwise before that, it means you had to settle the whole bill. We thought that was really something, a milestone for the whole country.”¹³¹

Social assistance programmes implemented by governments or others were sometimes not designed with persons with disabilities in mind. Lack of identification, including identification as a person with a disability, was a particular barrier for many to access social assistance.¹³²

“One of the requirements that the Government had provided [to receive food assistance] was you need to either have a citizenry or a disability card to receive those requirements. So when it comes to many, many indigenous women with disabilities they do not have [either] of them.”

– Pratima, an indigenous woman with a disability, Nepal

Manique, a woman with a disability in Sri Lanka, shared that inability to travel was another barrier for women with disabilities trying to access government assistance programmes during COVID-19, as women with disabilities may work and live in cities, but have their residences registered in the countryside:

Now, in Sri Lanka the government gave 5,000 rupees. They started with persons with disabilities and kidney patients and thereafter that they extended to suggest people who lost their daily income, but people with disabilities did not have a way of accessing this information. Some of them were in Colombo in the main city and due to the lockdown, they could not go to hometowns so in Colombo area they are not able to get this 5,000 rupees allowance because their hometown is somewhere else. So they had difficulties in accessing this 5,000 rupees and especially hearing-impaired persons, they didn't have a way of communicating with and especially during lockdown situation, no information was given to them.¹³³

Several virtual consultation participants shared that the pandemic had also had a significant impact on their basic need for human connection,¹³⁴ a situation that likely disproportionately impacted persons with disabilities whose access to technology may be more limited due to lower incomes, the inaccessibility of platforms and internet, and lower levels of education.

“When the pandemic started, it was [a difficult situation] for the Deaf community, because we like to be in contact with our peers and socialize, go to restaurants, to the movies or the clubs, and then suddenly that changed. Being at home with our families—who are not deaf—and not being able to communicate always creates a kind of discomfort and stress, and there were arguments, because they can't understand what we want, and we can't understand them either.”

— A deaf woman, Ecuador

Some virtual consultation participants shared that the lack of access to support they needed to meet their basic needs, compounded with the loss of income, had jeopardized their ability to live independently.¹³⁵ Jembell, a young woman with a physical disability in Panama, shared how this loss of independence particularly impacted her as a person with a disability:

I was used to living on my own, ... so the fact that I had to [go back to my parents' house] and spend six months with them and that I completely lost my autonomy and my capacity to make decisions, including on what things to buy at home, created a sort of internal shock, which led to my first anxiety crisis. ... When, as a person with a disability, you get to be autonomous and they tell you that you are better off at your parents', you realize that getting your independence was the most precious thing to you, and realizing that you are [losing] that is a kind of emotional shock, particularly when you are confronted with people who are always planning to decide for you. ... I don't think I have seen any initiative focusing on single, disabled mothers, who may in turn have a child with a disability, as it is my case.¹³⁶

A woman with a physical disability in Nepal further shared how the COVID-19 pandemic had set back the realization of rights and independence for women with disabilities in her country: “When I worked in the disability [sector] in 1993, women with disabilities' situation was worse, because they had to live inside the house. They had nothing to do. They were uneducated ... With the pandemic, that same situation is happening to women with disabilities again, because they are losing their jobs, they have to stay all day and night with the family and can't contribute to the family. It is a really hard time, especially for women with disabilities.”¹³⁷

LESSONS LEARNED AND CONCLUSIONS

As the findings above outline, response to the COVID-19 crisis has in many ways failed to ensure SRHR, freedom from violence, and related rights for women and girls with disabilities. Following this pandemic, there are at least three main lessons that States, global health actors, and others can take with them into future health emergencies and other crises, to ensure that the needs of persons with disabilities are met and that their SRHR and related rights are respected, protected, and fulfilled.

Lesson #1: In preparation for and response to crises, States must turn to existing international guidance on disability inclusion, SRHR, freedom from violence, and related rights.

Many of the issues that women and girls with disabilities identified both in the virtual consultations and written surveys had been anticipated in international guidance to crisis response and guidelines on rights-based and disability-inclusive service provision. However, States and others did not consistently employ such guidance in the response to COVID-19.

While guidance on emergency response has only recently begun to address the intersection of gender and disability, and in particular the SRH-related needs and rights of persons with disabilities, this guidance did exist ahead of the COVID-19 pandemic. For instance, the Inter-Agency Standing Committee Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action (IASC Guidelines), which were adopted in 2019, provide an extensive set of actions for States and others to take to ensure SRH in preparation for, during, and in the recovery from humanitarian emergencies.¹³⁸ With few exceptions, the IASC Guidelines specifically anticipated the types of gaps in SRH service delivery that have occurred during the COVID-19 crisis, including the breakdown of social networks and access to support services, lack of accessible transportation, the closure of health facilities, negative attitudes among healthcare workers about persons with disabilities, and the lack of pre-existing infrastructure to ensure healthcare, including SRH, for persons with disabilities.

The IASC Guidelines also provide a series of preparatory and response steps for ensuring SRH during an emergency. These include:

- ◆ Assessing, analysing, and planning for SRH, including mapping SRH services as well as accessibility, barriers, and risks when accessing SRH, planning to address gaps in access, and planning to deliver goods, services, and information to persons with disabilities in their homes;
- ◆ Mobilizing resources, including funding trainings and ensuring a disability module in all SRH trainings for staff, as well as recruiting persons with disabilities to be involved;
- ◆ Implementation, including integration of disability into SRH services, developing public information materials in accessible formats, ensuring informed consent in line with the CRPD, ensuring accessibility, and including SRH of persons with disabilities in sexuality education programmes;
- ◆ Coordination, including coordinating with providers of food assistance and the social determinants of health, protecting persons with disabilities from violence, and encouraging the participation of persons with disabilities in SRH working groups;
- ◆ Monitoring and evaluation, including collecting data, monitoring accessibility, and ensuring accountability.

This is only one in a range of guidance documents for ensuring the rights and well-being of women and girls with disabilities, both during and outside of crises.¹³⁹ Reference to these documents must be part of the planning, response, and recovery from any crisis, including a global health emergency.

This pre-existing guidance, while comprehensive and useful in planning for potential emergencies, is also complex and may not be user-friendly in the midst of an emergency. In the midst of emergencies, States and other actors may need compact tools that complement this guidance to ensure SRHR, as well as related rights, for women and girls with disabilities. With this in mind, as part of this project, the authors have created two COVID-19, Gender, and Disability Checklists, focused on (1) ensuring SRHR in response and recovery, and (2) preventing and addressing GBV.¹⁴⁰

Lesson #2: Women and girls with disabilities themselves must be included in the preparation for, response to, and recovery from crises.

Beyond existing guidance, an understanding of the lived experiences of women and girls with disabilities in particular local, national, and regional contexts is essential to comprehending how situations of risk might impact them and, once emergencies have occurred, how best to respond to and recover from those emergencies.

Under Article 29 of the Convention on the Rights of Persons with Disabilities (CRPD), States have an obligation to not only ensure an environment in which persons with disabilities can participate in decision-making on issues that impact them, but they must also “encourage their [persons with disabilities’] participation in public affairs.”¹⁴¹ Furthermore, under Article 33 of the CRPD, States have an obligation to ensure the full participation of civil society organisations, particularly persons with disabilities and organisations of persons with disabilities, in the monitoring of the implementation of the various articles of the CRPD.¹⁴² This obligation extends to participatory monitoring of the right to protection and safety during humanitarian emergencies (art. 11), as well as the rights to health, including sexual and reproductive health (art. 25), and to family life (art. 23), among others.¹⁴³

As such, in addition to consulting international guidance documents to ensure that the rights and needs of women and girls with disabilities are addressed during times of crisis, States and other actors also have an obligation to include these individuals in their emergency preparations, response, and recovery. Proactively including women and girls with disabilities helps ensure that their needs and rights are not overlooked, and that the impact of crises is lessened for this marginalized group.

Lesson #3: States must undertake long-term efforts to ensure the full respect, protection, and fulfilment of SRHR, the right to be free from violence, and related rights for women and girls with disabilities at all times.

States cannot ensure rights for women and girls with disabilities during global health emergencies if those rights are not fully respected, protected, and fulfilled outside of emergencies. As the CRPD Committee has consistently highlighted, States systematically fail to ensure SRHR and freedom from violence for all persons with disabilities.¹⁴⁴ This means that women and girls with disabilities in particular continue to face discrimination, stereotypes, and stigma in the context of SRH and to be denied the information, goods, and services they need to decide for themselves whether or not to have children and to engage in intimate relationships on an equal basis with others.¹⁴⁵

In 2018, UNFPA and WEI issued a set of guidelines on rights-based and gender- and disability-inclusive SRHR and GBV service provision (UNFPA-WEI Guidelines).¹⁴⁶ These guidelines provide detailed guidance on steps

States and service providers should take to ensure gender and disability inclusion, both during and outside of times of crisis, in SRH and GBV programming. This guidance includes, among other tasks:

- ◆ **Creating an enabling legislative and policy environment** for disability rights, SRHR, GBV, and related rights. This requires, for instance, ensuring not only that SRH information, goods, and services are legal and provided free or at low cost, but also that women and girls with disabilities are not denied legal capacity and that laws and policies enabled them to make healthcare decisions for themselves, including with support when needed and requested.¹⁴⁷
- ◆ **Ensuring access to disability inclusive SRH and GBV information and services.** This means conducting an accessibility audit of all existing services and information provided about SRH and GBV and creating a plan to address gaps, as well as training SRH and GBV providers on the rights and needs of women and girls with disabilities and ensuring respectful treatment. It also includes raising awareness within the community about the rights and needs of persons with disabilities in the context of SRH and GBV, to overcome stigma and stereotypes.¹⁴⁸
- ◆ **Ensuring that women and girls with disabilities are at the centre of the design, implementation, and monitoring of SRH and GBV programmes.** This includes ensuring that government and public health entities consistently work with women-led organisations of persons with disabilities at all stages of SRH, GBV, and related policy and programme development and that information and data are collected on their lived experiences—including disaggregated by gender, disability, age, and other statuses—is collected on access to SRH, in line with the Washington Group on Disability Statistics recommendations.¹⁴⁹

As this Impact Assessment has highlighted, women and girls with disabilities have in some cases experienced significant hardship because of the COVID-19 pandemic, and their lived experiences have been invisible to many of the people responding to this crisis. As this global health emergency continues, it is imperative that States learn these lessons and change their approach to be more inclusive and responsive to the rights of women and girls with disabilities. States, global health actors, and others involved crisis response should also take knowledge of these lived experiences and these lessons with them into preparations for and response to the next crisis, including the next global health emergency. By doing so, they will be helping ensure that women and girls with disabilities become visible in the face of crisis and that their human rights and dignity are assured.

CASE STUDY #1: INCREASED RISK OF VIOLENCE AND BARRIERS TO HEALTH SERVICES IN MALAWI

In September and October 2020, UNFPA and WEI worked with Disabled Women in Africa (DIWA) to conduct two virtual consultations with nine women with disabilities in Malawi, focused on the impact of COVID-19 on their lives and the lives of the people for whom they advocated. These individuals shared with researchers that COVID-19 and the government response in Malawi had reduced their access to SRH and other healthcare, elevated their risk of violence, and impacted their lives in a number of other ways, from preventing them from meeting basic needs to increasing barriers to accessing employment and education.

The 2018 Population and Housing Census indicated that there are 1,734,250 persons with disabilities in Malawi aged five years and above, representing about 11.6% of the total population.¹⁵⁰ Persons with disabilities in Malawi face social exclusion and discrimination, which extends to their SRHR, public and political life, general health, access to justice, and employment, among other areas.¹⁵¹ Of particular note, women with albinism face gruesome killings, abductions, and attacks for their bones, which are believed to contain magical powers,¹⁵²—more commonly than men with albinism.¹⁵³

Accessing SRH information, goods, and services was challenging for women with disabilities in Malawi even before the COVID-19 pandemic, due to accessibility barriers, discrimination, and biases when exercising their SRHR, as well as the exclusion of women with disabilities from laws and policies on SRHR.¹⁵⁴ For instance, Martha, a virtual consultation participant and advocate for deaf-blind persons in Malawi, shared, “For the deaf-blind, there is a challenge in terms of communication. The health practitioners don’t have communication skills to communicate with deaf-blind persons. For example, a deaf-blind girl wasn’t able to communicate with the healthcare provider and that resulted in the healthcare provider prescribing a wrong medication.”¹⁵⁵

Compared to many countries around the world, Malawi’s COVID-19 infection rate has been relatively low. Between April and December 2020, the country recorded 6,248 cases of infection, and the death toll in the country stood at 187.¹⁵⁶ Even before the first confirmed cases of COVID-19 in Malawi, which occurred in April 2020, the government and healthcare providers had taken significant steps to reduce and prevent transmission of the disease, including limitations on gatherings, changes in protocol at health facilities, and the closure of schools.¹⁵⁷

Some of these steps impacted SRHR for all persons in Malawi, but with a significant impact specifically for women and girls with disabilities. Pre-existing barriers to accessing SRH were exacerbated by the COVID-19 crisis, alongside confusion caused by changes to healthcare protocols, which were not always effectively communicated to women and girls with disabilities. For instance, Ruth, a woman with a partial visual impairment in Malawi who was pregnant at the beginning of the crisis, shared her stressful experience with changes to maternal healthcare, even before the first case of COVID-19 in Malawi:

At the time that this issue of COVID-19 was coming out, it was the time that I was heavily pregnant. I already had scheduled appointments with my doctor, however, on getting to the hospital, arrangements at the hospital had changed. Since social distance needed to be practiced now, the waiting chair was

quickly filled with very few people. The option was to wait in the car maybe or find your own isolated space, as we could no longer queue the old way, or maybe a particular appointment at that exact time should be scheduled so that you find yourself in doctor's office at exact time you arrive. I think that was something disrupting and even when you meet the doctor, you would not want to stay long, the doctors fear you and you fear the doctor as we don't know who is carrying the virus. Of course there was that constant fear. Like I was afraid, you know, when you're talking to the doctor, by the end of the day the conversation were on issues of COVID-19. Of course, at that time we had no case in Malawi, but yet during the delivery on the operating table having a C-section, the conversation was about COVID-19 of situation in other countries and how Malawi must be prepared and such discussion were very scary maybe compared to the time COVID-19 now had to come in I received the news of the first cases discovered in Malawi while my baby was at the Nursery special care at the Kamuzu, Ethel Mutharika hospital, I had stayed there for two weeks. It was tough moment as nurses and everyone was afraid and the hospital was the most feared place of spread of the virus.¹⁵⁸

Other virtual consultation participants shared negative experiences with accessing SRH services and goods, particularly due to the changes brought on by COVID-19. For instance, Lyness, a woman with a physical disability, shared that "accessing sexual and reproductive services was a challenge because of transportation issues during COVID. Most women with disabilities live below the poverty line and can't afford private transportation."¹⁵⁹ Lyness further shared that "during the COVID, most hospitals are not giving out family planning. Most of the family planning clinics in the hospital are closed to prevent the spread of COVID."¹⁶⁰

Virtual consultation participants also reported that they were cut off from family, interpreters, and other support persons in healthcare settings during the pandemic. For instance, Sekarani, a deaf person and advocate for the Deaf community in Malawi, shared that even before the pandemic, deaf women faced communication problems when in need of medical services, including SRH, as hospitals do not have sign language interpreters and there are no free services of those professionals available. During the pandemic, even when deaf persons were accompanied by an interpreter, the hospital would not let the interpreter into the hospital.¹⁶¹ Likewise, Lyness, a woman with a physical disability, shared, "I got admitted to the hospital after COVID hit, but the hospital wouldn't let any family member be with me, so I didn't have anyone to support and assist me. Moreover, most clinics [clinic services] were suspended due to COVID."¹⁶²

Barriers to SRHR in Malawi have been even more severe during the COVID-19 period for persons with disabilities living in rural areas, which, according to the 2008 Census, accounts for 85.1% of persons with disabilities in Malawi.¹⁶³ As virtual consultation participants reported, "in some areas in the rural communities, most of the women with disabilities access their SRHR through health workers who go for outreach for family planning in the communities but, during this COVID-19 period, such outreach is no longer happening. Hence, women with disabilities are not able to access the services."¹⁶⁴

The social determinants of health, including SRH, were also significantly impacted in Malawi due to the COVID-19 crisis. According to the World Bank, in Malawi, more than half of households surveyed had run out of food, with urban households being disproportionately affected.¹⁶⁵ In addition, school closures aggravated the problem by limiting children's access to school-provided food programmes.¹⁶⁶

The risk of GBV has also risen in Malawi, with specific risk factors for women and girls with disabilities. In Malawi, women with disabilities faced higher rates of violence than do men with disabilities even before the pandemic,¹⁶⁷ and the long-standing myth in some parts of Malawi that having sexual intercourse with a woman with a disability cures or cleanses HIV has historically fuelled sexual violence against women with disabilities.¹⁶⁸ During the pandemic, a range of factors have elevated this risk. For example:

- ◆ A virtual consultation participant observed that “women and girls with disabilities are forced to stay at home due to COVID and this led to GBV at their homes, and they usually don’t report it.”¹⁶⁹
- ◆ Stella, a woman with a disability and advocate for persons with disabilities in Malawi shared: “One girl who was forced to marry got pregnant, and because it was a forced marriage, she was being abused. Because of COVID-19, she was trapped and there were fears in that family.”¹⁷⁰

Access to justice and support services for GBV during the pandemic significantly diminished for women and girls with disabilities in Malawi. Sekarani, a deaf person and advocate for deaf women with disabilities in Malawi, noted that there are significant barriers to accessing justice for deaf persons who are victims of violence, even before the pandemic, which puts them at higher risk of violence: “Perpetrators take advantage to sexually abuse considering that no police can speak sign language. This could be remedied by having a sign language interpreter at a police station and empowering police to learn sign language.”¹⁷¹ An advocate for children with disabilities further shared that the pandemic has significantly altered access to justice: “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. They won’t tell relatives what has happened because it is often an uncle, brother, or father that has been the abuser.”¹⁷² Pamela, a virtual consultation participant, further shared that: “Women with disabilities wouldn’t know where to get help. Because many women with disabilities live below the poverty line in their villages, it is an issue. Also, many people may not believe them if they report [the crime].”¹⁷³

In 2009, Malawi ratified the CRPD.¹⁷⁴ Under section 13 (g) of the Malawi Constitution, the Malawi government must take necessary actions or measures to ensure full inclusion and participation of persons with disabilities in society. With this provision, the government may adopt policies or make directives for government departments and parastatals (other organisations serving the government), non-governmental organisations, private companies and/or institutions to make their premises accessible, promote active participation, and to exercise non-discrimination of persons with disabilities in all aspects, including employment opportunities.¹⁷⁵ In addition, several laws guarantee the rights of persons with disabilities, such as the Disability Act 2012.¹⁷⁶ The Disability Bill 2019, which would amend the Disability Act 2012, contains a reference to SRHR, establishing that persons with disabilities must have the same range, quality, and standard of accessible, free or affordable health care services as provided to other persons, including SRH services.¹⁷⁷ However, the Disability Bill 2019 had not yet been adopted at the time of this writing.

The Malawi government developed a national COVID-19 preparedness and response plan, aiming to ensure an effective response to the pandemic.¹⁷⁸ The preparedness and response plan includes a “protection” cluster, which aims at reducing protection threats for affected populations and protecting “vulnerable” groups from violence, exploitation, abuse and neglect. It further includes addressing the specific rights, needs, and vulnerabilities of women, girls, and persons with disabilities. The plan, however, does not take an intersectional approach and so does not directly address issues, such as the ones identified above, occurring during the COVID-19 pandemic at the intersection of gender and disability.

CASE STUDY #2: HIGH RISKS OF COVID-19, SOCIAL ISOLATION, AND BARRIERS TO HEALTHCARE FOR WOMEN WITH LEARNING DISABILITIES IN OXFORDSHIRE, ENGLAND

UNFPA and WEI worked with My Life, My Choice—a self-advocacy organisation for persons with learning disabilities in Oxfordshire, England—to hold two in-depth consultations in August and September 2020 with six women with learning disabilities, focused on the impact of COVID-19 on their lives. These women shared that COVID-19 and the government response in the United Kingdom (U.K.) had had a significant impact on their mental health and well-being, their access to health goods and services including SRH goods and services, and their access to their usual systems of personal assistance and support.

England is the most populous country in the U.K., which has been hit particularly hard by the COVID-19 pandemic. The U.K. has had one of the highest number of documented cases and deaths of any country in the world.¹⁷⁹ As of February 2021, the U.K. had entered its third lockdown, with significant restrictions on movement for its population, and these restrictions finally started to ease in April 2021.¹⁸⁰

At the time of the consultations in August and September 2020, the women with learning disabilities in Oxfordshire, England, had only experienced one of these three lockdowns (from late March to early May 2020) but noted how that lockdown had impacted them mentally, physically, and emotionally. In particular, they expressed concerns for their mental health in the event another lockdown should occur. One participant shared that life would not be worth living.¹⁸¹ Another reported that the lockdown situation made her depression worse.¹⁸²

Related to SRHR in particular, the women who participated in the consultations shared that, before the pandemic, they encountered some of the same barriers as other women with disabilities around the world in accessing SRH information, goods, and services. For instance, Gina reported that she had previously experienced a pregnancy, but before she had become pregnant, no one had ever explained to her how someone becomes pregnant, and that in fact her mother had told her she could not get pregnant.¹⁸³

Unlike many women with disabilities around the world, however, these women mostly had healthcare providers with whom they could speak about SRH and receive SRH information, goods, and services. Indeed, several of the women indicated that they were receiving care related to menopause¹⁸⁴ or were taking some form of contraception, though they said that choices related to contraception were not always well explained to them.¹⁸⁵

However, changes to the provision of healthcare in the U.K. during the pandemic had disrupted this access. For instance, Jackie reported that she used a “coil” to stop her from getting pregnant but later became confused about when the coil needed changing. She tried asking her doctor, and he said he would call back, but, at the time of the consultation, he had not done so.¹⁸⁶ Another consultation participant reported similar problems getting through to her doctor related to her healthcare needs.¹⁸⁷ These women fortunately had alternative sources for learning about their bodies, sex, and relationships, including through the women’s group at My Life, My Choice and through a programme called Mates and Dates, both of which had continued on virtual platforms during the pandemic.

The women also reported barriers to accessing other needed health services during the COVID-19 pandemic and particularly during the lockdown period. For instance, Lisa reported that there were issues with prescription delays due to the closing of pharmacies and that she had had to use her old prescriptions to meet her needs.¹⁸⁸ Another consultation participant reported that she needed her blood pressure checked every six months but had not been able to do so since the COVID-19 crisis began. Her doctors told her to get her own machine, but she could not afford it.¹⁸⁹

The experiences that consultation participants shared reflected what has at times been an overburdened health system during the COVID-19 pandemic in the U.K.¹⁹⁰ This has in turn particularly impacted the health and well-being of persons with disabilities. According to the Office of National Statistics, through November 2020, persons with disabilities broadly accounted for nearly 6 in 10 people (59.5%) who had died from COVID-19 in England.¹⁹¹ This higher death rate had particularly impacted persons with learning disabilities. A report from Public Health England issued in November 2020 indicated that, in the first months of the pandemic, persons with learning disabilities in England were up 6.3 times more likely to die from COVID-19 than was the general population, with young persons with learning disabilities (ages 18 to 34) up to 30 times more likely to die than their similar-aged peers.

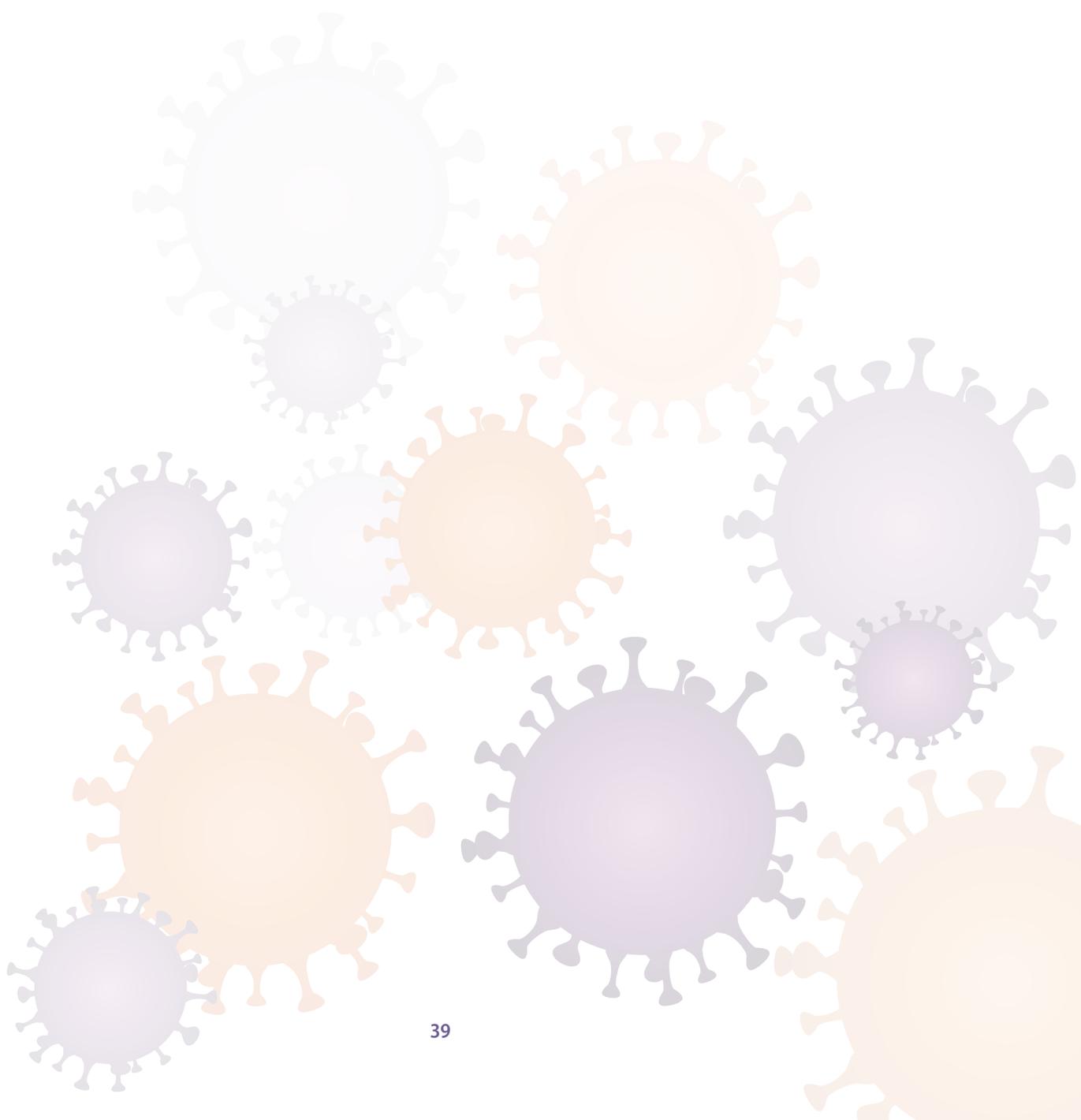
The reason for this higher death rate for persons with learning disabilities is unclear. However, in February 2021, Mencap—a U.K.-based NGO working with persons with learning disabilities—reported several instances during the COVID-19 pandemic in which persons with learning disabilities had been told that they would not be resuscitated if they contracted COVID-19.¹⁹² This is an indication that healthcare providers may not fully understand the lived experiences and rights of persons with learning disabilities. At the time of writing, the public health officials were undertaking a review of “Do Not Resuscitate” orders during the pandemic.¹⁹³

The women who participated in the consultations also indicated reasons they felt that persons with learning disabilities were particularly at risk because of COVID-19. For instance, they all expressed concern that caregivers and family could not visit them in the hospital during COVID-19, as lack of support would make it harder for them to communicate with healthcare providers. One of the participants, Dawn, indicated that it is really important to have someone with you, because nurses are too busy to explain things in a way persons with learning disabilities can understand.¹⁹⁴ Another consultation participant, Jackie, said she agreed that disabled people might need extra attention or explanation and so may need a support person in healthcare settings more than others do.¹⁹⁵ The women also shared that they were not receiving information from the government about COVID-19 in formats that were accessible to them. Instead, their primary way of learning about the COVID-19 pandemic and the myriad rules and developments had been through Easy Read materials and information provided by My Life, My Choice.

Another possible reason for the particular risk persons with learning disabilities in the U.K. faced due to COVID-19 is that they may rely on support from caregivers to help them meet their needs, and that support may have evaporated,¹⁹⁶ or caregivers may not always take necessary precautions. For instance, when one of the consultation participants, Lisa, had laryngitis during the pandemic, her caregivers and doctors thought it could be COVID-19, and as a result of quarantine measures, her caregiver could not come visit her for a week. Lisa had some meals pre-prepared, but no one else came in to help her during that time, and this was quite difficult for her.¹⁹⁷ Lisa also reported that her caregiver—who helps her with many daily hygiene tasks—does not have to wear a mask unless she is with “high-risk” individuals (Lisa is not considered “high risk”):

Because my support worker comes in because we trust each other, and I know she has not got it [COVID-19]. I haven't got it. Then she didn't wear a mask. She is very careful, but she still does the same business like shower me and everything and we are all safe because I have been near her quite a lot of times and we are all safe ...¹⁹⁸

As of February 2021, all persons with learning disabilities in Oxfordshire, England—where consultation participants are based—had been placed on the priority list for receiving COVID-19 vaccinations.¹⁹⁹ At the time of writing, it was unclear the extent to which persons with learning disabilities were able to make appointments and to receive the vaccine.



CASE STUDY #3: PRE-EXISTING BARRIERS TO SEXUAL AND REPRODUCTIVE HEALTH AND RELATED RIGHTS EXACERBATED BY COVID-19 IN CHILE

Nine women and gender non-conforming persons with disabilities who live in Chile participated in the two virtual consultations held by WEI, UNFPA, and Círculo Emancipador de Mujeres y Niñas con Discapacidad de Chile (Emancipatory Circle of Women and Girls with Disabilities in Chile, CIMUNIDIS). They shared how the pandemic affected their lives, with a particular focus on SRHR, and how the intersection of gender and disability has played an important role in their experiences during the COVID-19 crisis.

In Chile, 16.7% of the population is persons with disabilities, according to the National Registry of Disability.²⁰⁰ After ratifying the CRPD in 2008, the country adopted laws and policies aimed at persons with disabilities, guaranteeing their right to equality and inclusion in political participation, employment, education, and culture, among other rights,²⁰¹ although these rights are not yet guaranteed across the country.²⁰² Related to SRHR, the national policy on family planning guarantees access to contraceptive methods and SRHR information,²⁰³ but abortion is decriminalized only on three grounds: danger to the pregnant person's life, pregnancy due to rape, and lethal foetal unviability.²⁰⁴ Furthermore, Law 20.422 focuses on the right to health and accessibility in healthcare for persons with disabilities, but the law contains no specific reference to SRH and the accessibility of SRH information, goods, and services.²⁰⁵

In 2020, due to the COVID-19 pandemic, over 900 laws, regulations, and policies have been enacted in Chile to declare states of emergency, impose health protocols, to enforce isolation and quarantine, and so on.²⁰⁶ Financial aid was provided to the most vulnerable and/or unemployed families,²⁰⁷ and the government adopted a law regulating remote work.²⁰⁸ The government also adopted laws and policies to help meet basic needs, including the programme “Food for Chile” (Alimentos para Chile), which aimed at distributing 2.5 million food and hygiene baskets in the first three months of the pandemic,²⁰⁹ and assistance with housing, water, and electricity.²¹⁰ Specifically regarding the rights of persons with disabilities, following advocacy from civil society organisations, the government adopted guidelines on how to provide persons with disabilities with healthcare and administrative support, though these guidelines do not include specific reference to SRH.²¹¹

Even before the pandemic, access to SRH information, goods, and services—particularly abortion and emergency contraception—was restricted for all persons in Chile,²¹² and women and gender non-conforming persons with disabilities in Chile experienced complex barriers to accessing respectful and human rights-based SRH goods and services. In its 2016 review of Chile, the CRPD Committee noted that women with disabilities were not included in laws and policies addressing gender, that there was a “lack of necessary support to enable persons with disabilities to exercise their reproductive rights under the same conditions as others,” and that there was “a paucity of information on sexual and reproductive health that is available to persons with disabilities, especially women and girls and persons with intellectual and/or psychosocial disabilities.”²¹³

In 2020, the National Disability Services (SENADIS) created the Disability and COVID-19 Roundtable, which prepared recommendations for the treatment of persons with disabilities in hospitals around the country during the COVID-19 pandemic.²¹⁴ However, this working group does not have a specific budget allocation, and their work to date has not considered the gender and disability intersectional perspective.

Following the onset of the pandemic, access to SRH goods and services was compromised for women and gender non-conforming persons with disabilities. For instance, Valeria, a woman with multiple disabilities, reported that her doctor advised her to make an appointment with a gynaecologist and a social worker. However, the hospital denied the appointment, saying that it was just attending to emergencies.²¹⁵ Chileans with disabilities who lived in remote areas, including the southern-most parts of the country, faced even more significant challenges due to formal and informal restrictions around access to healthcare during the pandemic. Tamara, a non-binary autistic person who lives in Porvenir, an outlying island off the coast of Chile, described their experience:

I was bleeding for a month, and I went to the midwife, and they injected me with a 'hormone bomb' ... to stop the bleeding. After a month, I started bleeding again so they gave me another one ... because here there are no gynaecologists and that is the only thing the midwives can do to stop the bleeding until I can travel to Punta Arenas to see what is happening down there, because there must be something that is failing. In my case, I have a history of breast cancer. I have a cyst in my armpit that is under control, and I have to get a mammogram every year. The thing is this week I found a lump on my other breast and, sadly, I can do absolutely nothing about it, because as in this island there are no specialists, they won't take you out [to Punta Arenas] unless you are dying.²¹⁶

Changes in protocols around healthcare also made women and gender non-conforming persons with disabilities in Chile doubt the quality of care they were receiving. For instance, Ninoshka, a woman with a physical disability in Chile, decided to pause her treatment for an ongoing condition after a poor experience with her doctor during the pandemic:

The doctor changed his protocol. The distance between us was more than one meter. He was on one corner of the office, and I on the opposite one. He didn't examine me as he used to. Given my diagnosis, he has to be careful and meticulous with the physical examination, and he was just going over it. That made me feel insecure, because I did not trust his protocol. He was insecure, too ... so I decided to move my September appointment to October and see what happens.

Laws, policies, and practices limiting travel and changes to healthcare protocols unfortunately did not prevent Chile from being one of the most impacted countries in Latin America by the COVID-19 pandemic. By the end of June 2020, Chile had the highest per capita infection rate of any major country—13,000 cases for every 1 million people.²¹⁷ When the first cases of COVID-19 infection emerged, in April, the government designed a plan to provide testing and treatment, and health officials quarantined the most affected areas. In May, however, the cases increased abruptly, and the country recorded up to 6,000 new cases a day in June.²¹⁸ As of December 2020, the number of infections was growing steadily, and hospitals were working with almost 90% of their full capacity.²¹⁹

An economic backlash stemmed from this health crisis, the most serious in 35 years,²²⁰ deepening the social inequalities in Chile. According to the World Bank, the country has one of the greatest income inequalities in Latin America, and 30% of its population is economically vulnerable.²²¹ In spite of the lack of data regarding women, girls, and gender non-conforming persons with disabilities' economic situation in Chile, worldwide, they are usually among the most economically vulnerable groups.²²² As one virtual consultation participant reported, she had had more trouble during the COVID-19 pandemic than at any other time in trying to find employment and also reported that she could not access social protection vouchers aimed at persons with disabilities during the pandemic, because she did not have the degree of disability required for the vouchers.²²³

As the risk of GBV also increased in Chile during the COVID-19 pandemic, the government took some positive steps to try to prevent and address this issue. For instance, GBV support services and shelters were designated as essential, hotlines were put in place for remote support (though video calls with sign language interpretation were not always available), and online courses on how to identify and prevent GBV were developed. Likewise, the Supreme Court of Chile published guidelines on how to ensure the right to access justice for victims of gender-based or family violence during the pandemic, aimed at members of the judicial branch.²²⁴

These activities were positive steps, but they lacked a specific disability perspective. Indeed, virtual consultation participants reported that the COVID-19 pandemic had increased the risk of GBV for them, as restrictions on movement and social distancing measures had exacerbated tensions with family members and members of their communities, while support services were not always accessible.

- ◆ Tamara, a non-binary autistic person, reported that “we have been greatly impacted by the pandemic because we are living in a place in which we don’t want to live and we have to stay for work, sadly, ... because the things that we’ve been through—we’ve been in racist, homophobic and lesbophobic situations—have made my partner want to go back to the closet, they have made us as a couple try to go back to the closet and hide, and we started looking for family and couple’s therapy.”²²⁵
- ◆ Valeria, a woman with multiple disabilities, described an incident of emotional and psychological abuse from her parents during the time of the pandemic, weaponizing her disability: “When I moved in with [my partner], my father called me and said that I was dead to them. They did not help me in any way until April this year. He has called me on the phone and told me I was a ‘dirty pig’ ... My landlord spoke the following day with my dad, and my dad told him I was ‘not right in the head’ and that I had a mental disability so one should not believe everything I said.”²²⁶
- ◆ Constanza, a deaf woman, highlighted the increase of GBV against members of the Deaf community during the pandemic, as well as the lack of accessibility of helplines, which had no video available for sign language interpretation.²²⁷ She further shared tensions within her own family as a result of the pandemic. “My mom sometimes is fine, sometimes she is not. The lockdown has created challenges at home.”²²⁸

Restrictions on movement and access to needed goods and services also had the effect of isolating many individuals, including women and gender non-conforming persons with disabilities. Catherine, a virtual consultation participant and a woman with a visual impairment, reported that “I had to be practically alone because my family stayed [isolated] in other regions, so the issue of the COVID has been very difficult. I live in a building that has taken many measures to prevent the spread of infection. They didn’t let anyone who is not from the building in, but if you think about it from a visual disability perspective, it’s a major isolation.”²²⁹

CASE STUDY #4: LOW RATES OF INFECTION AND SIGNIFICANT RESTRICTIONS ON MOVEMENT IMPACTING RIGHTS FOR WOMEN WITH DISABILITIES IN FIJI²³⁰

COVID-19 restrictions globally have substantially affected women and young people with disabilities in many ways, including through an increased risk of GBV, restrictions on education, and challenges to meeting basic needs.²³¹ According to stakeholders and people with disabilities interviewed by the UNFPA-Pacific Subregional Office, WEI, and Pacific Disability Forum as part of a project to assess SRH-related needs for persons with disabilities in the Pacific, these global effects have been felt locally throughout much of the Pacific, in particular in Fiji.

Fiji responded swiftly to the COVID-19 pandemic, shutting down its international borders and instituting a nationwide lockdown in April 2020. Citizens and residents who were repatriated during this time entered into a mandatory quarantine, and until April 2021, Fiji was able to contain identified cases of COVID-19 and prevent community spread. At the same time, the steep decline in revenue from tourism, trade, and production had a significant economic impact on Fiji.²³²

Women with disabilities and service providers indicated that restrictions on movement due to COVID-19 resulted in the largest impact on daily life, with consequences for access to employment, essential goods and services, disability supports, and public transportation.²³³ With respect to the provision of SRH services in Fiji, service providers indicated that lockdowns restricted access to these services.²³⁴

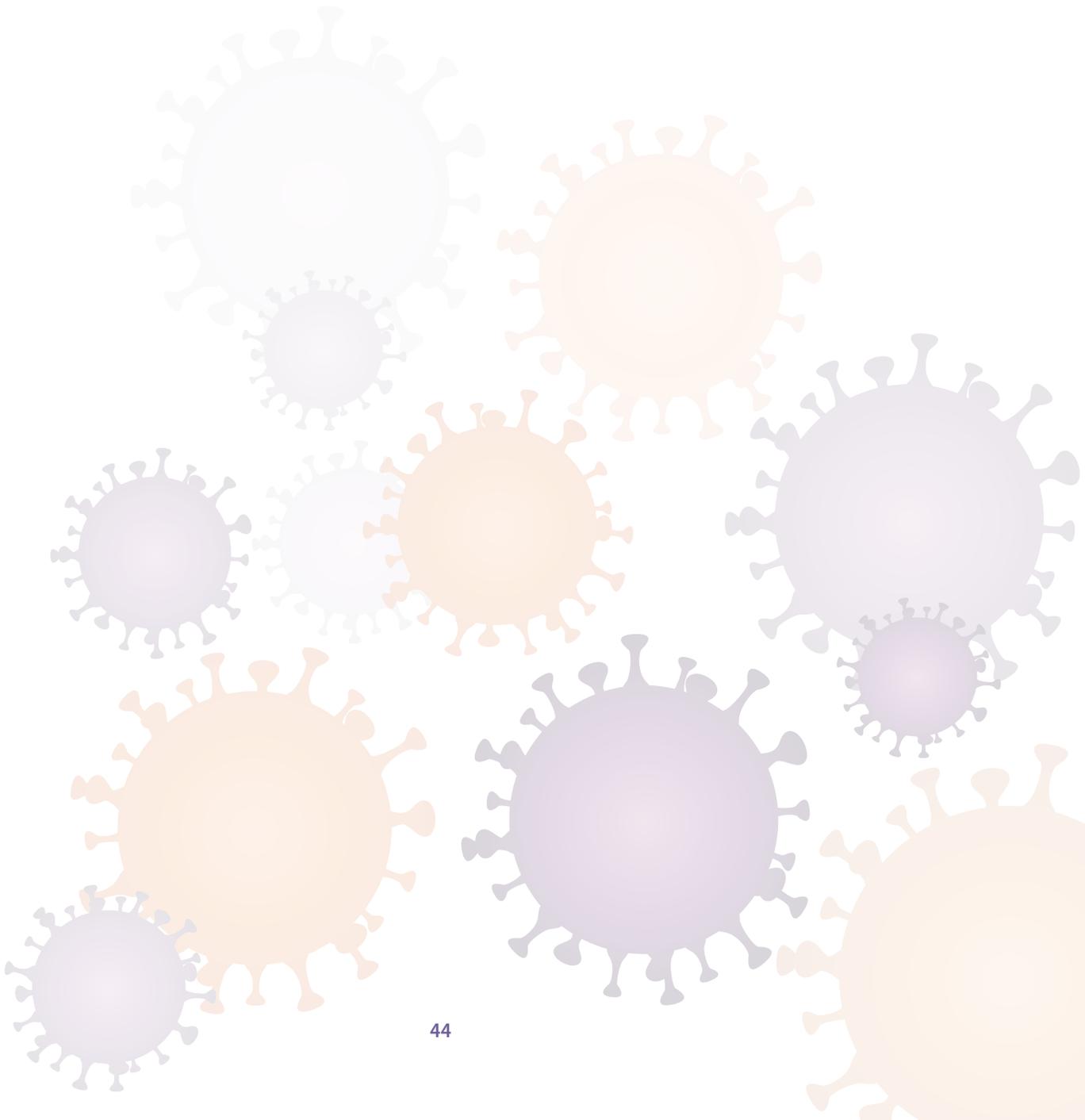
Interviewees and focus group participants generally indicated that they were able to access information about the virus, either through television, internet, or family members, though a survey carried out by the Psychiatric Survivors Association found that 65% of homeless persons with psychosocial disabilities in Suva were not aware of the virus.²³⁵ At the same time, the quality of information provided—particularly where translated into sign language—created issues in ensuring access to essential health services. For example, a 35-year-old deaf woman from Tailevu reported that the information available to the deaf community underscored that you could not leave your home; despite being pregnant, she was too scared to leave her home even to go to the hospital for maternity care.²³⁶

Several focus group participants reported significant impacts as a result of the lockdowns, particularly with respect to accessing essential healthcare services²³⁷ and experiencing heightened rates of verbal and physical abuse.²³⁸ One 20-year-old deaf woman from Gau Island recounted her attempt to secure police authorization to travel to the hospital to deliver her baby. She was in labor with her water broken. Her mother spent hours calling the police to secure the necessary pass to go to the hospital. As a result of this delay, she delivered her baby in the car on the way to the hospital—almost 18 hours after her mother had first contacted the police to try to secure a pass—and fainted during the delivery.²³⁹ Interviewees with psychosocial disabilities also reported not having access to mental health services at St. Giles during COVID-19 lockdowns.²⁴⁰

“The violence between deaf women and their husband has gotten worse because of no jobs or not enough money to support the family.”

— A deaf woman, Fiji, age 26

Several interviewees reported challenges in accessing public transportation during COVID-19, including being denied entrance onto buses, which restricted their ability to get to work and to health care facilities.²⁴¹ Several participants also reported losing their job, which led to financial hardships for some families.²⁴² Several women reported that financial hardships as a result of the pandemic have exacerbated the situation of GBV.²⁴³



ANNEX A: METHODOLOGY OF VIRTUAL CONSULTATIONS AND WRITTEN SURVEYS

The results outlined in this Impact Assessment stem from 20 virtual consultations with 173 women, girls, and gender non-conforming persons with disabilities, family members, and advocates for their rights in Latin America, Asia-Pacific, Sub-Saharan Africa, Europe, and Central Asia. The results of this impact assessment are also based on 137 responses to written surveys by women, girls, and men with disabilities and their support persons in the Arab region, Mauritania, and the Pacific. These consultations and written surveys were primarily administered in August through October 2020, with one consultation in December 2020.

Virtual consultations usually included between 5 and 10 individuals and were led by 1 or 2 facilitators from the staff of WEI and UNFPA, and local, national, and regional partner organisations.²⁴⁴ These virtual consultations varied in format based on the preferences and accessibility needs of facilitators and the participants in the consultations. Both virtual consultations and written surveys were focused on several topics, including access to healthcare, particularly SRH information, goods, and services; safety from violence; access to support services and other means to meet basic needs; and access to education, employment, and other income. The standard questionnaire for the virtual consultations and the written surveys is available in [Annex B below](#).

Virtual consultations focused on the following locations:

- ◆ 8 regional, sub-regional, and country-specific consultations with women and gender non-conforming persons with disabilities in Asia-Pacific;
- ◆ 4 country-specific consultations with women with intellectual disabilities and their family members or support persons in Eastern Europe and Central Asia;
- ◆ 3 regional and country-specific consultations with women and gender non-conforming persons with disabilities in Africa;
- ◆ 3 regional and country-specific consultations with women and gender non-conforming persons with disabilities in Latin America;
- ◆ 2 locality-specific consultations with women with learning disabilities in Oxfordshire, England, United Kingdom.

Consultations took place in several national and regional spoken languages, including English, Spanish, Portuguese, Urdu, Nepali, Bengali, Hindi, Tamil, Sinhalese, Bosnian, Albanian, and Russian, as well as local and international sign languages. Responses were translated into English for purposes of this Assessment, either simultaneously by professional interpreters or other native speakers of the local language or after the consultations by local partners or native language speakers who participated in consultations and reviewed transcripts or audio recordings. Written surveys were also administered in Arabic, French, and English and were translated into English by UNFPA staff for purposes of this Impact Assessment.

Geographical Distribution of Virtual Consultation Participants

Asia-Pacific:	85
Sub-Saharan Africa:	16
Latin America:	24
Western Europe:	6
Eastern Europe and Central Asia:	41

Geographical Distribution of Survey Respondents

Arab States:	111
West and Central Africa:	25
Pacific:	1

Virtual consultation participants and written survey respondents were asked for their consent to use information from their responses in this report and other work produced by WEI, UNFPA, and local, national, and regional partner organisations. They were informed that they could withdraw their consent for use of information at any time and that they did not have to answer any of the questions asked of them. Participants in virtual consultations were also asked to agree to ground rules for the group discussions, including keeping information they learnt from others private, respecting other participants, and ensuring space for discussion. Before questions on sensitive issues, including GBV, virtual consultation participants were reminded that they did not have to answer questions if they did not wish to and were provided with information about GBV services in their countries, if needed.

Virtual consultation participants and written survey respondents were further asked for consent to include any identifying information, including first name, age, location, gender and gender identity, and disability, alongside their responses. WEI, UNFPA, and partners obtained consent to use all responses and identifying information included in this report. Virtual consultation and survey responses have been lightly edited to resolve typographical or syntax errors.

Virtual consultation participants were primarily identified by national and regional civil society partners, with input from WEI and UNFPA. They were identified to try to represent a diversity of socioeconomic backgrounds, ages, ethnicities, geographic locations such as rural and urban communities, gender identities, and impairments or disabilities, with a particular emphasis on ensuring the inclusion of women, girls, and gender non-conforming persons with disabilities who are often underrepresented in global surveys. For instance:

- ◆ Six of the virtual consultations were focused on women and girls with intellectual or learning disabilities in Europe and Central Asia, and women with intellectual disabilities further participated in country or regional consultations as well as written surveys in Africa, the Arab region, the Asia-Pacific region, and Latin America.

- ◆ Deaf and hard-of-hearing persons participated in written surveys in the Arab States region and in nine national and regional consultations in Latin America, Sub-Saharan Africa, and Asia-Pacific.
- ◆ Women and gender non-conforming persons with psychosocial disabilities participated in the vast majority of consultations.
- ◆ A consultation with women with disabilities in Nepal included several indigenous women with disabilities, and consultations in Sri Lanka further included ethnic and language minorities.
- ◆ Non-binary persons with disabilities participated in consultations in Africa, Asia-Pacific, and Latin America;
- ◆ Written surveys and some virtual consultations also reached individuals in areas affected by conflict or other humanitarian emergencies.
- ◆ Young women and girls with disabilities were more than half of survey respondents in the Arab States region and made up a majority of virtual consultation participants in Eastern Europe and Central Asia.

Data from the virtual consultations and written surveys was analysed by WEI through a rubric developed based on questions in the standard questionnaire (see Annex A). Due to time limitations, not all virtual consultations covered every question in the survey, and not all virtual consultation participants answered every question. As such, data provided in this Impact Assessment is primarily qualitative, rather than quantitative.

The surveys and virtual consultations had some limitations. Virtual consultation organizers provided a small stipend (\$25 USD) to cover internet, transportation, or other costs incurred by participants in the consultations, when needed and requested. However, due to the barriers to internet access particularly in rural and remote areas, individuals from those areas are underrepresented in this Impact Assessment. Furthermore, the surveys and virtual consultations did not reach persons, particularly those with intellectual or psychosocial disabilities, living in psychiatric hospitals or long-term residential care institutions and who may have been particularly at risk during the COVID-19 pandemic. Finally, although virtually all consultations included young persons with disabilities, only consultations in Eastern Europe and Central Asia and written surveys in the Arab region reached girls with disabilities and directly documented their lived experiences during the pandemic. We hope that these gaps will be addressed in future research.

ANNEX B: CONSENT FORM AND MODEL QUESTIONNAIRE FOR VIRTUAL CONSULTATIONS AND SURVEYS

The questionnaire copied below served as the written survey administered by researchers in the Arab region, as well as in Mauritania. It also served as the model for live virtual consultations conducted in the other research regions. The consent form and questionnaire were translated into Spanish, French, and Arabic for purposes of administration.

IMPACT OF COVID-19 ON WOMEN, GENDER NON-CONFORMING, AND YOUTH WITH DISABILITIES

This survey is for women, gender non-conforming, and youth with disabilities about their experiences during the COVID-19 crisis, particularly those that are impacted by their gender and/or their disability. This survey is being conducted by the U.N. Population Fund (UNFPA) and Women Enabled International, a non-governmental organisation that works to advance human rights for women and girls with disabilities worldwide. UNFPA and Women Enabled International will use the information you provide in this survey to ensure that the COVID-19 response and the responses to future crises meet the needs of women, gender non-conforming, and youth with disabilities.

1. INFORMATION ABOUT YOU

We need to know some information about you in order to fully understand the information you share with us in this survey. We will not share this personal information with anyone else unless you give us permission to do so in Section 2 below.

- What is your name?
- How old are you?
- What country do you live in?
- Are you a woman, a man, a non-binary person or another description?
- What is your disability or impairment?
- Do you live in a place where there is war or conflict, or where there have been any recent disasters or crises besides COVID-19?

2. PERMISSION

In this survey, UNFPA and Women Enabled International will ask you to share information about your life. You do not have to answer any questions you do not want to answer. UNFPA and Women Enabled International would like to share the information you provide with other people, including in a report, if you give us permission to do so by signing this form, or having someone else sign on your behalf. We hope that by sharing this information, we can make the response to COVID-19 and future crises like this better for women, gender non-conforming, and youth with disabilities around the world.

- Can UNFPA and Women Enabled International share the information you give in this survey with other people, including in a report? Yes or No (circle the answer you choose)
- Can we include your name in the report? Yes or No (circle the answer you choose)
- Can we include your age in the report? Yes or No (circle the answer you choose)
- Can we include your country in the report? Yes or No (circle the answer you choose)
- Can we include your gender? Yes or No (circle the answer you choose)
- Can we include what your disability is? Yes or No (circle the answer you choose)

By signing below or having someone sign for you, you agree that UNFPA and Women Enabled International can share the information you provide in this survey with other people, including in reports and other written materials we produce, and to use the personal information you say is okay.

Signature

Printed Name

Name of Person Signing for Person Above, if applicable: _____

3. SURVEY: IMPACT OF COVID-19 ON WOMEN, GENDER NON-CONFORMING, AND YOUTH WITH DISABILITIES

Please answer the questions below as best you can. You do not have to answer some of the questions if you do not want to. You can make your answers as long or as short as you need to.

A. Access to Healthcare during COVID-19

1. How have you learned about COVID-19 (sometimes called the coronavirus) and how to keep yourself safe?
 - a. Have you tried to access any tests for COVID-19, and if so, how did that go?
 - b. Have you tried to access any treatment for COVID-19, and if so, how did that go?
2. Before COVID-19 happened, did you have a doctor, midwife, or healthcare provider who you would see who would tell you about and answer any questions you had about your body, sex, relationships, pregnancy, family planning, HIV/STIs, and giving birth to children (this is called sexual and reproductive healthcare)?
 - a. If yes, have you tried to see or speak to this doctor, midwife, or healthcare provider since COVID-19 started? How was the experience?
 - b. If no, have you wanted someone to talk about your body, sex, relationships, pregnancy, family planning, HIV/STIs, and giving birth to children during this COVID-19 period?
3. Are you aware of anything that doctors, other healthcare providers, or your government are doing right now that is helping make sure you get the sexual and reproductive healthcare that you need?

4. How has COVID-19 impacted access to the other healthcare you may have needed during the crisis (for instance, regular checkups, physical therapy, mental health services, medications, and wheelchairs or assistive devices)?

B. Violence

Next, we are going to ask you about safety from violence, including gender-based violence, during COVID-19. Gender-based violence means that someone in your home or community is hurting you, often because of your sex or gender. People may also target people with disabilities for violence or threats, because of their disability.

We know this issue can be hard to talk about. Please remember that you do not have to answer questions about this issue if you do not want to. UNFPA and Women Enabled International can also help you locate violence-related services if you or others need them.

1. Since COVID-19 began, have you felt safe? Have you been worried about someone hurting you (you do not have to tell us who)?
2. If your government made everyone stay at home for a while during COVID-19, did you feel safe during that time?
3. If someone hurt you at home or in your community, or if someone made you feel unsafe during COVID-19, would you know what to do to get help?

C. Access to Disability-Related Supports and Services

1. How did you receive support from service providers, family, friends, or community members to help with your daily life and overcome barriers due to disability before COVID-19?
2. Has this changed since COVID-19? If so, how?

D. Meeting Basic Needs

1. Since the COVID-19 pandemic began, has there been any change to your ability to meet your basic needs, such as accessing food and clean water, staying in your own home, or taking care of personal hygiene needs, including during your periods/menstruation?
2. Do you know about any government or other programmes to help you meet your basic needs during this time?

E. Employment, Income, and Education

1. Before COVID-19, did you have a job or go to school?
2. How has COVID-19 affected your job, your classes at school, or any other income you had? Do you know about any government programmes to help you with money or with school right now?
3. If you were in school before COVID-19, were you receiving information about your body, sex, relationships, and having children (sometimes called sexuality education)? Are you receiving any of this kind of information during COVID-19?

ENDNOTES

- 1 See, e.g., World Health Organization (WHO), *Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance 6*, 29-30 (June 1, 2020) (noting that, learning from past emergencies, reproductive health services should be considered a “high priority” category for continued health service provision during the pandemic, and providing guidance on continued provision of sexual and reproductive health services).
- 2 Pratima, an indigenous woman with a physical disability, Nepal (October 2020).
- 3 U.N. Committee on the Rights of Persons with Disabilities (CRPD Committee), *General Comment No. 3 (2016), Article 6: Women and girls with disabilities*, U.N. Doc. CRPD/C/GC/3 (2016) [hereinafter CRPD Committee, *Gen. Comment 3*].
- 4 Convention on the Rights of Persons with Disabilities, adopted Dec. 13, 2006, arts. 11, 16, 23 & 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]; Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, arts. 1, 2, 12 & 16(e), 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]; *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept.5-13, 1994, Sec. 6.30-33 & 7; U.N. Doc. A/CONF.171/13/Rev.1 (1995).
- 5 For more information about SRHR for women and girls with disabilities, see Women Enabled International: *Facts: The Sexual and Reproductive Health and Rights of Women and Girls with Disabilities* (2018), <https://www.womenenabled.org/fact-sheets.html>.
- 6 UNFPA and WEI partnered with 8 national- and regional-level organisations, most led by women with disabilities, to conduct this research. These included CIMUNIDIS (Chile), Movimiento Estamos Tod@s en Accion (Latin America), Disabled Women in Africa (Malawi and regional), My Life My Choice (United Kingdom), National Forum for Women with Disabilities Pakistan, Shantha Memorial Rehabilitation Centre (India), HYPE Sri Lanka, and Special Olympics in Eastern Europe and Central Asia.
- 7 See, e.g., CRPD Committee, *General Comment No. 6 (2018) on equality and non-discrimination*, para. 21, U.N. Doc. CRPD/C/GC/6 (2018).
- 8 Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, *Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz: Violence and discrimination based on sexual orientation and gender identity during the coronavirus disease (COVID-19) pandemic*, U.N. Doc. A/75/258 (2020).
- 9 Women Enabled International, *COVID-19 at the Intersection of Gender and Disability: Findings of a Global Human Rights Survey*, March to April 2020 (May 2020), <https://womenenabled.org/blog/COVID-19-survey-findings>.
- 10 WHO & WORLD BANK, *WORLD REPORT ON DISABILITY 28* (2011), https://www.who.int/disabilities/world_report/2011/report/en/.
- 11 WHO and United Nations Population Fund (UNFPA), *Promoting Sexual and Reproductive Health for Persons with Disabilities: WHO/UNFPA Guidance Note 3 6-7* (2009), <https://www.unfpa.org/publications/promoting-sexual-and-reproductive-health-persons-disabilities>.
- 12 S. Hameed, A. Maddams, T. Shakespeare, et al, *From words to actions: systematic review of interventions to promote sexual and reproductive health of persons with disabilities in low- and middle-income countries 2* (2020), <https://gh.bmj.com/content/5/10/e002903>.
- 13 See U.N. Committee on Economic, Social, and Cultural Rights (ESCR Committee), *General Comment No. 22: The right to sexual and reproductive health*, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, *Gen. Comment 22*].

- 14 Carolyn Frohmader & Stephanie Ortoleva, *Issues Paper: The Sexual and Reproductive Rights of Women and Girls with Disabilities* 6 (2013), https://www.womenenabled.org/pdfs/issues_paper_srr_women_and_girls_with_disabilities_final.pdf.
- 15 Michelle Lokot & Yeva Avakyan, *Intersectionality as a lens to the COVID-19 pandemic: implications for sexual and reproductive health in development and humanitarian contexts*, 28 *SEXUAL AND REPRODUCTIVE HEALTH MATTERS* 1, 2 (2020), <https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1764748>.
- 16 E. Burke, F. Kébé, I. Flink, M. van Reeuwijk & A. le May, *A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal*, 25 *REPROD. HEALTH* 43, 43–54 (2017); M.W. Gichane, M. Heap, M. Fontes & L. London, *“They must understand we are people”: Pregnancy and maternity service use among signing Deaf women in Cape Town*, 10 *DISABIL. HEALTH J.* 434, 434–439 (2017).
- 17 See, e.g., Maria, a woman with a disability, Pakistan (October 2020) (“If we talk about the SRHR health issues, I have never been to the doctor for such kind of issues, I personally.”); Maulani, a woman with a physical disability, Indonesia, age 58 (December 2020) (“Women with disability don’t go to doctors and nurses to talk about their sexual and reproductive health in Indonesia. They go only to give birth here.”); Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020) (reporting significant attitudinal barriers to accessing SRH for women with disabilities); a girl with a physical disability, Yemen, age 17 (written survey response) (“I don’t know what to do but they [SRH staff] need a lot of awareness to learn how to deal with persons with disabilities whether physical or mental. Added to that being a girl I faced many pressures from my family and the community, which resulted in severe depression for me.”); Gina, a woman with a learning disability, U.K., age 48 (reporting that, before she had become pregnant, no one had ever explained to her how someone becomes pregnant, and that in fact her mother had told her she could not get pregnant); a woman with a visual disability, Tunisia, age 23 (written survey response) (“We do not think about these issues before marriage. I have no information about these issues and no channels to hear about these issues. The only information I have is through friends’ experiences.”); a deaf woman, Nepal (October 2020) (sharing that, in school, deaf children are rarely given access to information about sexual and reproductive health, due to shame and stigma around this issue).
- 18 See, e.g., an advocate for persons with Down Syndrome, Nepal (October 2020) (“There has been a lack of sexual and reproductive health education for the people with intellectual disability. They do not have sense of bad and good touch, they are not given the education and knowledge about sexual and reproductive practices which makes them extremely vulnerable to sexual abuse.”).
- 19 Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities* 5 (2020) (on file with authors).
- 20 *Id.* at 3.
- 21 HYPE Sri Lanka and Women Enabled International, *Rapporteur’s Report of Virtual Consultations in Sri Lanka* 11 (November 2020) (on file with authors).
- 22 See, e.g., Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020) (sharing that even before the pandemic, there were significant attitudinal barriers to accessing SRHR for women and girls with disabilities in the Philippines. These included the perception that these women were asexual, did not have a right to have a family or to have a sexual relationship, and the perception that SRHR is not important for women with disabilities. SRHR providers were also not very sensitive to the needs and rights of women with disabilities, resulting in discrimination and abuse in some settings); Liya, an advocate for persons with disabilities, Ethiopia, age 35 (October 10, 2020) (“SRH providers have a misconception that women with disabilities cannot be sexually active and have sexual needs. When a blind woman went to a service provider, the service provider thought she was raped and told her to give away her baby and said, ‘Who dare to touch you, did you file a case in court?’ When another woman in a wheelchair went to a service provider, the guard thought she came for financial support and told her they don’t provide that.”); Lyness, a woman with a physical disability and advocate for children with disabilities, Malawi (September 2020) (“Health professionals think that persons with disability can’t have sexual relationship. In the hospital, they ask so many questions that lead to demotivation and avoiding going to the hospital.”); Maria, a woman with a disability, Pakistan (October 2020) (“If I go to the doctor, being a person with a disability and a woman with disability and say I want to, I am facing this kind of sexual and reproductive health issues, and I live with my family. So the day-to-day behaviour and reaction comes that why do you want to do that? You don’t need to do that. Just take care of yourself. And things like that.”).
- 23 Martha, an advocate for deaf-blind women, Malawi (September 2020).

- 24 Lyness, a woman with a physical disability and advocate for children with disabilities, Malawi (September 2020)
- 25 Gina, a woman with a learning disability, U.K., age 48 (September 2020).
- 26 See, e.g., Sekarani, a deaf person and advocate for deaf women, Malawi (September 2020) (“When it comes to deaf women, there are communication problems because hospitals don’t have sign language interpreter. Women with disabilities cannot find Sign language interpreters for free so that is also a challenge for economically marginalized women. If you don’t have a sign language interpreter, the doctors often say that they can’t help you because you don’t have sign language interpreter. Also, sometimes when you go with an interpreter, they won’t let the person to get in.”); a deaf woman, Nepal (October 2020) (“For deaf woman, it is difficult to reach the [sexual and reproductive health] doctors as they require supporters and interpreters.”); Martha, an advocate for deaf-blind women, Malawi (September 2020) (“For the deaf-blind, there is a challenge in terms of communication. The health practitioners don’t have communication skills to communicate with a deaf-blind person. For example, a deaf-blind girl wasn’t able to communicate with the healthcare provider and that resulted in the healthcare provider prescribing a wrong medication.”); a participant in a virtual consultation in Asia-Pacific (October 2020) (“When we go to the hospitals, we are expected to bring our support systems with us to enable interpretation.”).
- 27 See, e.g., a woman with a visual impairment, Tunisia, age 23 (written survey response) (“I went to many health civil society run centres and the services provided were counselling and contraceptives only.”); Lyness, a woman with a physical disability and advocate for children with disabilities, Malawi (September 2020) (“During the COVID, most hospitals are not giving out family planning. Most of the family planning clinics in the hospital are closed to prevent the spread of COVID.”); a woman with a visual impairment, Bangladesh (October 2020) (reporting that, during times in the pandemic, almost all health facilities were closed, including family planning facilities); Sofia, a woman with a disability, Argentina, age 21 (October 2020) (“It seems like there are no campaigns providing free contraception and condoms anymore. It is all about coronavirus. [There is nothing] about family planning, and regular check, like pap smears . . . are being rescheduled, as if sexual health was less important.”).
- 28 See, e.g., a woman with a learning disability, U.K., age 51 (September 2020); Nidhi, a woman with a visual impairment and advocate for women with disabilities, India (October 2020) (“Particularly in this phase of lockdown, there were situations around accessing sanitary napkins, sanitary wear, so it had impacted sexual health tremendously.”); a woman with a disability from a marginalized caste, Nepal (October 2020) (“There has been lack of the menstrual hygiene kit during this period and people are facing several issues. The lockdown has increased the issues regarding accessibility of resources. We have launched distribution programmes distributing the menstrual hygiene toolkit as well but it has not reached [enough] people.”).
- 29 Jackie, a woman with multiple disabilities, U.K., age 50 (September 2020); a virtual consultation participant in Malawi (October 2020) (“And other clinics were suspended due to COVID and persons with disabilities were not getting access to medications such as epilepsy medication.”).
- 30 See, e.g., a virtual consultation participant, Malawi (October 2020) (“Women with disabilities are scared to access these services because if their temperature is found to be high at the hospital, they might be forced to be quarantined and may not be allowed to go home.”); Sofia, a woman with a disability, Argentina, age 21 (October 2020) (“There are cases where you can’t go to the hospital because you run the risk of getting infected [with COVID-19] and medical practices are closed.”).
- 31 A woman with a visual impairment, Bangladesh (October 2020); see also Ruth, a woman with a visual impairment, Malawi (October 2020).
- 32 A girl with an intellectual disability, Morocco, age 12 (written survey response); Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020); Lyness, a woman with a physical disability and advocate for children with disabilities, Malawi (September 2020) (“Most women with disabilities live below poverty line and can’t afford private transportation.”); Laxmi, a woman with a disability, Nepal (October 2020) (“[A]fter the lockdown and even sometimes in between the lockdown period, public transportation, like some transportation were allowed, but public transportation and all were closed for so many months. So women with disabilities like everyone they don’t have their own private vehicles. So for other health-related needs, they could not have transportation to go for checkups.”); Patience, a woman with a physical disability, Nigeria, age 47 (October 2020) (“It [COVID-19] has made access to healthcare very difficult. A woman with disability told me that she has resorted to self-medication even more harmful because there’s no way the woman can reach the hospital.”).

- 33 For instance, Jembell, a young woman with a physical disability in Panama who did have access to accessible transportation, shared how challenging it was to obtain emergency contraception with many pharmacies closed or out of stock: “[During the COVID-19 pandemic], I tried accessing the morning after pill, and four out of five pharmacies asked me for a prescription . . . and I was wondering why they did that. . . . 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.” Jembell, a young woman with a physical disability, Panama, age 29 (October 2020).
- 34 Rejoice and Anne, advocates for women with disabilities, Malawi (October 2020) (“In some areas in the rural communities most of the women with disabilities access their SRHR through healthy workers who go for outreach for family planning in the communities but during this COVID-19 period such outreach are no longer happening hence women with disabilities are not able to access the services.”); an indigenous woman with a disability, Nepal (October 2020) (“In the inner areas of Dang, there is shortage of the family planning services which have resulted in unwanted pregnancy.”); Tamara, a non-binary autistic person, Chile, age 34 (September 2020) (reporting barriers to leaving Tamara’s remote island of residence to access SRH services because of COVID-19 restrictions).
- 35 A participant in a Focus Group Discussion by Naomi Navoce with members of the Fiji Association of the Deaf, in Suva, Fiji (November 2020).
- 36 Tamara, a non-binary autistic person, Chile, age 34 (September 2020).
- 37 Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020).
- 38 A participant in a Focus Group Discussion by Naomi Navoce with members of the Fiji Association of the Deaf, in Suva, Fiji (Nov. 2020).
- 39 Women with learning disabilities and other impairments, U.K. (September and October 2020).
- 40 Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020).
- 41 A woman with a disability from a marginalized caste, Nepal (September 2020).
- 42 A woman with a physical disability, Pakistan (October 2020).
- 43 See, e.g., Patience, a woman with a physical disability, Nigeria, age 47 (October 2020) (sharing that, for women with disabilities who have tried to access SRH care during the pandemic, “If it was easy to reach the hospital, the health workers were not even receptive to her.”).
- 44 See, e.g., Rama, a woman with a physical disability, Nepal (October 2020) (“[D]octors have prejudices about disability and COVID-19. They think all disabilities might bring the corona, so they have a negative attitude toward women with disabilities.”).
- 45 Participant in a virtual consultation in Asia-Pacific (October 2020).
- 46 See, e.g., Women Enabled International, *Facts: The Right of Women and Girls with Disabilities to be Free from Violence* (2018), <https://womenenabled.org/fact-sheets.html>.
- 47 UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID), UNITED STATES STRATEGY TO PREVENT AND RESPOND TO GENDER-BASED VIOLENCE GLOBALLY 7 (Aug. 10, 2012), <http://www.state.gov/documents/organization/196468.pdf>. It is worth noting that no global data exists on the incidence of such violence, and studies draw on different sources of data. While data on GBV against gender non-conforming persons with disabilities is largely unavailable, it is likely that they also disproportionately experience GBV. See, e.g., U.N. Human Rights Council, *Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, para. 62, U.N. Doc. A/HRC/38/43 (2018).
- 48 CRPD Committee, *Gen. Comment No. 3*, *supra* note 3, para. 31.
- 49 WHO & WORLD BANK, WORLD REPORT ON DISABILITY 59 (2011), https://www.who.int/disabilities/world_report/2011/report/en/.
- 50 Liya, advocate for persons with disabilities, Ethiopia, age 35 (October 2020).
- 51 CRPD Committee, *Gen. Comment No. 3*, *supra* note 3, para. 52.
- 52 Sekarani, a deaf person and advocate for deaf women, Malawi (September 2020).

- 53 Emma Pearce, *Disability Considerations in GBV Programming during the COVID-19 Pandemic* (Mar. 2020), http://www.sddirect.org.uk/media/1889/gbv-aor-research-query_COVID-19-disability-gbv_final-version.pdf.
- 54 WHO, *COVID-19 and violence against women: What the health sector/system can do 1* (2020), <https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf>.
- 55 UNICEF, *COVID-19 Response: Considerations for Children and Adults with Disabilities* (2020), https://www.unicef.org/disabilities/files/COVID-19_response_considerations_for_people_with_disabilities_190320.pdf.
- 56 See, e.g., Irene, a woman with a physical disability, Ecuador, age 28 (October 2020) (“I think that lockdown, the uncertainty (...) and the fact that we may have to be with the same people 24/7 creates a lot of stress, and that is somehow evidenced in the actions and reactions of all sides. ... That creates a sort of emotional imbalance that is sometimes difficult to handle.”); a woman with a physical disability, Palestine, age 32 (written survey response) (“Family is now more tense as we are always at home.”).
- 57 An indigenous woman with a disability, Nepal (October 2020).
- 58 See, e.g., Rejoice and Anne, women with disabilities and advocates for women with disabilities in Malawi (October 2020); Pamela, a woman with a disability, Malawi (October 2020); Stella, a woman with a disability and advocate for persons with disabilities, Malawi (October 2020); Jeeja, a woman with a disability, India (October 2020).
- 59 A deaf woman, age 38, Ecuador (October 2020).
- 60 See, e.g., a woman with a mental disability, Yemen, age 30 (written survey response); a woman with a physical disability, Yemen, age 23 (written survey response) (“I do not feel safe as I was verbally abused from some of my brothers.”); Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020) (reporting documentation of several cases of rape of women and girls with disabilities during the pandemic); Lyness, a woman with a disability and advocate for children with disabilities, Malawi (October 2020) (“There are cases which have been reported. Girls with disabilities have been raped and about 500 schoolgirls have been impregnated. Most girls are raped by their own family members. They take advantage of the hearing impairments because they think they are not able to explain what happened to them ... Most of the time women and girls with disabilities suffer in silence. They won’t tell relatives what has happened because it is often an uncle, brother, or father that has been the abuser.”); Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities 6* (2020) (on file with authors) (sharing that a young person in Bosnia and Herzegovina with intellectual disabilities faced sexual abuse by her uncle, who lives close by); Patience, a woman with a physical disability, Nigeria, age 47 (October 2020) (“During the lockdown in Nigeria, we saw a spike in violence against women with disability. 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 virtual consultation participant from Pakistan (October 2020) (“I have seen home violence... When everything is closed, there are no jobs and transportation facilities. My friend came over and told me about the situation she had been in with her husband at home.”).
- 61 Maulani, a woman with a physical disability, Indonesia, age 58 (December 2020).
- 62 See, e.g., U.S. Dep’t of Justice, Bureau of Justice Statistics, *Crimes against Persons with Disabilities 2009-2015: Summary 1* (2017), <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5986>.
- 63 Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities 5* (2020) (on file with authors).
- 64 *Id.* at 6 (sharing a case from Bosnia and Herzegovina, where a young person with an intellectual disability had been abused by her uncle and that abuse had been reported to police and prosecutors, but there had been little action on the case).
- 65 See, e.g., Valeria, a woman with multiple disabilities, Chile, age 33 (September 2020) (“When I moved in with [my partner], my father called me and said that I was dead to them. They did not help me in any way until April this year. He has called me on the phone and told me I was a ‘dirty pig.’ ... My landlord spoke the following day with my dad, and my dad told him I was ‘not right in the head’ and that I had a mental disability so one should not believe everything I said.”).
- 66 See, e.g., CRPD Committee, *Gen. Comment No. 3, supra* note 3, para. 29.

- 67 See, e.g., Misti, a woman with a disability, Bangladesh (October 2020).
- 68 See, e.g., Sekarani, a deaf person and advocate for deaf women, Malawi (October 2020) (“There are hotlines you can call to report GBV, but these are not accessible for Deaf women.”); Manique, a woman with a visual impairment, Sri Lanka (October 2020) (“When it comes to genderbased violence, there were hotlines to assist women on genderbased violence, but these were not accessible for women with disabilities.”); a deaf woman, Chile (September 2020) (“These are very dangerous situations that are emerging with lockdowns (...) and helplines and reporting lines are [not accessible for deaf people] lines where you have to make a call with no video.”).
- 69 See, e.g., WHO Global Health Cluster, *Gender-based violence in health emergencies* (2018), <https://www.who.int/health-cluster/about/work/task-teams/genderbasedviolence/en/>.
- 70 *Id.*
- 71 *Id.*
- 72 Janine, a woman with a visual impairment, the Philippines, age 43 (December 2020).
- 73 A woman with a physical disability, Yemen, age 23 (written survey response).
- 74 Nidhi, a woman with a visual impairment and advocate for women with disabilities, India (October 2020).
- 75 See, e.g., Lyness, a woman with a disability and advocate for children with disabilities, Malawi (October 2020) (“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.”).
- 76 Maulani, a woman with a physical impairment, Indonesia, age 58 (December 2020).
- 77 See, e.g., Pamela, a woman with a disability, Malawi (October 2020); a woman with encephalitis, Iraq, age 38 (written survey response).
- 78 Pamela, a woman with a disability, Malawi (October 2020) (“When that happens [violence], it is hard for people to bring forward the challenges that girls and women are facing in their homes. And later people will ask ‘Oh! She has a baby. What happened?’ But nobody wants to say what happened.”).
- 79 Shampa, a woman with a disability and advocate for persons with disabilities, India (October 2020) (“The system in India is we have police, but they are given the role of taking care of lockdown situations. ... They are not sensitized to disability or, either to gender inclusion. So all of a sudden when we call the police station, we just don’t find they are there.”); Misti, a woman with a disability and advocate for women with disabilities, Bangladesh (October 2020); Maulani, a woman with a physical disability, Indonesia, age 58 (December 2020) (“Limited mobility has rendered it difficult to collect evidence and take statements from witnesses to give a case during the pandemic.”); Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities 6* (2020) (on file with authors) (outlining a case in Bosnia and Herzegovina, in which police took little action to investigate a case of gender-based violence against a woman with an intellectual disability during the pandemic).
- 80 Hlobisile, a non-binary person with albinism and a visual impairment, South Africa, age 24 (October 2020).
- 81 See, e.g., Maulani, a woman with a physical disability, Indonesia, age 58 (December 2020) (noting that police officers did not know how to handle cases related to disability because they did not know how to communicate).
- 82 Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities 6* (2020) (on file with authors).
- 83 See, e.g., Women Enabled International, *Facts: The Right of Women with Disabilities to be Free from Gender-Based Violence* (2018), <https://womenenabled.org/fact-sheets.html>.
- 84 Manique, a woman with a visual impairment, Sri Lanka (October 2020); Shampa, a woman with a disability and advocate for persons with disabilities, India (October 2020).
- 85 For information on these topics, see the relevant sections below.

- 86 ESCR Committee, *Gen. Comment 22*, *supra* note 13, para. 7.
- 87 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, para. 40 (c), U.N. Doc. CEDAW/C/GC/35 (2017).
- 88 WHO, *Social Determinants of Health*, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (accessed March 1, 2021); ESCR Committee, *Gen. Comment 22*, *supra* note 13, paras. 7 & 8; Special Rapporteur on violence against women, its causes and consequences, *Report of the Special Rapporteur on violence against women, its causes and consequences, Yakin Ertürk: Political economy of women's human rights*, paras. 43-66, U.N. Doc. A/HRC/11/6 (2009).
- 89 See, e.g., a woman with a physical disability, Palestine, age 27 (written survey response); a woman with a learning disability, U.K., age 51 (September 2020); support person for a woman with a visual disability, Palestine, age 35 (written survey response) ("Her eye condition needs periodic checkups that have stopped as a result of the pandemic").
- 90 See, e.g., Ninoshka, a woman with a physical disability, Chile, age 35 (September 2020) ("I had to ask my sister to take me to the doctor. I used to go by Uber, but services like those stopped working, which for me meant losing my independence and autonomy."); a woman with a physical disability, Palestine, age 40 (written survey response) ("It was hard to reach health facilities and organizations who provide support equipment because of the lack of public transportation as a result of the lockdown."); Nurul, a woman with a physical disability, Indonesia, age 43 (December 2020) (reporting that healthcare facilities in her area had been closed and that she had not been able to access her regular check-ups); a virtual consultation participant, Pakistan (October 2020).
- 91 A woman with a disability, Pakistan (October 2020) ("I have to visit my doctors as I have a heart disease and that needs physical contact, now that COVID has lessened a bit they do not give enough time.").
- 92 Ninoshka, a woman with a physical disability, Chile, age 35 (September 2020).
- 93 A woman with a visual disability, Palestine, age 38 (written survey response).
- 94 See, e.g., a woman with a physical disability, Chile, age 32 (September 2020) ("[B]efore lockdown, I had a physical therapist come to my house and help me stretch my legs, and I lost that. ... it was a family decision to stop physical therapy."); a woman with a disability, Afghanistan (October 2020) ("The rehabilitation centres, like those provided by ICRC, had to reduce or limit their services in order to prevent the spread of coronavirus to help with keeping the required social distancing.").
- 95 See, e.g., Lisa, a woman with a mild learning disability, functional and gait disorder; and anxiety, U.K., age 33 (September 2020) (reporting that there were issues with prescription delays due to closings of pharmacies and that she had to use her old prescriptions to meet her needs); support person for a woman with a physical disability, Palestine, age 22 (written survey response) ("She needed some spare parts for her wheelchair and could not get them because of their price and because of the pandemic."); a woman with a physical disability, Yemen, age 23 (survey respondent) ("There is no medication available in war affected zones."); Manique, a woman with a visual impairment, Sri Lanka (October 2020) ("I must say especially for people with spinal cord injuries, they didn't have. ... a way of getting the catheters, the urine bags. So that was a huge blow for women with disabilities, because there was no transportation."); Evelyn, a woman with a disability, Malawi (September 2020) ("Government hospitals don't have some medicines for persons with disability so I had to get it by paying from other pharmacies."); support person for a woman with a physical disability, Palestine, age 32 (written survey response) ("Because of her psoriasis condition, she constantly needs ointments and antibiotics ... As a result of the lockdown, she was not able to receive her medication.").
- 96 See, e.g., Jannatul, a woman with a disability, Bangladesh (October 2020) ("My mom has diabetes, she is a diabetic patient and I have diabetes and we are all facing so stressful situation [about] where to get the medicine. Because in the beginning of this lockdown situation, the medicine shops are not open. It was only for a few hours these are open, and we had to wait for even more than one week to get the medicine that we pray will come, then we can collect the medicine from the shops.").
- 97 See, e.g., Shampa, an advocate for persons with disabilities, India (October 2020) ("[The lockdown] happened all of a sudden. So OPDs [organisations of persons with disabilities] of the mental health, the hospital here, they stopped giving OPD services to patients who used to get medicines, to come and get medicine on a regular interval."); a woman with a learning disability, U.K., age 51 (September 2020) ("I don't have any of them anymore, social workers or psychiatrists, I used to but since I married my husband, it all stopped. So it's a bit unfair really. There is no one to talk to because you can't get into to see your own doctor because of the strict guidelines."); HYPE Sri Lanka and Women Enabled

International, *Rapporteur's Report of Virtual Consultations in Sri Lanka* 10 (November 2020) (on file with authors) (reporting a rise in mental health-related issues during the pandemic, without recognition from authorities about the seriousness of these concerns. One participant shared that ambulance services refused to take persons with mental health concerns to hospitals, noting that such services would only be for those with physical ailments, while emergency hotlines also noted that they would not assist those with mental health concerns. Such provisions impact not only those who developed mental health issues during the pandemic, but also those with psychosocial disabilities who may have needed assistance.); Leonor, a bipolar woman, Ecuador, age 46 (October 2020) (“For people with psychosocial disabilities, this has been a very complicated situation. We have not received help, in psychological or psychiatric terms, as [the health system] was mostly focused on the pandemic and hospitals are cancelling our appointments.”).

- 98 An advocate for persons with psychosocial disabilities, Indonesia (October 2020).
- 99 Nidhi, a woman with a visual impairment and advocate for women with disabilities, India (October 2020) (“[There were also] digital accessibility barriers where the health app designed by the Government to keep people safe or have a track of COVID19 was inaccessible to blind individuals and deaf individuals...”).
- 100 See, e.g., A deaf woman, Chile, (September 2020) (“What is lacking is a thorough explanation of [COVID-19] and its consequences of this critical situation.”); a deaf woman, South Sudan (October 2020) (“The government didn’t make any information in easy to read for people with intellectual disabilities or communication difficulties to access. So, organizations had to kind of come up with their own easy to read information on COVID-19, which is what we distributed to other areas. And this has been the case for also other disability types or categories where the organizations have had to kind of make the information accessible.”); a woman with a learning disability, U.K., age 51 (September 2020); Shampa, an advocate for persons with disabilities, India (October 2020) (“A lot of mothers called up [our helpline] and they said that they are feeling very restless. They don’t know how to handle the situation. They cannot explain to their child or who is probably adult in age who has got intellectual disabilities, why certainly this change is happening. It’s impacted their life and all.”).
- 101 Laxmi, a woman with a disability, Nepal (October 2020).
- 102 Pratima, an indigenous woman with a physical disability, Nepal (October 2020).
- 103 Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities* 5 (2020) (on file with authors) (a mother of a woman with an intellectual disability reporting that COVID-19 treatment was inaccessible due to cost); an advocate for persons with psychosocial disabilities, Indonesia (October 2020) (reporting that COVID-19 testing was difficult to obtain and was not available in institutions); Katie, a woman with a learning disability and White Cycle syndrome, U.K, age. 37 (September 2020); Tamara, a non-binary autistic person, Chile, age 34 (September 2020) (recounting that she was not tested for COVID-19 when she went the hospital with breathing problems, despite Tamara asking for a test).
- 104 See, e.g., European Parliament, *Study on Discrimination and Access to Employment for Female Workers with Disabilities* 134 (2017), [http://www.europarl.europa.eu/RegData/etudes/STUD/2017/602067/IPOL_STU\(2017\)602067_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2017/602067/IPOL_STU(2017)602067_EN.pdf).
- 105 CRPD Committee, *Gen. Comment 3, supra* note 3, para. 58.
- 106 Soneni, a woman with physical disability, Zambia, age 35 (October 2020).
- 107 See, e.g., a woman with a physical disability, Palestine, age 37 (written survey response) (“I found an employment opportunity that did not come through as a result of the pandemic.”); a woman with a physical disability, Jordan, age 27 (written survey response) (“I was shortlisted for a job and it got delayed because of COVID.”); a woman with a physical disability, Egypt, age 38 (written survey response) (“I was let go [from my job].”); a woman with a physical disability, Egypt, age 31 (survey respondent) (“I got laid off.”); a deaf woman, Ecuador, age 38 (October 2020) (“I was made redundant because the company [I worked for] did not have a budget for [this situation].”); Soneni, a woman with physical disability, Zambia, age 35 (October 2020) (“COVID-19 has affected my job. Before COVID-19 struck Zambia, I had people wanting to give me employment. During that time, I was finalizing my studies by doing my attachment. So, after COVID-19, I tried to contact all those people. They’re telling me that I have to wait until COVID-19 calms down.”).

- 108** Maria, a woman with a disability, Pakistan (October 2020) (“And while we were working from home, there was so much like internet issues and technological challenges, and economic, like if I am working for the corporate sector. So the financial instability and uncertainty of being employed was really big, you can say trauma for me personally.”).
- 109** Irene, a woman with a physical disability, Ecuador. age 28 (October 2020).
- 110** See, e.g., Lena Morgon Banks, Calum Davey, Tom Shakespeare, et al, *Disability-inclusive responses to COVID-19: Lessons learnt from research on social protection in low- and middle-income countries*, 137 *WORLD DEVELOPMENT* 1, 1-2 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7455235/>.
- 111** See, e.g., Rejoice and Anne, advocates for women with disabilities, Malawi (October 2020) (“It has been a challenge for women with disabilities in the communities since most of the things around were not going on at normal circumstances hence most of the women who were doing small business has lost their businesses, so they face challenges in accessing basic needs.”); Evelyn, a woman with a disability, Malawi (October 2020) (“My mother and my sisters helped me with money because, as a photographer, I lost all my clients due to the pandemic. . . . As a photographer, I don’t have customers now due to the pandemic, so I am getting a support from my family.”); Jenipher Akinyi, a woman with an intellectual disability, Kenya, age 33 (October 2020) (“There are a lot of people especially with disabilities who have had to be laid off in different industries, so hotel or even within NGOs. So many people have had to be laid off even within the formal sector because we have a lot of parents, especially women, who have children with disabilities, especially intellectual disabilities within our groups who have had to start to do other things to get money. Maybe small businesses, which is not really working out. Because not everyone wants to buy clothes when they’re probably focusing on food or essential drugs. So, it’s been very hard for different people. And it’s affecting everyone within the society. Because there’s a lot of widespread unemployment.”).
- 112** Mother of a woman with an intellectual disability, age 58 (December 2020).
- 113** A participant in a virtual consultation in Latin America (October 2020) (“Working from home caused me several problems that needed a person without disabilities to be fixed. Luckily, I have family members and friends who live close by, but big changes in our daily routines like that are a bit frustrating.”).
- 114** A participant in a virtual consultation in Latin America (October 2020).
- 115** Jannatul, a woman with a disability, Bangladesh (October 2020).
- 116** See Women Enabled International, *Facts: The Right to Education for Women and Girls with Disabilities* 1 (2019), <https://womenenabled.org/fact-sheets.html>.
- 117** A participant in a virtual consultation in Latin America (October 2020).
- 118** Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities* 6 (2020) (on file with authors) (reporting that in Tajikistan, internet access was a major issue and had prevented them from logging into virtual classrooms); Jenipher, a woman with an intellectual disability, Kenya, age 33 (October 2020); Liya, an advocate for persons with disabilities, Ethiopia, age 35 (October 2020) (“Universities have shifted to online classes. Most of these classes are not accessible to women and girls with disabilities and most of them don’t have access to internet to attend online classes.”); A woman with a physical disability, Palestine, age 26 (written survey response) (“My father and I stopped working [due to the pandemic]. I was not able to pay my university tuition. I don’t know any programs to help.”); a deaf woman, Chile (September 2020) (“I am a teacher for deaf students. We have classes over Zoom . . . Everything has worked fine . . . but I have two students who do not have access to a computer, so I lent them mine until December. . . . They applied for help at SENADIS [the national disability service], but they have received no reply.”).
- 119** See, e.g., Lyness, a woman with a physical disability and advocate for children with disabilities, Malawi (September 2020) (“Service providers are working limited hours and they are only available on specific dates.”); a woman with a hearing impairment, Oman, age 31 (written survey response) (“I could not have my personal aid with me. Instead, I relied on sign book to translate what I need to say.”); a woman with a physical disability, Palestine, age 25 (“My sister in law helps me with my personal needs such as combing my hair and tying my shoes. [. . .] As for service providers, the sessions stopped for a while.”) (written survey response).
- 120** Lisa, a woman with a learning disability, functional and gait disorder, and anxiety, U.K., age 33 (September 2020).

- 121** See, e.g., a virtual consultation participant in Latin America (October 2020) (“It is harder for me to walk on the street now, people do not want to get close to you to help you because of the pandemic. The mask also bothers me because it makes it harder for people to listen to me, they cannot see my mouth if I am asking for their help.”); HYPE Sri Lanka and Women Enabled International, *Rapporteur’s Report of Virtual Consultations in Sri Lanka* 10 (November 2020) (on file with authors) (reporting that virtual consultation participants indicated that neighbours, who usually served as a strong support system for persons with disabilities, were not as willing to help as usual, and that ties persons with disabilities experienced with their communities were broken because of fears of contracting COVID-19).
- 122** Chanthey, a woman with visual and physical impairments, Cambodia, age 37 (December 2020).
- 123** See, e.g., Luciana, a woman with a physical disability, Uruguay, age 26 (October 2020) (“[When the pandemic started], I was in the midst of moving on my own, and I had anxiety attacks because I was alone. (...) I didn’t have my mother, or my sisters who were the ones that usually did things for me. I had to learn to do a lot of things of my own, because with the pandemic and the lockdown, I could not count on them [to help me.]”); Catherine, a woman with a visual impairment, Chile, age 45 (September 2020) (“I live in a building that has taken many measures to stop the virus spreading. They would only let you in if you lived in the building. If you think about it from a visual impairment perspective, this has led to further isolation. I believe that here ... there is a lack of clear protocols on how to treat people with disabilities ... Imagine if [you have to go to the doctor] and you are out in the street, and people don’t help you out... not because they are not willing to do it, but because of the fear that has entrenched that if you don’t keep a distance, you will get infected. That has affected people with visual impairments. Of course, there are people who are willing to help anyway and who are breaking the rules in doing so, but I think there is a lack of criteria in terms of health towards people with disabilities.”); a woman with a physical disability, Mauritania, age 53 (written survey response) (“I rely on other[s] for help and no one helps me.”).
- 124** Shampa, a woman with a disability and advocate for persons with disabilities, India (October 2020).
- 125** See, e.g., CRPD Committee, *Gen. Comment 3, supra* note 3, paras. 58 & 59.
- 126** Misti, a woman with a disability and advocate for women with disabilities, Bangladesh (October 2020).
- 127** See, e.g., a woman with a physical disability, Chile, age 32 (September 2020) (“I know that [the government] is giving baskets with groceries to people in vulnerable situations, but I don’t know of any policy towards people with disabilities. Regardless of the economic situation one is in, I think that [disabilities] make it more difficult for people to gather provisions. There should be a policy (...) to ensure people with disabilities get basic provisions, and there is none.”); Liya, an advocate for persons with disabilities, Ethiopia, age 35 (October 2020) (“Organizations like UNFPA and ECDP have been delivering food and sanitary materials for women and girls with disabilities. However, it wasn’t enough. The government’s response wasn’t inclusive of women and girls with disabilities.”); Nidhi, a woman with a visual impairment and advocate for women with disabilities, India (October 2020) (“[There were] physical infrastructure [barriers] where food and essentials could not be sought out in the light of social isolation in the light of tactile non-support, human non-support, etc.”); Laxmi, a woman with a disability, Nepal (October 2020) (“But the Government and even NGOs who distributed those relief packages, most of them did not identify and relocate where those women [with disabilities] live. So most of the women with disabilities who have severe disabilities, they did not have personal assistants with them because of the immediate lockdown. So those, they could not access those relief packages ... We heard so many cases of that.”).
- 128** HYPE Sri Lanka and Women Enabled International, *Rapporteur’s Report of Virtual Consultations in Sri Lanka* 9 (November 2020) (on file with authors).
- 129** A woman with a physical disability, Palestine, age 27 (written survey response) (“Because of financial shortage we could not pay rent.”); a woman with a physical disability, Mauritania, age 45 (written survey response) (“Food is very expensive and sometimes is not possible to find drinking water.”); Special Olympics, UNFPA, & Women Enabled International, *Regional summary on key findings and possible solutions, UNFPA-WEI Project on COVID-19, Persons with Disabilities, and Sexual and Reproductive Health and Rights: Virtual Consultations with Women, Girls, Gender Non-Conforming (GNC), and Youth with Disabilities* 4 (2020) (on file with authors) (reporting the need to resort to various self-measures to meet basic needs, including purchasing food on credit, making their own hand sanitizer, sewing masks, and getting help from family members).
- 130** See, e.g., a deaf woman, Ecuador (October 2020) (“They cut my running water service at home. These kinds of inconveniences are the result of a lack of communication, particularly with us as deaf people.”); Soneni, a woman with physical disability, Zambia, age 35 (October 2020) (“The issue of water, it’s also been a problem for me. ... We have one communal source of water where everyone gets it from. I have to send people to get water for me. And we pay for that water every day. COVID-19 has highly affected my livelihood.”).

- 131 Ruth, a woman with a visual impairment, Malawi (October 2020).
- 132 Misti, a woman with a disability and advocate for women with disabilities, Bangladesh (October 2020) (“They have to have their disability identification card or they will not get the support from the government who have under the social services. . . . Government still did not provide disability identification card to all people with disabilities in our country. So [people] who don’t have the disability identification card will not get any support from the government. And there is a huge process to get this.”); Manique, a woman with a disability, Sri Lanka (October 2020) (explaining that people need a particular identification card in order to obtain benefits, including during the COVID-19 crisis, but persons with disabilities had trouble obtaining this card or keeping the card valid as it expired or as they moved to a different home, which has made the benefits difficult to obtain).
- 133 Manique, a woman with a disability and advocate for persons with disabilities, Sri Lanka (September 2020).
- 134 See, e.g., a girl with a physical disability, Iraq, age 12 (written survey response) (“I stopped school and do not see any of my friends.”).
- 135 See, e.g., a woman with a physical disability, Mauritania, age 38 (written survey response) (“I don’t have any more resources to support myself.”); virtual consultation participants with learning disabilities in the U.K. (October 2020) (sharing that lack of access to social networks had led to depression and expressing fears about another lockdown).
- 136 Jembell, a woman with a physical disability, Panama, age 29 (October 2020).
- 137 Rama, a woman with a physical disability, Nepal (October 2020).
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- 139 See also UNFPA & WEI, *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* (2018), <https://womenenabled.org/wei-unfpa-guidelines.html> [hereinafter UNFPA & WEI, *SRHR AND GBV GUIDELINES*]; WHO, UNFPA, UNICEF, et al, *Integrating sexual and reproductive health into health emergency and disaster risk management* (2012), https://www.who.int/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf; CRPD Committee, *Gen. Comment 3*, *supra* note 3.
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- 141 CRPD, *supra* note 4, art. 29(2).
- 142 *Id.*, art. 33(3).
- 143 *Id.*, arts. 11, 23, & 25.
- 144 See, e.g., CRPD Committee, *Gen. Comment 3*, *supra* note 3, paras. 38–46; *Concluding Observations: United Arab Emirates*, para. 45, U.N. Doc. CRPD/C/ARE/CO/1 (2016); *Colombia*, para. 56, U.N. Doc. CRPD/C/COL/CO/1 (2016); *Uganda*, para. 50, U.N. Doc. CRPD/C/UGA/CO/1 (2016); *Serbia*, para. 51, U.N. Doc. CRPD/C/SRB/CO/1 (2016); *Qatar*, para. 45, U.N. Doc. CRPD/C/QAT/CO/1 (2015); *Ukraine*, para. 46, U.N. Doc. CRPD/C/UKR/CO/1 (2015); *New Zealand*, para. 51, U.N. Doc. CRPD/C/NZL/CO/1 (2014); *Mexico*, para. 49, U.N. Doc. CRPD/C/MEX/CO/1 (2014).
- 145 See, e.g., CRPD Committee, *Gen. Comment 3*, *supra* note 3, para. 38; Report of the Special Rapporteur on the Rights of Persons with Disabilities, *Sexual and reproductive health and rights of girls and young women with disabilities*, U.N. Doc. A/72/133 (2017) [hereinafter Special Rapporteur on Disability, *SRHR of girls and young women with disabilities*].
- 146 UNFPA & WEI, *SRHR AND GBV GUIDELINES*, *supra* note 139.

- 147 See also CRPD, *supra* note 4, art. 12; CRPD Committee, *Gen. Comment 3, supra* note 3, para. 63(a); Special Rapporteur on Disability, *SRHR of girls and young women with disabilities, supra* note 145, para. 62(a).
- 148 See also CRPD, *supra* note 4, arts. 8 & 25; CRPD Committee, *Gen. Comment 3, supra* note 3, para. 47; Special Rapporteur on Disability, *SRHR of girls and young women with disabilities, supra* note 145, paras. 62(d) & (i).
- 149 See, e.g., CRPD, *supra* note 4, arts. 29 & 31; CRPD Committee, *Gen. Comment 3, supra* note 3, paras. 63(c) & d; Special Rapporteur on Disability, *SRHR of girls and young women with disabilities, supra* note 145, paras. 62(k) & (l).
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- 184 A woman with a learning disability, U.K., age 51 (September 2020); Dawn, a woman with a visual impairment and learning disability, U.K. (September 2020).
- 185 Gina, a woman with a learning disability, U.K., age 48 (September 2020).
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