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Disability Rights and SRHR: An Intersectional Approach to Ending VAW

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SEXUAL AND GENDER-BASED VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITIES:

A Mapping of Key Issues in an Asia-Pacific Context

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Background. It is estimated that one in five women live with a disability.[1] There is a higher prevalence of disability among women (19%) than men (12%).[2] In comparison to girls and women living without disabilities, girls and women with disabilities are more likely to be excluded from public participation, decision-making and leadership.[3] Given issues around access, stigma and ableist-patriarchal notions[4] of social acceptability, especially in the Asia Pacific region, they are more likely to be contained to private spaces like homes and institutions. This leads to their exclusion from public spheres like education, employment, politics, and decision-making. They are also more likely to be impacted by conflict, marginalisation and external shocks due to multiple intersectional forms of discrimination and oppression. These experiences are further intensified by intersectional factors like caste, class, ethnicity, and Sexual Orientation and Gender Identity (SOGI). Given such complex power dynamics, women with disabilities are often rendered disproportionately vulnerable to violence and discrimination. It also means that women, girls, and gender non-conforming persons with disabilities may face unique forms of violence and vulnerability in comparison to their peers without disabilities.

Sexual and Gender Based Violence (SGBV) refers to violence that persons are subjected to by virtue of their gender within hetero-patriarchal power relations and structures.[5] Such gender-based violence reflects imbalances in actual and perceived power, often at the disadvantage of those deemed female, feminine or effeminate. Violence on this basis perpetuates gendered subordination and control. This is not to say that men and masculine presenting persons are immune to gender-based violence. They too are subject to the behaviours, expectations and power dynamics of hegemonic masculinity.

> *From an Asia Pacific perspective, this rejection is based on notions of burden and devaluation held in place by stigma and shame. Female infants with disabilities are more likely to be subject to euthanasia or 'mercy killings' than male infants with disabilities .*

SGBV can take multiple forms. It may be experienced directly as physical, sexual, psychological or economic violence or more indirectly as societal norms, practices, stereotypes and attitudes that normalise the devaluation of a certain segment of the population, both in public and private spheres on the basis of gender. This article affirms that gendered devaluation, combined with ableism, denigrates and dismisses the value and worth of persons with disabilities and results in the multiple oppression of women, girls and gender non-conforming persons with disabilities.

Experiences of SGBV by Women and Girls with Disabilities: A Lifecycle Approach. According to UNFPA (2018), women and girls with disabilities are 10 times more likely to experience violence than women and girls without disabilities.[6] They are often faced with onto-violence or violence they experience by virtue of being who they are. A lifecycle approach captures the experience of onto-violence during the life course of women and girls with disabilities.

Sex selection and son preference remain a common practice, especially in highly hetero-patriarchal societies. From the outset, societal structures work against women and persons with disabilities. Therefore, the pressure on mothers to abort a fetus is much greater when the fetus or infant has impairments or disabilities.[7] Hence, even at the juncture of 'coming into being', girls with disabilities are most likely to face discrimination either before or soon after birth. Such practices are closely linked with devaluation of females and persons with disabilities along with assumptions about associated costs and 'burdens' including the perceived cost of care. These assumptions lead to the rejection of baby girls with disabilities from their family or primary care networks. From an Asia Pacific perspective, this rejection is based on notions of burden and devaluation held in place by stigma and shame. Female infants with disabilities are more likely to be subject to euthanasia or 'mercy killings' than male infants with disabilities.[8]

It is not uncommon for families, especially mothers, to face ethical judgement for giving birth to girls and/or infants with disabilities. They are stigmatised by association, and often subject to judgmental moral narratives. Such discourses may lead to the marginalisation of mothers of children with disabilities and expose them to violence from the wider family network. Also, socio-familial pressures lead to the abandonment of children, especially girls with disabilities, or the isolation and containment of such children to homes or rooms within homes. Shackling remains a common practice in many Asia Pacific countries,[9] especially among low income families. The stigma and shame surrounding female family members with disabilities means that their births are often not registered by families.[10] The absence of birth certificates leads to the socio-legal invisiblisation and erasure of women and girls with disabilities. This in turn acts as a barrier to accessing education, public services, healthcare and other social services. It also means that unregistered girls and women are excluded from electoral registries and census data, rendering them virtually non-existent in the state apparatus. This heightens their vulnerability to SGBV.

The perceived high 'burden of care' in the wake of economic hardship may mean that families are not able to cater to the specific needs of members with disabilities. This, combined with stigma, may lead to their neglect and mistreatment. Children with disabilities are nearly four times more vulnerable to experiencing violence than children without disabilities.[11] The invisibility and isolation of girls with disabilities means that the neglect, violence and abuse that they experience could go unreported and undocumented. Such isolation is likely to be greater in rural communities.[12]

The everyday experience of discrimination, including micro violence, by women, girls and gender non-conforming persons with disabilities, often leads to personal and social erosion of confidence, worth, and dignity. They often manifest as internalised ableism among persons with disabilities. The internalisation of harmful narratives by girls with disabilities may lead to low levels of self-esteem and heightened risk of self-harm[13] as well as high risk sexual behavior.[14] A World Bank study revealed that internalised ableism which results in girls and young women with disabilities fostering feelings of unattractiveness or undesirability may induce them to accept untoward sexual advances and violence.[15]

The stigma and shame surrounding female family members with disabilities means that their births are often not registered by families. The absence of birth certificates lead to the socio-legal invisiblisation and erasure of women and girls with disabilities.

It also means that unregistered girls and women are excluded from electoral registries and census data, rendering them virtually non-existent in the state apparatus. This heightens their vulnerability to SGBV.

Contrary to popular belief, children, especially girls with disabilities, are often expected to perform household chores instead of pursuing education.[16] They may not have access to resources to participate in education and public engagement including play and sports. They are also disproportionately impacted by poverty, often being considered last during acute periods of resource/income crisis like the COVID-19 pandemic.[17]

The abandonment of infants and children with disabilities, especially girls, means that they are often placed in orphanages and similar care institutions by the state or their families. This is partially due to inadequate support provided to low income families to provide home-based, respectful, and dignified care for girls with disabilities with heightened care needs.[18]

Institutionalisation brings with it unique challenges and vulnerabilities for women, girls and gender non-conforming persons with disabilities. The legal capacity, especially of women and girls with learning or developmental disabilities is often called into question when determining the 'best interests' of such individuals. Substituted decision-making as opposed to supported decision-making, continues to remain a preferred means of determining the best interests of persons with disabilities in the Asia Pacific region.[19] Ableist understandings of legal capacity may lead to medico-legal interventions that undermine the dignity and sexual and reproductive health rights (SRHR) of women and girls with disabilities. As per interventions like 'menstrual management', women and girls with disabilities may be subjected to forced sterilisation and contraception.[20] This may be the case in institutional settings with large numbers of inhabitants where the 'menstrual management' of many may be seen as an 'undue burden'. It may result in violent and harmful interventions that nullify the reproductive rights of women and girls with disabilities. In a sense, it is a means of 'de-gendering' young women with disabilities. It also carries eugenic undertones and must be approached with restraint and caution. 'Rolelessness' is a form of indirect violence associated with women with disabilities. Whilst the disassociation of women with disabilities from socially valorised reproductive roles like wife and mother may at the outset seem like liberation from hetero-patriarchal expectations, the experiential impact is one of unworthiness, devaluation, marginalisation and deprivation of what it means to be a socially valued and validated 'woman'. The Committee on Economic, Social and Cultural Rights (ESCR) General Comment number 5 on persons with disabilities recognises how women with disabilities are often treated as 'genderless human beings'.[21] This notion is often used to naturalise the sterilisation of women and girls with disabilities.[22] The historical shadow of eugenic violence against women with disabilities is recognised in General Comment number 20 of the Human Rights Committee that emphasises the special protection with regard to medical and scientific experimentation for 'persons not capable of giving valid consent'.[23]

> *'Rolelessness' is a form of indirect violence associated with women with disabilities... the experiential impact is one of unworthiness, devaluation, marginalisation and deprivation of what it means to be a socially valued and validated 'woman'.*

Girls and young women with disabilities are also vulnerable to human trafficking and sexual exploitation.[24] They are likely to be 'sold off' as informal sector workers and may be used and abused in begging rackets and mafias.[25] The likelihood of experiencing violence, including sexual violence, is higher for street children and homeless persons.[26] Young women and girls with disabilities, particularly those with hearing related or intellectual impairments may be more likely to be subjected to sex trafficking as they are often deemed more compliant and less likely to seek assistance.[27] The criminalisation of trafficked persons and the lack of shelters and services for such persons lead to heightened vulnerability. Girls with disabilities are also less likely to attend school than their male counterparts and are more likely to be kept at home and made to do chores and household work.[28]

Adolescents, especially girls with disabilities are unlikely to be exposed to comprehensive sex education or any form of SRH training and awareness.[29] This lack of awareness makes them particularly vulnerable to abuse, including abuse by family members and caregivers. The widespread assumption that women and girls with disabilities are asexual may lead to them being excluded from screenings for domestic and sexual violence.[30] They may also be automatically excluded from regular reproductive health checks.

Abuse by caregivers or family members put women and girls with disabilities in a highly compromising position as they maybe reliant on the perpetrators of violence to fulfill their basic physical, financial and emotional needs. Combined with a lack of accessibility, this high level of dependence means that women and girls with disabilities often find it virtually impossible to end abusive relationships and living arrangements.[31] The deprivation of reproductive rights which is often tied to perceived diminished marriageability of women with disabilities in the Asia Pacific region also undermines their right to bear children. Women with learning or intellectual disabilities may be actively discouraged from having or raising children, often leading to the removal of children from such mothers on the assumption of incapacity to care or hyper-sexuality.[32] Their ability to meet gendered care roles is brought into question, often leading to the abandonment of women who acquire disabilities following marriage.[33] In contrast to other women, women with disabilities are also more likely to experience violence from non-partner family members.[34]

Cultural beliefs and practices such as the assumption that girls with disabilities are virgins or the belief that having sex with girls with disabilities can cure cancer may make them more vulnerable to sexual violence and abuse.[35]

> *The containment of women and girls with disabilities to private abodes and relatively unregulated institutions means that they have very limited opportunities to obtain help in the face of violence and oppression.*

Women with disabilities also face very specific forms of violence which render them particularly vulnerable. Many persons with disabilities rely on long term medication, rehabilitation, therapy and other health-related services. Others may be reliant on assistive devices like wheelchairs, crutches, white canes and other assistive technologies, software and services. Perpetrators of violence may sometimes withhold treatment, medication and assistive technologies to assert control and domination over persons with disabilities, especially women and girls. Such abuse further exacerbates their isolation and minimises the possibility of obtaining aid, safety interventions and legal recourse. Women with disabilities may also be coerced with the threat of punishment, degradation and involuntary institutionalisation. They may also be denied access to or control over financial resources and inheritances.[36] The containment of women and girls with disabilities to private abodes and relatively unregulated institutions means that they have very limited opportunities to obtain help in the face of violence and oppression.

Structural factors such as the inaccessibility of emergency and justice services lead to their heightened vulnerability. Most shelters and safe havens for survivors of SGBV are inaccessible to a wide range of women and girls with disabilities.[37] Beyond physical access to buildings and spaces, access also requires the availability of information in accessible formats (braille, easy to read, Sign Language etc.) as well as access to emergency, legal aid and health care workers who are sensitised and equipped to interact with women, girls and gender non-conforming persons with disabilities.

Women and girls with disabilities who are survivors of violence often face the barrier of implicit bias in judicial systems.[38] This may dissuade them from reporting violence and abuse to law enforcement authorities. Challenges like misinterpretation by Sign Language interpreters or the unavailability of interpreters may discourage certain women, especially those who are deaf or with hearing impairments, from seeking justice. Arguments and beliefs around legal capacity and the 'fitness to testify' mean that reports of violence or abuse experienced by women and girls with disabilities are often dismissed, questioned or discredited. This is especially the case for women and girls with learning, sensory and communication related disabilities. The competence of women with disabilities to bear witness is also subject to scrutiny.[39]

Compounding Factors. The threat of violence, including rape and abduction, is heightened during situations of armed conflict.[40] Refugees and internally displaced persons with disabilities are less likely to seek legal recourse in such situations. Armed conflict is also a major source of impairment and disability. Women with disabilities in particular may face a heightened risk of violence in refugee camps and shelters. This is also the case for those living in shelters and informal living arrangements in the aftermath of natural disasters and other humanitarian crises.[41] Women and girls with disabilities are often likely to be left behind during events of displacement, evacuation or exodus, leaving them vulnerable to the actual threat or to secondary impacts like sexual violence and rape.

> *Older persons are more likely to experience impairment and disability. They are likely to experience neglect, homelessness and institutionalisation. The family-based care framework also means that persons with disabilities institutionalised as children may remain in such settings until old age. The experience of violence over the course of life may create an additional level of distress for older women with disabilities .*

In General Comment 35, the Human Rights Committee recognises the restrictions to liberty and the propensity for harm faced by persons in institutional custody including persons with psychosocial disabilities subjected to involuntary hospitalisation.[42] It highlights the need to address the harms of institutionalisation by providing community-based or alternative social care to ensure greater liberty and security for persons with disabilities including women and girls. Women with disabilities, especially those with psychosocial or intellectual disabilities are more likely to be incarcerated and imprisoned.[43]

In terms of intersectional violence, indigenous women with disabilities are disproportionately impacted.[44] The proliferation of cyber violence also disproportionately impacts women with disabilities, particularly those from already marginalised communities.[45] Women with disabilities may get harassed, stalked or bullied or subjected to other forms of degradation including online sexual harassment. Women with disabilities may become the objects of non-consensual online fetishisation, non-consensual image/video sharing and other forms of objectification.[46] Intimate partners and caregivers may willingly or unwillingly engage women with disabilities with such online activities leading to heightened vulnerability. Harassment on social media platforms may cause enduring psychosocial trauma and distress which may lead to victims experiencing self-harm, suicidal thoughts or other maladaptive strategies.[47]

Older persons are more likely to experience impairment and disability. They are likely to experience neglect, homelessness and institutionalisation.[48] The family-based care framework also means that persons with disabilities institutionalised as children may remain in such settings until old age. Women with psychosocial disabilities who are involuntarily admitted to hospitals may also not be reaccepted into family and community settings due to stigma, shame and fear leading to them living in institutional settings in a state of limbo even after recovery and rehabilitation.[49] According to the World Bank (2016), disability is an added risk factor for older women regardless of whether it is lifelong or acquired over time.[50] The experience of violence over the course of life may create an additional level of distress for older women with disabilities.[51]

Conclusion. Women with disabilities are more likely to experience SGBV due to structural oppression and vulnerability. They are subject to the threat of violence even before birth. This violence is compounded by intersectional factors like race, indigeneity, age, immigrant status and type of impairment among others. Women with disabilities experiencing poverty or engaging in informal sector occupations, including sex work, are particularly vulnerable. Such complexities require an intersectional, life course-oriented approach to mitigating SGBV experienced by women and girls with disabilities. It also requires a twin-track approach that recognises disability as cross-cutting all other issues including the many compounding factors that contribute to the heightened vulnerability of WWDs. Access in all its forms needs to be prioritised by SGBV service providers and the voices and needs of women and girls with disabilities need to be centred and prioritised in the broader SRHR landscape.

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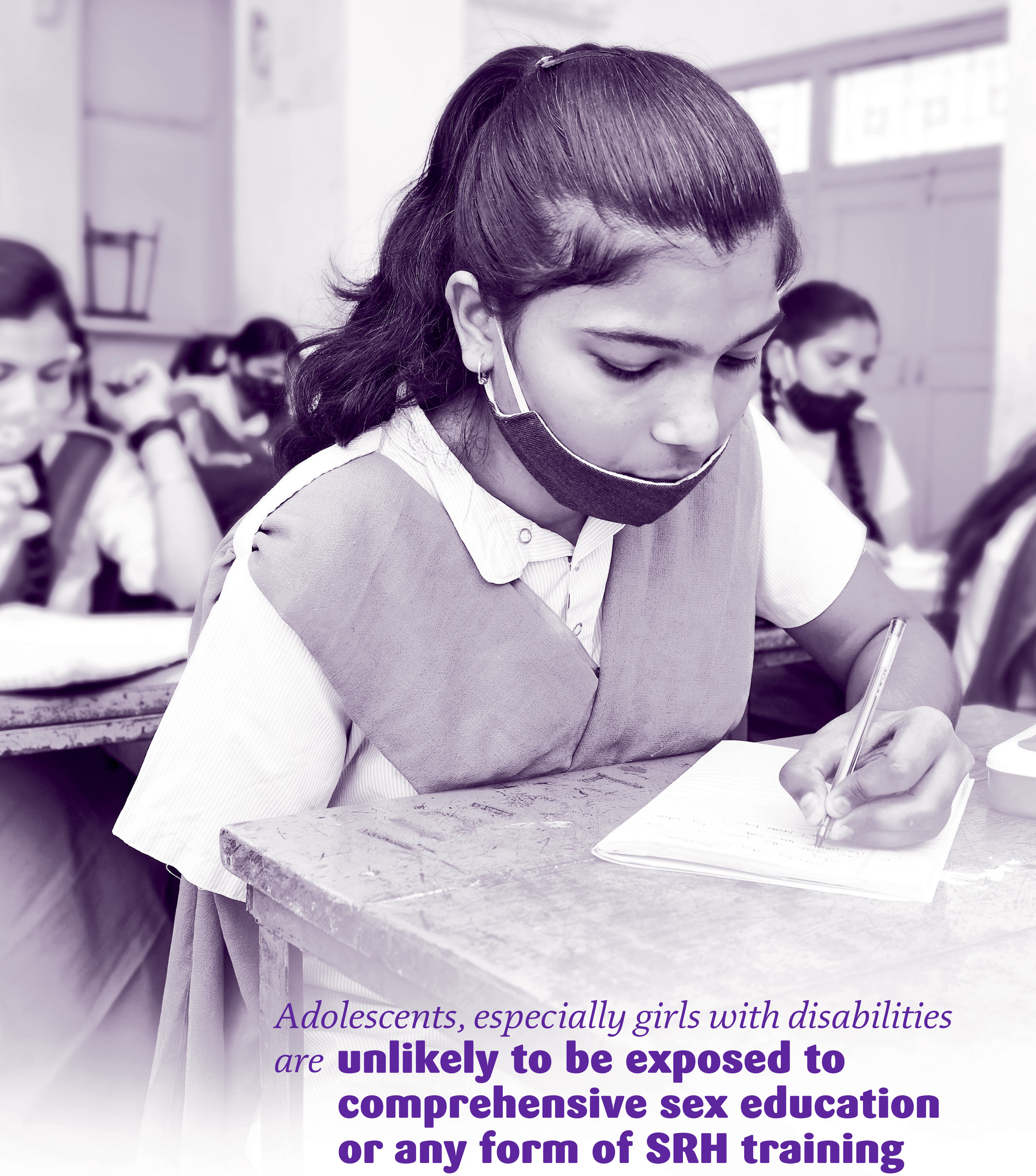

Adolescents, especially girls with disabilities are **unlikely to be exposed to comprehensive sex education or any form of SRH training and awareness,** *making them particularly vulnerable to abuse, including abuse by family members and caregivers.*

ACCESS TO JUSTICE BARRIERS: *Women and Girls with Disabilities Facing All Forms of Violence and Discrimination*

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Introduction. This article primarily focuses on the barriers to the access to justice faced by women and girls in Bangladesh when confronted with violence, abuse and exploitation. Women and girls with disabilities face a multitude of challenges when accessing the justice system and this particularly affects women and girls with disabilities facing sexual and gender-based violence (SGBV). This article takes a deep dive into some of these barriers, informed by the Women with Disabilities Development Foundation (WDDF) who work to ensure access to justice rights and prevention of SGBV against women and girls with disabilities[2] and the real-life situation of women and girls with disabilities who have been affected.

> *Women and girls with disabilities in Bangladesh are some of the furthest behind among the most marginalised groups in Bangladesh. A majority of these women and girls, in addition to lack of access to education, employment, etc., are also more than often deprived of their inheritance rights.*

Background. Persons with disabilities account for 9.12% of the total population in Bangladesh according to the Household and Population Census carried out by the Bangladesh Bureau of Statistics. The World Health Organization (WHO) puts the number of persons with disabilities to 15% of the total population of Bangladesh. This percentage matches the unofficial survey findings conducted by various DPOs and NGOs which also shows the total number of persons with disabilities to be 13-15% of the total population in Bangladesh. It is estimated that at least half of the population with disabilities is comprised of women and girls with disabilities. WHO estimates the figure to be roughly 12 million in Bangladesh. The Household and Population Census carried out by the Bangladesh Bureau of Statistics puts the approximate value at 8.2 million.

The absence of accurate data on the total number of women and girls with disabilities and the gap in our laws and policies when it comes to upholding the rights of women and girls with disabilities, makes this group particularly susceptible to various forms of discrimination, abuse, neglect, violence and exploitation in society. The lack of access to education, employment, information and services, health, including their sexual and reproductive health and rights, to name a few, significantly affect their lives from childhood to adulthood.[3] Women and girls with disabilities in Bangladesh are some of the furthest behind among the most marginalised groups in Bangladesh. A majority of these women and girls with disabilities, in addition to lack of access to education, employment, etc., are also more than often deprived of their inheritance rights. All of these factors contribute to their weak socio-economic standing within the society and the continuous cycle of discrimination, abuse and neglect faced by women and girls with disabilities puts them in a position where they are prevented from exercising their agency or realising their rights to the fullest.

Access to justice barriers faced by women and girls with disabilities. All of the above factors indicate towards an increased risk of the issues related to discrimination, abuse, neglect and violence against women and girls with disabilities remaining unaddressed. The recent ongoing survey being conducted by the Ministry of Social Welfare in Bangladesh was only able to identify 21 *lakhs* persons with disabilities and in majority of these cases, the nature of disabilities recorded in their identity card was incorrect. These numbers include women and girls with disabilities and the inconsistencies in identity cards is a serious issue as it keeps policymakers and service providers in the dark about the demands and needs of women and girls with disabilities in the country. This also means policymakers and justice sector actors lack knowledge on the number of women and girls with disabilities who face SGBV and it keeps those concerned uninformed about the steps that ought to be taken to better their lives, especially with regard to prevention of all forms of discrimination, violence and abuse against them. The case studies highlighted below illustrate the powerlessness and vulnerability experienced by women and girls with disabilities and their families when faced with sexual and gender-based violence such as rape.

Case Study 1: Chonda is a girl with intellectual disabilities living in a village called Sonatola, situated in Bogura. She was raped by some local miscreants of her village and has been waiting for justice since 22 September, 2016. Every single year, the case gets delayed for a number of reasons (trial dates getting postponed, the absence of witnesses on the defendant's side, etc.). The long delay in trials have affected the probability of her getting justice as most of the witnesses on her side are either leaving the village for employment or relocating to new areas. The delay in justice faced by Chonda and her family has created frustration, anger and a sense of insecurity within her community and the village at large, leading to the general population of the village losing trust in the overall justice system.

Case Study 2: Rifat, a girl with disabilities, did not get any justice when she filed a case after being raped (the case was delayed) and became a victim of rape for the second time, where the perpetrator this time was the paternal cousin of the accused. Her family members were reluctant to cooperate in her case which was one of the major reasons why the case made no progress. The family members indicated that the perpetrators were members of the family and given that Rifat is a girl with disabilities, they were not keen on taking matters any further. Rifat is dependent on her family and there is no infrastructure currently in place in Bangladesh that would secure her education, housing and other necessities if she chooses to pursue the case without the support from her family. Her situation resonates with the situation of a majority of women and girls with disabilities who, without the support of their families, are unable to lead safe lives and exercise their rights to get justice when their rights to be free from violence, torture, abuse and exploitation are violated.

Case Study 3: Turin is a girl with intellectual disabilities. She was repeatedly raped by her maternal grandfather until she became pregnant. However, she did not realise she was pregnant until she was in the sixth month of her pregnancy. When her family came to know, they took her to a One Stop Crisis Centre where she received treatment and delivered her baby. A government shelter took the responsibility to look after her child but due to complications arising from the delivery, the child eventually passed away at the shelter. Although the accused in her case initially confessed to the crime, the investigating officer was unavailable to record the confession, and due to the officer's prolonged illness and absence, the overall case proceedings were delayed. In the meantime, the accused hired local miscreants to harass Turin's family and bribed local government officials to prevent Turin's family from going to/cooperating with the court and other relevant authorities. The perpetrator died from COVID-19 in 2020 but his extended family members falsely turned his death into a murder and made Turin's father and her young adolescent brother, the accused party to the murder case. For the last year, Turin's family has been living a life of misery and hopelessness.

The absence of accurate data on the total number of women and girls with disabilities *and the gap in our laws and policies when it comes to upholding the rights of women and girls with disabilities, makes this group particularly* **susceptible to various forms of discrimination, abuse, neglect, violence and exploitation in society.**

WDDF's own experiences working in the field of establishing access to justice and rights of women and girls with disabilities have repeatedly put us face to face with the grim reality of the difficulties faced by women and girls with disabilities. The chances of them getting justice for the crimes perpetrated against them and the probability of getting legal remedy/relief is curtailed by a number of factors, the key ones being the following:

1. Accessibility issues create challenges for women and girls with disabilities in getting into police stations, court buildings, etc (lack of ramps, lifts, etc.). Accessibility issues also lead to other difficulties related to communication, affecting delivery and receipt of necessary information and services (unavailability of sign language interpreters, and lack of knowledge on how to record statements from those with multiple disabilities or those who have intellectual disabilities). The COVID-19 pandemic exacerbated this issue as the country-wide lockdown led to service and information delivery disruptions, shortage of sign-language interpreters and restrictions in mobility arising from public transport closures.[4]

2. Delay in swift disposal of cases affecting justice seeking women and girls with disabilities has an impact on the quality of evidence, and victims or witnesses can die or become unavailable over time.

3. The limitations within the current framework, where response measures do not include any community support or witness protection programmes, or safeguard the affected women and girls with disabilities and/or their families with 'safe homes', including during a crisis such as a pandemic, natural disaster, etc. One Stop Crisis Centres are not equipped with the knowledge or provisions to cater to the violation of SRHR that happens when the victim/survivor faces SGBV.[5]

4. Lack of awareness among justice sector actors, women and girls with disabilities and their families on the rights to SRHR and its interlinkages with the right to have access to justice, and the right to be free from violence, abuse and exploitation. The lack of data on the situation and lives of women and girls with disabilities and how it is affected by factors such as the pandemic, natural disasters, migration, including climate migration to name a few—prevents the adoption of strategies, policies or initiatives that are inclusive, holistic and sensitive to the needs of women and girls with disabilities.

5. Preventive laws in Bangladesh for women and girls facing violence, whether it is the Child Marriage Restraint Act, the Domestic Violence (Prevention and Protection) Act or the *Nari O Shishu Nirjaton Damon Ain* 2000, fail to mention women and girls with disabilities and none of the laws contain guidelines on how to deal with cases involving women and girls with disabilities. The Persons with Disabilities Rights and Protection Act 2013 contains some useful indications but weak implementation of the law means that none of these guidelines are followed in reality.

It is imperative for the government and other stakeholders to invest resources and attention in addressing the above areas and this is particularly important for Bangladesh, given that the country is a signatory to the Convention on the Rights of Persons with Disabilities (CRPD) and has incorporated the provisions contained within the CRPD into the Persons with Disabilities Rights and Protection Act 2013,[6] that guarantees access to justice rights for all persons with disabilities.

Moreover, as Bangladesh moves ahead with the Sustainable Development Goals (SDG) 2030 agenda, it is more important now than ever for greater emphasis to be put on SDG 16, which compels the government to promote peace, just and inclusive societies, particularly through ensuring access to justice for the most marginalised, which includes women and girls with disabilities facing all forms of violence.

> *Preventive laws in Bangladesh for women and girls facing violence, fails to mention women and girls with disabilities and none of the laws contain guidelines on how to deal with cases involving women and girls with disabilities. The Persons with Disabilities Rights and Protection Act 2013 contains some useful indications but weak implementation of the law means that none of these guidelines are followed in reality.*

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[2] Since 2019, WDDF has been working with ARROW on a Bogura District focused project that aims to prevent all forms of violence against women and girls with disabilities through establishing their SRHR and through the mobilization and empowerment of women with disabilities to catalyze positive changes in their own communities.

[3] Unofficial estimates gathered by NGOs and DPOs further show that 99% of women and girls with disabilities live below the poverty line. Out of this percentage, only 1% of girls with disabilities get the chance to attend school. Less than 1% of women with disabilities are in leadership positions and even fewer are in a position to exercise their political rights.

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COMMUNITY RESILIENCE SUPPORT FOR PREVENTION OF SEXUAL AND GENDER-BASED VIOLENCE AND DISCRIMINATION AGAINST WOMEN AND GIRLS WITH DISABILITIES:

A Case Study from Bangladesh

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Bangladesh is a signatory of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is the first comprehensive human rights treaty that acknowledges different types of persons with disabilities and reaffirms that they must enjoy all human rights and fundamental freedoms.[1]
In alignment with the CRPD, the government of Bangladesh has adopted “Persons with Disabilities Rights and Protection Act 2013”. Both the CRPD and Rights and Protection Act 2013 recognise that persons with disabilities have equal rights as others to enjoy the highest attainable standards of health without discrimination on the basis of disability. This also covers the right to family formation, marriage, parenthood, emotional and sexual relationships, and other important aspects of sexual and reproductive health (SRH). However, until now, sexual and reproductive health and rights (SRHR) of persons with disabilities remains a neglected topic in Bangladesh, partly because of the misconception that persons with disabilities are asexual, infertile or have no sexual desire.[2]

So far, only a few interventions have been implemented by the government, non-governmental organisations (NGOs) and organisations of persons with disabilities (OPDs) to address the SRHR needs of persons with disabilities in Bangladesh. One such intervention is the Wish2Action project implemented by Young Power in Social Action (YPSA) with technical support from Handicap International – Humanity & Inclusion (HI) during the period from June 2019 to July 2021. The main aim of the project was to ensure equitable access to family planning and SRHR services among young, marginalised and persons with disabilities in selected areas of Bangladesh.[3]

As a result of limited focus and interventions on SRHR of persons with disabilities, particularly women and girls with disabilities, many are unaware about their SRHR. A recent nationwide survey, conducted among 5,000 persons with disabilities by the James P Grant School of Public Health (JPGSPH) at BRAC University, found that only 29.5% (29.2% males and 29.8% females) of survey participants have comprehensive knowledge on SRHR issues. Less than half (44.9%) of the adolescent girls with disabilities had knowledge on menstrual hygiene management and 80.7% of ever married women with disabilities had knowledge on family planning methods. The study also found that approximately three-fourths (74.3%) of women and girls with disabilities aged between 10 and 49 years experienced emotional abuse followed by 33.2% physical abuse and 10.3% sexual abuse during their lifetime.[4] The perpetrators of violence range from close family members, intimate partners to strangers. However, many women and girls with disabilities do not share their experience of violence with others because of the fear of further violence, fear of being judged and being abandoned. When some of them share such experiences, they share it with close family members. Majority of the victims of violence seek support from close family members and relatives. They also seek support from local influential people such as community leaders and local political leaders.[5] In a country like Bangladesh, where religious and social norms greatly influence people’s perception about accessing services, community level interventions may play a critical role to address violence against women and girls with disabilities.

In this article, we discuss a community level intervention currently being implemented by the Women with Disabilities Development Foundation (WDDF) with support from The Asian-Pacific Resource and Research Centre for Women (ARROW) under the project titled “Defending Sexuality Rights of Women and Girls with Disabilities in Bangladesh”. The intervention aims to develop a cadre of trainers (community mobilisers) to educate women and girls with disabilities on different SRHR issues including sexual and gender-based violence (SGBV) against women and girls with disabilities in 10 unions of five sub-districts in Bogura.

Bogura is a city in northern Bangladesh with a total land area of 2,899 sq. km. and a total population of over 3.2 million residents.[6] A baseline survey to assess the current situation of women and girls with disabilities facing violence in selected areas of Bangladesh conducted by JPGSPH, BRAC University in 2020 listed 1,539 women and girls with disabilities in the 10 unions of five sub-districts. The WWDF intervention targets all these women and girls.

The WDDF started implementing the intervention in early 2021 and the activities are continuing now. At the beginning, disability rights activists and SRH experts from both WDDF and ARROW utilised the ARROW module titled *"Reclaiming SRHR of Women and Girls with Disabilities: A Training of Trainers (ToT) Manual on Disability Rights, Gender, and SRHR"* to train the community mobilisers (10 mobilisers in 10 unions). The training covered topics related to disability, body image and self-esteem, gender, sex, sexuality, intersectionality, sexual and reproductive anatomy and physiology, menstruation and its management, desires, pleasures, SRH, abuse and violence, and SRHR advocacy. After attending the training, the community mobilisers started visiting households of women and girls with disabilities to educate them on different SRHR issues including SGBV against women and girls with disabilities. During household visits, they carry a flipchart which has relevant information on SRHR and SGBV against women and girls with disabilities. The community mobilisers conduct three days of sensitisation sessions with women and girls with disabilities and three days with their family members and neighbors. They discuss prevention, awareness, and cases of SGBV, SRH concerns, and SRHR. The participants are also informed of the "999" government-provided emergency call services.

We talked with one of the community mobilisers, who shared her experience as follows: *"I am grateful to ARROW and WDDF. I learned many things relevant to SRHR, sexually transmitted diseases (STDs) and SGBV by attending the seven-day comprehensive training. I learned about my body, sexuality, romance, and relationships. I also learned the rights persons with disabilities are entitled to enjoy. I learned that we (women and girls with disabilities) have preferences and have the right to say "No" or express our desires to our partners. I am now applying my knowledge and skills to educate other women and girls with disabilities in my areas, their family members, and neighbors."*

By attending the WDDF meetings, Shaba learned about SRHR, menstrual health, sexual health, different forms of violence commonly experienced by women and girls with disabilities and ways to seek support when someone experiences any violence.

We also discussed with a beneficiary, Shaba (pseudonym), who is a 35-year-old woman with a physical disability. She has studied up to class 9. She is happily married with two daughters. Her husband is a small trader. She is a homemaker and does tailoring as a hobby. Recently, Shaba was introduced to a WDDF intervention. When Shaba was asked what she learned from the intervention, she informed us that she had attended several meetings arranged by the WDDF. By attending those meetings, she learned about SRHR, menstrual health, sexual health, different forms of violence commonly experienced by women and girls with disabilities and ways to seek support when someone experiences any violence. She added that now she and many other women in the community have learned the courage to talk about the violence they face daily, so that they can also defend and claim support if needed.

Shaba shared that two years ago she was naive and hardly had the courage to raise her voice. She could not help her maternal aunt from the violence she was experiencing at her in-law's house. Instead, Shaba was brutally abused when she tried to protect her aunt. But now, she gives advice to both women with and without disabilities.

"Two years back, my maternal aunt was verbally and physically abused several times by her brother-in-law and mother-in-law. Her husband did not assault her but he never stood up to protect his wife. Eventually, one day when my aunt was brutally beaten, we went to the police station to file a complaint. But her in-laws managed to dismiss the case. After going home she was beaten again and I was there. So, naturally, I tried to stand up for her. Then a policeman beat me badly with the help of a few local women. He was in support of my aunt's in-laws. After the incident, I went to the police station, but they refused to file a complaint because it was against someone from their profession. A few people advised me to seek support from journalists, but as that was at the time of the local election, there was political unrest, so I did not take it further."

Sharing the case, Shaba regrets that during that time she was not aware of women's rights so she could not fight for her aunt. But now that she is aware, she helps others practice their rights. In Shaba's opinion, women alone are powerless. When it comes to women with disabilities, the challenges are even more. Having a connection to an organisation like WDDF gives her more power and acceptance. But the situation is not similar for all women. In fact, she fears that her situation will not be the same without the support of the organisation. So, she is demanding that the government protect all women and take initiatives so that they can easily access justice. In her words, *"It should be considered that they are powerless and prone to violence. Most women are denied justice and forced to compromise. It should be ensured that no women is turned back without administrative help."* Only recently the government of Bangladesh and development sector have recognised the importance of addressing the SRHR needs of persons with disabilities. This neglected area of public health needs continuous attention and improvement. Besides, it is widely believed that persons with disabilities themselves do not raise their voices on SRHR in Bangladesh, partly because they do not see it as a basic need.

The community-level support intervention described here shows how the community mobilisers educate other women and girls with disabilities on different aspects of SRHR in their communities, which helps prevent SGBV and alleviates discrimination against women and girls with disabilities. This kind of intervention should be considered by policymakers and other stakeholders (e.g., NGO and OPD professionals) involved with the disability and SRHR sector to prevent SGVB against women and girls with disabilities and address the SRHR needs of persons with disabilities in Bangladesh.

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THE RIGHT TO LEGAL CAPACITY, ITS RECOGNITION IN HUMAN RIGHTS LAW, AND CHALLENGES FOR WOMEN WITH DISABILITIES

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Introduction. Persons with disabilities around the world struggle to make the kinds of decisions about their lives that many other people take for granted. These include decisions about whom to marry, how to vote, whether to have children, and more. Chester Finn, a prominent disability rights advocate, has explained many of the decision-making barriers that persons with disabilities face which are rooted in widespread beliefs that persons with disabilities are less capable than others: *"For a long time, people have felt that people with disabilities were incapable of a lot of things. We started to change the narrative and advocated for what we can do, and we showed people that we're capable of things. But still somehow they don't believe it."*[1]

Among the many kinds of barriers to exerting control over their lives faced by persons with disabilities are formal rules about who is allowed to exercise "legal capacity." Legal capacity refers to a person's authority to enter into legal relationships with others or to take on binding legal obligations.[2] A common example of exercising legal capacity is entering into a contract. Before someone may enter into a valid contract with someone else, most legal systems first require that they both be considered eligible to do so.

Beyond entering into contracts, having legal capacity is often a threshold requirement for exercising many other fundamental rights, such as the right to vote.[3] Legal capacity "enables persons to sculpt their own legal universe" by "open[ing] up zones of personal freedom" and "facilitat[ing] uncoerced interactions".[4] As a "shield," the right to exercise legal capacity allows persons with disabilities to fend off unwanted interference in their lives. As a "sword," this right also empowers persons with disabilities to impress their will and preferences upon the world. In other words, having legal capacity imbues real meaning into the notion of personhood.

From Disability to Incapacity. Imposing requirements on people when making consequential decisions serves a purpose: these prerequisites aim to help protect people who may not be prepared to take on certain responsibilities. However, when these rules are combined with discriminatory attitudes, they can become exclusionary and harmful, not only for persons with disabilities but also for other marginalised groups, including women and indigenous peoples. In practice, legal capacity restrictions have exposed persons with intellectual and psychosocial disabilities to forced abortion and sterilisation, forced medication, involuntary hospitalisation, involuntary institutionalisation, disenfranchisement, ineligibility for adoption or marriage, forfeiture of property or child custody rights, and more.[5]

Medical professionals play an outsize role in the application of such legal capacity rules. Many legal systems authorise medical professionals to determine a person's "mental capacity," that is, whether a person understands the nature and consequences of their actions. Where medical professionals determine that a person lacks the capacity to understand the nature and consequences of a specific kind of decision, that mental incapacity determination provides a justification for formal legal capacity restrictions. Thus, many legal systems require that a doctor obtain informed consent from someone other than the patient when the doctor believes the patient lacks the capacity to consent to understand the ramifications of a health care treatment. While in some cases such a requirement may be a vital safeguard, in other cases, especially if doctors harbor biases about persons with disabilities' capabilities, the mental incapacity determinations that lead to legal capacity restrictions can cause violations of international human rights law.

> *Imposing requirements on people when making consequential decisions serves a purpose. However, when these rules are combined with discriminatory attitudes, they can become exclusionary and harmful, not only for persons with disabilities but also for other marginalised groups, including women and indigenous peoples.*

The Role of Human Rights Protections. Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) affirms that persons with disabilities have a right to exercise legal capacity free of discrimination.[6] Further, it grants persons with disabilities the right to receive support in doing so. This means that even if persons with disabilities may have some difficulty satisfying a legal system's threshold requirements for exercising legal capacity, they are entitled to receive the assistance they may need in order to do so. Effectively, Article 12 flips the script: instead of using legal capacity rules as a tool for excluding persons with certain disabilities, duty-bearers must create enabling conditions that allow persons with all kinds of disabilities to make important decisions about their lives. As a result, the United Nations Committee on the Rights of Persons with Disabilities has consistently interpreted Article 12 to prohibit legal capacity restrictions that are based on mental incapacity determinations.[7]

Just as women with disabilities face multiple and aggravated forms of discrimination in all areas of life,[8] they also face unique legal capacity challenges. Take, for example, the right to make consequential decisions about one's sexual and reproductive health.

The 2009 case Suchita Srivastava v. Chandigarh Administration involved an orphaned woman with intellectual disability who lived in a state-run institution in the city of Chandigarh, India, where she was raped.[9] After institution staff learned she was pregnant, the city government appointed a medical board that included a gynecologist, a radiologist, a pediatrician, and a psychiatrist to examine Ms. Srivastava. They determined that it was in her interest to terminate the pregnancy. The city government petitioned the High Court of Punjab and Haryana for permission to do so. The High Court constituted an expert body of medical experts and a judicial officer, who determined that Ms. Srivastava was "unable to appreciate and understand the consequences of her own future and that of the child she is bearing." The expert body also found that Ms. Srivastava was "happy with the idea that she has a baby inside her and looks forward to seeing the same." Even though the expert body opined that Ms. Srivastava should be permitted to bring her pregnancy to term, the High Court and granted the city government permission to terminate against her wishes.

However, on appeal, the Supreme Court of India overruled the High Court. Noting India's obligations under the CRPD, and presaging more recent, sweeping vindications of disability rights, the Supreme Court reasoned that the High Court impermissibly used Ms. Srivastava's mental capacity as a basis for restricting her legal capacity and overriding her express wishes. Denying her the opportunity to decide for herself whether she wanted to have children would "amount to an arbitrary and unreasonable restriction on [her] reproductive rights." Asserting the "need to look beyond social prejudices" about the capabilities of women with disabilities, the Court flatly acknowledged that "even medical experts and judges are unconsciously susceptible to these prejudices." Thus, the Supreme Court ordered the city government not only to honor Ms. Srivastava's choice to bring her pregnancy to term, but also to provide her the support she required to handle the consequences of her choice, namely, to raise the child.

Challenges to Making the Right to Legal Capacity a Reality. While the Indian Supreme Court's Suchita Srivatasa decision gives reason to hope that courts will vindicate the right of women with disabilities to legal capacity in times of need, the myriad local laws that restrict their human right to legal capacity under international law underscore the challenges that remain. For example, although Bangladesh's Rights and Protection of Persons with Disabilities Act, 2013 contains a right to legal recognition under the law that appears to correspond with CRPD Article 12, dozens of other national laws authorise restrictions on persons with disabilities' right to legal capacity. In contrast to the CRPD Committee's views adopted in Bujdoso & 5 Others v. Hungary,[10] Article 122 of Bangladesh's Constitution and the Electoral Rolls Act, 2009 formally bar people with disabilities from voting if their legal capacity has been restricted by a court. Section 11 of the Contract Act, 1872 effectively bars persons of "unsound mind" from executing contracts, which in practice prevents many persons with intellectual and psychosocial disabilities from accessing services. A similar provision in Section 118 of the Evidence Act, 1872 in practice bars many women with intellectual and psychosocial disabilities from offering evidence of sexual assault and domestic violence in criminal proceedings.

Beyond such codified restrictions of legal capacity, societal attitudes about women with disabilities' mental capacity can remove them from international human rights protections. Take the case of a homeless Bangladeshi rape survivor with psychosocial disabilities living in Mymensingh district.[11] She became pregnant after surviving a rape by a stranger. After she sought refuge in a government-run women's shelter, the subdistrict social welfare officer reported the case to the police. However, the police refused to open a case, justifying their inaction on the woman's insufficient mental capacity to assist with their investigation and prosecution. Although a court had never formally restricted her legal capacity, the police unilaterally predetermined the outcome of its investigation based on her mental capacity, thereby divesting her of her human rights to access to justice and freedom from exploitation, violence and abuse.

The Road Ahead. Because legal systems' reliance on legal capacity as a threshold requirement for exercising a broad array of rights is deeply entrenched, the rules surrounding legal capacity will not change overnight. Nor will the prejudices and discriminatory attitudes that can convert even well-intentioned safeguards into tools of exclusion.

Here, organisations of persons with disabilities (OPDs) must play a critical role. With the proper resources, OPDs can catalyse meaningful, multisectoral change by raising awareness of the CRPD and supporting women with disabilities and their allies to combat rights violations stemming from legal capacity restrictions.[12] In particular, self-advocacy organisations, which are groups formed by persons with intellectual disabilities,[13] as well as the psychiatric survivor movement, driven by persons with psychosocial disabilities, will need to feature prominently in civil society advocacy efforts.[14] Only then will women with disabilities show others how capable they are and become empowered to breathe life into international human rights protections.[15]

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MANAGING MENSTRUATION WITH DISABILITIES:

Experiences of Women and Girls

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More than one billion people, or approximately 15% of the world's population, live with some form of disability, one-third of those are women who may menstruate, and 80% live in developing countries.[1]

For most women, girls and transmen, menstruation is more than a physiological process. The socio-cultural norms ranging from being banished to cowsheds during menstruation (Chhaupadi in far-west Nepal), menstrual isolation, perception of menstrual blood as impure, patriarchy; coupled with socio-economic system hindering access to nutrition, products, rest, healthcare, etc. denies their right to dignified and healthy menstruation.

Most women, girls and transmen with Disabilities (WWD) have gynecologic healthcare needs similar to others during menstruation[2] yet they face additional constraints imposed by limited mobility, cognitive capacities and the socio-cultural implications of being female with a disability. The menstrual needs and experiences of WWD are poorly acknowledged, suppressed, and remain unaddressed on several fronts.

Overarching Concerns. Menstruation experienced by WWD differs according to the intensity of their impairment. For people with mobility and visual impairments, inaccessible water, sanitation and hygiene facilities are a major challenge; while lack of information to them and their caregivers is the barrier for people with intellectual and hearing disability. Other common overarching concerns include:

Menstruation of WWD not recognised: People with disabilities are presumed to be either hypersexual or have no sexual desire at all. In either case, they are not "expected" to be sexually active and that they do not need to bear children. Hysterectomies (removal of the uterus), mostly without their consent, to avoid menstruation or pregnancy, is common among WWD.

Non-conducive policy environment: Limited countries have formulated separate policies on menstruation but they do not address WWDs. Policymakers are not adequately sensitised on the issue either.

Experiences not documented: WWDs remain under-represented in census or other national surveys. Consequently, literature documenting their unique experiences and needs are minimal, let alone documenting experiences of trans people or other vulnerable WWDs. Research is heavily skewed towards documenting medical interventions, impacting advocacy, intervention designs, and funding commitments.

Inadequate education: WWDs are less likely to access information on menstruation due to their dependence on caregivers. The major source of information for most girls is their mother or sister. But WWDs who stay in hostels of special schools rely on their seniors, who themselves might have limited information. High cost of assistive communication devices like smart wheelchairs, screen readers, smartphones, etc. restrict access to information for WWDs. Existing education materials do not include WWDs, or cater to their unique learning requirements. Simple yet cost-effective modifications in IEC materials such as sign language interpretations, closed captions, accessibility features, printing in large fonts or braille, etc. can enhance information access.

Experiences In Managing Menstruation. WWDs who can manage their own toilet hygiene can, and are expected to, manage their menses independently, but those with severe cognitive impairment rely on caregivers. This section discusses how WWDs experience and manage their menstruation.

Menstrual stigma and discrimination. The intensity of menstrual stigma and discrimination for WWD is congruent with other women in that society, meaning that disability is not accepted as an excuse to waive menstrual isolation. Women with cerebral palsy in Bangladesh have reported exclusion from peer and familial networks, and are expected to 'quietly endure' menstruation.[3] In Nepal, WWDs follow menstrual restrictions due to the fear of being cursed if they did not.[4] Visually impaired women feel guilty when they touch kitchen or prayer rooms, though their mobility is based on tactility. Inadequate sensitivity among school management leading to dropping out of schools is not uncommon among WWDs.

Accessing appropriate products. The most widely accepted product to manage periods are disposable pads because of its convenience to use and dispose, usable for a variety of disabilities, non-invasive method of use, and are provided by the school or government free of charge in certain contexts. However, for a WWD with limited mobility, changing pads and taking multiple trips to the bathroom with a caretaker is a cumbersome experience and an invasion of privacy. WWDs use "touch" as a strategy to identify cues for changing sanitary items, lining up pads using underwear seams and wearing dark clothing to disguise leaks. Many WWD do not have adequate information on the correct use of products, and visually impaired women need to be taught how to change pads tactilely. For autistic women, sensory differences hinder their ability to use products through touch. Wheelchair users are often sitting all day; a position that can cause pads to slip.

Moreover, the use of tampons and menstrual cups are limited for being too difficult to insert and remove. The development of new period products such as The Flex Cup (https://flexfits.com/products/flex-cup) or Keela cup feature adjustable pull strings making it easier to use. Modi-bodi, recently released period underwear with clasps on either side, making them more accessible for some disabled people.

However, the cost of these products, or even sanitary pads, is still beyond reach for many. A study showed that 75% of WWD in Bangladesh use old clothes and tissues during their menstruation.[5] For transmen, finding disposable bins or washing a menstrual cup in a sink at the men's toilet is next to impossible.

Caregivers' specific needs. WWD are already considered a burden by their families, so families are not willing to invest additional funds for care. Hiring a separate caregiver is not prioritised, so mothers are expected to be the primary caregivers. A study showed that 80.9% of adolescents with intellectual disability rely on their caregivers for managing menstruation.[6]

As much as onset of menses is a challenging phase for girls, it is too for their caregivers. In a study, more than 50% of caregivers reported concern and anxiety related to menarche,[7] or feeling overwhelmed or isolated. Caregivers have limited knowledge and have referred to menstrual blood as "impure." Many caregivers do not provide information, either because they perceive the child to be too young or because they doubt their child's ability to understand. Conversely, it was found that adolescents were not able to communicate their need to their caretakers.[8] No support mechanisms exist for caregivers, highlighting the need for guided support for caregivers too.

Health interventions and care. Non-friendly infrastructure or the economic burden of hiring a taxi, for people using wheelchairs for instance, limits WWD's access to healthcare. For the hearing impaired, sign language interpretation is usually not available on site. Other disabilities also need to take a caretaker along with them, thus invading their privacy.

Hormonal treatment is often requested by the WWD and her family to alleviate abnormal bleeding, and for contraception. However, the treatment risks of these on WWD are not adequately studied. The major ethical question is the autonomy of women in making a decision over her body. In Taiwan, even for women with mild intellectual disability, the decision to perform tubal ligation was mostly made by the husband or parents-in-law, and almost none of the women were involved in the decision-making.[9] Though the international ethical guidelines suggest that non-therapeutic hysterectomy (removal of the uterus) in WWD should not be recommended as a method to cope with menstruation, it is not uncommon in practice. In high-income countries it is performed with authorisation from the court; but such regulations do not exist in low-income countries.[10]

Conclusion. The state must fulfil the obligations of international conventions such as CEDAW, CRPD, ICPD and other international commitments. It should create a conducive policy environment through meaningful engagement of WWDs, while civil society should advocate for state accountability. While framing this paper, it was evident that literature on WWD's menstruation experiences is limited, placing an emphasis on increased investment for the same. In order to improve the menstrual experiences of WWDs, it is important to promote innovation of products, increase access to information, establish support mechanisms for caregivers, make healthcare centres WWD friendly and sensitise the community to reduce stigma of being women with disabilities.

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DISABILITY JUSTICE AND AUTONOMY: *Intersections With SRHR and Gender in Ending All Forms of Violence and Discrimination*

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People with disabilities (PWD) are often excluded from conversations in the reproductive rights movement. While there are notable cross-movement efforts happening in changing the discourse to be more inclusive of diverse constituencies, in reality, most fall short to consider that practising intersectionality as feminists is more than just enumerating identities. Above all else, intersectionality is the confluence of oppressions and experiences that explores multiple domains and contexts of struggle. For this piece, I spoke to two advocates of disability justice from India to understand one of the most invisibilised forms of oppression that progressive feminists should pay attention to, as it is harming women and girls with disabilities (WGWD), where they are denied access to sexual and reproductive health rights (SRHR) and multiply subjected to systemic violence.

A Delhi-based 24-year old disability justice advocate with acquired physical disabilities, who prefers to be called Nu (they/them) told me in an online interview that today's society mispercieves WGWDs as two extremes—either asexual or hypersexual. "Disabled women are seen as people who are 'unfit for reproduction' and so are termed as asexual because a society that is driven by heteronormative norms states that the main purpose of sex should be reproductive," Nu said. Most able-bodied folks do not believe that WGWDs have the same sexual and reproductive health needs as their able-bodied counterparts, which explains the avalanche of barriers to information and services they face.

> *This is a cause for concern about the limits of the reproductive movement on what it means to be 'pro-choice' because the privileges that come with the freedom to choose are not afforded to WGWDs, especially if they are marginalised due to race, class, status and/or sexuality.*

Research on the exclusion of WGWDs from SRH services in the Global South speaks for itself. About 20% of women with disabilities have never used any sexual and health reproductive service in Cameroon;[1] women with physical disabilities experience pressure from their families and healthcare providers to not have children in India;[2] and healthcare providers' insensitivity to and discrimination of WGWDs restricts full access of maternity care services in the Philippines.[3] Being discouraged to have children and having limited access to SRHR information increases the chances of gender-based violence, such as the forced use of contraceptives or sterilisations in their so-called 'best interest'.[4] Such occurrences of violence stem from having little to no sensitivity to and knowledge of the interests and needs of WGWDs.

Another issue is the silo-ing of disability rights conversations from SRHR matters for both cis-het women and queer folks in India—not to mention on the internet. Nu and two other advocates in Delhi founded an online magazine-turned-collective called 'Revival Disability India'[5] made by, for and with PWDs as an act of dissent to the institutional violence and dehumanisation of the disability community. "Revival developed into a tool of storytelling," Nu said. "I called it Revival because it's a revival of my acceptance for my queer, disabled self and letting go of compulsive able-bodiedness. Letting go of societal scripts, norms, and rules."

By 'scripts, norms and rules', Nu referred to able-bodied people barraging WGWDs and queer folks with disabilities with words like, you are "too disabled" or "too weak" to have rights to bodily autonomy and integrity. This is a cause for concern about the limits of the reproductive movement on what it means to be 'pro-choice' because the privileges that come with the freedom to choose are not afforded to WGWDs, especially if they are marginalised due to race, class, status and/or sexuality. A US-based reproductive justice organisation, SisterSong – Women of Color Reproductive Justice Collective,[6] has spearheaded this very framework by and for women of colour rejecting the entitled and West-centric illusion of 'choice' in pro-choice, and argue for a truer narrative of their lived realities under reproductive oppression. “Disabled folks are seen in isolation of their disability, not in multitudes of their identities. Information and toolkits on how to navigate the world as a single, sexual, queer disabled woman are missing,” Nu explained. The ‘choice’ perspective is a luxury for the community, scratching the surface of physical accessibility, sidestepping the needs of people with intellectual disabilities and disregarding sexuality altogether.

> *What this shows is very scarce awareness on SRHR applicable to WGWDs, therefore lacking the tools and skills to protect themselves from health risks, violence and abuse. The fault lines and lack of a collaborative strategy in the reproductive rights movement give rise to ignorant arguments such as invoking disability rights as a justification to restrict access to abortion.*

Gauri Gupta, a 20-year-old disability inclusion facilitator[7] in India who is a friend of Nu’s and fierce advocate of disability justice, educates able-bodied people on social media about access being an immense barrier for WGWDs and says being marginalised as women, queer or belonging to a lower economic class[8] only compounds violence and discrimination, excluding them from human rights circles and resulting in the absence of specific laws and legislation to protect their rights. What this shows is very scarce awareness on SRHR applicable to WGWDs, therefore lacking the tools and skills to protect themselves from health risks, violence and abuse. The fault lines and lack of a collaborative strategy in the reproductive rights movement give rise to ignorant arguments such as invoking disability rights as a justification to restrict access to abortion.[9]

Another overlooked matter is the right to bodily autonomy. To choose often lies at the mercy of their caregivers, who may also be partners in a relationship, due to pre-existing stigma. “Ever since entering my teens, I’ve been noticing the Otherness in people’s eyes when they look at me,” Nu lamented. They go on to say that the othering extends heavily to dating and sex, leaving them and others feeling like they are undesirable, filled with self-hate and low self-esteem. Particularly around desirability and bodies, ableism is worsened by the sheer abuse of power that underlie patriarchal conceptions of sexual pleasure and reproduction. According to research published in the Lebanon-based journal article, Kohl, this phenomenon is termed “medical patriarchy”, which is defined as “medical practices that normalise their meddling with women’s body image and autonomy”.[10] Body shaming young girls, rejecting non-normative sexual orientations and projecting a white, cis-het, thin and able-bodied woman as an acceptable standard of beauty is, in fact, a by-product of public healthcare systems in the Global South. Because they are designed with the able-bodied in mind and lack resources to include education for healthcare providers on the needs for WGWDs, the system further accentuates hierarchical and reductive approaches to SRHR services.

For Nu, their disabled body is viewed as a “burden in the queer community” just as much. They also mentioned that the existence of structural oppression in the form of ableism—albeit, internalised—is replicated in queer communities due to the lack of appropriate and accessible disability-aware sex education. “We have always felt lost within the larger abled queer community: too visibly disabled, not queer enough because we might not have had access to certain paths of exploration so we’ve had to prove our queerness time and again,” Nu explained.

The larger issue at play here is that exclusionary discrimination of WGWDs do not stem from specific individuals, but is a consequence of our society’s structure that see disability as a monolith. Revival Disability India and SisterSong are two such advocacy groups that branched out from the reproductive rights movement to nurture the feminist praxis with deep complexity in race, gender, sexuality and class—forging an intersectional dialogue and creating a repository of knowledge that centres folks at the margins of disability and feminist thought. As Audre Lorde puts it: *“There is no such thing as a single-issue struggle, because we do not lead single-issue lives.”* We need to do better as feminists in the pursuit of justice to listen to the voices of WGWDs and exercise our privilege as able-bodied people to create support systems that strive for nuanced understandings of liberation that equally accounts for physical and neuro-diversity.

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BIOPOWER AND THE BIOPOLITICS OF DISABILITY

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The COVID-19 pandemic broke open the raw realities of biopower[1] at play in our societies. Since the 1990s, health systems have been geared towards the efficient use of scarce health resources utilising the DALYs measure (disability adjusted life years). This measure has meant that some types of bodies (abled, young, un-diseased) have been prioritised over others (disabled, old, diseased) when it came to decision-making on allocation of health resources. This paradigm of market eugenics was well at play before the pandemic. The enormous stress exerted by COVID-19 on health systems only resulted in an amplification of the existing inequalities of bodies. As hospital and intensive care unit (ICU) beds, ventilators, oxygen supplies and personal preventive equipment (PPE) became scarce, discrimination based on parameters such as pre-existing conditions, short-term and long-term survival prospects and additional care needs (sign language interpretation, additional caregivers) at triage saw persons with disabilities being denied treatment for COVID-19.

The paucity of data, especially in the Asia-Pacific region, does not allow for in-depth analysis of discriminations faced by persons with disabilities during the pandemic. However key research reports are able to paint the broad strokes of the situation. Moreover, in the Asia-Pacific region, pre-pandemic, the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) stated[2] that disability prevalence was under-estimated by 450 million persons from the region. This 'invisibilisation' of persons with disabilities makes data collection on the impact of COVID-19 all the more difficult.

> *The enormous stress exerted by COVID-19 on health systems only resulted in an amplification of the existing inequalities of bodies. As hospital and intensive care unit (ICU) beds, ventilators, oxygen supplies and personal preventive equipment (PPE) became scarce, discrimination based on parameters such as pre-existing conditions, short-term and long-term survival prospects and additional care needs (sign language interpretation, additional caregivers) at triage saw persons with disabilities being denied treatment for COVID-19.*

The key report on the impact of COVID-19 on persons with disabilities is the 'Global Report on Findings of the COVID-19 Disability Rights Monitor'[3] which covered 2,152 testimonies from 134 countries including responses from South, Southeast, East and Central Asia, and Oceania. The Global Report sheds light on inadequate measures to protect persons with disabilities in institutions, breakdown of community supports, disproportionate impact on underrepresented groups and denial of access to healthcare as key overall findings. 62% of respondents to the Global Report survey identified as women, with 25% of its respondents identified as women with disabilities.[4]

Across countries, persons with disabilities (including those with psychosocial disabilities) living in care institutions—they and their health personnel did not receive adequate information and protective measures during the COVID-19 pandemic although they were more at risk. Lockdown policies alienated persons with disabilities from their workplaces, from their communities of care and support, and from their own health needs (for therapy such as physiotherapy/ behavioural therapy).

Much of the information about the pandemic, preventive measures, information about lockdowns and curfews, cash and welfare aid by the government and other stakeholders were not in accessible formats.

In the Global Report—half of the respondents said that people in their respective countries could not access therapies; 43% said that people in their respective countries did not have access to rehabilitation; and 30% of respondents said that they did not have access to medications during the pandemic. This included essential, life-saving medications, and medications used in the treatment of psychosocial disabilities.[5] Amongst the key barriers in accessing medications were high, unaffordable costs of medications, inability to leave home due to curfews and loss of personal assistance services.[6] Rising costs of living during the pandemic meant persons with disabilities, regardless of whether they were from high, middle or low-income countries, found it difficult to afford medications.

Testimonies in the Global Report cite how persons with intellectual disabilities were issued with ‘Do Not Resuscitate’ (DNR) orders without the consent of their families.[7] Equally important to recognise was that healthcare resources were diverted at a time of enhanced need from vulnerable groups such as older persons and persons with disabilities.

Who can access what health services, when and where, became a crucial public health question. Sexual and reproductive health services, mainly sought by women and girls, were deprioritised across almost all countries.[8] Women and girls with disabilities (15% of the female population) were further invisibilised during the pandemic. Data from the region is greatly lacking on how COVID-19 actually impacted women and girls with disabilities though some research pieces, as shared below, help shed light on the situation.

In Sri Lanka, a study of two women’s lives, noted that women with disabilities resorted to private transport as public transport became hostile and unaccommodating for persons with disabilities during lockdowns. Cash aid doled out by the government was not sufficient especially with regards to medicines as a shortage of medicines at public hospitals meant there was a need to purchase these medications from private pharmacies at higher prices.[9] These two women with disabilities noted that they had to seek medical care, during the curfews, from the medical outposts nearest to them – who did not have medical histories or medical supplies specific to their needs. Some of these medical outposts were manned by the military, hence, gendered needs i.e. sanitary napkins for menstrual hygiene and contraception were completely missed out.

Women and girls with disabilities were more gravely affected by the pandemic due to the intersecting discrimination of disability, gender and age resulting in sexual assault, domestic violence, and police brutality. The Global Report itself received 25 complaints of grave human rights abuses. The isolation women and girls with disabilities experienced through the pandemic mitigation measures taken by governments increased the risk of sexual violence. Redress was also made impossible as these women and girls were not able to access shelters, law enforcement agencies, counseling or health services.[10]

In Nepal, a study noted that women and girls with disabilities suffered from not being able to access SRH services.[11] Counting for pre-existing barriers, new protocols in health care and community settings that were disabled-unfriendly (lack of special equipment and facilities, stigma surrounding disability and inadequate training and negative attitude of health care providers) also exacerbated this lack of access. Harsh lockdown measures also meant that persons with disabilities and their caregivers often risked police harassment, brutality, violence, and undue fines in order to meet even their most basic needs. Curfews with small windows of time to get basic supplies were premised on ability, rather than dis-ability. For a person in a wheelchair navigating the built environment and the different transport limitations, such tight time windows made it well-nigh impossible.[12]

Amongst the basic necessities persons with disabilities were not able to access were food and adequate nutrition. In the Global Report, Bangladesh and India were amongst the 10 countries with the highest percentage of respondents reporting no access to food. In a number of countries, persons with psychosocial disabilities were rendered homeless when their families were unable to care for them. In rural areas, there were hardly any measures for persons with disabilities during the pandemic.

The mental health of persons with disabilities was also severely affected. Persons with disabilities were cut off from their disabled communities where common forms of communication and expressions bound them together. In lockdowns they were either isolated or cooped up with their families who have more abled forms of communication and expression.[13] In the Asian context, pandemic measures saw persons with disabilities being further cemented in dependence on familial support systems which would have increased the care burden at home, and reinforced the feelings of helplessness, hardship and exclusion of persons with disabilities. The familial support system may not always be the best equipped, best prepared or the most cordial to persons with disabilities. Both familial and institutional support are prone to violence and abuse as standards of care and treatments for persons with disabilities are deficient in many countries in the region. Younger school-going persons with disabilities also suffered disproportionately as many schools were relying on more traditional methods of teaching.[14] Digital resources for persons with disabilities have not been prioritised either at the state nor at the community level. All of these had an effect on the mental health of young people and datasets tell us of high levels of depression and anxiety amongst persons with disabilities due to the pandemic.

The biopolitics of disability emerge across the different issues and themes of denial of rights and essential services to persons with disabilities. Biopolitics further entrenched the dependence, inequality and poverty of persons with disabilities during the pandemic. If we are to build back better, we need to reimagine and rebuild health systems to be more inclusive and perform better in service of persons with disabilities.

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14 Nicola Jones, Ingrid Sanchez Tapia, Sarah Baird, Silvia Guglielmi, Erin Oakley, Workneh Abebe Yadete, Maheen Sultan, Kate Pincock Intersecting barriers to adolescents' educational access during COVID-19: Exploring the role of gender, disability and poverty.

ACCESSIBILITY:
A Precondition for Full and Effective Participation in Social Life and Development for Women and Girls With Disabilities

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Accessibility is defined as the provision of flexibility to accommodate each user's needs and preferences. When accessibility is connected to women with disabilities, it denotes to any place, space, item or service, whether physical or virtual, that is easily approached, reached, entered, exited, interacted with, understood or otherwise used by women of diverse disabilities. Accessibility is a precondition and an inherent right to exercise all rights and fundamental freedoms that are empowered to participate fully and equally in society for all persons, including women and girls with disabilities. Women and girls with disabilities are heterogeneous groups with multiple identities who are shaped by the social influences around them. They face multiple challenges in their lives, both in private and public spheres, where they are often denied an enabling environment, treated unequally, afforded limited opportunities to express their feelings, restricted from participating fully in social, economic and political life, and are excluded from exercising their rights. The realisation of the fundamental rights of women and girls with disabilities often requires inclusive policy interventions and their implementation in practice and spirit to address the multiple barriers they face in their daily lives. A major part of this process, or state of accommodation, is often referred to as accessibility in a general sense.

Accessibility includes technical environmental, communication and attitudinal barriers which are interconnected and hinder the lives of women and girls with disabilities in different settings. Without access to the physical environment, transportation, including access to other facilities such as information, communication and technological systems, women and girls with disabilities will not have equal opportunities for meaningful participation in mainstream activities. Women and girls with disabilities are faced with difficulties in attaining access to adequate housing, health, education, vocational training and employment and are more likely to be institutionalised[2] with limited participation in social life and development.[3] The family members of women and girls with disabilities most often deny/force/limit or overprotect them, where they lack a conducive and enabling environment within their homes, which often has a detrimental impact on their ability to express, interact, and move around. Women and girls with disabilities also experience discrimination at workplaces, in relation to hiring, promotion rates and pay for equal work, access to training and retraining, credit and other productive resources, and are seldom encouraged to participate in economic decision-making.[4] Women and girls with multiple marginalised identities from different ethnic/caste and gender backgrounds face additional communication, information, attitudinal and prejudicial obstacles in expressing their needs of accessibility in different settings. Moreover, their surrounding environment is influenced by the social, and cultural norms of the ableism and they have no power to exercise their rights.

Three major international instruments have guided the understanding and promotion of accessibility within the United Nations policy framework to date. The World Program of Action concerning Disabled Persons,[5] The United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities[6] and The Convention on the Rights of Persons with Disabilities (UNCRPD)[7] require respective Governments and the international community to recognise the importance of accessibility in ensuring the equalisation of opportunities for persons and women with disabilities, with a view to empowering them to live independently and participate fully in all aspects of life. These instruments give particular attention to accessibility in the physical environment, as well as access to information and communication, and affirm the importance of access to public services such as transportation, education, and health care among others.

In addition, General Comment No. 2 on Accessibility by the CRPD committe (CRPD/C/GC/2)[8] provides a comprehensive understanding of accessibility. All these instruments should be reviewed through the interlocking analysis of other international human rights treaties like Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), Convention on the Rights of Child (CRC), Convention on the Elimination of all forms of Racial Discrimination (CERD) and United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), among others. The UNCRPD Article 6 mentions women with disabilities where the State Party should recognise that women and girls with disabilities are subject to multiple discrimination and states should take measures to ensure the full and equal enjoyment by them to all human rights and fundamental freedoms ensuring full development, advancement and empowerment of women. The General Recommendations of the CEDAW and UNCRPD Committees to member states including Nepal and General Comments by the UNCRPD Committee provide an important space for the all stakeholders to engage in an intersectional framework that can help to catalyse collaboration between and across different agencies and different social movements for ensuring accessibility measures and standards for women with disabilities.

> *Persons including women and girls with disabilities should have equal access to all goods, products, and services that are open or provided to the public in a manner that is non-discriminatory and addresses their special requirements with a view of ensuring their dignity.*

Some of the barriers faced by persons/women with disabilities in relation to gaining physical access are infrastructure, public buildings, adequate housing, indoor and outdoor facilities, information communication and technology, rural urban areas, access to services like health and education, vocational training, employment , staircases built at the entrances of buildings, absence of ramps, lifts, and elevators in multistoried buildings and private entities that offer services and others. Information, communication and technology (ICT), includes any information and communication device or application and its content and encompasses a wide range of access to technologies, such as radio, television, satellite, mobile phones, fixed lines, computers, network hardware and software, which should be in accessible formats with assistive technologies for all types of impairments groups like Sign Language Interpretation (SLI) for a deaf person, Braille, an alternative script for a visually impaired person, Easy to read formats and augmentative and alternative modes of communication for intellectual, deaf-blind and psychosocial disabilities, access to mother/local language to ethnic/indigenous/rural communities including adequate and proper training to staff.

Persons, including women and girls with disabilities should have equal access to all goods, products, and services that are open or provided to the public in a manner that is non-discriminatory and addresses their special requirements with a view of ensuring their dignity. Like minimum standards for accessibility of banking services, automatic teller machines (ATM) should be provided by private financial institutions for persons with visual and other types of impairments, which is unheard of in the present context. This approach is aligned with the prohibition against discrimination. Denial of access to equal opportunities and special services constitute a discriminatory act, regardless of whether it is a public or private entity.

Ground evidence shows that women with disabilities cannot access education, health, employment, livelihood opportunities, socialisation, tourism and others in absence of accessible and safe infrastructures in the built, transit, and external environment. Lack of accessible public amenities and poor maintenance of public spaces like roads, toilets and water tap/resources pose another threat to women with disabilities. The lack of these resources leave them to use open fields exposing them to the danger of sexual assault and other dehumanising activities.[9] Article 16 of the UNCRPD mentions that State Parties should take all appropriate measures to promote physical, cognitive, and psychological recovery and rehabilitation and social integration of persons with disabilities who become victims of any form of exploitation, violence or abuse through the provision of protection services and such recovery and reintegration should take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the persons that takes account to gender and age specific needs.[10]

Accessibility should take into account the gender, age, cultural and contextual dimension for all persons including women with disabilities particularly, while providing for health care, particularly reproductive health care for women and girls with disabilities, including gynecological and obstetric services. It is important that accessibility is addressed in all its complexity, encompassing the physical environment, transportation, information, communication, technology services and attitudinal behaviors.
It is necessary to ensure that both mainstream and disability-specific social protection measures and government services are provided in an accessible manner. In a similar vein, accessible buildings with ramps, lifts, elevators where appropriate, and workplaces that are easy, accessible with an enabling and conducive environment for all women and girls with disabilities including those from indigenous, *dalit* and other religious minorities should be ensured because these vulnerable groups suffer due to lack of information, administrative hurdles, physical distance, affordability issues and culturally inappropriate technological hurdles to access their right to information.[11] Women with disabilities from marginalised communities find no option and rely on strangers for help and some strangers, on the pretext of helping them, manipulate them which leads them to higher risk.[12]

> *Accessibility adds value to the live-in environment and benefits all members of the society and bridges the gap between the special needs of women and girls with disabilities and the realisation of their social, economic, cultural and political inclusion.*

The UNCRPD has noted accessibility as a process that ensures access for persons with disabilities, on an equal basis with others, to the physical environment, transportation, information and communications, including information, and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and rural areas. It introduces the concepts of reasonable accommodation and universal design to provide guidance in ensuring accessibility, and encourage States "... to undertake or promote research and development of universally-designed goods, services, equipment and facilities and promote universal design in the development of standards and guidelines".[13] This means all the standards related with accessibility need to ensure availability, accessibility, acceptability and quality (AAAQ) framework. It should be available in terms of quantity and type. Second, it should have physical, information, technology and social accessibility. Third, all services should be acceptable to ensure that it is respectful of all individuals' cultures, ethnic, indigenous, minorities, communities with ethical and professional with gender, age, disability and indigenous culture standards. Fourth, all the services should ensure quality with minimum necessary skills and training with that meet relevant standards. With these universal standards, personal mobility of individuals enshrined in Article 20 of the UNCRPD ensures that persons with disabilities can move around with greatest possible of independence, affordability, availability and acceptance of their personal mobility. In order to introduce and implement these standards that allow better accessibility for persons with disabilities, it is necessary to take a holistic approach by defining and localising practical workable national-level policies and provisions framed in the context of a non-discriminatory approach which means adequate standard of living and social protection. It includes appropriate steps to safeguard and promote realisation of the rights as enshrined in the Article 28 of the UNCRPD.[14] Similarly, influencing changes in behavior and attitudes towards persons and women and girls with disabilities is imperative to stand up against stigma, attitudinal beliefs, perceptions and discrimination. This could be achieved through ongoing education efforts, awareness-raising, cultural campaigns, communication and advocacy on disability rights and cross-cutting issues.

Accessibility adds value to the live-in environment and benefits all members of the society and bridges the gap between the special needs of women and girls with disabilities and the realisation of their social, economic, cultural and political inclusion. Mainstreaming accessibility into the international development agenda by rights holders is necessary for a truly inclusive and sustainable future because it harnesses independence and an open door for choices, promotes self-respect, equality, dignity, and empowerment, including safety and social security. In addition, People with Disabilities and their respective organisations (OPDs) including other Civil Society Organisations (CSOs) have to advocate and lobby for ensuring accessibility and collaborating with government and likeminded stakeholders. Addressing some of the existing barriers primarily through participatory and right-based approaches lends a voice to all persons including women and girls with disabilities to exercise their rights at all levels. Most importantly, accessibility has to be integrated by all right holders, duty bearers and stakeholders into the goals, targets, and policies that have shaped the Sustainable Development Agenda with a view of translating the notion of no one is left behind into a reality.

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1 Pratima Gurung is a faculty member at Padmakanya College, Tribhuvan University, Nepal and engages in research and advocacy on gender, indigenous peoples, disability, other marginalized issues and inclusion through the intersectional lense in Asia and globally.

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in their own words

CHAMPIONING THE RIGHTS AND INCLUSION OF GIRLS AND YOUNG WOMEN WITH DISABILITIES IN NEPAL: *An Interview with Laxmi Nepal*

In this interview, ARROW spoke with Laxmi Nepal, a disability rights activist from Nepal currently working at Access Planet Organization, an NGO that envisions economically empowered women and youths with disabilities living dignified lives through the availability and use of accessible technology.

Can you tell us a bit about yourself and the work that you do as an activist?

I'm Laxmi Nepal, a women and disability rights activist, and I specifically work for the rights and inclusion of girls and young women with disabilities in Nepal. I am a person with visual impairment which means that I am completely blind. I am the founder of an organisation named Access Planet Organization. The organisation works on women's rights and focuses on technological empowerment, sexual and reproductive health and rights, and economic rights for women and girls with disabilities. Beside Access Planet, I am also involved in other women and disability rights organisations advocating for inclusive and cross-cutting issues such as gender and SRHR intersectional disability issues.

How long have you been working in this field?

It's difficult to exactly count but I have worked in the sector through different platforms for around the past 10 years, but even in my adolescent age I already started to work on issues related to women and disability rights.

Can you share with us a little on what are the challenges that you face as a person with disabilities—in terms of your activism work and/or in your day to day life? We realise that your experiences are not just at the country level but also at the regional spaces.

It's very difficult to identify where to begin when we talk about challenges because being born and working in a country like Nepal, the life of people with disabilities, specifically women and girls, is full of challenges. When we start from childhood, in education itself, there are so many challenges that women and girls face in Nepal. I was admitted to an inclusive school but the support system was not strong enough. It was an inclusive school but without Braille books and without any support system. Receiving a good quality education is one of the major challenges for women and girls with disabilities. The same goes for travelling and mobility due to many sexual abuse and violence cases, even for women who don't have disabilities. Mobility has been a huge challenge that I personally, and other girls and women with disabilities, face in Nepal. Access to employment opportunities and quality training has been another challenge. Employment, especially for people with disabilities and specifically for women with disabilities, is scarce. We don't have any exact data but the employment rate, especially in the private sector, is very low. Finally, being specific to women with disabilities, sexual and reproductive health and rights and access to any other basic health facilities has also been a major challenge that we are facing.

What you have really highlighted are the structural issues that exist and are very exclusionary. Do you want to touch a little bit on the challenges you face in the regional advocacy spaces?

Besides Nepal, I have been involved in some regional and global advocacy platforms. I also have friends with disabilities all across the globe. We see the situation of women and girls with disabilities as almost similar across the South Asian region. We are facing similar situations of lack of access to infrastructure as well as lack of accessible information and opportunities in regards to different issues, as well as the same types of stereotypes, stigma and prejudice associated with women and girls with disabilities. Many women and girls across the region are not able to come out of their houses and we are still facing challenges to sensitise society on this issue.

> *Even amongst the organisations that work for women's rights, they significantly lack knowledge on disabilities and inclusion, and most of the time they will say they have used the word 'marginalised' in the advocacy spaces which will cover all the issues...but if people don't understand the accessibility perspective and have no knowledge about the issues specific to disabilities, then women and girls with disabilities will still be left behind.*

I want to share an example from Nepal's perspective—even within disability rights, if a man has a disability, he will certainly face challenges, but he has privilege in comparison to a woman with a disability. There are many examples but I want to highlight one of a family where both the brother and sister were blind. The brother was sent to school, he earned an education, and he had a good employment opportunity working as a teacher in a government school. However, for the sister, we wanted to involve her in some of our training activities but she did not even have a mobile phone to be connected to our virtual activities. Lack of access to technology is also another barrier that women with disabilities are facing across the region.

I also want to touch on the difficulties in the advocacy spaces that we are facing. At the regional level, even amongst the organisations that work for women's rights, they significantly lack knowledge on disabilities and inclusion, and most of the time they will say they have used the word 'marginalised' in the advocacy spaces which will cover all the issues.

Although disabilities may come under the term 'marginalised issues', if people don't understand the accessibility perspective and have no knowledge about the issues specific to disabilities, then women and girls with disabilities will still be left behind. Even amongst the governments and the CSOs in the region, there is a significant lack of actual knowledge on how they can actually include people with disabilities. Fortunately, inclusion has started a little, but I have found that inclusion has mostly been in terms of participation at events and not at the decision-making level of Board and staff positions.

Would you like to share some of your experiences accessing SRHR services as a person with a disability? This could be your own personal experience or experiences you have observed during your work.

I would like to focus on the experiences that I have observed, mostly on the SRHR of girls with disabilities. The situation in Nepal is that girls with disabilities stay in hostel settings for the purpose of their education. Because Nepal is full of mountains and hills, school areas are far from people's homes. Girls who have severe disabilities, such as deaf and blind girls, and girls who have other physical disabilities, generally stay in the hostels. In these hostels, there is a lack of actual practical knowledge on SRHR. Parents are responsible, especially the mother or the older sister, to teach girls about SRHR related issues such as menstruation from the very beginning. But when these girls with disabilities stay in the hostel, though there may be some courses on SRHR in school, it is just taught in a superficial way that is simply to cover the course requirements. When we visited many schools where girls with disabilities were studying we found a lack of practical knowledge.

As an example, we were providing training for girls with visual impairment and some of them even lacked knowledge on how to use a sanitary pad during menstruation because it was either their first time or they hadn't been shown how to before. These instructions on how to use pads might be shown through pictures or through demonstrations but visually impaired girls have to be taught through touch so this practical knowledge was lacking for them. For other women with disabilities, there are many other challenges such as a lack of a volunteer service system. Much of the time, abusers are the people that women with disabilities are dependent on. In such situations, if any abuse occurs, it becomes difficult for them to report. Without such a volunteer service, we cannot request an aid service or needs-based services. Due to this, women and girls with disabilities are most of the time dependent on the perpetrators of their abuse.

Furthermore, not only in the case of abuse, but also when we talk about SRHR services, if a woman or girl with disabilities wants to check if they are pregnant, the availability of these types of services is very rare. We have been seeing many cases of deaf girls and women who are facing challenges in accessing SRH services due to the lack of sign language support when they visit the hospital. Therefore, it is not always safe to get SRH services, or to go with family members, when there is already so much stigma associated with disabilities and SRH rights.

Another challenge I have significantly seen, which is not even reported to organisations like us, is related to intellectual disabilities. As parents cannot always stay with their children with disabilities, in these situations they may have to go to work in the field or the farm and leave their child with disabilities in the home alone. There have been so many cases of abuse and rape that the parents decide to remove the uterus from these girls so that they will not become pregnant. These types of cases are often underreported.

Finally, another issue that we have been facing in terms of SRH services is a lack of accessible materials. We need accessible materials of SRH services that are in braille, in soft copy format, in easy-to-read version, or in pictorial format for those with intellectual disabilities. Even in video form with subtitles for deaf girls and women. We significantly lack all of these materials.

> *If we just say 'marginalised' but the accessibility aspect is not met, the issues of women and girls with disabilities in terms of SRH will never be addressed.*

Do you have any recommendations, moving forward on these issues you have talked about?

I think we need to focus on a two-track approach. One is including the issues of disability in overall SRH projects. The second approach is to conduct projects and programmes related specifically to the disability population. Both types of approaches are needed. I strongly recommend that there should be a project launched that specifically targets girls with disabilities and their parents because now is the right time for these girls to get their education. There are so many cases in Nepal, and also at the regional level, where girls are kept at home instead of being sent to school because of the fear of violence and abuse. I strongly recommend that CSOs work on a project that focuses on girls with disabilities and their SRHR in South-Asia. Another aspect we need to focus on is the development of accessible materials which can be touched, felt, or seen, according to the specific disabilities. Furthermore, we need to ensure that there is an SRHR training manual or at least some form of training materials created for women and girls with intellectual and developmental disabilities at the regional level.

What needs to change at the country policy level so that we can live in a more accessible and inclusive society? What kind of recommendations would you expect as a young person?

Policies at the country or regional level should clearly mention violence against women and girls with disabilities. In the case of Nepal there are programmes on domestic violence but they don't touch on disabilities. Unless the policies recognise disabilities, they cannot just be defined as 'marginalised' communities and left like that. If we just say 'marginalised' but the accessibility aspect is not met, the issues of women and girls with disabilities in terms of SRH will never be addressed. In the case of people with disabilities, there are certain services that need to be made accessible and they should be clearly defined at both the national and regional policy levels.

When we talk about recommendations from a young person's perspective, training should be provided to each girl with disabilities, either in home-based or school-based settings, on what is good touch and bad touch as well as what SRHR is. Another recommendation would be the inclusion of young persons with disabilities at the important regional and country level platforms. It is significantly important that they should not only be invited as just participants of the trainings, but also that their voices should be heard at the advocacy and policy levels.

DEMENTIA, A GENDERED ISSUE THAT INTERSECTS WITH AGEING AND DISABILITY RIGHTS IN MALAYSIA

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Fifty-five million people worldwide who are mostly older adults above 65-years old, live with dementia, a chronic neurocognitive disorder that affects brain functioning and causes progressive loss of cognitive, social, and physical skills.[1] My dementia journey as a full-time care partner[2] to my 88-year old mother living with dementia shapes my perspective that dementia intersects with gender, ageing and disability, and guides my advocacy for a disability rights model in dementia response.

Malaysia is home to around 270,000 persons with dementia; 10% are women compared to 7% of men,[3] echoing the global pattern of its impact on women disproportionately developing dementia. More women than men live with dementia (female-to-male ratio of 1:69) as they live longer than men and comprise most older adults at advanced ages. On average, compared to older men, older women have had less education; a risk factor for dementia.[4] Women make up 65% of total dementia-related deaths.[5]

Driven by gender roles, women represent two-thirds of informal care partners globally.[6] We experience physical, mental, social and financial impacts, including developing dementia. Generally, we report higher levels of burden, stress and depressive symptoms than our male peers.[7] We are the "invisible second patient" whose aspirations and needs are ignored. We are unpaid, yet our contributions account for half the estimated US$1.3 trillion cost of dementia care.[8] These facts highlight gender inequalities that harm women's well-being, rights and progress.

Advanced age is the strongest risk factor for dementia, but it is not a normal part of ageing. The National Health and Morbidity Survey (2019) reported that 8.7% of older adults above 60 years live with dementia.[9] The prevalence may increase to around 11% as the country becomes an ageing society. Older adults with dementia go through two progressions of ageing and dementia. The challenge of dementia pushes holistic care and support to a higher level. As such, if Malaysia gets it right with the dementia and disability responses, it will do well with meeting the needs of older adults in general.

Dementia is a major cause of disability and dependency in adults aged 65 and above.[10] Yet, the global responses, including Malaysia, are predominantly driven by the medical model which focuses on the condition and treatment rather than the needs and wishes of the individuals. The relational dynamics between the person and their care partners, and the needs of the latter are often neglected.

Although dementia is not specifically stipulated in the Convention on the Rights of Persons with Disability (CRPD),[11] persons living with dementia are protected by it because dementia fits in the definition of disability – *Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*. Malaysia ratified the Convention and adopted this definition in its Persons with Disability (PWD) 2008 Act but omitted the phrase *'on an equal basis with others'*.[12] This Act, the provisions under the Mental Health Act 2001,[13] relevant policies and programmes generally still fail to protect the rights of all persons with disabilities and care partners.

Persons with dementia can identify themselves as disabled under the PWD Act by obtaining the OKU card,[14] and accessing its accommodations. But few choose to do so because upon a dementia diagnosis, the person typically becomes defined by the condition and is devalued and exposed to stigma, discriminatory practices and rights violations. By extension, my identity as a care partner has reduced me to nothing more than a moral symbol, embodiment of a filial daughter, despite my lived experience and professional public health and rights work record.

Related is an example of exclusion and violation of rights to engage in decision-making processes that affect our lives. In 2019, the Ministry of Health drafted the National Dementia Action Plan 2021-2030 along the WHO guidelines that include empowerment and engagement of persons with dementia and care partners in advocacy, policy, planning, legislation, service provision, monitoring and research of dementia as a cross cutting principle. My advocacy for the implementation of this principle and attempts to contribute has largely been ignored.

Without access to the Plan, below are my questions.[15]

Does the Plan:

1. Reflect the expressed aspirations, needs and human rights of constituents (persons with dementia and care partners), in line with
    a. The CRPD and other relevant instruments;
    b. Intersectionality of age, gender and disability with societal factors in upholding constituent rights;
    c. Gender sensitivity and equity?
2. Include social and financial benefits that support care partners beyond their care partnering role?
3. Allocate resources for constituent empowerment and a platform for authentic engagement?

Despite the reservations, it is critical for all stakeholders to recognise dementia as a disability to (1) identify the societal physical and attitudinal barriers that prevent social inclusion, rights realisation and access to services, and (2) provide a framework for advocacy from the disability rights model that recognises these barriers and impacts.[16] Removing these barriers, and addressing gender inequalities, will pave the way for all persons affected by disabilities to live in dignity and self-determination.

Notes & References

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YOUTH PERSPECTIVES ON WOMEN AND GIRLS WHO ARE DEAF AND/OR HARD OF HEARING IN SRI LANKA

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Women and girls with disabilities are among the most vulnerable populations in Sri Lanka, especially in the context of post-civil war, post COVID-19, and the ongoing economic crisis. The Department of Census and Statistics reports that the rate of persons with disabilities in Sri Lanka is 8.7% (approximately 1,617,924 persons, among whom 57% are female). Fifty-four per cent of people living with disabilities have visual impairments (approximately 996,939 people). Persons living with hearing disabilities also constitute 21% of the total population living with disabilities (approximately 389,077 people). They constitute the third largest group of people living with disabilities in Sri Lanka.[1]

As of September 2022, Sri Lanka is struggling to survive through the worst economic crisis in its recent history. There are shortages of essential goods and lifesaving medications, daily power cuts sometimes extending up to 13 hours a day,[2] disruptions of transportation, and miles long fuel queues due to fuel shortages. The economic crisis has brought on political instability and a massive display of continuous public dissent and the already restricted access to information and services for the most vulnerable part of the population has been further restricted.

Apart from the effects of the economic crisis and the aftermath of the COVID-19 pandemic, the complexities of the plural nature of races and ethnicities in post-civil war Sri Lanka also creates a disparity between the North and South. Women and girls who live in war-affected areas face another hurdle in accessing services and information. In comparison to the South, women with disabilities in the Northern part of Sri Lanka have not experienced an increase in quality of life even after the cessation of hostilities.[3]

The case studies based on lived experiences of women and girls with disabilities living in the eastern area of Sri Lanka indicate that the services have not reached the post-conflict areas; and that in addition to living with disabilities in a non-inclusive setting, they have to provide for their household as well as face routine domestic violence.[4]

The legal recognition of disability in Sri Lanka has been described as weak at best. Disability is not recognised under the fundamental rights chapter in the Sri Lankan Constitution.[5] Sign language is not enshrined in the Language Chapter in the Constitution either.[6] The existing laws and policies which have been enforced with the intention of creating inclusivity are not implemented, or worse, they further adversely affect the rights of persons with disabilities.[7] The public administration circular which mandates that 3% of the recruitments should be allocated to persons with disabilities hasn't been implemented to date. The national election law which provides for a person with visual impairments to be accompanied by another person to assist the voting process only violates the right to privacy of the person voting.

Challenges Faced By Women And Girls From The Deaf Community In Being Understood By The Wider Society. The United Nations Universal Periodic Review on Disability in Sri Lanka – 2017 recognises the deaf community as the most marginalised group of people with disabilities in Sri Lanka. This is because communicating with the masses and accessing legal representation, healthcare, and important information (public service announcements on power cuts, fuel availability, healthcare information, etc.) are extremely restricted as announcements are almost never made in Sign Language.[8] They also face a challenge in communicating their needs and being understood by service providers of any kind. Most public officials, including healthcare service providers, police and judicial officers, are not sensitised on working with people from the deaf community. From a government official to a shopkeeper in a small boutique, the community faces major challenges in being understood. However, it must be noted despite all the impediments to communication, more and more young people in the deaf community rely on tools such as messaging apps and social media platforms and have improved their communication.

Women and girls from the deaf community have to rely on a sign language interpreter to communicate their problems, which are often deeply personal. This imposes a serious adverse effect to their right to privacy and their agency.

As one of the few youth organisations working with the deaf community in Sri Lanka, Youth Advocacy Network, in operating its mobile clinics, has come across cases of women and girls with hearing disabilities who needed post-abortion care, mental health services, and medical attention regarding conditions related to the reproductive system such as poly cystic ovarian syndrome. These mobile clinics were designed in such a way to take the service providers to the deaf community. Although we were able to solve one aspect of the problem by improving access, we still faced a major challenge in ensuring privacy and confidentiality. The single most prominent reason as to why these women did not seek medical support was the difficulty in communicating and being understood. Women and girls from the deaf community have to rely on a sign language interpreter to communicate their problems, which are often deeply personal. This imposes a serious adverse effect to their right to privacy and their agency.

The Impediments To Service Providers In Ensuring Access To Services And Information To The Women And Girls In The Deaf Community. The other side of this coin is the challenge of disseminating accurate information among the deaf community. The available channels of information to the deaf community are extremely limited and often inaccurate; and sometimes even distorted. The information from outside the deaf community reaches predominantly through sign language interpretation. This information comes colored with different predispositions and other prejudices of the interpreters. Although the developments in technology have improved access to accurate information to young people specifically, the connection they share with the sign language interpreters and their general reliance on them for day-to-day communication causes them to put more weight to the information given to them by the sign language interpreters.

To demonstrate this with an example, in 2018 as a peer educator facilitating SRH sessions at the school for the deaf in Ratmalana, I discovered that the female student body avoided consuming pineapple. They were not able to give me a clear explanation as to why. Upon closer examination, my finding was that the common notion in Sri Lanka that raw pineapple can cause an abortion had reached these young girls from the deaf community in a distorted form and caused the female students at the deaf school to avoid consuming pineapple altogether.

Until 2016, there weren't dedicated signs to explain many SRHR terms in the sign language used in Sri Lanka.[9] Although a sign language glossary was published in collaboration with the UNFPA, Youth

Advocacy Network Sri Lanka and Sri Lanka Central Federation of Deaf to bridge this gap, popularising the new signs remains a challenge to date. The gravity of this particular issue is that SRHR information is being completely blocked out due to a lack of language. This has made women and girls from the deaf community vulnerable to exploitation and sexual abuse and leaves them with no redress whatsoever due to the lack of sign language to explain what has transpired.[10]

The extended power disruptions that began in early 2022 further limited the opportunities to communicate for the deaf community. The extended power cuts also caused disruptions and drops in internet speeds. As a community which relies on video features of messaging apps and social media platforms to communicate,[12] this has caused major challenges in communicating. The continuous use of masks as a public health measure has restricted the community's communications with outside society. The deaf community relies heavily on lip-reading to understand other people. With the use of masks, even this limited means of communication is severely restricted.

As of this year, Sri Lanka is ranked 110th out of 146 countries in the Global Gender Gap Index. Women and girls in the deaf community face all these challenges on top of the gender disparity that is already prevalent in Sri Lanka. A school for the deaf in Ratmalana has dedicated vocational training courses such as hairdressing and making jewelry for girls. However, there is no guarantee for a job placement.[13] Higher education opportunities are minimal. Although women in general have a high rate of opting for higher education, the same tendency doesn't apply to women with disabilities.[14] Statistics indicate that girls living with disabilities who are not being sent to school are far greater than boys living with disability. In terms of higher education, although the young persons living with disability who qualify for tertiary education have been steadily increasing (although not enough), this tendency does not extend to the deaf community. They engage in a limited set of vocations and most women and girls in the deaf community remain unemployed.[15] This has created a sense of frustration and distrust towards the wider society among the youth of the deaf community.

SRHR information is being completely blocked out due to a lack of language. This has made women and girls from the deaf community vulnerable to exploitation and sexual abuse and leaves them with no redress whatsoever due to the lack of sign language to explain what has transpired.

Listening To The Deaf Community – The Way Forward In Meaningful Inclusion. As observed before, there is a huge omission in laws and policies to create inclusivity of the deaf and hard of hearing community in Sri Lanka. The situation is being further exacerbated by factors such as the disparities between North and South of Sri Lanka due to the civil war, the COVID-19 pandemic, and the economic crisis. How some of the legislation passed to improve inclusivity act in detriment to persons with disabilities is proof of lack of political will and apathy on the part of the authorities responsible. There is a clear need for facilitating meaningful engagement with persons with disability, with a heavy emphasis for the deaf community, in revising and bringing more realistic and practical changes to improve the access of services and information to people living with disability.

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8 Disability Organizations Joint Front, UN Universal Periodic Review – Sri Lanka 2017, (2017), https://www.ohchr.org/sites/default/files/Documents/Issues/Disability/RightAccessJusticeArticle13/CSO/DisabilityOrganizationsJointFrontSrilanka.pdf

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10 This was the case for Ms. X who was diagnosed with depression post miscarriage during the SRHR mobile Clinic conducted by YANSL in 2019 September. The healthcare service provider had to take a very long time and consideration to come into this diagnosis due to a language barrier and unique way of manifestation.

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RESOURCES FROM THE ARROW SRHR KNOWLEDGE SHARING CENTRE

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***ARROW's SRHR Knowledge Sharing Centre (ASK-us)** hosts a special collection of resources on gender, women's rights, and sexual and reproductive health and rights (SRHR) to make critical information on these topics accessible to all. ASK-us is also available online at http://www.srhr-ask-us.org/. Please email: keshia@arrow.org.my.*

ARTICLES AND BOOKS

Das, Shreshtha. "Reclaiming SRHR of Women and Girls with Disabilities." Asian Pacific Resource and Research Centre for Women (ARROW), 2022. https://arrow.org.my/publication/reclaiming-srhr-of-women-and-girls-with-disabilities/

This manual aims to equip women and girls with disabilities with necessary SRHR information and knowledge to make informed choices free from coercion, violence, discrimination, and abuse. The manual contains detailed modules on gender, sexuality, disability, rights, and their interlinkages in the context of addressing sexual and gender-based violence against women and girls with disabilities. Through this, it seeks to provide accessible information and knowledge on SRHR to women and girls with disabilities in various contexts, including in the face of the ongoing COVID-19 pandemic. This publication is also available as an audio book.

United Nations Population Fund (UNFPA). "Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realising Sexual and Reproductive Health and Rights." 2018. https://www.srhr-ask-us.org/publication/young-persons-with-disabilities-global-study-on-ending-gender-based-violence-and-realising-sexual-and-reproductive-health-and-rights/

This study seeks to contribute to the strengthening of US state laws and policies that foster social inclusion and gender equality for the benefit of young persons with disabilities, especially young women and girls with disabilities; to eliminate discrimination against them, particularly with regard to access to and enjoyment of SRHR and GBV prevention and response services; and to recognise and promote their right to be active members of society with the acknowledged capacity to make decisions on issues affecting them. The study also seeks to identify areas in which data are missing or insufficient and in which additional research would be valuable.

Women Enabled International. "Sexual and Reproductive Health and Rights of Women and Girls with Disabilities." 2018. https://www.srhr-ask-us.org/publication/sexual-reproductive-health-rights-women-girls-disabilities/

This article by Women's Enabled International (WEI) addresses the issue of sexual and reproductive health and rights (SRHR) of women and girls with disabilities. The SRHR violations against women and girls with disabilities such as the physical and informational barriers to accessing SRH information, goods, and services and discriminatory sexual and reproductive health care are highlighted. Sexual and reproductive rights, and Government obligations to ensure SRHR and realising SRHR for women and girls with disabilities are also outlined.

Shakespeare, Tom, Shaffa Hameed, and Lizzie Kiama. "Actions, not words: progress since ICPD on disability and SRHR." Sexual and reproductive health matters 27, no. 1 (2019): 340-342.

It is welcome to see how prominent disability issues were in the International Conference on Population and Development (ICPD). This inclusion was prescient, given that the human rights of persons with disabilities would only grow in significance in the intervening years, as evidenced by the Convention on the Rights of Persons with Disabilities (CRPD), with its specific reference to sexual and reproductive health in Article 25 (Health). The ICPD recognised persons with disabilities as a significant minority in society – now known to be one billion people worldwide, 15% of the global population – and called for awareness and knowledge of disability issues around sexual and reproductive health, and actions to promote shared caring responsibilities, together with continued action to achieve the goals of full participation and equality for persons with disabilities. This article gives an overview of the progress since ICPD on disability and SRHR.

Looking for a particular resource material?

ASK-us

Winarni, Tri Indah, Hardian Hardian, Suharta Suharta, and Annastasia Ediati. "Attitudes towards sexuality in males and females with intellectual disabilities: Indonesia setting." Journal of Intellectual Disability-Diagnosis and Treatment 6, no. 2 (2018): 43-48.

Sexual and reproductive rights of individuals with intellectual disabilities (ID), particularly in developing countries, are often neglected. This study explores the attitudes towards sexuality and reproductive rights of individuals with ID in Indonesia, a developing country with strong religious and culture beliefs. The findings are expected to contribute to the movement in recognising sexual and reproductive health and rights (SRHR) of individuals with ID.

Shrestha, Era, and Rita Bhadra. "Barriers in Accessing Sexual and Reproductive Health Services among Adolescent Girls and Young Women with Visual Impairments." Prayatna Nepal and Mama Cash, the Netherlands, 2021. https://prayatnanepal.org/wp-content/uploads/2022/07/SRHR-research.pdf

This study aims to explore the barriers in access to Sexual and Reproductive Health (SRH) services of adolescent girls and young women with disabilities, particularly, of those with visual impairments. When it comes to accessing essential health care services, girls and women with disabilities face numerous obstacles. As a result, they have not only faced numerous challenges to maintain personal health and hygiene but also have been forced to compromise their fundamental human rights, such as Sexual and Reproductive Health (SRH), which is an overarching construct. Within the broad spectrum of SRHR; this study focuses on the SRH 'services', addressing the 'access' aspect of it, from the perspective of the service recipients or the users of the services.

Shiwakoti, Rupa, Yogendra Bahadur Gurung, Ram Chandra Poudel, Sandesh Neupane, Ram Krishna Thapa, Sailendra Deuja, and Ram Sharan Pathak. "Factors affecting utilization of sexual and reproductive health services among women with disabilities-a mixed-method cross-sectional study from Ilam district, Nepal." BMC health services research 21, no. 1 (2021): 1-19.

Persons with disabilities can have physical, mental, intellectual, or sensory impairments which can hinder their social participation. Despite Sustainable Development Goals call for "universal access to sexual and reproductive health (SRH)", women with disabilities (WWDs) continue to experience barriers to access SRH services in Nepal. This study evaluates factors affecting the utilisation of SRH services among WWDs in Ilam district, Nepal.

Sharma, Seema, and Muthusamy Sivakami. "Sexual and reproductive health concerns of persons with disability in India: an issue of deep-rooted silence." Journal of biosocial science 51, no. 2 (2019): 225-243.

The objective of this paper is to highlight the paucity of research on the sexual and reproductive health concerns of PWDs, particularly women, in the Indian context using existing literature on India, and to identify the possible reasons of this neglect. The study describes the obstacles faced by PWDs, particularly women, in acquiring sexual and reproductive information and services, based on the results of empirical studies. Given the lack of research on this in India, the evidence largely comes from studies conducted elsewhere in the world. Lack of information and education about sexual health concerns, physical and/or infrastructural inaccessibility, judgemental provider attitudes, limited provider knowledge about disability issues and individual factors, including inhibitions about seeking health care and financial barriers, are identified as factors inhibiting the sexual and reproductive rights of people with disabilities in India.

Hall, Matthew. "Disability, discourse and desire: Analyzing online talk by people with disabilities." Sexualities 21, no. 3 (2018): 379-392.

Drawing on discourse analysis, the author examines electronic talk by people with disabilities in a disability specific online community website. His analysis shows their rejection of mainstream discourses positioning them as asexual and the deployment of mainstream discourses, which draw on gender, sexuality and intimacy, as well as the circulation of disability-specific sexual pleasure discourses with sex workers and caregivers. The use of social media in expressing marginalised sexual identities is also discussed.

Sakairi, Etsuko. "Medicalized pleasure and silenced desire: sexuality of people with physical disabilities." Sexuality and Disability 38, no. 1 (2020): 41-56.

This paper focuses on opinions concerning the issue of masturbation assistance in Japan by introducing two assistance organisations. Since not much research is conducted in this area in Japan, this paper contributes by examining how the dominant discourse medicalises the pleasure of people with physical disabilities in the name of "nursing care", and by presenting the diverse responses from people with physical disabilities regarding such assistance in their own words. Through this paper the researcher hopes to raise awareness of the current situation of how masturbation assistance and sexuality are treated as "taboo" for people with disabilities. The researcher also hopes to raise awareness of the complexity of this ethical and human rights issue and the danger of oversimplifying it, as it involves such factors as the form of the assistance, the gender of the assistant, and differing opinions on the extent to which masturbation assistance can be considered nursing care.

Smith, Elizabeth, Tessa-May Zirnsak, Jennifer Power, Anthony Lyons, and Christine Bigby. "Social inclusion of LGBTQ and gender diverse adults with intellectual disability in disability services: A systematic review of the literature." Journal of Applied Research in Intellectual Disabilities 35, no. 1 (2022): 46-59.

Lesbian, gay, bisexual, transgender, queer (LGBTQ) and gender diverse adults with intellectual disability experience exclusion within disability services. This review explores the experiences of social inclusion/exclusion of this cohort in the context of disability services. It was found that marginalisation of LGBTQ adults with intellectual disability in western societies is mirrored in disability organisations. There remains a dearth of research into experiences of transgender people with intellectual disability who use disability services. Research into interventions that support the inclusion of this cohort in disability support services is needed.

Wotton, Rachel. "Paid sexual services for people with disability: Exploring the range of modalities offered throughout the world." In The Routledge Handbook of Disability and Sexuality, pp. 433-449. Routledge, 2020.

Sex work, sexual surrogacy, sexual assistants and "compassionate masturbation services." Where are these services being offered to people with disability? This chapter examines the different sexual and socially structured frameworks which people with disability are offered to explore their sexual expression, outside of the usual dating and relationship paradigms. This will include mapping their geographical locations while discussing the nuances within each modality. Options for service provider training will also be identified and discussed. Building awareness around these current and emerging practices can assist people with disabilities and other third parties to differentiate between the different types of sexual services that may be available in their location. This information can support positive legislative changes to allow for these options to be legally recognised occupations, in all countries. This information can also inform different Disability and Aged Care sectors about policies, procedures and training requirements in regard to supporting their clients' needs and sexual expression.

Devkota, Hridaya Raj, Emily Murray, Maria Kett, and Nora Groce. "Are maternal healthcare services accessible to vulnerable group? A study among women with disabilities in rural Nepal." PLoS One 13, no. 7 (2018): e0200370

Studies report that vulnerable groups like people with disabilities have less access to healthcare. This study compares health service access between women with and without disabilities in general and explores the challenges encountered by women with disabilities in accessing maternal healthcare services during pregnancy.

Hole, Rachelle, Leyton Schnellert, and Gloria Cantle. "Sex: What is the big deal? Exploring individuals' with intellectual disabilities experiences with sex education." Qualitative health research 32, no. 3 (2022): 453-464.

This article offers perspectives shared by self-advocates in the first phase of a community-based participatory research project untaken to address barriers that individuals with intellectual disabilities face with respect to sexual health knowledge. Using descriptive qualitative methods, it interviewed 19 individuals with intellectual disability about their experiences and knowledge related to sexual health. The research question guiding this project was: What are self-advocates' with intellectual disabilities experiences learning about sexual health and sexuality? The findings highlight that participants faced barriers and lack of access to sexual health education, and while they learned about sexual health through formal sexual health education, frequently this knowledge came through lived experience. Finally, the findings underscore that participants knew what they wanted with respect to sexual health education and offered recommendations. The importance of accessible sexual health education for self-advocates that supports their rights and desires to express their sexuality and sexual agency is highlighted.

OTHER RESOURCES

FILMS/DOCUMENTARIES

Take A Look At This Heart (2019) is a documentary about love, sexuality, and the human bond within the disability community. It follows the journey into the lives of 17 very unique people; some with disabilities and the partners who love them, others struggling to get by in a world that seems to often overlook them. The film attempts to show what love and intimacy feels like for people without arms or legs, or those restricted to wheelchairs. The trailer is available here: https://www.youtube.com/watch?v=UXpAU9w8pcs.

Accsex (2013) explores notions of beauty, the 'ideal body' and sexuality through four storytellers; four women who happen to be persons with disability. Through

the lives of Natasha, Sonali, Kanti and Abha, this film brings to fore questions of acceptance, confidence and resistance to the normative. As it turns out, these questions are not too removed from everyday realities of several others, deemed ‘imperfect’ and ‘monstrous’ for not fitting in. Accsex traces the journey of the storytellers as they reclaim agency and the right to unapologetic confidence, sexual expression and happiness.
More on the film here: https://vimeo.com/374090173.

Somebody to Love (2014) is a documentary that explores love, sex and disability, taking us into the romantic lives of people with physical or intellectual disabilities. More on the documentary here: https://vimeo.com/ondemand/somebodytolove.

DEFINITIONS

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Communication: “Includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.”[1]

Convention on the Rights of Persons with Disabilities (CRPD): “The Convention is intended as a human rights instrument with an explicit, social development dimension. It adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced.”[2]

Discrimination on the basis of disability: “...any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.”[3]

Invisible Disabilities: “Refers to symptoms such as debilitating pain, fatigue, dizziness, cognitive dysfunctions, brain injuries, learning differences and mental health disorders, as well as hearing and vision impairments. These are not always obvious to the onlooker, but can sometimes or always limit daily activities, range from mild challenges to severe limitations, and vary from person to person.”[4]

Persons with Disabilities: “Those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”[5]

Psychosocial Disabilities: An internationally recognised term, in particular by the United Nations, to describe the experience of people who have mental impairments which, in interaction with various societal barriers, may hinder the full realisation of their rights.[6]

Reasonable Accommodation: “Any necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.”[7]

Reproductive Health: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.”[8]

Reproductive Rights: “[E]mbrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human right documents.”[9]

Sexual Health: “A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.”[10]

Universal Design: “The design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. “Universal design” shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.”[11]

Notes & References

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9. United Nations, “Programme of Action,” para 7.3.
10. This is a working definition, not an official WHO position. See: WHO, “Sexual and Reproductive Health,” http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
11. United Nations Convention on the Rights of Persons With Disabilities. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

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factfile

LOCALISING SDGS AND INTERNATIONAL HUMAN RIGHTS STANDARDS AROUND RIGHTS OF WOMEN AND GIRLS WITH DISABILITIES

By: Nawmi Naz Chowdhury
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The rights of women and girls with disabilities, particularly their right to sexual and reproductive rights and their right to be free from all kinds of violence and discrimination, will only be realised on a national level if the international human rights treaty provisions are implemented successfully.[1]

The disability rights movement has come a long way from a position where the solution to issues faced by persons with disabilities were embedded within various national social welfare and social service policies as a welfare-based approach was deemed the appropriate way forward by countries in the region. In the last few decades however, a subtle shift from the welfare-based approach to a rights-based one has been evident as the disability rights movement, through its efforts to challenge prejudices and stereotypes regarding persons with disabilities, has been successful in prompting necessary legal and political changes to further the rights of persons with disabilities in line with international human rights standards.[2] At a time where the space for civil society as a whole is shrinking, disability rights activists, especially women human rights defenders, face challenges as they try to engage with human rights mechanisms and influence policies and strategies on the national and grassroots level.

Article 1 of the UN Declaration on Human Rights Defenders states “everyone has the right, individually and in association with others, to promote and to strive for the protection and realisation of human rights and fundamental freedoms at the national and international levels.” However, the existing international human rights mechanisms provides tools that can be utilised for furthering the advocacy on realisation of rights of women and girls with disabilities including their SRHR and right to be free from all kinds of violence.

While all core human rights treaties have addressed issues related to health rights, the right to be free from all forms of violence and discrimination and equal protection before the law, the Convention on the Rights of Persons with Disabilities (CRPD) that came into force in 2006 is unique among international human rights instruments for including a "civil society mandate". Within the convention, persons with disabilities and their respective organisations, were identified as having the responsibility to "be involved and participate fully in the monitoring process" of the CRPD (Article 33). The Optional Protocol to the CRPD also provides for the additional, and important, right of individuals or groups to petition the appropriate Convention body to review the implementation progress of a country.[3] In addition to the core human rights treaties including the CRPD, consultation, collaboration and engagement with the National Human Rights Institutes (NHRI's), likeminded CSOs and the government on implementation of the following international instruments can strengthen the role of disability rights advocates within the monitoring mechanism. This will also prevent the poor domestication of ratified international and regional treaties:[4]

- General Recommendations
- General Comments
- Concluding Observations
- UN General Assembly Resolutions
- International documents, particularly the UN Special Rapporteur on violence against women[5]
- UN Special Rapporteur on the rights of persons with disabilities[6]

For as long as women and girls with disabilities are left behind and remain marginalised, this region will be far from reaching the goal of achieving gender equality and empowerment of women in line with the international human rights standards and the 2030 Agenda on Sustainable Development Goals. It will also render the domestication of international norms and standards around disability rights ineffective in its purpose of upholding the rights of women and girls with disabilities, including their sexual and reproductive health and rights and the freedom to be free from all forms of violence, abuse, discrimination and exploitation.

CORE HUMAN RIGHTS TREATIES	KEY GENERAL RECOMMENDATIONS
CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)	> **General Comment No.1** Equal recognition before the law > **General Comment No.3** Women and girls with disabilities. > **General Comment No.6** Equality and non-discrimination. > **General Comment No.7** Participation of persons with disabilities, including children with disabilities, through their representative organisations, in the implementation and monitoring of the Convention.
CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)	> **General Recommendation No.19** Violence against women, gender-based violence (GBV) recognised as a violation of human rights, definition of GBV now encompasses SRHR. > **General Recommendation No.24** Access to health care, including reproductive health. > **General Recommendation No.33** Women's access to justice. > **General Recommendation No.35** Gender-based violence against women, updating general recommendation No. 19.
INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (ICESCR)	> **General Comment No.5 (1994)** Persons with disabilities. > **General Comment No.19** The right to social security (Article 9).
INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR)	> **General Comment No.19** On the right to protection of the Family, the Right to Marriage and Equality of the Spouses (Article 23).
CONVENTION ON THE RIGHTS OF THE CHILD (CRC)	> **General Comment No.9 (2006)** On the rights of children with disabilities. > **General Comment No.13 (2011)** On the right of the child to freedom from all forms of violence. > **General Comment No.15 (2013)** On the right of the child to the enjoyment of the highest attainable standard of health. > **Joint General Comment No.18** Of the Committee on the Rights of the Child. > **Joint General Recommendation No.31** Of the Committee on the Elimination of Discrimination against Women on harmful practices.

UN RESOLUTIONS	KEY PROVISIONS
GENERAL ASSEMBLY RESOLUTION 63/150	> States to pay special attention to the gender specific needs of persons with disabilities, including by taking measures to ensure their full and effective enjoyment of all human rights and fundamental freedoms (operative paragraph 8).
GENERAL ASSEMBLY RESOLUTION A/77/166	> Inclusive development for and with persons with disabilities, including in the context of the ongoing efforts by the international community to advance disability inclusion in the recovery from the COVID-19 pandemic.

INTERNATIONAL DOCUMENTS	THE LINKAGE TO HUMAN RIGHTS TREATIES
ICPD POA[7]	> The ICPD Programme of Action has helped shape the development and application of binding international human rights standards including those enshrined within CEDAW, ICCPR, ICESCR, CRC and CRPD and established the "inherent link between sustainable development, the eradication of poverty, and gender equality, and committed to address these issues in tandem. Furthermore, states agreed that coercive laws, policies, and practices that do not respect individuals' autonomy and decision making must be eliminated. In adopting the ICPD Programme of Action, states committed to take legal, policy, budgetary, and other measures to effectuate the principles and rights enshrined in the document.[8]
BEIJING PfoA	> The Beijing Platform for Action entrusted the CEDAW Committee with monitoring its implementation by explicitly calling upon all States to report to it.[9] The review of the Platform for Action allows for monitoring of the extent to which States have fulfilled their commitment to ensuring the full implementation of the human rights of all women, and to work towards the ratification and implementation of international and regional human rights treaties to promote and protect women's human rights.[10]

For as long as women and girls with disabilities **are left behind and remain marginalised, this region will be far from reaching the goal of achieving gender equality and empowerment of women** *in line with the international human rights standards and the 2030 Agenda on Sustainable Development Goals.*

Domestic Level Protection of Rights of Women and Girls With Disabilities. Several countries in the region, being a follower of the dualist[11] system, have now incorporated international norms and standards around disability rights and recognised the universality of a human rights perspective in domestic laws. According to the UN Treaty Collection[12] database the following countries in the Asia-Pacific have now ratified the International Convention on the Rights of Persons with Disabilities (CRPD):

ASIA PACIFIC COUNTRY	DATE OF CONFIRMATION, ACCESSION (A), RATIFICATION[13]
AFGHANISTAN	18 September 2012 (A)
AUSTRALIA	17 July 2008
BANGLADESH	30 November 2007
BHUTAN	21 September 2010 (Signatory)
BURMA	—
BRUNEI	11 April 2016
CAMBODIA	20 December 2012
CHINA (including special administrative regions of Hong Kong and Macau)	1 August 2008
COOK ISLANDS	8 May 2009 (A)
FEDERATED STATES OF MICRONESIA	7 December 2016
FIJI	7 June 2017
INDIA	1 October 2007
INDONESIA	30 November 2011
JAPAN	20 January 2014
KIRIBATI	27 September 2013 (A)
LAO PEOPLE'S DEMOCRATIC REPUBLIC	25 September 2009
MALAYSIA	19 July 2010
MALDIVES	5 April 2010
MARSHALL ISLANDS	17 March 2015 (A)
MONGOLIA	13 May 2009 (A)
NEPAL	7 May 2010
NEW CALEDONIA	—
NEW ZEALAND	25 September 2008
NIUE	—
NORTH KOREA	—
PAKISTAN	5 July 2011
PALAU	11 June 2013
PAPUA NEW GUINEA	26 September 2013
PHILIPPINES	15 April 2008
SINGAPORE	18 July 2013
SOLOMON ISLANDS	23 September 2008 (Signatory)
SOUTH KOREA	11 December 2008
SRI LANKA	8 February 2016
TAIWAN	—
THAILAND	29 July 2008
TIMOR-LESTE	—
TONGA	15 November 2007 (Signatory)
TUVALU	18 December 2013 (A)
VANUATU	23 October 2008
VIETNAM	5 February 2015

Most of these countries are yet to adopt policies and laws that fully reflect the provisions of the International Convention on the Rights of Persons with Disabilities (CRPD). The table below shows the number of countries in Asia where this has been done through the adoption of pro-disability legislations. However, domestication or localisation of international human rights standards are not enough to protect the rights of women and girls with disabilities as implementation of these domestic laws remains weak, failing to protect the rights of persons with disabilities and prevent their marginalisation in society. In practice, what is more ubiquitous is the neglect, discrimination and stigmatisation, prejudices, myths and misconceptions arising from the lack of understanding regarding the lives of persons with disabilities that is deeply entrenched within societal attitudes towards persons with disabilities at large.

The prevailing scenario particularly affects women and girls with disabilities who face the double discrimination due to their disability and gender. Global research, data analysis and statistics[14] indicate that women and girls with disabilities are twice as vulnerable as victims of abuse, violence and discrimination as other women, putting them at a heightened risk of sexual and gender-based violence. Negative attitudes about the sexual and reproductive health and rights of women and girls with disabilities affect the quality of their life from childhood into adulthood. Sexism, ableism, neglect, discrimination and maltreatment towards women and girls with disabilities and their needs prevent them from roles related to participation, decision-making and leadership which infringes upon their empowerment and diminishes their rights in the private and public sphere of life.[15]

A Global Indicator's Brief of the World Bank Group revealed that out of 190 economies studied worldwide, only 86 had a gender equality and disability rights law and out of those, a mere 30 economies mention 'women and girls with disabilities' in their gender equality law and disability rights law.[16] The brief goes on to highlight the gaps in these national laws where the varied experiences of women and girls with disabilities and the multifaceted discrimination faced by them is not accounted for. In other words, the national laws in this circumstance fail to adequately provide the legal support and protection of the law that women and girls with disabilities are entitled to. It is therefore important that national laws are robust where legal remedies/relief are available to women and girls with disabilities facing intersectional and multi-layered forms of discrimination.[17]

FIGURE 1: WHILE THE NUMBER OF ECONOMIES WITH DISABILITY LAWS HAS NEARLY TRIPLED FROM 1990 – 2022, ONLY ABOUT ONE-THIRD OF THEM SPECIFICALLY ADDRESS WOMEN.[18]

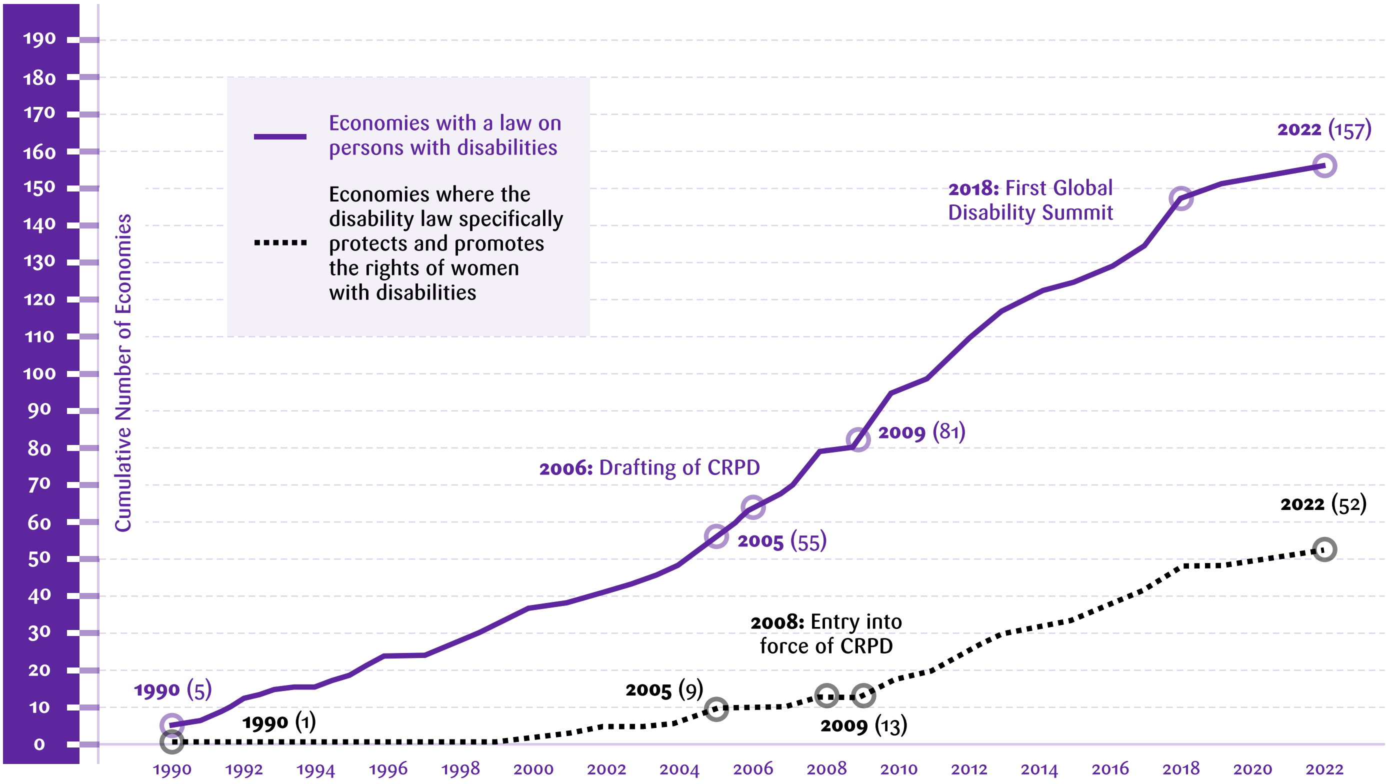

TABLE 3: LAWS FOR PERSONS WITH DISABILITIES BY COUNTRY (ASIA)[19]

COUNTRY	DOMESTIC LAWS/ACTS ON DISABILITY RIGHTS	YEAR OF ENACTMENT
BANGLADESH	> Rights and Protection of Persons with Disabilities Act 2013.	2013
CAMBODIA	> Law on the Protection and the Promotion of the Rights of Persons with Disabilities	2009
CHINA	> The Law of the Peoples Republic of China on the Protection of Disabled Persons (2008)	2008
INDIA	> Persons with Disabilities Act 2016	2016
INDONESIA	> Law No. 8/2016 on persons with disabilities	2016
LAO PEOPLE'S DEMOCRATIC REPUBLIC	> Decree on the Rights of Persons with Disabilities	2014
MALAYSIA	> Persons with Disabilities Act (Act 685)	2008
MALDIVES	> Protection of the Rights of Persons with Disabilities and Provision of Financial Assistance (Law no.8)	2010
MONGOLIA	> Law on the Human Rights of Persons with Disabilities 2016	2016
MYANMAR	> Pyidaungsu Hluttaw Law No. 30/2015 Law on the Rights of Persons with Disabilities	2015
NEPAL	> Act No. 2039 of 1982 on the Protection and Welfare of the Disabled Persons	1982
PAKISTAN	> The ICT Rights of Persons with Disability Act	2020
PHILIPPINES	> Republic Act No. 7277 Magna Carta for Persons with Disabilities	1992
SINGAPORE	> There is no law on disability rights yet.	—
SRI LANKA	> Protection of the Rights of Persons with Disabilities Act No. 28	1996
THAILAND	> The Persons with Disabilities Empowerment Act B.E. 2550	2007
TIMOR-LESTE	> There is no law on disability rights yet.	—
VIETNAM	> Law on Persons with Disabilities (No. 51/2010/QH12) Decree 28/2012/ND-CP dated April 10th 2012 of the Government guiding the implementation of some articles of the Law on Persons with Disabilities	

A Global Indicator's Brief of the World Bank Group revealed that out of 190 economies studied worldwide, **only 86 had a gender equality and disability rights law** *and out of those,* **a mere 30 economies mention 'women and girls with disabilities'** *in their gender equality law and disability rights law.*

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5 The mandate of the UN Special Rapporteur on violence against women, its causes and consequences (SRVAW) in 1994, as the first expert mechanism at the UN level to specifically recommend measures on the elimination of violence against women, its causes and consequences. See reports at https://www.ohchr.org/en/special-procedures/sr-violence-against-women/annual-thematic-reports

6 The Special Rapporteur on the rights of persons with disabilities is one of the thematic special procedures overseen by the United Nations Human Rights Council. Relying on the 2006 Convention on the Rights of Persons with Disabilities, the Special Rapporteur promotes the rights of persons with disabilities by engaging in dialogue with States and other stakeholders, consulting with persons with disabilities and their representatives, supporting national efforts to realize the rights of persons with disabilities.

7 https://www.unfpa.org/icpd

8 https://www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf

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11 A dualist system treats the international and domestic systems of law as separate and independent. For more information see: https://www.oxfordbibliographies.com/view/document/obo-9780199796953/obo-9780199796953-0168.xml

12 https://treaties.un.org/pages/ViewDetails.aspx?chapter=4&clang=_en&mtdsg_no=IV-15&src=IND

13 The instruments of "acceptance" or "approval" of a treaty have the same legal effect as ratification and consequently express the consent of a state to be bound by a treaty. In the practice of certain states acceptance and approval have been used instead of ratification; n when, at a national level, constitutional law does not require the treaty to be ratified by the head of state. [Arts.2 (1) (b) and 14 (2), Vienna Convention on the Law of Treaties 1969]; "Accession" is the act whereby a state accepts the offer or the opportunity to become a party to a treaty already negotiated and signed by other states. It has the same legal effect as ratification. Accession usually occurs after the treaty has entered into force. The Secretary-General of the United Nations, in his function as depositary, has also accepted accessions to some conventions before their entry into force. The conditions under which accession may occur and the procedure involved depend on the provisions of the treaty. A treaty might provide for the accession of all other states or for a limited and defined number of states. In the absence of such a provision, accession can only occur where the negotiating states were agreed or subsequently agree on it in the case of the state in question. [Arts.2 (1) (b) and 15, Vienna Convention on the Law of Treaties 1969]; "Act of formal confirmation" is used as an equivalent for the term "ratification" when an international organization expresses its consent to be bound to a treaty. [Arts.2 (1) (b bis) and 14, Vienna Convention on the Law of Treaties between States and International Organizations or between International Organizations 1986]. Available at the glossary of terms: https://treaties.un.org/pages/Overview.aspx?path=overview/glossary/page1_en.xml [Accessed 22 October 2022]

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